



**The 'Can Do' Initiative:
Managing Mental Health and Substance Use in General Practice**

***'Can Do' for Young People, Families and Carers
Facilitator's guide***

***Presentations and facilitator's notes,
case studies and facilitator's trigger questions***

**Unit one: Young people, mental health and
substance use – *where do we start?***

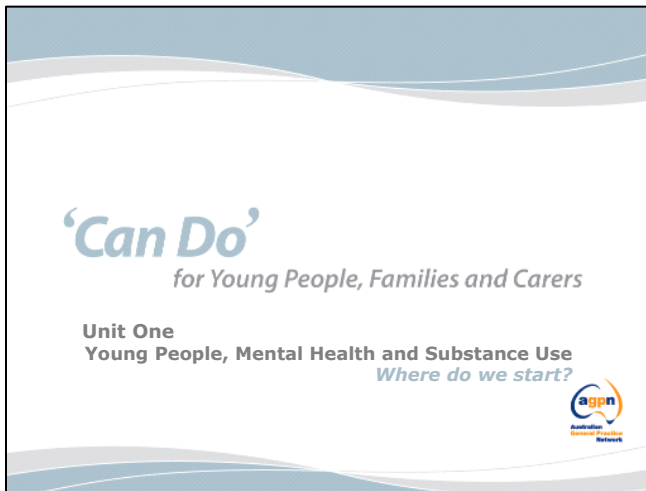
Joint learning module for general practitioners, allied health practitioners and other service providers involved in the provision of care for young people at risk of or experiencing mental health and substance use issues.

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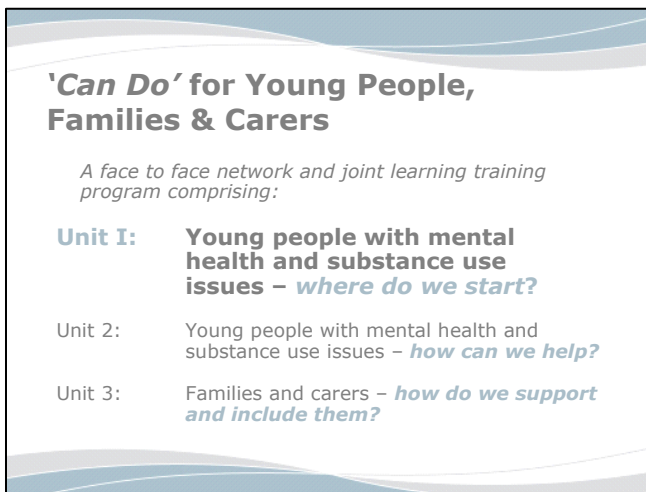
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Slide 1: Title page



This is the title slide for the session. It is a good idea to have this slide up as participants are entering and during welcome.

Slide 2: About the training module



This slide describes the whole training module

Key points

- Emphasise to participants that this is a series of three units.
 - This is the first of the three.
 - Participants are encouraged to attend all three sessions
-

Slide 3: Learning objectives

Learning objectives

Participants will :

- Share information with other service providers
- Map local services
- Identify local networks
- Explore ways to work together
- Identify appropriate referral pathways for young people
- Understand the role and needs of families and carers

'Can Do' is about working together for better health and social outcomes

The overall educational goal of this accredited training program is to provide general practitioners, allied health professionals and other service providers with specific knowledge and skills to work with young people and their families and carers to improve mental and drug health.

Key points

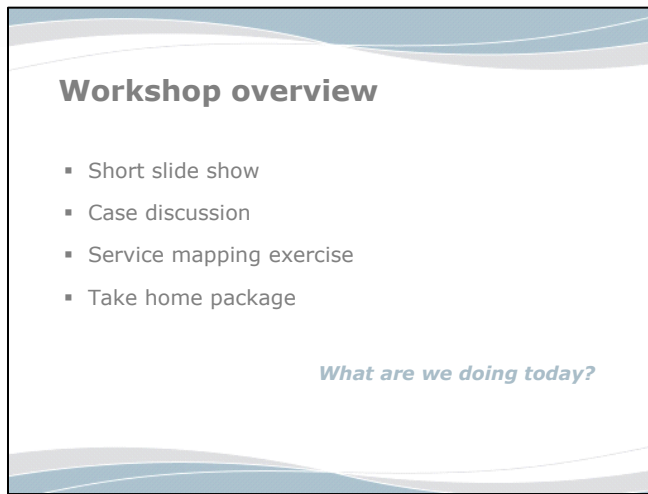
On completion of this course participants will be able to:

- demonstrate an increase in confidence, capacity and understanding of general practitioners, allied health professionals and other service providers when working with young people with mental health and substance use issues
- demonstrate an increase in awareness of the risks and protective factors associated with common mental health problems and substance use in young people
- demonstrate increase understanding of the role of families and carers in treatment of young people with mental health and substance use issues
- demonstrate increased confidence in providing support and understanding required by families and carers of young people with mental health and substance use issues
- identify health and community services at the local level, particularly those that engage with young people, their families and carers
- demonstrate an increase in ability and confidence in developing appropriate pathways of referral and care for young people with mental health and substance use issues and their families and carers.

The following are the desired key outcomes of 'Can Do' for Young People, Families and Carers:

- local partnerships and interagency collaboration is fostered
 - professional networking is enhanced
 - young people's needs are understood
 - families and carers are included
 - shared care arrangements are understood and strengthened
 - knowledge about local services is improved
 - referral protocols and processes are identified
 - care plans are streamlined
 - stigma about working with young people with mental health and substance use comorbidity is reduced.
-

Slide 4: Workshop overview



This slide provides an overview of the 'Can Do' for Young People, Families and Carers workshop format

Key points

- Provide an outline of the workshop
 - Note that coexisting mental health and substance use in young people is an extensive and complex subject
 - Key issues and ideas will be highlighted in the slide show
 - Discussion of youth stories will provide an opportunity to share knowledge, skills and practical advice on working with young people, their families and carers
 - Service providers will be given an opportunity to introduce their service in the service mapping exercise
 - Additional material and references are in the take home package provided
-

Slide 5: Young people



Young people

- Youth is a time of change, growth and experimentation
- Issues vary depending on age and developmental stage
- The needs and responses of young people (aged 12 - 25) differ from those of the adult population
- Exposure and vulnerability to risk and availability of protective factors influences health outcomes
- Detecting issues early may prevent significant mental health disorders developing and reduce associated risks.

Each young person is unique – one size will NOT fit all!

The 'Can Do' for Young People, Families and Carers initiative defines 'young people' as those aged 12–25 years. There are a number of individual, family, community and environmental factors leading to an increased risk of substance use and mental health issues, including economic hardship, housing inadequacy, poor social support networks, and poor family functioning. Detecting these issues early and identifying protective factors that can counter or reduce risk may prevent significant mental health disorders developing or minimise the associated risks that accompany such conditions, such as the development of substance dependence. Risk and protective factors and underpinning determinants are addressed in slides 9-13.

Key points

- Young people (12-24 years) represent around 18% of the Australian population (AIHW, 2007).
- Mental disorders (e.g. anxiety and depression; schizophrenia) are a major cause of illness in young Australians, together with injury (e.g. road traffic accidents) and poisoning.
- Income, motivation, parental role, awareness and other factors affecting coping ability (including mental health) all influence the ability of the individual to maintain optimum physical health.

Developmental stages of young people can generally be clustered as:

- 12 – 15 y/o: usually involves school attendance; increased exposure to alcohol, tobacco and illicit substances; increasing autonomy or desire for autonomy; increasing awareness of sexuality; profound hormonal changes occurring; still legally considered a child.
- 16 – 19 y/o: involves the assumption of formal adult status; begin to be treated as adults under the law; permitted to drive motor vehicles; may be completing school and attempting university entry or may have left school and be working, training or unemployed. May be living at home or have left home. Experimental substance use and sexual activities are common for this age group.
- 20 – 25 y/o: increasing assumption of adult responsibilities and freedoms. Likely to be regarded culturally and socially as adults.

Additional information

General health

General health amongst young people is not at an optimum, despite generally positive reporting and outlooks by the group itself. Overall, 25% of young people in 2004–05 were overweight or obese. Coinciding with this, less than half of young people (46% of males and 30% of females) were meeting recommended physical activity guidelines in 2004–05 (AIHW, 2007).

Income, motivation, parental role, awareness and other factors affecting coping ability (including mental health) all influence the ability of the individual to maintain optimum physical health. In remote areas, the level of availability of fresh foods generally is also an important factor.

Age and developmental stage:

Issues for young people vary depending on developmental stages. Whilst difficult to generalise, stages may be clustered as;

12 – 15 y/o usually involves school attendance; increased exposure to alcohol, tobacco and illicit substances; increasing autonomy or desire for autonomy; increasing awareness of sexuality; profound hormonal changes occurring; still legally considered a child.

16 – 19 y/o involves the assumption of formal adult status; begin to be treated as adults under the law; permitted to drive motor vehicles; may be completing school and attempting university entry or may have left school and be working, training or unemployed. May be living at home or have left home. Experimental substance use and sexual activities are common for this age group.

20 – 25 y/o increasing assumption of adult responsibilities and freedoms. Likely to be regarded culturally and socially as adults.

Local, socio-economic and cultural factors can profoundly influence the experience of developmental stages. Mental health problems and substance use are both outcomes and causes of difficulties experienced during these stages.

References:

- AIHW (2003) analysis of the ABS 2003 Survey of Disability, Ageing and Carer's confidentialised unit record file
AIHW: Al-Yaman, F., Bryant, M. & Sargeant, H. (2002). Australia's children: their health and wellbeing 2002. Cat. no. PHE 36. Canberra:
AIHW (2007) Australian Institute of Health and Welfare 2007. Young Australians: their health and wellbeing 2007. Cat. no. PHE 87. Canberra: AIHW.
Nicholson, J., Carroll, J.A., Brodie, A., Waters, E., & Vimpani, G. (2004) Child and youth health inequalities in Australia. The status of Australian research 2003. Paper prepared for the Health Inequalities Research Collaboration: Children, Youth and Families Network, October 2004.
NNDSS (National Notifiable Diseases Surveillance System) 2007. National Notifiable Diseases Surveillance System. Canberra: DoHA. Viewed 1 March 2007, <<http://www9.health.gov.au/cda/source/CDA-index.cfm>>.
Yung, A. & Cosgrave, E (2006) Cigarettes and Alcohol and Youth at Risk *Australian Doctor*, March 2006 pp27

Slide 6: Burden of disease

Rank	Males	%	Females	%
1	Anxiety and depression	17.4	Anxiety and depression	31.8
2	Road traffic accidents	10.1	Asthma	7.1
3	Schizophrenia	9.6	Migraine	6.6
4	Suicide and self-inflicted injuries	7.1	Other genitourinary diseases	6.0
5	Heroin or polydrug dependence and harmful use	5.5	Schizophrenia	4.0
6	Alcohol dependence and harmful use	4.7	Road traffic accidents	3.8
7	Migraine	3.5	Personality disorders	2.8
8	Cannabis dependence and harmful use	3.4	Bulimia nervosa	2.7
9	Personality disorders	3.1	Bipolar disorder	2.6
10	Bipolar disorder	2.6	Anorexia nervosa	2.2

Source: Begg et al. 2007. The burden of disease and injury in Australia, 2003. Canberra: AIHW.

This table demonstrates that the leading causes of death, illness and injury burden amongst young people are strongly associated with issues of mental health and substance use. Gender is an important factor that must be taken into account when assessing the issues affecting young people. Issues faced by males and females can be divergent, or they can be similar issues but have markedly different expression as a result of gender pressures.

Key points

- Patterns of disease and injury burden among young Australians differ from those in other age groups.
- Mental disorders, injury and poisoning are the leading causes of disease and injury among young people aged 12–24. (AIHW 2007)
- Anxiety and depression rank highly among both male and female young people.
- Death rates increase substantially with remoteness: very remote areas have death rates almost five times greater than those of major cities. Young Aboriginal and Torres Strait Islander people account for over 50% of all young people in Australia living in very remote areas.
- The death rate among young Aboriginal and Torres Strait Islander Australians is over four times that of young non-Aboriginal and Torres Strait Islander Australians.

Additional information

Patterns of disease and injury burden among young Australians are distinct from other age groups. For example, the leading causes of burden of disease and injury for the 'all ages' category is dominated by circulatory diseases (specifically ischaemic heart disease and stroke) and cancers (for example, lung and breast cancer), while for young people aged 12–24 years, mental disorders (for example, anxiety and depression; schizophrenia; bipolar disorder; eating disorders), injury (dominated by road traffic accidents) and poisoning are the leading causes. An important exception to this is anxiety and depression, which ranks highly among young people and people of all ages as a cause of disease and burden of injury (AIHW, 2007).

In 2004, there were 1,470 deaths among young Australians aged 12–24 years with males accounting for 69% of these (AIHW, 2007). A greater proportion of deaths amongst young people occur in early adulthood (18–24 years) than in the younger 12–17 age group (AIHW, 2007).

Of the approximately 3.7 million young people (1.9 million males and 1.8 million females) in Australia, the majority do not express concern about the current state of their health. In 2004-2005, 70% of people in the 15-24 age bracket rated their health as excellent or very good, with a further 23% rating health as good. A minority of 7% reported health that was fair or poor (AIHW, 2007). This statistic is a positive indicator of outlooks on health; however, it may also indicate that areas of morbidity affecting this age group are not always perceived as issues of health (and therefore as subject to positive interventions).

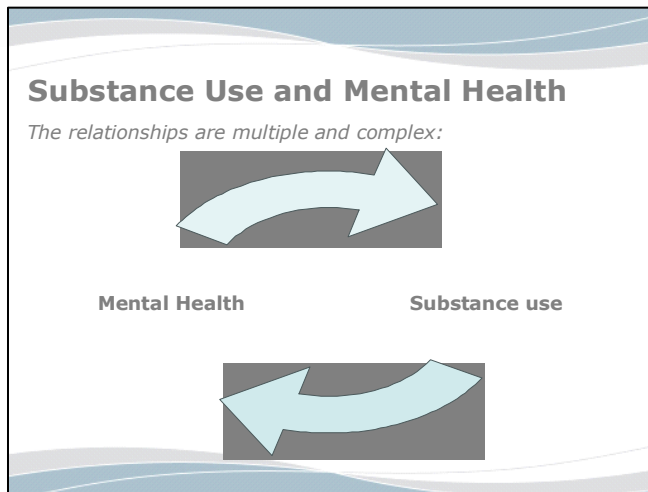
References:

AIHW (2007) *Young Australians Their health and wellbeing 2007 Selected highlights* Australian Institute of Health and Welfare Canberra AIHW cat. no PHE 88

Australian Institute of Health and Welfare 2007. *Young Australians: their health and wellbeing 2007*. Cat. no. PHE 87. Canberra: AIHW.

TABLE Source: Begg et al. (2007). *The burden of disease and injury in Australia, 2003*. Canberra: AIHW.

Slide 7: Substance use and mental health



The relationships between mental health and substance use are multiple and complex and change over time. Young people who use substances may not relate this to their mental health and many would not recognise their mental health is in any way a problem or likely to be. In reverse they may be worried about their mental health (e.g. depression) but not associate this with their substance use, nor may they consider their substance use as problematic.

Key points

- Onset of depression, anxiety and substance use disorders typically occurs during adolescence and early adulthood.
- Depression, coupled with substance use, increases vulnerability to adverse life experiences and antisocial and suicidal behaviour in young people (Andrews et al. 1999).
- Those with mental illness are more vulnerable to the harmful effects of psychoactive substances. The impact of substance use is greatest in those who suffer from chronic schizophrenia or major mood disturbance.
- Those with severe mental illness have higher rates of substance use than the general population.
- The challenge with treatment is to get the young person and their families and/or carers to acknowledge the relationship between substance use and the symptoms of mental illness. This may assist engagement and compliance with efforts aimed towards reducing use and optimising treatment for the underlying condition.

Additional information

Definition

The terms dual diagnosis and comorbidity refer to the co existence of two disorders within an individual at a particular time. Since the use of substances and the occurrence of mental illness are both common in our society, it is not surprising that the two often co exist within the same individual.

The terms are imprecise, as they are used to describe individuals whose mental illnesses vary widely in severity and pathology and whose substance use also varies widely – from use to abuse or harmful use to dependence. The terms are also unfortunate misnomers since there are many other dual diagnosis/ co morbid groups within psychiatry and general medicine (for example, those with co morbid learning disability). Most of those with co morbid substance use disorders also avail

themselves of numerous other diagnostic categories (such as personality disorder or a host of other health conditions).

Prevalence of dual diagnosis/comorbid substance use and mental health in young Australians

Onset of depression, anxiety and substance use disorders typically occurs during adolescence and early adulthood, accounting for 75% of the burden generated by all mental disorders (Andrews & Wilkinson, 2002). A high proportion of young people who experience a major depressive disorder also have another mental disorder—commonly an anxiety disorder, substance use disorder, or behavioural disorder (Bhatia & Bhatia, 2007).

For young males, the leading cause of hospital separation due to mental and behavioural disorders was psychoactive substance use (24%), followed by schizophrenia (20%) and depression (13%) in 2004–05. For young females, the leading causes were depression (19%); eating disorders (14%) and psychoactive substance use (12%). Approximately half of all hospital separations for psychoactive substance use among young males and females were due to use of alcohol (AIHW, 2007).

Mental health and substance use in young Aboriginal and Torres Strait Islander people

Schizophrenia was the main mental and behavioural disorder associated with hospitalisation among young Aboriginal and Torres Strait Islander males in 2004–05 (35%). This was followed by mental and behavioural/ disorders due to psychoactive substance use (32%) (13% due to alcohol use alone) and reaction to severe stress and adjustment disorder (9%) (AIHW, 2007).

Among young Aboriginal and Torres Strait Islander females, the main reasons for mental and behavioural disorder hospital separations were psychoactive substance use (25%) (9% due to alcohol use alone), reaction to severe stress and adjustment disorder (16%) and schizophrenia (15%). Use of alcohol was responsible for 42% and 35% of hospital separations for psychoactive substance use among young Aboriginal and Torres Strait Islander males and females respectively (AIHW, 2007).

Common explanations of the coexistence of substance use and mental health:

Non-dependent substance use as well as dependency can be a cause of significant mortality and morbidity in those with mental illness. This is perhaps the major reason for health professionals becoming familiar with the range of effects of substances on individuals with mental illness. This need is supported by international prevalence studies, which indicate that those with severe mental illness have higher rates of substance use than the general population. For example, in Australia, Fowler et al (1998) found higher rates of alcohol, amphetamine and cannabis use among patients with schizophrenia than the general population.

The medical models suggest four possibilities for the co occurrence of mental illness and substance use disorders:

Mental illness leads to drug use and development of substance use disorders. Psychiatric illness may lead to use of psychoactive substances in an attempt to relieve the distress of the illness and its consequences (e.g. a mental sluggishness, a sense of hopelessness and a reduced range of coping mechanisms).

Substance use leads to mental illness either as a direct result of toxicity or indirectly as a consequence of the psychosocial consequences of drug use (Meyer, 1986). Substance use may precipitate mental illness in a vulnerable individual, for example cannabis use triggering schizophrenia in an individual with a genetic predisposition.

Shared aetiological factors (genetic and environmental) for the development of both substance use disorders and mental illness. These include socio-economic disadvantage, emotional deprivation, social disorganisation, childhood abuse, genetic loading and adult trauma.

Berkson's paradox - the high rates of co morbidity found in research studies are an artefact of the population being investigated; that is, there is an over representation of people with comorbid mental health and substance use problems within hospital and treatment service settings.

Why traditional substance use treatments may not work for those with a mental illness

It is often a source of frustration and confusion for mental health and alcohol and other drug (AOD) health professionals alike when attempts to address substance use related problems among people with a mental illness fail to be effective. There have been many explanations put forward:

- Polarisation of specialities – 'he's not mad, it's the drugs'
- Confrontational and abstinence-based models– these may lead to worsening of some symptoms
- Unrealistic goals and failure to assess the capacity of the young person to achieve goals set by clinicians
- 'Revolving door' syndrome among people with mental illness
- Therapeutic nihilism (in other words, a sense of hopelessness) among both health professionals and young people

Concentration on severe mental health disorders and AOD dependence despite the high prevalence of problematic non-dependent drug use with anxiety and depression. These disorders are not the focus of drug treatment or mental health services.

References:

- AIHW (2007) Australian Institute of Health and Welfare (2007) Young Australians: their health and wellbeing 2007. Cat. no. PHE 87. Canberra: AIHW.
- Andrews G, Hall W, Teesson M, Henderson S. (1999) The mental health of Australians. Canberra: Mental Health Branch, Australian Department of Health and Aged Care
- Andrews, G. & Wilkinson, D. (2002) The prevention of mental disorders in young people. *Medical Journal of Australia* 177(7 Suppl):S97-S100.
- Bhatia SK & Bhatia SC (2007). Childhood and adolescent depression. *American Family Physician* 75(1):73-80.
- DHAC (Department of Health and Aged Care) 2000. Promotion, prevention and early intervention for mental health: a monograph. Canberra: DHAC.
- Fowler I. Carr V. Carter N (1998) Patterns of current and lifetime substance use in schizophrenia. *In Science Bulletin* 24:443-455
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- Meyer RE. (1986) How to understand the relationship between psychopathology and addictive disorders: Another example of the chicken and the egg. In: Meyer, RE, ed. *Psychopathology and Addictive Disorders*. New York. Guildford. pp. 3-16
- Winstock, A. (2006) The 'Can Do' Initiative: Managing Mental Health and Substance Use in General Practice Clinical Education Module for Training General Practitioners and Allied Health Professionals Australian General Practice Network. Canberra

Slide 8: What to look out for

What to look out for

- Physical health
- Mental health
- Substance use
- Sexual health
- Disability

Don't forget the importance of:

- Social connectedness
- Life events and situations
- Environmental and cultural issues

Take a holistic approach to care and support

This slide emphasises the need for consideration of an holistic approach to health and wellbeing. Whether you are a health professional or a community service provider it is vital to consider the whole person, the support they have around them and the context in which they lead their lives and are included in community

Key points

- Individual physical health is an important factor in present and future coping ability. For example, 25% of young people were overweight or obese in 2004-2005. Obesity can affect self esteem and impact on mental health and substance use behaviours.
 - Onset of depression, anxiety and substance use disorders typically occurs during adolescence and early adulthood. The interrelationships between mental health and substance use have been covered in slide 7.
 - Sexual health is an important issue for young people. Sexual risk taking under the influence of alcohol and other drugs is common for both male and female adolescents and can include having multiple sexual partners, inconsistent condom or other contraceptive use and being intoxicated during intercourse (Yung and Cosgrave, 2006).
 - Sexual risk taking under the influence of alcohol and other drugs can lead to a range of adverse health consequences including unwanted pregnancy, exposure to unwanted sexual activity (including forced intercourse) and sexually transmitted diseases such as gonorrhoea, Chlamydia, syphilis and HIV/AIDS (Yung and Cosgrave, 2006).
 - In 2003, approximately 249,300 young people aged 15-24 years had a disability.
-

Slide 9: Risk and protective factors and their influence on mental health and substance use

Risk and protective factors and their influence on mental health and substance use

- Risk and protective factors may be found in individual, peer, family, school and community contexts
- Each individual brings a set of characteristics to daily interactions colouring the nature and tone in a positive or negative way
- Protective factors balance and buffer risk factors (Hawkins 1992)
- The more risks that can be reduced and the better the balance between risk and protective factors, the less vulnerable the young person is to developing health and social problems (Hawkins, Catalano & Miller 1992)

Prevention is the best cure!

Issues for young people vary depending upon developmental stages. The assumption of adult freedoms and responsibilities increases through adolescence and into early adulthood. Prevention and early detection of mental health and substance use in young people is better understood in the context of issues for the individual and their broader family, social, community and cultural setting. This necessitates the need for engagement of a broad range of service providers involved in the provision of care for young people at risk of or experiencing mental health and substance use issues.

Key points

- Exposure and vulnerability to risk factors is an important consideration in health outcomes for the individual. Alcohol, illicit drugs, intimate partner violence, child sexual abuse and occupational exposures were the risk factors contributing the most to the burden of illness in young people (AIHW, 2003).
- Protective factors may be biological, social or environmental. The following are all well documented protective factors for positive health and social outcomes:
 - Personal resilience and problem solving skills,
 - good physical and mental health,
 - belonging in a family or having a caring consistent adult mentor and role model,
 - inclusion in school or community activities
- Risk and protective factors from individual contexts to societal include:
 - **individual:** biological and psychological dispositions, attitudes, values, skills, knowledge, problem behaviours
 - **peers:** norms and activities
 - **family:** function, management, bonding and communication
 - **school:** bonding, climate, policy, performance, interaction
 - **community/society:** bonding, norms, resources, awareness/mobilisation, policy/sanctions

Additional information

Risk factors that increase the likelihood that mental health problems will develop include:

- individual factors (such as prenatal brain damage, genetic factors)

- family or social factors (such as marital discord between parents and social isolation)
- school context (such as bullying, failure to achieve academically)
- life events and situations (such as physical, sexual and emotional abuse and neglect)
- community and cultural factors (such as socioeconomic disadvantage)

Protective factors reduce the likelihood of mental health problems and mitigate the potentially negative effects of risk factors. Protective factors include:

- individual factors (such as adequate nutrition, problem-solving skills)
- family or social factors (such as family harmony, social support)
- school context (such as a positive school environment)
- life events and situations (such as economic security, good physical health)
- and community and cultural factors (such as social networks, involvement in community groups)

References:

AIHW (2007) Australian Institute of Health and Welfare 2007. Young Australians: their health and wellbeing 2007. Cat. no. PHE 87. Canberra: AIHW.
DHAC (2004) Responding to the mental health needs of young people in Australia. Discussion paper: principles and strategies, February 2004. Canberra: DHAC
Hawkins J, Catalano R, (1992) Communities that care: Action for Drug Abuse prevention. Jossey-Bass Publishers. San Francisco
Marmot M, Wilkinson R. (2000) Social Determinants of Health. Oxford University Press. London.

Slide 10: Think about social connectedness

Think about social connectedness

- Families, friends and other carers can give important support
- Peer groups can encourage or discourage risky behaviour
- Social participation and support protects against mental illness
- Young people with mental illness but strong social connections experience better health than those socially isolated
- Access to transport significantly affects social connectedness as well as attendance at health services

Put yourself in their shoes

This slide highlights the importance of families and social connections (including access to transport) for young people at risk of mental health and substance use. Young people have better outcomes if they have at least one significant adult who consistently 'looks out' for them and where they are actively part of their community (e.g. have a consistent place to live, attend school, have a job, meet up regularly with friends for recreational purposes) rather than being isolated from it.

Key points

- Families and communities make an important contribution to young people's health (AIHW, 2007).
- Family functioning is an important predictor of academic and behavioural outcomes (Sawyer et al. 2000; Zubrick et al. 1995). Increased risks of disruptive behaviour and depressive illness occur with coercive parenting styles, poorer family cohesion and family conflict.
- Families may be regarded as at risk, as well as individuals. Young people living in low-income families or with parents who have a disability or mental illness can experience poor family functioning (Wise, 2003).
- Throughout the 12-24 age groups, peer groups are of increasing importance. Social influence may play a part in young people's decisions including: not to use drugs; to experiment with smoking, alcohol and other drugs; to escalate use; as well as decisions regarding sexual activities.
- Social isolation is identified as a major risk factor that increases the likelihood that mental health problems will develop (DHAC, 2004).
- The internet and 'virtual communities', networked computer games and community portals such as MySpace are becoming increasingly important to young people's self expression and connection with their peers. Unfortunately access to computers, the internet and high speed broadband diminishes in rural areas where there is the greatest need to invest in social infrastructure for young people.

Additional information

Family, housing & accommodation:

Family issues and circumstances for young people can be disparate. At the 2001 Census, approximately 30% of young people aged 15-25 years did not live with their parents. Of these,

34% were married or in a de facto relationship, 5% were in lone-parent families, 27% lived in group households, 15% lived with related individuals (other than their parents), 8% were living with an unrelated family and 11% lived alone (ABS, 2004a). At the younger end of the age group, young people are required to be under the care of a guardian. The proportion of young people on care and protection orders and in out-of-home care is increasing. Over 9,000 12–17 year olds were on a care and protection order in 2006 (AIHW, 2007).

Young people in extreme family circumstances are at high risk of homelessness. 34% of clients of agencies funded through the Supported Accommodation and Assistance Program (SAAP) (agencies providing assistance to homeless people) were aged 12–24 years in 2004–05. For males, accommodation problems were the main reason for seeking assistance, and interpersonal relationships was the main reason for females (AIHW, 2007).

Examples of living situations:

- living at home;
 - +/- siblings and co-resident children
 - both parents
 - single parent
 - between parents (+/- step parents)
 - guardian or extended family
 - foster parents
 - living with or cared for by grandparents
- young people as parents
- own home, mortgagee
- living with extended family members
- children of alcohol/drug-using parents
- children of parents with mental health issues
- boarding school
- away from home (renting, share accommodation etc)
- supported accommodation
- transient
- homeless

Social participation

Social participation and support is a major protective factor against mental illness in young people. People with an existing mental illness but strong social connections generally experience better health outcomes than people in isolated circumstances. Sources of social connection include:

- friends and peers
- sporting activities
- educational activities (school, TAFE, university etc)
- employment and paid work
- music and recreational activities
- community centres
- volunteering and community participation
- opportunities for occupational participation and achievement
- church and religious activities

The internet and 'virtual communities', networked computer games and community portals such as *MySpace* are becoming increasingly important to young people's self expression and connection with their peers. Where 'community' was traditionally used to describe a geographic or demographic demarcation, it may now be applied more generally to describe the people or portals accessed 'online'. Unfortunately access to computers, the internet and high speed broadband

diminishes in rural areas where there is the greatest need to invest in social infrastructure for young people.

Websites, established by credible organisations (such as Kids Help Line, *beyondblue* and *headspace*) are able to provide information to young people concerned about their mental or drug health and provide opportunities for information sharing and problem solving through interactive media such as discussion forums and chat rooms.

Transport issues for young people

Young people may experience a range of important issues related to their access to and autonomy in transport:

- *No transport or limited transport*: contributor to social isolation; occupational limitations; affects ability to access services and keep appointments.
- *Reliant on another*: can entail vulnerability to risky behaviours in others; limited autonomy and potential conflict.
- *Public transport*: financial considerations; experience likely to vary according to infrastructure; disruptive behaviour (due to mental health or substance use) is likely to attract police attention.
- *Driver's license with own car or access to private car*: issues of responsibility; finance and risky or thrill seeking behaviour.
- *Community transport service*: issues of availability and dependence; limited freedom of movement.
- *Disability transport service*: issues of availability and dependence; limited freedom of movement and planning is required (usually dependent on a carer).

References:

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Slide 11: Consider the influence of life events and situations

Consider the influence of life events and situations

Additional risk factors for mental health & substance use include:

- Childhood abuse
- Bullying at school and failure to achieve
- Unemployment, financial hardship and debt
- Encounters with the law
- Violence and injury
- Being male
- Being Aboriginal and Torres Strait Islander and young
- Sexuality (especially homosexuality)

In practice, identifying events and circumstances that place young people at risk may help to prevent the onset of mental health and substance use issues. The needs of young people should be considered in the context of their educational, employment, financial and legal circumstances.

Key points

- Young people in Australia face a highly competitive education system at senior levels, with the ramifications of stress, anxiety, depression and loss of motivation leaving young people vulnerable to substance use.
- Unemployment, financial hardship and debt are associated with poor health outcomes including stress and distress, problems accessing health and other services, and social isolation (Nicholson et al., 2004).
- Young people represent 38% of the unemployed population. Mental health and substance use issues pose a significant challenge for young people acquiring and maintaining secure employment.
- The adverse effects of debt are affecting younger populations (AIHW, 2007). Financial and telecommunication companies' strategy of '*buy now, pay later*' coupled with young people's lack of financial management experience is leading to an alarming rate of debt.
- Young people who come into contact with the criminal justice system represent a particularly disadvantaged population characterised by high levels of socioeconomic stress, physical abuse, sexual abuse and childhood neglect (AIHW, 2007). Further issues may arise from periods of incarceration and exposure to other disadvantaged groups.
- Aboriginal and Torres Strait Islander young Australians are heavily over-represented in the child protection and juvenile justice systems. Among young people aged 18–24 years, the Aboriginal and Torres Strait Islander imprisonment rate was 14 times the non-Aboriginal and Torres Strait Islander rate in 2006 (AIHW, 2007).
- Gender also affects the risk of serious legal problems, with young males far more likely to be imprisoned than young females. In 2006 males represented 94% of imprisoned young persons.

Additional information

Education:

The majority of young people (85% of those aged 15–19 years and 76% of those aged 20–24 years) were participating full time in education and/or work in 2006 (AIHW, 2007). Examples of types of formal educational experience are:

- attending school
 - local high school
 - boarding school
 - distance education
- TAFE or technical college
- university
- college
- apprenticeship
- not participating in education or training.

Finance and employment

Employment and financial status are important factors affecting all aspects of health. Financial and employment status for young people may include one or a combination of the following:

- working fulltime/part time/casual (e.g. student)
- apprenticeship
- welfare (e.g. disability pension, sole parent pension, family assistance, education-linked payments, unemployment benefit)
- no income
- informal income (e.g. family support)
- debt (mobile phone bills, car repayments/ expenses, credit card debt, debts to friends, gambling and personal bank loans are the most common forms of debt (dangar research, 2003))
- bankruptcy.

A majority of young people have some income from work or from welfare support. In 2006, the average weekly income of employed 15–19 year olds was \$234 and the average weekly income of 20–24 year olds was \$570 (the difference reflects both part-time versus full-time employment patterns and relative rates of pay). Males in both age groups earned more money than their female counterparts (AIHW, 2007).

Approximately 20% of 15–24 year olds received some form of income support in 2006. The main type of income support received by young people was Youth Allowance (AIHW, 2007).

Decisions around the disposal of income have important associations with wellbeing. In 2001, 32% of young people aged 15–19 years and 6% of those aged 20–24 years did not have any formal income (AIHW, 2007), though a proportion would receive some income from informal sources - for example, family.

Unemployed young persons mostly have access to some income support, but are 'low-income' for at least the duration of the unemployment. Long-term unemployment is likely to affect the next generation: living in a jobless family may have long-term effects on young people's development, their educational progress and their own employment prospects (AIHW, 2007). Mental health issues and substance use are important factors affecting, and affected by, occupational functioning and motivation. Opportunities exist for positive interventions and support in the clinical environment and in the community.

Legal issues and encounters with the law

Encounters of young people with the law occur across a spectrum. Young people may have encounters with the police whether they have engaged in criminal activity or not (e.g. as a result of behaviour or appearance that is perceived to be suspicious).

Young people with serious mental illness are likely to have experience with the police in their role as guardians, prior to admission at a mental health facility.

Where an offence has been committed, the type of further involvement in the criminal justice system depends upon the age of the young person, the seriousness of the offence and, in some cases, the prior history of offence. Outcomes include:

- caution/warning
- diversion programs/treatment orders
- community service
- detention/probation
- juvenile justice
- incarceration.

Young people who come into contact with the criminal justice system represent a particularly disadvantaged population, characterised by high levels of socioeconomic stress, physical abuse, sexual abuse and childhood neglect (AIHW, 2007). Childhood neglect is considered to be one of the strongest predictors of later youth offending. There are a number of family and community factors leading to neglect, including economic hardship, housing inadequacy, poor social support networks, and poor family functioning (AIHW, 2007).

Young adults (those aged 18–24 years) accounted for 20% of the total prison population in 2006, and there were over 9,000 12–17 year olds under juvenile justice supervision in 2003–04 (AIHW, 2007). Young offenders often have significant physical and mental health needs, and many have engaged in risky health behaviours from an early age (Allerton & Champion, 2003; Bickel & Campbell, 2002).

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Slide 12: Don't forget environmental and cultural influences

Don't forget environmental and cultural influences

- Aboriginal and Torres Strait Islander status
- Ethnicity
- Language
- Refugee status
- Geographical location
- Religion
- Spirituality

Where they come from

Where young people live, the communities they grow up in and the cultural groups they belong to strongly influence their knowledge of and access to services. The perception of mental health and substance use, appropriate treatment and expected role of the clinician may also be different depending on culture, religion and traditional beliefs and values.

Key points

- Young Aboriginal and Torres Strait Islander people have significantly higher rates of death, injury and chronic disease compared with other young people in Australia. This is particularly evident in remote areas (AIHW 2007).
- Culture and language may be a barrier to community and school inclusion and to accessing services.
- Refugee status and language barriers may affect a young person's knowledge of and access to services.
- Availability and access to services for young people may be limited in rural and remote areas. The stigma of accessing services in small rural towns increases.

Additional information

Young Aboriginal and Torres Strait Islander people

In 2001, there were 116,698 young Aboriginal and Torres Strait Islander (ATSI) people aged 12–24 years, making up 3.4% of all young people in Australia and less than 1% of all people in Australia. Young people represent a higher proportion of ATSI populations: they were 26% of the total ATSI population in 2001, whilst this age group represented only 18% of the total population (AIHW, 2007).

In 2001, 31% of young ATSI people aged 15–24 years lived in major cities, 42% in inner regional and outer regional areas and 27% in remote or very remote areas.

Young ATSI people have higher rates of death, injury and some chronic diseases compared with other young Australians (AIHW, 2007). During 2002–2004, the death rate for young ATSI people was almost 4 times the rate for other young Australians, and the injury burden rate was almost 5 times that of other young people.

Young ATSI people are heavily over-represented in the child protection system (AIHW, 2007). Causes of this over-representation may include the intergenerational effects of the 'stolen generation' such as separation from family and culture, the poor socioeconomic status of many

ATSI families, family violence and cultural differences in child rearing practices (AIFS, 2005; AIHW: Al-Yaman et al., 2006; Cunneen & Libesman, 2000; Memmott et al., 2001).

The AIHW (2007) analysis of prison populations in 2006 indicates that ATSI people are over-represented in Australian prisons. In 2006, Indigenous people made up 24% of the prison population, and 1.8% of the total adult population (ABS 2006). Young ATSI people experienced similar patterns. The rate of Indigenous 12–17 year olds in juvenile justice supervision was 13 times the non-indigenous rate for both sexes. Among young people aged 18–24 years, the ATSI imprisonment rate was 14 times the non-Indigenous rate. Young ATSI people were almost one-third of the prison population aged 18–24 years, despite making up an estimated 3.3% of this age group in the Australian population (AIHW, 2007).

Young people who are culturally and linguistically diverse

Young people aged 15–24 years born overseas represented 16% of young people in Australia in this age group (2.2% of the total population) in 2006 (AIHW, 2007). This figure does not include young people born to overseas-born parents, but does include, for example, young people who are overseas students and long-term residents of Australia. Around two-thirds of overseas-born young people were from mainly non-English speaking countries. The most common countries of birth were China, Philippines, India, Vietnam, Hong Kong, Malaysia and Indonesia. Of those born in English-speaking countries, more than three-quarters came from New Zealand or the United Kingdom (ABS, 2007).

Training health professionals to act with cultural sensitivity may be useful to bridge communication issues for young people with mental health and substance use issues from culturally and linguistically diverse backgrounds.

Geographical location

Those living in remote and very remote areas account for just over 2% of all young people. These young people have substantially higher rates of death and hospital separation for specific health conditions and are more likely to engage in certain risky health behaviours than young people in major cities (AIHW 2007).

Young Aboriginal and Torres Strait Islander people account for over 50% of all young people in Australia living in very remote areas. Young Aboriginal and Torres Strait Islander people have significantly higher rates of death, injury and some chronic diseases compared with other young people in Australia.

Vast geographic distances coupled with young people's risk taking behaviour results in most alcohol-attributable deaths in young people occurring when they are drivers or passengers in a vehicle. In 2004, transport accidents accounted for 45% of all injury deaths in young people aged 12 – 24 years. The risk of death is significantly higher in teenage males and the risk of injury is higher in those that live in rural and remote areas despite these areas having a very small percentage (only 2%) of the young population (AIHW, 2007).

Cultural and linguistic diversity

Young people in Australia are culturally and linguistically diverse. In 2006, 16% of young Australians aged 15 – 24 were born overseas (2.2% of the total population). These young people may be exposed to additional stressors including racism, language and learning difficulties and confusion about their cultural identity.

Refugee status

Refugee status and language barriers may affect a young person's knowledge of and access to services. With the arrival of young refugees from war torn countries, there is a likeliness of exposure to violence, torture and trauma, deprivation and poverty resulting in post traumatic stress disorder and other mental health presentations.

Religious and spiritual beliefs and customs may affect young people and family perceptions of mental health and substance use and their willingness to access mainstream services.

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Slide 13: Mental health conditions in young people

Mental health conditions in young people

Mental health conditions found in young people include:

- dyslexia or autism
- attention deficit disorder/ hyperactivity
- conduct disorders
- anxiety and depression
- schizophrenia

Early detection and treatment of anxiety, depression and behavioural disorders can greatly improve adult health outcomes

Early detection of mental health conditions can greatly improve adult health outcomes. If not treated early, anxiety, depression and behavioural disorders such as ADHD and conduct disorder can have profound implications for adult health outcomes such as poorer quality of life, physical health problems, lowered academic and vocational attainment, substance use, suicidal behaviour, and family discord (Raphael 2000).

Key points

- Experiencing a mental disorder is associated with lower educational attainment, joblessness and poorer physical health. Mental disorders accounted for almost 50% of the total disease burden among young people in 2003.
- Suicide is the second most common cause of death in 12-24 y/o in Australia, with young males 3 times more likely to die from suicide than young females.
- The number of young people who commit suicide is relatively low compared with the number who self-harm. Self harm involves behaviours such as cutting and poisoning (typically overdosing on medication), self-battery and hanging. In 2004-05, 71% of hospital admissions for self harm were females aged 12- 24 y/o. This was 2.5 times higher than the rate for young males (AIHW, 2007).
- Young people should be asked about self harming behaviour and suicidal thoughts, and a suicide risk assessment conducted if needed (for more information see 'Can Do' for Young People, Families and Carers unit two: *how can we help?*).

Additional information

Common mental disorders found in children and young people include developmental disorders such as dyslexia or autism; behavioural disorders such as attention deficit/hyperactivity disorders (ADHD) and conduct disorders; anxiety disorders; depression; and schizophrenia (U.S. Department of Health and Human Services 1999).

Young people may not attend services seeking help for their mental health. Stress, anxiety and depression may present in practice as headaches and migraines, sleep disorders and general gastrointestinal complaints such as nausea and cramping. Repeated requests for 'sick notes' permitting time off work or school, or treatment for headaches and insomnia may alert a clinician to make further investigations and conduct a mental health and drug use assessment.

Definition of mental illness

A mental illness has been defined by the World Health Organization (WHO) as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised medically diagnosable illness or disorder. Those illnesses defined include alcohol use disorders and drug use disorders, as well as the high prevalence mental health disorders such as anxiety and depression. Experiencing a mental disorder is associated with lower educational attainment, joblessness and poorer physical health (DHAC, 2004).

Prevalence

Mental disorders were the leading contributor to the burden of disease and injury (49%) among young Australians aged 15–24 years in 2003, with anxiety and depression being the leading specific cause for both males and females (AIHW, 2007).

Young people are becoming increasingly more stressed (AIHW, 2007). In 2004–05, the proportions of young males and females aged 18–24 years reporting high or very high levels of distress were 12% and 19% respectively, a significant increase from 1997 when the corresponding proportions were 7% and 13% respectively. Young females (51%) were more likely than young males (40%) to report moderate to very high levels of psychological distress (AIHW, 2007). This is reflected in the higher rates of eating disorders, self harming behaviour and migraines identified as the leading cause of injury burden for young women.

Behavioural disorders such as ADHD and conduct disorder are typically diagnosed during childhood, but may persist into adulthood. If not treated early, these disorders can have profound implications for adult health outcomes such as poorer quality of life, physical health problems, lowered academic and vocational attainment, substance use, suicidal behaviour, and family discord (Raphael 2000).

Other mental health considerations include:

- Anti social behaviour
- Poor impulse control
- Thrill seeking behaviour
- Anxiety & depression
- Eating disorders
- ADHD
- Post Traumatic Stress Disorder (from issues such as childhood sexual abuse)
- Gambling
- Obsessive Compulsive Disorder
- Phobias
- Schizophrenia
- Self harm and suicide

References:

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Slide 14: Drug use in young people

Drug use in young people

- There is a wide range of legal and illicit drugs
- Legal substances and prescription medications may be used illicitly
- Drugs are pharmacologically diverse and affect people differently
- Poly drug use is common



tobacco



cannabis



Over the counter



Prescription drugs



Alcohol




Heroin



Cocaine



Meth/
amphetamines



GHB



LSD



ecstasy



Inhalants

Young people frequently use a combination of alcohol and other drugs and the pattern of drug use changes depending on cost, availability and peer group trends. Alcohol is the largest contributor to substance related injury and high risk taking behaviour. Alcohol, tobacco and cannabis are often used experimentally by this age group. A change in drug using patterns (including drug type and route of administration) or an escalation in frequency and dose to achieve the desired effect can alert a clinician to the development of tolerance and potential substance dependence.

Key points

- There are a wide range of legal and illicit drugs available in Australia. These drugs exist on a spectrum and are pharmacologically diverse. They have different psychotropic and physiological effects, likeability, abuse liability and dependence potential. That is, they vary in the relative probability that they will become a social, psychological, or physical problem for an individual or for society (WHO, 2005).
- In 2004, almost one-third (31%) of young people drank alcohol in amounts that put them at risk or high risk of alcohol-related harm in the short term, and 11% at risk of long-term harm.
- Around 17% of young people were cigarette smokers in 2004 (AIHW, 2007).

For additional information, see handout 1.1

References:

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Slide 15: Why do young people use drugs?

Why do young people use drugs?

- To experiment
- To have fun - increase confidence and reduce inhibitions
- To relieve boredom, stress or negative feelings
- Influenced by peers

Young people's values and perceptions about drugs may differ from your own – check it out!

Issues for young people vary widely, as do their reasons for using drugs. Finding out what is their drug of choice and its desired effect may help you determine an appropriate treatment. Information you provide about drugs and their associated risks needs to be targeted appropriately. Failure to secure the interest and confidence of the young person at the initial appointment makes subsequent contact less likely.

Key points

- To encourage changes in behaviour: allow a young person to gain insights into their drinking or drug use by helping them identify the perceived benefits (such as increasing confidence and having fun with friends).
- Follow this by identifying the negative consequences (such as inability to concentrate at school, financial troubles or disputes with friends or family) as well as other consequences they may be at risk to (motor vehicle accidents, sexual assault). This allows a young person to develop a greater awareness of their drug use; the impact on their mental health and social/academic functioning; and the consequences and risks of bingeing and longer-term use.

Additional information

Slide 16 details the likeliness of those with mental health issues to initiate drug use at an early age and the coexistence of both mental health and substance use disorders in young people.

Risks associated with drug use

Young people in Australia are becoming increasingly more stressed (AIHW, 2007) and the corresponding increase in alcohol and substance use suggests these are being used to cope with these occupational and emotional strains. Young people have a tendency of impulsive behaviour characterised by bingeing and difficulty setting limits, placing many at risk of harm associated with acute intoxication.

Risks associated with drug use can be specific to drug class:

- psychotic symptoms and hyperthermia with amphetamines,
- respiratory depression and overdose with opioids and benzodiazepines.

Risks may be related to the direct trauma of the route of administration:

- local abscesses with injection

- risk may also be *related to pathogens* introduced through injecting such as HIV and hepatitis C
- septal perforation with snorting.

The greatest risks for young people are the **high risk behaviours** that are related to drug use either through **intoxication**:

- aggressive behaviour - fights, violence, assault
- injury - falls, trauma and self harm
- risk taking - driving under the influence of alcohol, speeding
- risky sexual practices and sexual assault
- self harm and suicide attempt

or **procurement**:

- 'doctor shopping'
- drug dealing
- crime
- sex work.

All of these behaviours are exacerbated by severe acute intoxication and compounded when mental health issues are present.

Assessment

When initiating assessment of drug use and the associated risks use a normalising approach to lessen the impact of sensitive questions. For example 'Some people your age are starting to experiment with smoking cigarettes, drinking alcohol or taking other drugs. Have you ever tried these?' or 'Sometimes when people feel very sad they think about hurting themselves. Have you ever had thoughts like this during the periods of sadness you are describing?'

Alcohol, substance use and the risk of self-harm and suicide

There is a close link between alcohol consumption, drug use and suicide. According to Yung & Cosgrave (2006) the way in which alcohol interacts with suicidal ideation/ intent is not entirely clear but may act by:

- increasing psychological distress (including depressed mood or feelings of hopelessness)
- facilitating aggressive behaviour (including self harm)
- precipitating acting on suicidal ideation
- inhibiting effective coping strategies.

In young people, suicide attempts are common and more likely to occur in those who drink alcohol heavily or frequently (Chikritzhs et al., 2004).

References:

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Slide 16: Mental health and substance use

Mental health and substance use

For those experiencing mental health issues, drugs are perceived to:

- relieve feelings of distress and hopelessness
- provide a predictable mental state
- be less stigmatised than mental health conditions

Those with mental illness are more vulnerable to:

- adverse effects of drugs
- difficulties with access to appropriate health care
- higher rates of suicide
- violence
- encounters with police

I just want to feel normal

Young people with mental health issues use drugs to feel better and gain pleasurable effect – even if feeling good only lasts a short time. As the effects are wearing off, the same mental health problems are likely to return, and may be even more severe. The young person may incorrectly think that the symptoms they have during withdrawal from the substance are an indication of the true severity of other problems (insomnia, pain, anxiety or depression). They may then take the substance again. As tolerance for the drug effects occur and withdrawal becomes more severe, they may become caught in a cycle of increasing frequency and amount of drug use.

Key points

It is essential to engage with young people by building rapport. Hearing what they have to say about their reasons for using substances can help determine an appropriate management plan.

Examples include:

- Alcohol use by a young person with social anxiety. Intoxication may provide a period of increased confidence and reduced self monitoring.
- Amphetamine use by those with depression. Amphetamines may give a depressed young person a brief period of feeling better about themselves and allow them socialise with peers etc (although amphetamine use will exacerbate their depression).
- Young women with eating disorders may smoke cigarettes or use amphetamines as appetite suppressants.
- The misuse of Ritalin or dexamphetamine. Teenagers and University students may use unprescribed medication to stay awake while studying or in the believe they increase attention/effectiveness.
- Substance use to reduce the adverse effects of prescribed psychiatric medication. For example nicotine may offset the hypotensive effects of some antipsychotics, amphetamines may offset weight gain, fatigue and mental sluggishness that can be associated with other antipsychotic medications.

Additional information

Young people with mental health and substance use comorbidity are usually in treatment for a single disorder, and the services are not enabled to tackle comorbidity. Although less disabling alone, substance use disorders seem to exacerbate and prolong symptoms of comorbid psychiatric disorders. They also impede and complicate treatment for comorbid disorders. Mental illness

combined with harmful drug use, previous suicide attempts or intentional self-harm are also linked to suicide (Beautrais 2000; Goldney 1998).

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Slide 17: Engaging with young people



Engaging with young people

- Build rapport
- Explain consultation processes and reasons for assessment
- Ask open-ended questions
- Clarify if unsure of terminology
- Offer a menu of treatment options
- Develop care plan with client participation
- Discuss merits and limitations of different interventions
- Provide fliers/ information handouts
- Arrange follow up

Share some of your own stories - ask for theirs

Securing the interest and confidence of the young person at the initial appointment or interaction makes subsequent contact more likely. Young people may not directly raise questions about things they are concerned about and therefore it is important that you use the contact you have opportunistically by exploring other issues such as drug use, mental and sexual health.

Key points

- Ask the young person to explain any terms they use (such as street names for drugs, amounts use and route of administration).
- Feedback to the young person what you have identified and provide a menu of options for them to consider. Pamphlets and 'take-home' information may be useful.
- Develop a care plan with the young person making sure you clearly describe the relative merits and limitations of the suggested interventions.
- Base your care planning on what the young person wants and what is realistically achievable. Ensure there are follow appointments for ongoing assessment and review.

Additional information

Engaging young people

A consultation should be a process of information exchange. Risk identification and the provision of immediate safer partying information should be considered a priority, as is an assessment of how drug use has impacted on their overall wellbeing including their mental health.

Ask the young person to explain any terms they use so that there is no ambiguity over what is being referred to. Such clarification empowers the young person who is able to act as 'educator to the professional' and is then a source of very useful information to the clinician.

Although it may not be possible at the end of an initial assessment to determine a complete care plan, there should be some attempt at feeding back to the young person what you have identified and provide a range of potential interventions for them to consider. Make sure you clearly describe the relative merits and limitations of the suggested interventions.

Young people may have difficulty with transport, housing, debt, communication, relationships and physical health issues necessitating the need for flexible services and appointment times. Requests that may seem simple to comply with to the practitioner may be well outside the scope or understanding of the young person. Base your planning on what the young person wants. Be realistic and expect small steps forward at a time.

Slide 18: Story gathering for health professionals

Story gathering for health professionals

- Stories bring surprises. Go with the flow.
- Start with simple, undemanding questions. Tell a story of your own to get things started.
- Use conversational language
- Show you're interested in the whole story not just bits you think are relevant.
- Help prompt memories:
 - 'Tell me about the time you...'
 - 'What happened the first time you...?'

Story can be very useful for strengths based approaches. Young people will often tell a story much more happily than they'll answer a direct question. Stories provide revealing details and surprising insights. Recounting experiences helps the young person reflect on details and make connections. It can take them back to a time when their lives were very different. It also creates a more natural and secure environment.

Key points

- Stories help the listener as well! An anecdote or memory can create a context that's familiar to us and can take us back to experiences in our own lives, when we were younger and vulnerable.
- Stories break down generational differences help us remember our similarities as humans. This creates possibilities for greater understanding.
- Often a young person doesn't know what information to offer a service provider and can be uncomfortable about giving too much or too little. Asking them to tell their story (or experience/memory is less confronting than a straight interview and can get a young person talking and elicit meaningful small details. Good story technique will also prompt memories and help the storyteller put the stages of their story together.
- Start with simple, undemanding questions. Reveal a story of your own to kick things off if necessary. Try not to tell a story with a lesson in it. The young person will sniff it out straight away!
- Use language that is natural to you but as conversational as possible. Generally...When? and Where ? questions will lead to story answers. How? and Why? questions will lead to judgements and opinions.
- The young person needs to feel that you really care about the conversation and that it is a conversation, not an interview. Sit back in a listening mode. Try not to have a preconceived agenda about what information is important.
- Avoid distractions. Keep note taking to a minimum. And follow your normal conversational instincts by asking one question at a time, allowing silences.
- Phrases like 'Think about how you felt when...', 'Do you remember a time when...', 'Tell me about the first time you...' will prompt memories and help the young person imagine themselves out of your office and in their own lives.
- Reflect back to keep the story alive and moving: 'So it sounds like you really had a difficult time...?'

- Indirect questions show your empathy and can lead to deeper reflection and detail. Instead of 'Were you frightened?', try 'It sounds like that might have been really frightening for you.'
 - Don't interrupt to check facts or express surprise. This can send a story off in a new direction.
-

Reference:

ONLY HUMAN COMMUNICATIONS 2007. Website: www.onlyhuman.com.au

Slide 19: Tips for working with young people

Tips for working with young people

- Accept and engage
- Friendly staff
- Respect confidentiality & privacy
- Accessible
- Freely available information
- Permit appropriate requests
- Free or flexible payment options

Train ALL your staff in youth friendly work practice and crisis management (including practice managers, receptionists, practice nurses, other frontline staff)

The key to effective consultation with young people is the establishment of a supportive and trusting relationship. Young people often feel self-conscious, mistrustful, and anxious about seeing a GP. A sensitive approach and the effective use of communication skills can help to overcome these barriers (Kang & Chown, 2004).

Key points

- The needs of young people are different to the adult population.
- It is essential to engage young people by building rapport and inviting open discussion.
- Confidentiality & privacy are important to young people. Let them know that unless there is a safety issue their parents or carers do not need to be informed.
- Frequently young people can be deterred by not being able to access a service promptly and many don't return. Explaining how the service works (waiting times etc) may help alleviate frustrations.
- Having information available in waiting rooms (such as posters or pamphlets) is a good way of 'passively' providing information to young people.
- Try to be flexible about methods of payment and explain payment options.

Additional information

What is youth friendly? Tips for working with young people

- **Acceptance and engagement** is important for young people. They need to be acknowledged and feel welcomed.
- **Staff attitude and communication:** Friendly reception staff with a positive attitude to working with young people.
- **Confidentiality & privacy** is vital, let them know that unless there is a safety issue their parents or carers do not need to be informed (slide 20 covers confidentiality in more detail).
- **Accessibility/availability:** Ideally, appointment times are available to fit in with school, employment and transport needs. Frequently young people can be deterred by not being able to access a service promptly and therefore don't return.
- **Explanation of waiting times:** Long waiting times are often a reality but an explanation can help understanding.

- **Freely available information (posters, fliers or handout):** Some young people may not ask specific questions however information provided discreetly (such as pocket size cards and brochures) may be useful. Posters and fliers freely available in waiting areas or bathrooms may also be useful. Giving young people information to take home may also be beneficial to ensure they are clear about the information you have provided and treatment options.
- **Attitude:** Often young people present for one issue, but they have other things they're concerned about. They are more likely to discuss their concerns if you are non-judgmental and interested in their situation.
- **Ask open questions** where possible. Use scenarios to make the discussion less threatening and invite storytelling. Regularly use positive feedback. Help them define the problem and options.
- **Appropriate requests permitted** where possible, appropriate requests (e.g. contraception) are not denied.
- **Billing:** Try to be flexible about methods of payment and explain payment options. Bulk bill young people where possible and explain how bulk billing works. If your practice does not bulk bill, display consult prices and explain the young people of their entitlement to apply for their own Medicare card from the age of 15.
- **Medicare cards** (see slide 23 for more information). Some young people may present for an appointment without their Medicare card. If a patient does not have their card, you can call Medicare Australia Health Insurance Commission (HIC) anywhere in Australia on **132 150** to obtain their number.

References:

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GP Guide, Services for Young People (2006) Eastern Sydney Division of General Practice NSW Australia
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Medicare Australia website (sourced June 2007) www.medicareaustralia.gov.au

Slide 20: The three Cs for working with young people

The three 'Cs' for engaging young people

- Confidentiality
- Consent
- Communication

Some exceptions where a service provider is required to report information are if a young person:

1. is threatening to harm themselves
2. is threatening to harm someone else
3. indicates someone is threatening to harm them
4. is the subject of abuse
5. has a notifiable disease
6. has blood alcohol reading taken after a car accident

Young people often have a broad range of health concerns, but may be reluctant to seek health care from service providers. They may be concerned about confidentiality breaches, lack of trust in the service provider and embarrassment in discussing personal issues. Ensuring confidentiality (at the beginning of the consultation) and engaging young people helps to establish trust and build rapport, allowing young people to discuss sensitive issues. When adolescents understand a service is confidential, they are more willing to disclose information about behaviours that entail a health risk, to seek health care and to return for follow-up.

Key points

Confidentiality

- Sensitive issues are more likely to be disclosed when confidentiality is assured at the beginning of the consultation.
- A young person's perception of whether a health service respects their confidentiality can influence whether they attend the service.
- It is important to explain the situations when confidentiality must be broken and that you will always discuss this with the young person beforehand.
- Let the young person know that information they reveal about substance use does not need to be reported. They may then be more likely to reveal if they are using any substances and feel more comfortable to ask you about any concerns they have about their using.

Consent

- A young person from 16 years of age would be able to consent according to the 'mature minor' or *informed consent* principle however capacity to consent does not depend on age alone but on the patient's developmental and intellectual capacity to understand treatments, side effects, benefits and alternatives if they refuse treatment

Communication

- A young person is more likely to return to see the same GP if they feel they gained a trust and rapport with the GP in the initial consultation.

Additional information

Confidentiality

Young people can interpret normal history taking as intrusive to their privacy. It is therefore important to reassure them that it is part of a routine consultation and let them know (at the

beginning of the consultation) that what is said in the consultation room will not be repeated to anyone. This will prevent the young person from holding back vital information in fear it will be repeated to their parents or others.

Some exceptions where the GP is required to report information are:

1. If the young person is threatening to harm themselves
2. If the young person is threatening to harm someone else
3. If the young person indicates that someone is threatening to harm them
4. If the young person has been the subject of abuse
5. if the young person has a notifiable disease
6. blood alcohol reading after a car accident

It is also important to outline these exceptions to the young person, and reassure them that confidentially will only be breached in the examples above, and that it would only be to keep them or others safe. Also add that in situations where other people do need to be contacted, that you will speak to them first and together you will decide who to contact.

Reporting requirements differ across jurisdictions- please check your state or territory requirements.

Confidentiality breaches can be accidental such as a pap smear reminder, pathology account or Medicare forms sent to the young person's parents to be signed. These issues should be discussed with the receptionist and young person so alternative arrangements can be made.

An example of how to raise the issue of confidentiality with a young person:

"I know you've only come in for a sore throat but as I haven't met you before I'd like to explain what confidentiality means in my clinic. I see many young people and I realise they get concerned about this, so for your future reference I'd like to check that you understand that a consultation between doctor and patient is kept confidential. I'm not going to run off and tell your parents or teachers what you tell me without your permission. There are exceptions where I may need to tell other people to keep you safe. These are, if you told me you were going to seriously harm/kill yourself, that you were contemplating injuring/killing someone else or if someone were physically or sexually abusing you. But in these situations, I would talk to you about it first and we could contact the people who could help you together. Is that OK?"

Points to consider when respecting confidentiality:

- On the telephone, do you repeat patient's first and last names? Are you at the front counter, or close to the waiting room whilst doing this? You could be breaching confidentiality.
- Social occasions. People are naturally curious! We all are! People may not intentionally want you to breach confidentiality, but even giving sketchy details can give the person away.
- Working in the same organisation doesn't mean that patient information can be shared freely between staff. Patient information should only be accessed or discussed on a need-to-know basis as part of our work or profession, e.g. when working directly with the young person, and with their permission.
- Patient notes, letters, faxes etc should be put facedown on desks, put away when not used, and disposed of sensibly. Patient lists should be kept out of public view.
- Chatting with patients. It should be assumed that any information shared with you by a patient while they are accessing a service (e.g. visiting the clinic) is confidential. Even the fact that they are accessing the service is privileged information.

Consent

A young person from 16 years of age would be able to consent according to the 'mature minor' or informed consent principle. However capacity to consent does not depend on age alone but on the patient's developmental and intellectual capacity to understand treatments, side effects, benefits and alternatives if they refuse treatment. Young people under 14 years of age are not assumed to be able to make a sound reasoned decision. The GP should therefore assess the 14 year old's level of maturity and obtain a second medical opinion in the instance where the young person refuses to inform, or have the GP inform, their parents or legal guardian. If the 14 year old agrees, their parent or legal guardian should consent to procedures.

Communication

The young person will be more likely to return to see the same GP for a second appointment if they feel they gained a trust and rapport with the GP in the first appointment. If you feel there are underlying problems the young person is facing such as stress, depression or substance use, it is always helpful to walk to the reception desk with them after the first consultation to ensure a time is booked for a follow up appointment. A loose arrangement such as "if things don't settle down come back and see me" may send a signal to the young person that you are not taking their problems seriously; you are too busy for them; or not interested in their situation.

It is also important to try and make an appointment to a referral service with the young person if you feel this is needed. Just giving the young person a card/ pamphlet is not enough in ensuring they will seek out the service. It is advisable to have a list of local youth friendly referral services at your finger tips so the young person can choose which service they may prefer or find more convenient to travel to.

When communicating with a young person in consultation, try to:

- use open ended questions that elicit a response beyond just 'yes and no'
- avoid open ended *why* questions. Asking 'what? where? When? And how? Helps them to describe events and feelings
- use a normalising approach to lessen the impact of sensitive questions. For example "Sometimes when people feel very sad they think about hurting themselves. Have you ever had thoughts like this during the periods of sadness you are describing?" or "Some people your age are starting to experiment with smoking cigarettes, drinking alcohol or taking other drugs. Have you ever tried these?"
- Young people may not have the language to articulate their feelings therefore offering an explanation and inviting them to agree or disagree can help them communicate how they feel. For example "Someone in your situation might have felt a bit [sad, angry, confused, jealous or guilty...] Can you remember how you felt?"

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Slide 21: About the GP's role

About the GP's role

- Often the first point of contact with health care system
- Experienced in working with people with complex needs
- Able to provide a range of services:
 - Support and information
 - Early detection/ assessment
 - Brief interventions
 - Treatment
 - Referral to specialist services
- Able to access a range of complementary initiatives
 - National Better Access to Mental Health Care initiative
 - National Medicare Allied Health and Dental Care initiative
- Linked to other agencies and services

GPs are often the first point of contact with the health system for young people experiencing problems with substance use or mental health. Many young people believe GPs have a role in managing lifestyle related illnesses and are a credible source of information by providing information, treatment and referral to specialist services. This slide is intended to generate discussion about current initiatives aimed at improving primary mental health care, such as the Better Access to Mental Health Initiative.

Key points

- GPs are often the first point of contact with the health care system for a young person, their families or carers. GPs are able to offer a unique service, managing the young person's mental health and substance use in a confidential and easily accessible environment. They are able to provide referrals to a variety of services and case manage the young person's treatment ensuring they receive continuity of care.
- Other roles the GP can play include:
 - early detection/assessment
 - pharmacotherapy prescribing
 - ambulatory/home detoxification
 - relapse prevention
 - psychological care
 - medical treatment for other health conditions
- There are a number of Australian Government initiatives that offer additional Medicare rebateable services to young people with chronic or complex conditions including access to GPs and a range of other health care providers.
- Under these initiatives a 'chronic condition' is one that has been or is likely to be present for at least six months including mental disorders. A patient is considered to have complex care needs if they require ongoing care from a multidisciplinary team consisting of their GP and at least two other health or care providers.

Additional information

The potential for GPs to be involved in treatment of young people with substance use or mental health issues is currently not maximised. There is strong evidence that brief interventions for the treatment of alcohol and tobacco use have shown positive results when applied in the general practice setting (Penrose-Wall et al 2000). As primary care providers, GPs are able to provide

continuity of care and are often seen as credible sources of health information by their patients. In addition to this, the role of the GP in the management of drug and alcohol issues includes:

- support (and information) for individuals and their families and carers
- early detection/assessment
- referral to specialist treatment services
- pharmacotherapy prescribing
- ambulatory/home detoxification
- relapse prevention
- psychological care
- medical treatment for other health conditions

About the National Medicare Allied Health and Dental Care initiative

The Medicare Allied Health and Dental Care initiative commenced on 1 July 2004. It provides for Medicare benefits to be paid for certain services provided by eligible allied health professionals, dentists and dental specialists to people with chronic conditions and complex care needs who are being managed by a GP under an **Enhanced Primary Care** (EPC) plan.

Allied health services attracting Medicare benefits

The following groups of allied health professionals are eligible to provide services under the Medicare Allied Health and Dental Care initiative. Allied health professionals must meet the provider eligibility requirements and be registered with Medicare Australia.

- Aboriginal health workers
- Audiologists
- Chiropodists
- Chiropractors
- Diabetes Educators
- Dieticians
- Exercise Physiologists
- Mental health workers
- Occupational Therapists
- Osteopaths
- Physiotherapists
- Podiatrists
- Psychologists
- Speech Pathologists

Medicare

Australia

The day-to-day administration and payment of benefits under the Medicare arrangements is the responsibility of Medicare Australia. Enquiries concerning matters of interpretation of Schedule items should be directed to Medicare Australia and not the Department of Health and Ageing. The following telephone numbers have been reserved by Medicare Australia exclusively for enquiries relating to the Schedule:

NSW – 02 9895 3346

QLD – 07 3004 5450

WA – 08 9214 8488

ACT – 02 6124 6362

VIC – 03 9605 7964

SA – 08 8274 9788

TAS – 03 6215 5740

NT – use South Australia Number

References:

- Australian Government Department of Health and Ageing - Allied health and dental care initiative website (June 2007) <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=M.3&qt=noteID&criteria=allied%20health>
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Slide 22: Medicare benefits

Medicare benefits

- A **Medicare card** ensures young people have access to free or low-cost medical, optometry and hospital care
- A **Health Care card** entitles young people to benefits such as cheaper health care, cheaper medicines and travel concessions

Explain how to get a health care/Medicare card

There are a number of health initiatives to ensure all Australians have access to free or subsidised health care. Young people are more likely to attend a service if it is free or the payment options are flexible and explained clearly. Fees for service may be a financial disincentive for young people accessing health services.

Key points

Medicare cards

- Young people aged 15 years and older are eligible to apply for their own Medicare number and Medicare card.
- Young people under <15 years old can apply for their own card, but their number will be linked to their parents/guardians. The application form also needs to be signed by a parent or guardian for people under 15 years of age.

Health Care cards

- A Health Care card entitles young people to benefits such as cheaper health care, cheaper medicines and travel concessions.
- If a young person is receiving benefits from Centrelink they may be eligible to receive a Health Care card.
- If the young person is younger than 16 and their parents have a Health Care card, the young person is able to use their parents card. If a young person is 16 years or older and earns less than a certain amount each week, they are eligible for a Health Care card and apply at any Centrelink office.

Additional information

Medicare and young people

Young people aged 15 years old and older are eligible to apply for their own Medicare number and Medicare card. To do this, they will need to provide two forms of identification; either a birth certificate, proof of age card or drivers license. They will need to complete an *Application to copy or transfer from one Medicare card to another* and either post it to, or visit a Medicare office.

Young people under 15 years old can apply for their own card, but their number will be linked to their parents/guardians. The application form also needs to be signed by a parent or guardian for people under 15 years of age.

Application to copy or transfer from one Medicare card to another

http://www.medicareaustralia.gov.au/resources/medicare/Medicare_3170_0307.pdf

For more information: Medicare Australia

- website www.medicareaustralia.gov.au
- email medicare@medicareaustralia.gov.au
- call 132 011**
- visit any Medicare office
- write to Medicare, GPO Box 9822 in your capital city
- translation Information Services (TIS) 131 450** if you need help translating this information call
- TTY call 1800 552 152*** (hearing and speech impaired services)

NOTE: If a young person presents for an appointment without their Medicare card your receptionist can call Medicare Australia Health Insurance Commission (HIC) anywhere in Australia on 132 150 to obtain their number.

Health Care cards

A Health Care card entitles people to benefits such as cheaper health care, cheaper medicines and travel concessions.

If a young person is receiving benefits from Centrelink they may be eligible to receive a Health Care card.

If the young person is under sixteen, and their parents have a Health Care card, the young person is able to use their parents card; if a young person is sixteen years of age or over, and earns less than a certain amount each week, they are eligible for a Health Care card. They can apply at any Centrelink office.

References:

Adolescent Health Schools Program Information for General Practitioners (2006) Produced by the Hornsby Ku-ring-gai Division of General Practice, NSW Australia
GP Guide, Services for Young People (2006) Eastern Sydney Division of General Practice NSW Australia
Medicare Australia website (sourced June 2007) www.medicareaustralia.gov.au

Acknowledgements:

Information provided by the Mid North Rural SA Divisions of General Practice and the Centre for the Advancement of Adolescent Health: Extract from the GP On-Line Resource Kit <http://ndya.adgp.com.au>

Slide 23: Story vignettes and case discussion – story A

Story vignette A - Eloise

Discussion points

1. What are the important issues here for Eloise and her parents?
2. How would you identify and prioritise the risks that Eloise faces?
3. If Eloise was telling YOU this story, how would you engage with her?
4. What interventions are possible and who would be best to coordinate these?
5. What support could local health and community services offer at this point?
6. Could you involve the parents? How?

Story vignette A – Eloise

"When I wake up, it's just black. Life's just black. But I don't want to tell Mum about that or other things. If I tell her what's really going on, I know she's going to panic and go off and try to do stuff to fix it. Like, even though I'm 16, she's still into making appointments for me with her doctor and then she gets cut when I don't turn up. I try to tell her that I didn't ask her to do it and there's no way I want to get grilled by someone.

Mum doesn't listen to that. And she doesn't listen when you tell her that everything's under control. She just goes off and loses it and then the whole thing spins out and she'll end up crying and begging me to be like I was and then Dad comes home and he loses it with me for upsetting Mum. And then he starts fighting with her, himself. And then I just feel as guilty as shit.

I knew Mum was reading my diary because she was watching me all the time. And crying at the sink when she did the washing up. I write everything in my diary, so all the drug and sex stuff would have been a bit of a shock. I used to tell Dee, my best girlfriend, all those things but she OD'd and died and left me. Mum's so scared that this is going to happen to me. But I'm not scared 'cause when you OD, you don't feel anything. You don't know you're dying..."

Points for discussion

1. What are the important issues here for Eloise and her parents?
2. How would you identify and prioritise the risks that Eloise faces?
3. If Eloise was telling YOU this story, how would you engage with her?
4. What interventions are possible and who would be best to coordinate these?
5. What support could local health and community services offer at this point?
6. Could you involve the parents? How?

Story vignette - feedback session:

- The points for discussion are to trigger group discussion.
- Use the whiteboard to write up main ideas.

- The facilitator's notes below are to direct discussion and prompt further exploration of important issues.
- Ensure only one participant speaks at a time and is heard by the entire group. Be aware of who is speaking and who is not.
- Invite participation from everyone.
- Reflect, and if necessary, rephrase the participant's comment to link its relevance to the topic.

Facilitator's notes

- What does this story tell us about a young person's perception of adult effectiveness and adult understanding of young problems? (Refer back to the stages of change model).
- What services/actions could effectively work with this perception? (include reference to school support and youth services as well as health services).
- What does Eloise mean by everything being 'just black'? (ensure participants discuss depression and suicidal ideation).
- Explore the possibility of a family history of depression.
- How would participants raise the question of suicide with Eloise?
- Recommend that as a key part of her care, she needs a full alcohol and other drug history and mental health assessment completed. Identify how and by whom this would be initiated.
- Have participants remembered to assess her sexual health as well as her physical and mental health?
- Explore the benefits/barriers of working through Mum's doctor. What confidentiality issues are raised by this story?
- Remind participants that Eloise is entitled to her own Medicare card.
- Ask participants to describe the strategies they would use to engage with Eloise, particularly the way in which they might be able to understand and assess her mental health and substance use.
- What local services are there for *young* people in the area? What interventions may be useful for Eloise?
- Explore ways that Eloise's mum and dad can be included in her health care.
- Identify the issues affecting Eloise's parents, recognise the stress they are feeling and note local support services that may support them.

Note:

Be mindful of potential conflict. Participants may focus on service deficiencies, vent their frustrations or recount negative experiences. Contain the discussion by:

- acknowledging the difficulty/ frustration
- identifying the problem or issue
- problem solving as a group (if time permits).
- if time doesn't permit, offer an alternative e.g. agree to meet about later or pass the issue on to relevant people.

Above all, maintain a sense of humour and encourage participants to do so as well!

Slide 24: Story vignettes and case discussion –story B

Story vignette B - Jake

Discussion points

1. What are the important issues here for Jake?
2. What are Jake's strengths and when is he at risk?
3. If Jake was telling YOU this story, how would you engage with him? Would you involve his parents?
4. What strategies could you suggest to Jake to prevent the 'here I go again' situations?
5. What role can the general practitioner play in Jake's health care?
6. What support could other local health and community services offer at this point?

Story vignette B – Jake

"I was diagnosed when I was 17. That was more than five years ago now. We were told to just accept that I'd be on meds for life and to forget about me ever being 'well'. It was pretty heavy, not just for me, but for Mum and Dad too.

One of the hardest parts is after I've had an episode. I come out of hospital with a change in my medication but not really with much information about it. Or what the side effects might be. So I go home and Mum and Dad have to deal with the new 'me' and it's guesswork for them and they basically have to play it by ear and just keep doing the stuff they know works with me. Or works best, anyway.

They're really into me keeping routines going like say, I have to get up every morning at a normal time and do something with my day. And I have to exercise. They can see the difference in me when I come back from walks, so they push all that. I hate it though. I'd do anything just to stay in bed. I volunteer three days a week in an op shop which I think is important because you're doing something of value. And you're learning how to get on with other people. If you sit at home doing nothing, you don't know how to socialise at all.

It's lonely when you're sick. You don't see many of your old friends - they don't get what's happening for you. And you miss being able to do all the stuff that other people your age do. I think that's why when I start to do well I sort of think I'm doing better than I am, and I start feeling okay about seeing my old friends again. Problem is that they all do a bit of grass and they drink and stuff and so I party with them. And I think it's all going to be okay. And then, before long, I'm not taking my meds and it always crashes down and I go backwards and it's like, 'Here I go again.'

I see a lot different doctors and services so I'm telling my story a lot and sometimes I feel like I've had enough of talking. And I don't want to talk about it anymore. I don't even know how therapy is that useful for me anyway."

Points for discussion

1. What are the important issues here for Jake?

2. What are Jake's strengths and when is he at risk?
 3. If Jake was telling YOU this story, how would you engage with him? Would you involve his parents?
 4. What strategies could you suggest to Jake to prevent the '*here I go again*' situations?
 5. What role can the general practitioner play in Jake's health care?
 6. What support could other local health and community services offer at this point?
-

Story vignette - feedback session:

- The points for discussion are to trigger group discussion.
- Use the whiteboard to write up main ideas.
- The facilitator's notes below are to direct discussion and prompt further exploration of important issues.
- Ensure only one participant speaks at a time and is heard by the entire group. Be aware of who is speaking and who is not.
- Invite participation from everyone.
- Reflect, and if necessary, rephrase the participant's comment to link its relevance to the topic.

Facilitator's notes

- What might Jake's diagnosis be? Discuss the possibility of schizophrenia and the medication he may be on as a result.
- What does this story tell us about the value of social connections/ boundaries/structures in management of mental health issues?
- Explore ways in which clear information about mental health conditions and medications can be provided to both Jake and his family.
- Encourage participants to build on Jake's strengths to maintain and lengthen periods of good health.
- Explore the role that health services, especially general practitioners can play in care and support for Jake.
- Discuss the importance of review and regular re assessment of Jake's mental and drug health and of his medication.
- Alert participants to the risks and counter effects of using drugs (e.g. cannabis and alcohol) together with prescribed medications.
- How can services improve communication and assistance for families like this? What opportunities are there to keep the parents in the loop?
- This story reminds us of the extreme tiredness connected with mental health and meds: how responsive is your service to this? How adaptable re scheduling appointments etc? Is there anything you could do better?
- Jake is now resistant to talking about his situation. Whose problem is that? Who might he still talk with? How could you facilitate that?
- Voluntary work creates community awareness and support: how could services create more opportunities here?
- What local services are there for *young* people in the area? What interventions may be useful for Jake?

Slide 25: Access and referral to local services



Access to local services

- Service philosophy
- Service programs
- Youth specific?
- Inclusive of families and carers?
- Location (near public transport)
- Opening hours
- Waiting list
- Referral process
- Contact telephone numbers/emergency contact
- Inclusion/exclusion criteria
- \$ cost

Knowing what is available and what works

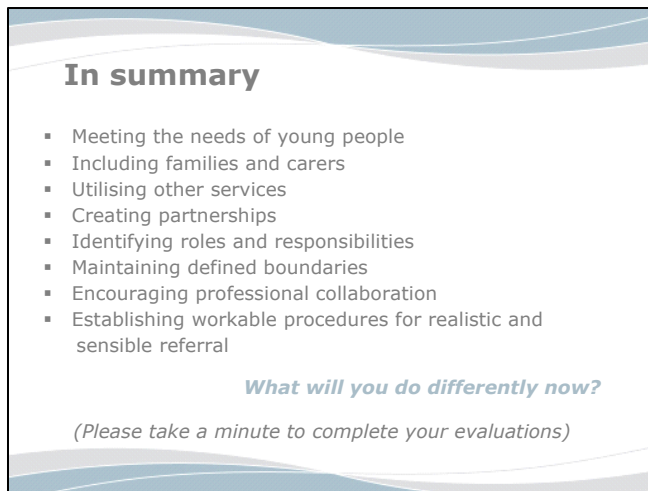
Service mapping exercise:

Participants are provided with a service mapping template which they should complete and bring with them to the training session. If they have not, ask them to spend a few minutes completing the template.

Key points

- Participants share information about their services based on the areas outlined in the slide.
 - Map key services on the white board or ask the coordinator to scribe information.
 - Be as precise as possible and include contact phone numbers and key information.
 - Where possible, include other agencies and services such as non Government Organisations and community or Council programs.
 - Ask participants for consent to circulate the information provided to all participants.
 - Following the workshop, ensure the coordinator circulates a copy of this information to all participants.
-

Slide 26: In summary

A slide titled 'In summary' with a list of eight bullet points. Below the list is the text 'What will you do differently now?' and a note '(Please take a minute to complete your evaluations)'. The slide has a decorative wavy border at the top and bottom.

In summary

- Meeting the needs of young people
- Including families and carers
- Utilising other services
- Creating partnerships
- Identifying roles and responsibilities
- Maintaining defined boundaries
- Encouraging professional collaboration
- Establishing workable procedures for realistic and sensible referral

What will you do differently now?

(Please take a minute to complete your evaluations)

This slide provides a summary of the training session content.

Key points

- Ask the question: *What will you do differently?* (as a result of knowledge and information received at the training sessions).
 - Ask participants to complete the post test evaluation.
 - Hand out information packs.
-