



**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 two: Young people, mental health and  
substance use – *how can we help?***

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.

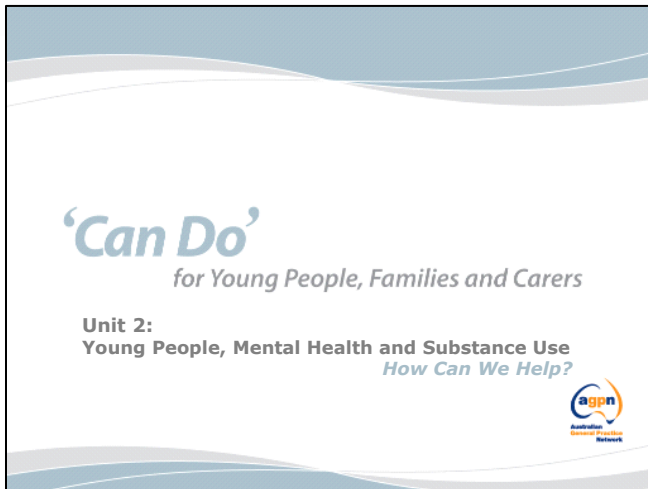
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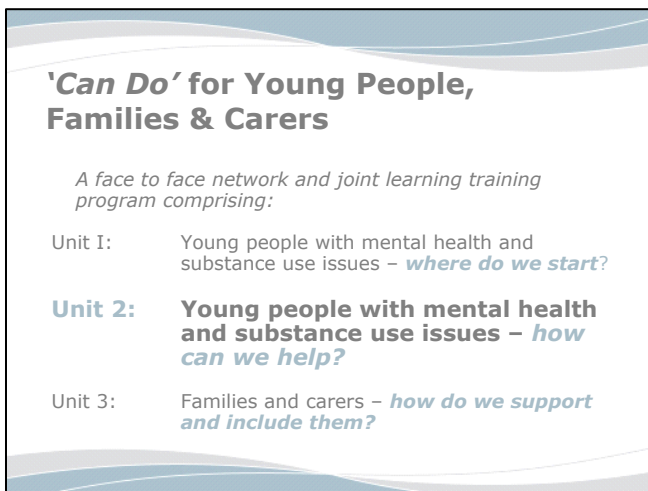
## Slide 1: Title page



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.

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## Slide 2: About the training module



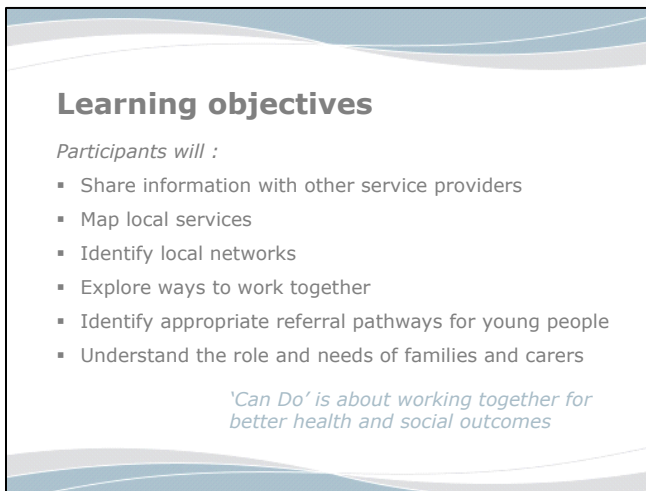
This slide describes the whole training module

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### Key points

- Emphasise to participants that this is a series of three units.
  - This is the second session, building on the information provided in unit one.
  - 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

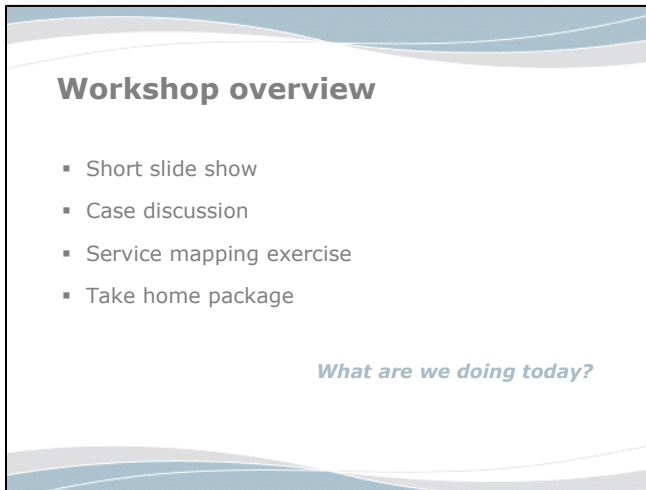
On completion of this course participants will be able to:

- 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



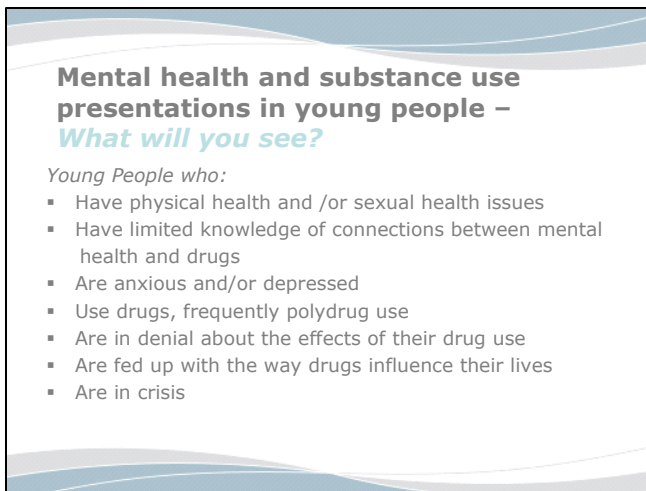
This slide provides an overview of the 'Can Do' for Young People, Families and Carers workshop format

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### 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: Mental health and substance use presentations in young people – *what will you see?*



**Mental health and substance use presentations in young people – *What will you see?***

*Young People who:*

- Have physical health and /or sexual health issues
- Have limited knowledge of connections between mental health and drugs
- Are anxious and/or depressed
- Use drugs, frequently polydrug use
- Are in denial about the effects of their drug use
- Are fed up with the way drugs influence their lives
- Are in crisis

Young people present to health and other services at different points along a continuum of increasingly problematic mental health and substance use. They may not present with these issues directly and they may not think that their mental health is a problem or conversely that their substance use is a problem. The triggers for seeking help are outlined in the slide. It is common for young people to present (often with a family member) at the time of or following a crisis (such as family discovery that there is substance use involved, a psychotic episode, an encounter with the law, a traffic accident, a suicide attempt).

### **Key points**

The following key points are adapted from the Adolescent Health Resource Kit for GPs (NSW Centre for Adolescent Health and Transcultural Mental Health Centre 2004)

- Use presentations at services to screen for depression and other mental health concerns
- Provide early intervention and treatment.
- Assist young people to access specialist services if required.
- Actively promote young people's mental health and resiliency by teaching positive coping strategies and problem solving skills.
- Educate families and carers and involve them in care plans.
- Collaborate with other health professionals in the provision and coordination of comprehensive multidisciplinary care.
- Ideally bring service to the young person rather than expecting the young person to access multiples separate services on their own.

### **Additional information**

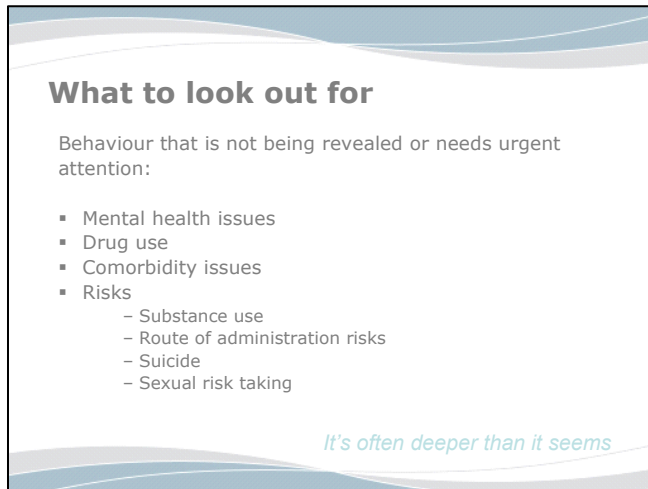
- Routinely enquire about psychological distress, depression and risk behaviours.
- Use the HEEADSSS psychosocial assessment (explained in detail in slide 7) for detecting the presence of risk factors and mental health problems.
- Consider if more in depth assessment is needed to diagnose specific disorders – this may mean referral to a specialist service.
- If a young person presents repeatedly with vague or non-specific complaints consider the possibility of depression or other mental problems.

- Clarify the role that risk behaviours play in a young person's life (e.g. alcohol and drug use may be a means of relieving emotional distress).
  - Take into account the young person's cultural background – ask if there are any experiences that may impact on mental health (e.g. the experience of torture, of refugee trauma, of displacement).
- 

**Reference**

Chown P, Kang M, Bennett D, and Sanci L (2004) *Adolescent Health: Enhancing the Skills of General Practitioners in caring for young people from culturally diverse backgrounds. A Resource Kit for GPs*. Transcultural Mental Health Centre and NSW Centre for the Advancement of Adolescent Health, Sydney. [[www.caah.chw.edu.au/resources/#03](http://www.caah.chw.edu.au/resources/#03)]

## Slide 6: What to look out for



**What to look out for**

Behaviour that is not being revealed or needs urgent attention:

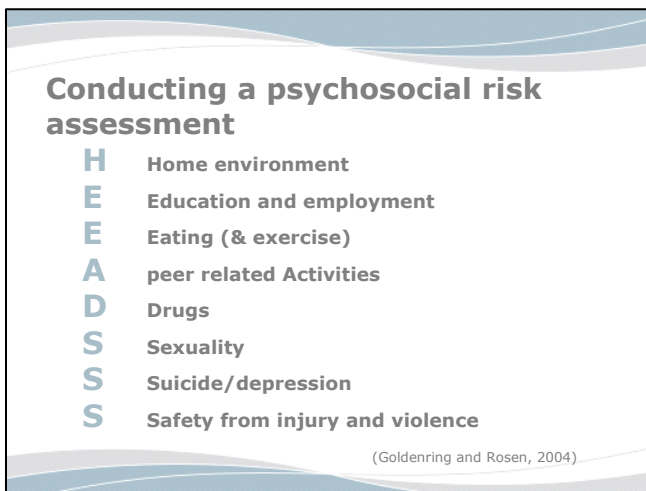
- Mental health issues
- Drug use
- Comorbidity issues
- Risks
  - Substance use
  - Route of administration risks
  - Suicide
  - Sexual risk taking

*It's often deeper than it seems*

When visiting a health professional, young people may not want to raise questions about their mental health or drug use, or may not think that either or both of them are a problem.

Using the assessment tools detailed in the following slides can assist in bringing up topics that the young person may not want to or reveal underlying issues that may need to be treated with urgency.

## Slide 7: HEEADSSS assessment



**Conducting a psychosocial risk assessment**

- H** Home environment
- E** Education and employment
- E** Eating (& exercise)
- A** peer related Activities
- D** Drugs
- S** Sexuality
- S** Suicide/depression
- S** Safety from injury and violence

(Goldenring and Rosen, 2004)

The HEEADSSS assessment gives the GP or other health professional a structure for developing rapport with a young person while systematically gathering information about their world – their family, peers, school and inner world. It is also a useful tool for a brief risk assessment and screening for specific risk behaviours. In turn this allows the practitioner to identify areas for intervention and prevention and to develop a picture of the young person's strengths and protective factors

### Key points

- Securing the interest and confidence of the young person at the initial appointment makes subsequent contact more likely.
- It is important to note that young people may not 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.
- Identify what the young person wants and what is their expectation of your role in providing support for this.
- Assess their readiness for change and assist them in setting realistically achievable goals.
- Arrange follow up appointments to provide ongoing assessment and review of their management plan.

### Additional information

Coming soon for **headspace** sites – psychosocial screening framework and recommended interviewing techniques.

### Conducting a HEEADSSS assessment

#### H- Home environment

Explore home situation, family life, relationships and stability:

- *Where do you live? Who lives at home with you?*
- *Who is in your family (parents; siblings; extended family)? What language is spoken at home?*
- *Does the family have friends from outside its own cultural group / from the same cultural group?*

- *What is your / your family's cultural background?*
- *Do you have your own room?*
- *Have there been any recent changes in your home environment (moves; departures; etc.)?*
- *How do you get along with mum and dad and other members of your family?*
- *Who could you go to if you needed help with a problem?*

### **E – Education and employment**

Explore sense of belonging at school/work and relationships with teachers/ peers/ workmates; changes in performance:

- *What do you like/ not like about school (work)? What are you good at/ not good at?*
- *How do you get along with teachers /other students / workmates?*
- *How do you usually perform in different subjects?*
- *Some young people experience bullying at school, have you ever had to put up with this?*
- *What are your goals for future education/employment?*
- *Any recent changes in education/employment?*

### **E – Eating (and exercise)**

Explore how they look after themselves; eating and sleeping patterns:

- *What do you usually eat for breakfast/ lunch/ dinner?*
- *Sometimes when people are stressed they can overeat- or under-eat. Do you ever find yourself doing either of these?*
- *If screening more specifically for eating disorders you may ask about body image, the use of laxatives, diuretics, vomiting, excessive exercise, and rigid dietary restrictions to control weight.*
- *What do you do for exercise?*

### **A – peer related Activities**

Explore their social and interpersonal relationships, risk taking behaviour, as well as their attitudes about themselves:

- *What sort of things do you do in your free time out of school/work?*
- *What do you like to do for fun?*
- *Who are your main friends (at school/out of school)?*
- *Do you have friends from outside your own cultural group / from the same cultural group?*
- *How do you get on with others your own age?*
- *How do you think your friends would describe you?*
- *What are some of the things you like about yourself?*
- *What sort of things do you like to do with your friends? How much television do you watch each night?*
- *What's your favourite music?*
- *Are you involved in sports/hobbies/clubs, etc?*

### **D – Drugs**

Explore the context of substance use (if any) and risk taking behaviours:

- *Many young people at your age are starting to experiment with cigarettes/ drugs/ alcohol. Have any of your friends tried these or other drugs like marijuana, injecting drugs, other substances? How about you, have you tried any?*
- *How much are you talking about and how often?*
- *What effects does drug taking or smoking or alcohol, have on you?*
- *Has your use increased recently?*
- *What sort of things do you (& your friends) do when you take drugs /drink?*

- How do you pay for the drugs / alcohol?
- Do other family members take drugs / drink?

### **S - Sexuality**

Explore their knowledge, understanding, experience, sexual orientation and sexual practices – Look for risk taking behaviour / abuse:

- *Many young people your age become interested in sexual relationships. Have you ever had a sexual relationship with a boy or a girl (or both)? – explore...*
- *Do you have a boyfriend / girlfriend?*
- *How do you feel about relationships in general or about your own sexuality?*
- *What do you know about contraception and protection against STDs?*
- *Has anyone ever touched you in a way that has made you feel uncomfortable or forced you into a sexual relationship?*

### **S – Suicide/depression**

Explore risk of mental health problems, strategies for coping and available support:

- *Sometimes when people feel really down they feel like hurting, or even killing themselves. Have you ever felt that way? Have you ever tried?*
- *What prevented you from going ahead with it?*
- *How did you try to harm / kill yourself?*
- *What happened to you after this?*
- *What do you do if you are feeling sad, angry or hurt?*
- *How do you feel in yourself at the moment on a scale of 1 to 10?*
- *Who can you talk to when you're feeling down?*
- *How often do you feel this way?*
- *How well do you usually sleep?*

It is also important to explore:

**S – Safety** Sun screen protection; immunisation; bullying; abuse

**S – Spirituality** Beliefs; religion; What helps them relax, escape? What gives them a sense of meaning?

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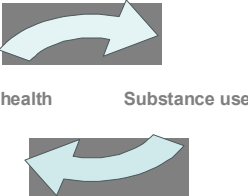
#### **References:**

- Access SERU. (1999), *Improving young people's access to health care through general practice – A guide for general practitioners and Divisions of General Practice*. Access SERU Department of General Practice & Public Health, University of Melbourne.
- Goldenring, J. and Cohen, E. (1988) Getting into adolescents' heads. *Contemporary Pediatrics*. 1988, July: 95-90.
- Chown P, Kang M, Bennett D, and Sanci L (2004) *Adolescent Health: Enhancing the Skills of General Practitioners in caring for young people from culturally diverse backgrounds. A Resource Kit for GPs*. Transcultural Mental Health Centre and NSW Centre for the Advancement of Adolescent Health, Sydney. [www.caah.chw.edu.au/resources/#03]
- Kang, M., Bernard, D., Usherwood, T., Quine, S., Alperstein, G., Kerr-Roubicek, H., Elliott, A., Bennett, D., (2005) *Better Practice in Youth Health. Final Report on Research Study: Access to Health Care Among Young People in NSW Phase 2*. Sydney: NSW Centre for the Advancement of Adolescent Health, The Children's Hospital at Westmead.
- Sanci, L. (2001) *Adolescent Health Care Principles*. Centre for Adolescent Health. The Royal Australian College of General Practitioners. Melbourne.
- Rowe, L. (2000) *Clockwork: time for young people. Making general practice work for young people*. Clockwork Youth Health Service. Geelong Victoria 2000.
- 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: Psychiatric history, mental health and drug use

**Psychiatric history, mental health and drug use**

- Differentiate intoxication effects from symptoms of mental illness
- Determine if there is an underlying mental health issue that has led to substance use or vice versa
- Regardless of how the problems started, when one problem gets worse, so does the other
- Need to determine which poses the greatest risk to the young person now



Mental health      Substance use

When asking about experiences such as episodes of panic, paranoia or hallucinations it is important to differentiate what may be acute drug effects from the symptoms of mental illness. The challenge is to get the young person and their carers to acknowledge the relationship between substance use and their mental health. This may assist engagement and compliance with efforts aimed towards reducing use and optimising treatment.

### Key points

- When differentiating intoxication effects from personality/ pre-existing psychopathology, most psychoactive drugs have relatively short-lived effects on mood (usually between 4 - 24 hours) therefore it is imperative to identify when the drug was last taken. The experiences should be specifically related to amount used, route of administration, duration of current use episode, and setting.
- The functioning and context of drug use should also be identified since this will help determine whether the experience was the reason the drug was taken or was the result of its use. For example, is use more common after feeling anxious or does the anxiety only come after the drug is taken?
- The existence of the symptoms prior to the onset of substance use or in periods of no drug use strongly points to an underlying mental health condition. Exacerbation of underlying symptoms should not be confused with their de novo appearance. Most importantly where there is significant symptom resolution with cessation (or after any withdrawal) the assessor can become more confident in the nature of the association (related to short-term drug use).
- A family history and any past psychiatric history outside the context of substance use may suggest an underlying mental illness.
- As a person who works with young people, you should provide feedback about your observations and offer a range of interventions aimed at reducing consumption and improving health. 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**

The 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).

Rates of comorbidity vary by mental disorder and substance type. Tobacco use is very common in both those with mental illness and substance dependence. Rates of substance use tend to be highest among those with the most severe illness and 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.

The rate of smoking among people with severe mental illness is as high as 80% and among many injecting drug users the same high rate of smoking is observed. Reciprocal relationships are seen however with between 30 - 80% of those with a substance use disorder reporting symptoms compatible with mental illness. Indeed the co-occurrence of the problems is so common it is no longer the exception.

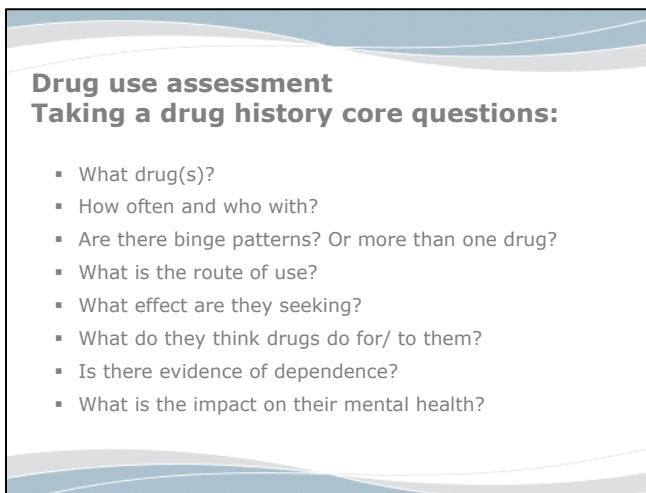
All clinicians should assess drug use on all treatment occasions and advise on quitting smoking with the offer of Nicotine Replacement Therapy.

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### **References:**

- Farrell M. Howes S. Taylor C. Lewis G. Jenkins R (2003) Substance misuse and psychiatric co morbidity: an overview of the OPCS National Psychiatric Morbidity. *Int Rev Psychiatry*. 2003;15:43-49.
- Merikangas KR. Mehta RL. Molnar BE. Walters EE (1998) co morbidity of substance use disorders with mood and anxiety disorders. *Addictive Behaviours*. Nov-Dec;23(6):893-9
- 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 9: Drug use assessment



**Drug use assessment**  
**Taking a drug history core questions:**

- What drug(s)?
- How often and who with?
- Are there binge patterns? Or more than one drug?
- What is the route of use?
- What effect are they seeking?
- What do they think drugs do for/ to them?
- Is there evidence of dependence?
- What is the impact on their mental health?

Doing a drug use assessment may be the first time a young person has had to address aspects of his or her drug use. Some young people may have minimal insight into the potential problems associated with continuing to use drugs. A drug use assessment may be an opportunity for you to assist the young person to become aware of these potential problems and to contemplate lifestyle changes to reduce negative social and health aspects of their behaviour (PDDI, 2007).

### Key points

- Conducting a comprehensive alcohol and other drug assessment is necessary to gain an insight into young people's drug using history and risk taking behaviour.
- Asking about use of alcohol, tobacco, OTC, prescribed and illicit drugs should be part of every routine history. Also ask about current use, past use, risk of use and past treatments for use. Screening tools (AUDIT etc) may be helpful
- Ask the young person to clarify if you are unsure of terminology (street terms for drugs, amounts used, route of administration).
- Drug using patterns will generally reflect street availability, cost and the culture that dominates in the user's community. Availability and price influence use – this is, for example, particularly relevant during periods of street shortage/ high price of heroin when other substances are often substituted for their drug of choice.
- Some young people will require minimal intervention and no follow-up. For others, this assessment will represent the first stage in a long-term change process. For these young people it is important to set realistic and achievable goals and arrange regular follow up and reviews.

### Additional information

#### Ask permission

Although consent is often assumed by the patient's presence the clinician may introduce the topic through an opening remark. For example ask: "As part of my routine assessment process, I need to get some information about your use of alcohol and other substances. Is it ok with you if I ask a few questions about that?" Or "You mentioned that you drink alcohol, can I ask you, do you use any other drugs or over-the-counter medication? Is that ok?"

## Communication

When communicating with a young person about substance use, try to:

- Use open-ended questions that elicit a response beyond just 'yes and no'. However, 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?"*
- Be mindful that you may not use the same language to communicate about emotions and 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?"*

## Purpose of the assessment:

- to enable information exchange between young person and health care worker
- to permit the young person to raise issues of concern to them
- to identify the functions and risks for substance use
- to identify risky behaviours and dependent/ harmful patterns of use
- to document drug-specific issues such as intoxication and withdrawal
- to explore previous treatment experiences
- to identify other significant medical/ psychiatric/ social risk issues
- to elicit immediate goals and level of motivation
- to provide information and education on the effects of drugs and harm reduction strategies
- to facilitate access to other services such as youth services, specialist medical clinics or welfare agencies
- to establish a correct diagnosis/ case formulation
- to permit discussion of an initial menu of treatment options that you think may be suitable
- to explain any other further investigations/ assessments you would like to undertake
- to make initial plans with the young person regarding appropriate interventions.

Give the opportunity at the end of the assessment for the young person to ask questions and contribute to the care plan. It is important to arrange follow up and reviews of the care plan.

## What drugs are they currently using?

- Make sure you specifically enquire about the use of prescribed and over the counter (OTC) medications and alcohol as well as illicit substances. Note: many young people may not consider tobacco, alcohol, OTC preparations or benzodiazepines as *'drugs'*.
- If either benzodiazepines or methadone/buprenorphine are reported to be have been used, then at this point, make sure you find out whether it is prescribed (and if so by whom); whether there is evidence of doctor shopping for benzodiazepines; and identify what types and dose of benzodiazepines they use.

## How much are they using? (and how long have they been using at this level?)

Accurate quantification of drug and alcohol use can be difficult for young people, both as result of recall and concerns over how the answer might impact their treatment (for example a heroin user may over estimate their daily use, hoping to get a higher dose of methadone, while the drinker may wish to underplay how much they are drinking).

**Quantity** (weight, money spent, number of pills etc).

The amount used might be described in terms of money, number of pills or weight. If the amount is given in one unit e.g. a gram, ask how much that costs. Likewise if they report how much money they spend, ask 'how much' in drugs that is.

Most illicit drugs other than cannabis and ecstasy pills are sold by weight, with typical daily amounts used by dependent clients averaging about 0.5-1.0gm/day heroin (\$250-400), cocaine 1-2gm/day (\$250-600) cannabis >3gm/day (\$50-80), amphetamine 2-5gm/day. For benzodiazepines ask about dose and type. For alcohol note the type of beverage, its percentage alcohol and the volume consumed (for example a "bottle of vodka" can be a small bottle of 2 units or big one with 40 units!). Ask if you do not understand a term that may be used to describe amounts (e.g. 'a cap' of heroin).

**Past drug use history**

**Age of first use (for each drug and alcohol)**

- Many people will start using drugs in their mid to late teens, usually commencing with alcohol, tobacco and/or cannabis.
- A drug history reporting either the onset of use at a much earlier age should raise suspicions of significant life disruptions occurring around these times that prematurely precipitated use.
- The early onset of the first use of alcohol and other drugs and the rapid progression through substance groups may also be a pointer towards a recent life event.

**Changing pattern of use: amount and frequency increasing over time**

- In determining the evolution of substance-related problems, questions regarding the age of first use of different substances should be followed by questions about when they started to use more often (e.g. using daily or weekly), when they developed tolerance and first experienced withdrawal. In the case of heroin or amphetamines the timing of the transition from smoking to injecting is very important.
- These questions may help you understand the progression of someone's drug use from experimental to harmful through to potentially dependent.

**Problems associated with use**

- What problems have they experienced? (relationships, employment, legal, health, financial). These allow you assess whether they have continued their substance use despite experiencing significant problems related to it (a diagnostic criteria for dependence).

**Attempts at detoxification**

- Ask about past treatments. One of the best predictors of a response to treatment interventions is by reviewing the outcomes of previous treatment episodes.
- Many dependent users will have experienced periods of abstinence. The hallmark of the dependent user is the rapid return to dependent use (with the rapid regaining of tolerance) once use has recommenced.

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**References:**

Police Drug Diversion Initiative (PDDI) South Australia (website sourced June 2007 <http://www.divert.sa.edu.au>)  
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 10: Risks associated with drug use

### Risks associated with drug use

- Intoxication related high risk behaviours
- Route of administration
- Behaviours related to procurement
- Psychosocial consequences
- Impact on other medical or psychiatric conditions
- Misdiagnosis & inappropriate treatment
- Encounters with the law

The use of alcohol and other drugs and mental health issues exposes young people to a range of risks (such as driving under the influence, risky sexual practices and propensity to violence). Outcomes for young people vary greatly and depend upon the ability of all potential sources of support to identify and address their individual needs. As someone who works with young people, you can reduce these harms by offering advice about drug use, which may help prevent intoxication and exposure to other associated risks.

### Key points

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.

Other associated risks include the impact on family, employment and occupational functioning. Substance use may also impact on other medical or psychiatric conditions and in some cases lead to misdiagnosis or inappropriate treatment.

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## **Additional information**

### **Safer alcohol use**

Some tips for advising young people on how to control their drinking:

- Plan ahead, set limits and stick to them.
- Start with a non-alcoholic drink.
- Drink slowly. Take sips, not gulps.
- Remember that 'alco-pops' (sweet-flavoured pre-mixed drinks) often mask the taste of the alcohol, but they do not mask the effects.
- Try the low-alcohol alternative (e.g. light beer).
- Eat before or while drinking, and avoid salty snacks, which make you thirsty.
- Avoid buying in rounds or 'shouts'.
- Have one drink at a time so you can keep track of your drinks—avoid 'topping up'.
- Pace yourself.
- Stay busy—don't just sit and drink.
- Have at least two alcohol-free days a week.
- Be assertive—don't be pressured into drinking more than you want or intend to.
- Know your limits.
- Nominate a non-drinker to drive and generally to look out for those who will be drinking.
- Make sure there is a family member or a friend who can be called for assistance.

It is important to note that young people 14 -17 years have a similar drinking pattern to adults however they are at much greater risk of harm due to their smaller physical size, and emotional and intellectual inexperience. The NHMRC guidelines are established for the legal drinking age, those 18 years and over.

### **Safer partying ('club drugs')**

Nightclubs, raves and other entertainment venues and events can get very crowded and hot. Some drugs, such as ecstasy and speed, raise the body's temperature, while alcohol dehydrates the body. Young people should be advised to:

- Take regular rests from dancing—use a 'chill-out' space to rest or recover.
- Wear light, absorbent clothing.
- Replace lost fluids with water—500ml per hour if active and 250ml per hour if inactive.
- Watch your drink (drink spiking).
- Allow your body to recover—make sure you eat well and get enough sleep.
- Don't mix drugs.
- Don't mix GHB and alcohol—this mix has been associated with overdose.
- Call an ambulance for medical assistance (tel. Emergency 000 or 112 from mobile phones).

### **Safer inhalant use**

While prevention is preferable, it may not be possible to prevent all use of inhalants. As someone who works with young people, you can work to reduce the harms by offering advice on how to lower the risks and reduce accidents. Strategies include advising users:

- that some substances (such as glue) are less harmful than others
- not to sniff alone or in dangerous places

- not to put plastic bags over their heads
  - smaller bags reduce the risk of suffocation
  - substances are flammable (no smoking)
  - using alcohol or other drugs while intoxicated with inhalants increases the chance of accidents and overdose.
- 

**References:**

- Australian Drug Foundation (2002) Facts about Binge Drinking. Fact sheet Number 1.10 November 2002 DrugInfo Clearinghouse
- Australian Drug Foundation (2003) Club Drugs. Fact sheet Number 2.6 August 2003 DrugInfo Clearinghouse
- Australian Drug Foundation (2004) Inhalant use. Fact sheet Number 2.3
- Chikritzhs, T. et al. (2004) *Under age Drinking Among 14 - 17 Year olds and Related Harms in Australia National Drug Research Institute, Perth.*
- Yung, A. & Cosgrave, E (2006) *Cigarettes and Alcohol and Youth at Risk Australian Doctor, March 2006 pp27*
- 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 11: Route of administration

Route of administration				
	Smoke	Inject (IV and IM/ SC)	Oral	Snort
Heroin	++	+++		+
Methadone		+	+++	
Cocaine (freebase crack)	+	++		+++
Amphetamine	+++	+++	++	++
MDMA (Ecstasy)		+	+++	+
Cannabis	+++		+	
Benzodiazepines		++	+++	

+ Less common  
 ++ Common  
 +++ Very common

Many substance users (especially heroin and amphetamine users) subsequently climb the ladder of routes which yield increasing bioavailability and speed of onset of the effect, moving from snorting intranasally, smoking ("chasing the dragon"), subcutaneous "skin popping" to intravenous use.

**Key points**

This slide outlines the common route of administration for different drug types.

- 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, 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.

**Reference:**

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 12: Route of administration - risks

### Route of administration- risks

- Route of administration is a significant factor in determining associated risks of drug use
- Bioavailability and speed of onset differ by method of administration (drinking, snorting, smoking, inhalation, injecting, per rectum)
- Informing young people about risks may prevent other health problems:
  - Infection
  - Viral transmission
  - Organ or vessel damage

The route of administration is one of the most significant factors in determining the pattern of associated problems with drug use. There are different risks associated with the various routes of administration (for example blood borne viruses with intravenous use). Inform young people of these risks and offer strategies to minimise harm.

### Key points

The risks associated with intranasal use, smoking, inhalation and injecting drug use are briefly outlined below:

- **Intranasal/snorting:**
  - The trauma of snorting (e.g. often sharp, coarse crystals or powder designed for injection and distilled from liquids) causes damage to the soft nasal epithelium.
  - Trauma can lead to bleeding with delayed healing, secondary to the vasoconstrictive effects of cocaine and amphetamines.
  - There is also a risk of hepatitis C transmission in those sharing straws.
- **Smoking:**
  - Smoking is a very effective and rapid means of delivering a drug into the body.
  - Smoking any substances can exacerbate asthma and other respiratory problems.
  - Nicotine in cigarettes is a major contributor to cardio pulmonary disease and cancer but many young people will not look that far ahead.
- **Inhalation:**
  - The process of filling a bag or jar with glue and inhaling the fumes by placing you mouth over the entrance causes a contact dermatitis.
  - Inhalation of all combustible products is detrimental to health.
  - The risks of fainting, vomiting and aspiration are high.
- **Per rectum "shafting/shelving"**
  - Some drugs, such as ecstasy are administered per rectum (suppository) which can lead to local infection.
- **Injecting drug use: Intravenous (IV)**
  - This route is associated with the greatest risk of dependence (high speed onset, 100% bioavailability) and associated with a number of local and more distal problems.
- **Injecting drug use: Intramuscular (IM) and Subcutaneous (SC)**

- Although not popular, in the absence of venous access, drugs can be administered Intramuscular (IM) and Subcutaneous (SC).
- Injecting causes risk of abscesses, embolisms, infection and transmission of blood borne viruses.

## Slide 13: Self-harm and suicide

### Self-harm and suicide

- Young people behave impulsively which puts them at greater risk of self-harm and suicide (especially with alcohol use!)
- Risk factors include:
  - Childhood sexual abuse, mental health issues, family history, debt, legal problems, previous suicide attempt
- Warning signs include:
  - Talking about feelings of hopelessness, heavy drinking or substance use, changes in sleep or eating patterns, risky behaviour (eg reckless driving)

Suicide is the second most common cause of death in 12-24 year olds in Australia, with young males three times more likely to die from suicide than young females. A range of interacting factors are associated with increased risk of suicide among young people including individual, family, community and environmental circumstances. Mental health issues combined with harmful drug use, previous suicide attempts or intentional self-harm are also linked to greater risk of suicide (Beautrais 2000; Goldney 1998).

### Key points

- 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 is 2.5 times higher than the rate for young males (AIHW, 2007).
- Studies of people who self-harm have shown that more than 90% have at least one mental disorder, commonly depression.
- Young people should be asked about self-harming behaviour and suicidal thoughts, and a suicide risk assessment conducted if needed.

### Additional information

#### Self-harm

The term 'self-harm' refers to a range of behaviours that, at the milder end of the spectrum, includes mild to moderate self-injury as a response to emotional pain and, at the more extreme end, includes attempted suicide. In many cases, self-harm is not intended to be fatal (Skegg 2005).

Self-harm frequently involves cutting and poisoning (typically overdosing on medication), but may also involve behaviours such as self-battery and hanging (De Leo & Heller 2004; Skegg 2005).

### **Prevalence of self-harm in young Australians**

Self-harming behaviour is not widely investigated in schools or health services resulting in a lack of research or 'best practice guidelines' for clinicians. In 2002 a small survey involving year 10 and 11 students (age 15 – 17 years) was conducted. It was found that 6% of students reported having deliberately self-harmed in the previous 12 months and 12% reported that they had deliberately self-harmed at some point in their lives (De Leo & Heller 2004).

Experiencing a mental disorder is a risk factor for self-harm and suicide (AIHW, 2007). Studies of people who self-harm have shown that more than 90% have at least one mental disorder, commonly depression (Skegg 2005). The use of alcohol and other substances may exacerbate self-harming behaviour by reducing inhibitions, reducing coping mechanisms and increasing pain thresholds.

Self-harming behaviour is both premeditated as well as impulsive and may be a result of peer influence (particularly groups of teenage girls and young women). In 2004–05, there were 7,874 hospital separations for intentional self-harm among young people aged 12–24 years, a rate of 218 separations per 100,000 young people. Of these, 71% were for females. The separation rate for intentional self-harm among young females was 2.5 times the rate for young males (AIHW, 2007).

The Australian Institute of Health and Welfare found in 2004-05 the main cause of intentional self-harm for both males and females was self-poisoning, accounting for 80% of self-harm hospital separations (AIHW, 2007). Poisoning, typically overdosing on medication, may overlap with substance use disorders and may in fact be observed as 'drug overdose'. Intentional self-harm by sharp object was the cause of 15% of the separations (1,169 separations) (AIHW, 2007).

### **Suicide**

A range of interacting factors are associated with increased risk of suicide among young people. These include individual, family and social circumstances. Mental illness combined with harmful drug use, previous suicide attempts or intentional self-harm are also linked to suicide (Beautrais 2000; Goldney 1998). A family history of suicide or suicidal behaviour is also associated with significant suicide risk. In addition, socioeconomic disadvantage, including low educational achievement, unemployment, imprisonment, experience of abuse in childhood and easy access to firearms are important contributors to the risk of suicide (Beautrais 2000).

### **Prevalence of suicide in young Australians**

Suicide is the second most common cause of death in 12 – 24 year olds (Chikritzhs et al., 2004).

While male suicide rates were 4 to 7 times as high as female rates in the 1980s, more recently the gap between young males and females has narrowed with the declining male suicide rate since 1997. In 2004, the male suicide rate was 3 times as high as that of females (AIHW, 2007).

In 2004, hanging, strangulation and suffocation were the major methods of suicide among young people (149 deaths or 55%), followed by poisoning (48 deaths or 18%), jumping from a high place (26 deaths or 10%) and firearms (15 deaths or 6%) (AIHW, 2007).

### **Risk of self-harm and suicide**

There is a close link between alcohol consumption 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 and impulsivity (including self-harm)

- precipitating acting on suicidal ideation
- inhibiting effective coping strategies.

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

**Clues that a young person may be vulnerable to risk of suicide** include evident distress. Alternatively they may not react to usual conversational cues (makes little body movement, frowns and avoids eye contact). There may be preoccupation with negative thoughts (hopelessness, helplessness, worthlessness), tearfulness, social or occupational decline, impaired physical health (weight loss, weight gain, poor self hygiene) and/or evidence of past or recent self harm (e.g. cuts on wrists or arms). Consider use of the Mental Health Act (see your *State* equivalent) if the young person is uncooperative with assessment and is at risk of self-harm.

Failure to document and share information with other services about violent risky behaviours places the young person, clinician and community at risk.

### **Risk factors of suicide**

- loss of health, relationship, friend, job etc
- mental illness (e.g. depression, anxiety, schizophrenia)
- family history of suicide
- previous suicide attempt or history of self-harm
- socio-economic disadvantage, low educational achievement or unemployment
- debt, financial hardship and legal problems
- childhood sexual abuse
- access to means (e.g. guns)
- high stress
- sexual preference.

### **Warning signs**

- depression or fatigue
- changes in sleep and eating patterns
- talking of hopelessness, helplessness or worthlessness
- talking or joking about suicide
- preoccupation with death
- loss of interest in things previously enjoyed
- saying goodbye to people
- giving away possessions
- drinking heavily and substance use
- risk taking behaviour (e.g. reckless driving).

### **Know what to do**

1. Take it seriously.
2. Be alert for calls for help.
3. Help immediately.
4. Listen and make time for them.
5. Ask them if they have ever contemplated suicide.
6. Don't leave them alone and discard anything that could be used in a suicide (e.g. guns).
7. Refer to crisis team or police.

**References:**

- AIHW (2007) Australian Institute of Health and Welfare (2007) Young Australians: their health and wellbeing 2007. Cat. no. PHE 87. Canberra: AIHW.
- Barlow, D.H. & Durand, V.M. (1999) Abnormal Psychology Brooks/Cole Publishing
- Beautrais, A.L. (2000) Risk factors for suicide and attempted suicide amongst young people. Australian and New Zealand Journal of Psychiatry 34(3):420-36.
- Chikritzhs, T. et al. (2004) Under age Drinking Among 14 – 17 Year olds and Related Harms in Australia National Drug Research Institute, Perth.
- De Leo, D. & Heller, T.S (2004) Who are the kids who self-harm? An Australian self-report school survey. Medical Journal of Australia 181(3):140-4.
- Goldney, R.D. (1998) Suicide prevention is possible: a review of recent studies. Archives of Suicide Research 4(4):329-39.
- Mental Health Association NSW Inc (2004) What you should know about suicide. A fact sheet produced by the Mental Health Information Service
- Suicide Awareness/Voices of Education – [www.save.org](http://www.save.org)
- Metanoia, breaking Down Barriers - [www.metanoia.org](http://www.metanoia.org)
- Suicide Can Be Prevented (1998) Suicide Information and Education Centre, Lifeline
- Skegg K (2005) Self-harm. Lancet 366(9495):1471-83.
- Yung, A. & Cosgrave, E (2006) Cigarettes and Alcohol and Youth at Risk Australian Doctor, March 2006 pp27

## Slide 14: Sexual risk taking

### Sexual risk taking

**Includes:**

- having multiple sexual partners
- inconsistent condom or other contraceptive use
- being intoxicated during intercourse

**Adverse consequences include:**

- unwanted pregnancy
- exposure to unwanted sexual activity (including forced intercourse and intimate partner violence)
- sexually transmitted diseases such as gonorrhoea, chlamydia, syphilis and HIV/AIDS

During early teenage years and adolescence there is a cascade of hormonal changes. Experimenting with alcohol and other drugs is often accompanied by engaging in experimental sexual activities. Young people with mental health and substance use issues may be at greater risk of exposure to unwanted sexual contact or less likely to use contraception during consensual sex. As a person who works with young people, you can help minimise these harms by providing safe sex information, appropriate interventions and referral to specialist services such as family planning and sexual health clinics.

### Key points

- 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).
- Intimate partner violence accounted for the greatest risk of disease and injury among young females (6%), while for young males, illicit drugs (12%) and alcohol (11%) were the largest contributors to disease burden (AIHW, 2007).
- Childhood sexual abuse is a predicting factor in the development of mental health and substance use issues and may contribute to risky sexual activity.
- A young person's confusion about sexuality or same sex attraction was identified as a major risk factor in suicide according to the NSW Mental Health Council (2004).
- If a young female is participating in unprotected sex, it is perhaps wise to discuss with her about considering the use of other contraception methods like the oral contraceptive pill (aka 'the pill'), hormonal implant (e.g. Implanon) or hormonal injection (e.g. Depo-Provera or Depo-Ralovera). Issues to consider before prescribing contraception include cost of contraception and age of consent - There is no legal requirement for a young person aged 16 years or more to get consent from a parent to receive contraceptive medical advice or treatment. When a GP believes a young person aged 16 or younger can give informed

consent, they are able to prescribe contraception with out permission of the parent or guardian.

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## **Additional information**

### **Risky sexual practices**

A study of Australian 16 – 17 year olds showed that 15% had recently engaged in sexual risk taking behaviour while under the influence of alcohol (Bonomo, 2001) and about half of all incidents of unwanted sexual activity involve the use of alcohol or other drugs by the victim, perpetrator or both.

### **Sexually transmitted infections**

In 2005, there were 51,546 STI notifications in Australia. Of these, 25,571 or 50% were for young people aged 12–24 years. Chlamydia infection was the most commonly reported STI for all people as well as among young people aged 12–24 years (NNDSS 2007).

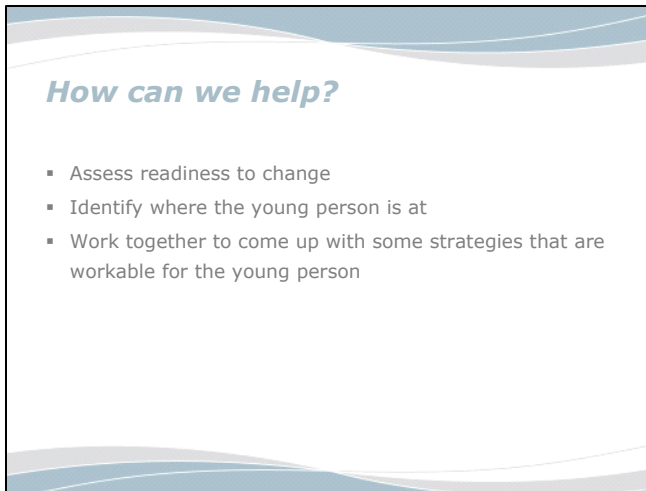
In 2005, there were 2,212 notifications of syphilis in Australia (NNDSS 2007) and 14% (315 notifications) of these were for young people aged 12–24 years (AIHW, 2007).

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### **References:**

- Australian Institute of Health and Welfare 2007. Young Australians: their health and wellbeing 2007. Cat. no. PHE 87. Canberra: AIHW.
- Bonomo, Y. et al., (2001) Adverse outcomes of alcohol use in adolescents. *Addiction* 2001 96:1485-96
- Mental Health Association NSW Inc (2004) What you should know *about suicide*. A fact sheet produced by the Mental Health Information Service
- 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
- Australasian Legal Information Institute, Legal Information Access Centre (LIAC) website, Hot topic: Young people and health. Viewed September 2007. <[http://www.austlii.edu.au/au/other/liac/hot\\_topic/hottopic/2000/5/8.html](http://www.austlii.edu.au/au/other/liac/hot_topic/hottopic/2000/5/8.html)>

## Slide 15: Working with young people to improve their mental health and drug use

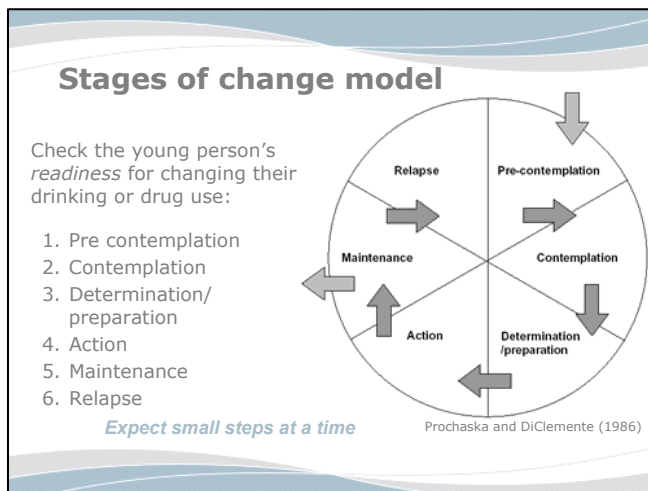


***How can we help?***

- Assess readiness to change
- Identify where the young person is at
- Work together to come up with some strategies that are workable for the young person

These issues are described in detail on the following slides.

## Slide 16: Stages of change model



It is important to identify what the young person wants and what is their expectation of your role in providing support for this. You can help to identify their readiness for changing their drinking or drug use and assist them in setting realistically achievable goals as well as provide ongoing assessment and review of their management plan.

### Key points

The 'stages of change model' may help to identify these:

- **Pre-contemplation stage** – the young person does not believe they have a problem or does not want to change.
- **Contemplation stage** – they are beginning to evaluate their drinking or drug use and starting to think about changing their behaviour.
- **Determination stage (readiness to change)** - they decide they **do** want to change.
- **Action stage** - they change their drinking or drug use patterns by cutting down (reducing the amount or frequency) or quitting.
- **Maintenance stage** - they keep their reduced level or no use.
- **Relapse** – they return to or increase use.

### Additional information

#### Pre-contemplation stage

During pre-contemplation the disadvantages of change outweigh advantages. You may be concerned about some consequence of the young persons drug use, but they may accept this as okay for them.

Commonly, there is resistance to 'action oriented interventions' and explanations about how to 'give up', but relevant information about risks, and how to avoid or minimise them, may be well received. For example, a young person injecting amphetamines might welcome information about how to avoid blood borne viruses or how to manage sleep disorders. A heroin user may be keen to get advice on how to avoid overdose. Use motivational interviewing to help them explore the advantages and disadvantages of current patterns of drug use.

### **Contemplation stage**

The balance of costs and benefits begin to shift, although the young person may appear not interested in change. 'I should give up because of all the problems. But what am I going to do instead? I'll be bored and will miss my friends.'

### **Determination stage (readiness to change)**

The balance has shifted. The young person is preparing to take action and has confidence in their capacity to change. Change is seen as worthwhile. This is often a planning stage. Goal setting, identifying internal and external supports/resources and identifying strategies to support change can help.

### **Action stage**

The young person is taking steps to change. Support and specific skill training can be provided. Review initial reasons that led to the decision to change.

### **Maintenance stage**

Changes in behaviour maintained for six months or more are usually associated with substantial improvements in the quality of life (e.g. housing, employment, relationships, physical and mental wellbeing). Without such changes, the effort to change may not seem worth it and relapse is more likely. Encourage them to talk about the positive reasons for maintaining change to reinforce their decisions.

### **Relapse**

This is when the young person has returned to use of drugs after a period of change. It can be a one off incident or could be more regular use. This is quite common.

You play an important role in assisting the young person to see relapse as a learning experience, to assess their motivation to change and to develop strategies to overcome the issues and triggers involved with going back to their drug use.

### **References:**

Prochaska, J.O. and Di Clemente, C.C. (1986). Towards a comprehensive model of change. In: W.R. Miller and N. Heather (Eds), Treating addictive behaviours: Processes of change. New York: Plenum Press.  
Police Drug Diversion Initiative (PDDI) South Australia (website sourced June 2007 <http://www.divert.sa.edu.au>)

## Slide 17: Recreational drug use

### Recreational drug use

Abstaining from drug or alcohol use is the best prevention.

However it may not be possible to prevent young people using alcohol and other drugs. Therefore advise them to:

1. Plan ahead and prepare
2. Party safe
3. Rest and recover

The primary message for young people is that it is better not to use alcohol or other drugs. However it is not always possible to prevent all drug use. As someone who works with young people, you can reduce the harms by offering advice on recreational drug use, which may help prevent intoxication and exposure to the associated risks of drug use.

### Key points

Young people should be advised to:

- 1. Plan ahead and prepare:** e.g. eat before partying; set limits; organise a designated driver or make sure they have money for transport home (e.g. bus or taxi); organise a friend to keep an eye on you.
- 2. Party safe:** don't mix drinks or drugs; space alcohol with non alcoholic drinks; be aware of drink spiking; take regular breaks from dancing; don't use alone and look out for friends; do not leave people alone if they are unconscious; if someone collapses always call an ambulance for medical assistance; practice safe sex and don't drive while intoxicated or under the influence of drugs.
- 3. Rest and recover-** allow time to recover; eat, sleep and hydrate well after partying. Inform young people of the effects of recreational drug use and changes in behaviour or mood (such as depression following ecstasy or amphetamine use) and invite them to discuss these you or another health worker.

### Additional information

The following information outlines strategies for safer use of alcohol and other drugs;

- Safer alcohol use
- Safer partying ('club drugs')
- Safer inhalant use

### Safer alcohol use

Some tips for advising young people on how to control their drinking:

- Plan ahead, set limits and stick to them.
- Start with a non-alcoholic drink.

- Drink slowly. Take sips, not gulps.
- Remember that 'alco-pops' (sweet-flavoured pre-mixed drinks) often mask the taste of the alcohol, but they do not mask the effects.
- Try the low-alcohol alternative (e.g. light beer).
- Eat before or while drinking, and avoid salty snacks, which make you thirsty.
- Avoid buying in rounds or 'shouts'.
- Have one drink at a time so you can keep track of your drinks—avoid 'topping up'.
- Pace yourself.
- Stay busy—don't just sit and drink.
- Have at least two alcohol-free days a week.
- Be assertive—don't be pressured into drinking more than you want or intend to.
- Know your limits.
- Nominate a non-drinker to drive and generally to look out for those who will be drinking.
- Make sure there is a family member or a friend who can be called for assistance.

It is important to note that young people 14 -17 years have a similar drinking pattern to adults however they are at much greater risk of harm due to their smaller physical size, and emotional and intellectual inexperience. The NHMRC guidelines are established for the legal drinking age, those 18 years and over.

### **Safer partying ('club drugs')**

Nightclubs, raves and other entertainment venues and events can get very crowded and hot. Some drugs, such as ecstasy and speed, raise the body's temperature, while alcohol dehydrates the body. Young people should be advised to:

- Take regular rests from dancing—use a 'chill-out' space to rest or recover.
- Wear light, absorbent clothing.
- Replace lost fluids with water—500ml per hour if active and 250ml per hour if inactive. Note that some young people may however drink much more water than they need.
- Watch your drink (be aware of drink spiking).
- Allow your body to recover—make sure you eat well and get enough sleep.
- Don't mix drugs.
- Don't mix GHB and alcohol—this mix has been associated with overdose.
- Call an ambulance for medical assistance (tel. Emergency 000 or 112 from mobile phones).

### **Safer inhalant use**

While prevention is preferable, it may not be possible to prevent all use of inhalants. As someone who works with young people, you can work to reduce the harms by offering advice on how to lower the risks and reduce accidents. Strategies include advising users:

- that some substances (such as glue) are less harmful than others;
- not to sniff alone or in dangerous places;
- not to put plastic bags over their heads;
- smaller bags reduce the risk of suffocation;
- substances are flammable (no smoking);
- using alcohol or other drugs while intoxicated with inhalants increases the chance of accidents and overdose.

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#### **References:**

Australian Drug Foundation (2002) Facts about Binge Drinking. Fact sheet Number 1.10 November 2002 DrugInfo Clearinghouse  
Australian Drug Foundation (2003) Club Drugs. Fact sheet Number 2.6 August 2003 DrugInfo Clearinghouse  
Australian Drug Foundation (2004) Inhalant use. Fact sheet Number 2.3

## Slide 18: Preventing blood borne viruses

### Preventing blood borne viruses (BBV)

To reduce transmission of BBVs (eg HIV and hepatitis C) offer information about safer:

- injecting practices
- body piercing
- tattooing

*This includes encouraging use of:*

- clean equipment and surroundings
- single use equipment (and not sharing equipment)
- alcohol swabs
- sterile (or at least clean) water for IV drug use
- skin penetration hygiene (eg hand washing)
- information about needle syringe programs and user organisations

Injecting drug use, body piercing and tattooing are activities where blood borne viruses (BBVs) can be transmitted between young people. It is important to provide credible information about how to prevent BBV transmission and promote safer injecting or skin penetration practices.

### Key points

Safer injecting practices:

- **Clean equipment:** wherever possible, use all new and sterile injecting equipment.
- **General hygiene:** get hands as clean as possible - if you don't have access to running warm water and soap, remember to get extra swabs and use one of these for each finger and thumb. Get surface as clean as possible (with soapy water or wipe away dirt etc). Lay out all the equipment in the order in which you use it to make the process smoother and quicker.
- **Swabs:** alcohol swabs clean away dirt and bacteria but **not** viruses like hepatitis or HIV. Use swabs to clean spoons or any equipment (like pocket knives or keys) that come in contact with the drugs to be injected.
- **Water:** sterile water ampoules are the safest option (available at most needle/ syringe outlets). NOTE: mix only once and then discard (don't recap it for later) as bacteria grows easily in sterile water. If sterile water is not available, use boiled water drawn up from near the surface (as heavy metals sink to the bottom and shouldn't be injected). Wait until it cools to avoid vein damage as well as warping the rubber plunger in the fit (as it will stick) making it unusable.
- **Tourniquets:** infrequent users or those with good veins may not need a tourniquet. Blood contact is more common with tourniquets. Use something soft and easy to release. Release the tourniquet after the needle is inserted but *before* injection.
- **Barbes/blunt needles:** barbed or hooked needles that have been used already or knocked can damage veins. Use new needles or check they are not damaged prior to use.
- **Using in groups:** blood borne viruses (BBVs) like hepatitis C and HIV can be spread by traces of blood that *cannot be seen* by the naked eye. Try and be aware of this at all times, especially when using with other people and never share needles or equipment.

### Reference:

NUAA (2005) NSW Users and AIDS Association Inc Safe Injecting Practices Patient Information Sheet

## Slide 19: Involving families and carers

### Involving families and carers

Families and carers provide essential support to young people with mental health and substance use issues

- Often know the young person best
- Provide emotional support and encouragement
- Assist in navigating through services, following up referrals, making bookings
- Are often in for the 'long haul'

Young people who have the support of families or carers or the presence of a consistent caring adult "other" in their lives do better in self management of their mental health and substance use and in access and retention in treatment than those who are alienated from family, carers or significant 'others'.

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### Key points

- Engaging the family and gaining the trust of family members is critical in treating young people.
- It is important to work out a balance between engaging the family members and supporting the young person's ability to make decisions for themselves.
- When the young person is accompanied by a family member or carer, explain the need for you to see the young person alone and explain to the family member why this is important.
- In many cultures, participation in health care is a family rather than an individual responsibility.
- If the young person's English is limited, avoid using family members as interpreters.

**Unit Three provides more detail about working with families and carers.**

## Slide 20: Story vignettes and case discussion – story A

**Story vignette A - Sean**

**Discussion points**

1. What mental health and substance use issues is Sean describing in this story?
2. Discuss how communication blocks affected Sean and how these might be avoided in the future
3. Is Sean ready to change his current pattern of behaviour?
4. If Sean were telling YOU this story, what history and assessment steps would you take?
5. What opportunities would there be to assist Sean in seeking help through a GP?
6. What interventions might be helpful and which local services could you draw on to help Sean?

*"I thought it was normal for teenagers and that everybody would go through it at some stage. It started in about Year 10. I'd always been in the top classes and then my schoolwork started going down hill and the effort of keeping it all together was just so exhausting. I'd get home and slam my bedroom door and just let it all out and howl and howl. It was like I was two people. One on the outside and one on the inside.*

*I guess my teachers must have noticed that things were a bit weird but because I'd always done so well, they probably expected that I'd muddle through. And no-one talked to me or Mum from memory. Mum did take me to a counsellor because she was worried that I wouldn't talk to her but I didn't open up to him either. He said it was normal teenage rebellion and told me to be more considerate because my mother was worried about me.*

*When I think about it now, I think that if only I'd got a diagnosis earlier then things would have turned out a lot better. I would have been more realistic about what I could achieve in the HSC for example. And maybe I would have found other ways to get to Uni or TAFE.*

*But after I crashed in the exams, I spun out and started pushing the physical boundaries: late nights, stressful relationships, cannabis, a bit of e, a bit of speed. And all of these things have made my recovery so much harder. I'm on this merry-go-round of uppers and downers and I'm sick of it."*

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### Points for discussion:

1. What mental health and substance use issues is Sean describing in this story?
  2. Discuss how communication blocks affected Sean and how these might be avoided in the future
  3. Is Sean ready to change his current pattern of behaviour?
  4. If Sean were telling YOU this story, what history and assessment steps would you take?
  5. What opportunities would there be to assist Sean in seeking help through a GP?
  6. What interventions might be helpful and which local services could you draw on to help Sean?
-

**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**

- Discuss Sean's history and possible diagnosis.
- Discuss the fact that Sean is a high achiever and how this may have 'blocked' recognition that things were not going well for him.
- Ask participants to identify key points at which problems could have been identified and potentially prevented or short circuited.
- What seem to have been the main communication blocks in this story?
- Discuss the effects of the mix of drugs that Sean is taking and the physical and psychosocial risks that may result.
- What role can a GP play in Sean's health care?
- Ask participants to investigate how a GP would review and assess Sean's health and wellbeing at the present time and how the GP would gain support of other services in developing a care plan for Sean.
- How might Sean be helped to access a GP? And would the GP be the preferred health care provider?
- What local services are there for *young* people in the area?

**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 21: Story vignettes and case discussion – story B

**Story vignette B - Darren**

**Discussion points**

1. What are the risks to Darren's mental and physical health? Especially given he is still seen as a carer by the younger kids?
2. How might further risk be averted and some of the current problems be resolved or alleviated?
3. If Darren told you this story, what would YOUR response be?
4. What health care would benefit Darren? What particular role could a GP play?
5. What issues does this story raise in terms of duty of care and confidentiality?
6. What support could other local health and community services provide?

*"Ordinary kids don't know about sex or drugs or stuff until later. But I already knew all that when I was still in primary. There was nothing new to me about it.*

*Mum's friends came around all the time: people I didn't even know, just walking in, straight through our house, past us, into her room. And this isn't no good for the little ones. When babies and little kids see someone they don't know, they get scared. They'll be staring and they'll be thinking, 'Who's that? I don't know him?'*

*...And then they're looking at me, their eyes asking, 'Is it all right?' They're looking at me to make sure. And to them it is because I'm there. They're thinking, 'My brother's here. I'm all right.' That's what they're thinking. But I've got no-one to look up to, to feel safe with, except Mum, and after she let those blokes in, she was with them. Not me.*

*With drugs, you know your Mum cares for you and stuff but she doesn't show it anymore. With drugs, Mums care more about what's to come, than for what they've already got.*

*I'm 17 now and sometimes I've got too much in my head and I get pretty spun out. And I feel myself getting depressed – and angry. Sometimes I think I'll use the drugs too – there's plenty lying around at home. So I just try to get away by myself. I go to the community centre. That's like another life for me. I go into the gym and do weights and some of the volunteers, the adults, they help me out. The other kids still run after me and stuff. They're always saying, 'Where's Darren? Where's Darren?' And that's good. But I need space for myself too. To work it out..."*

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### Points for discussion:

1. What are the risks to Darren's mental and physical health? Especially given he is still seen as a carer by the younger kids?
  2. How might further risk be averted and some of the current problems be resolved or alleviated?
  3. If Darren told you this story, what would YOUR response be?
  4. What health care would benefit Darren? What particular role could a GP play?
  5. What issues does this story raise in terms of duty of care and confidentiality?
  6. What support could other local health and community services provide?
-

**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**

- Encourage participants to discuss the family situation, especially safety issues.
- Focus on Darren – consider the burden of care he is shouldering, the long term 'parenting' role he has been playing and the impact on his physical, mental and emotional health during adolescence.
- Explore the fact that his only 'time out' is on his own rather than with his peers
- How might Darren be introduced and helped to access local health services?
- What other services can provide support and positive experiences for Darren? Include reference to mentoring programs.
- Highlight the use of the HEEADSSS assessment as a way to explore Darren's current state of health and wellbeing.
- How much of a problem is Darren's depression and anger and what strategies could you suggest that will continue to prevent him using the drugs in the home?
- Explore the role that health services, especially general practitioners can play in care and support for Darren.
- Discuss the duty of care that health and other services will have in regard to Darren and the situation he is in. Does mandatory reporting come into play here?
- Explore issues of confidentiality.
- What local services are there for *young* people in the area? What interventions may be useful for Darren?

## Slide 22: 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.

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### **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 23: In summary

**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.

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### 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.
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