Training Frontline Workers
Young People, Alcohol & Other Drugs

Frameworks for AOD Work
Project Outline

This project, an initiative of the National Illicit Drug Strategy, has developed teaching and learning resources to assist frontline workers address the need of young people on issues relating to illicit drugs. They will support a training organisation in the delivery of training. The modules explore work with young people, drug use and suitable intervention approaches.

Project Management

The development of the resources has been managed by:

- New South Wales Technical and Further Education Commission (TAFE NSW) through the Community Services, Health, Tourism and Hospitality Educational Services Division
- Drug and Alcohol Office (Western Australia)
- The Northern Territory Health Service.

Acknowledgements

The original consultations, writing, practitioner review and revision of the materials has involved a large number of services including:

- Alison Bell Consultancy
- Centre for Community Work Training, Association of Children’s Welfare Agencies (NSW)
- Community and Health Services (Tas)
- Community Education and Training (ACT)
- Curtin University
- Department of Community Services (NSW)
- Department of Juvenile Justice (NSW)
- Drug and Alcohol Office (WA)
- Health Department of NSW
- National Centre for Education and Training in Addictions
- New England Institute of TAFE, Tamworth Campus
- Northern Territory Health Service
- NSW Association for Adolescent Health
- Ted Noff’s Foundation (NSW)
- The Gap Youth Centre (NT)
- Turning Point (Vic)
- Youth Substance Abuse Service
- Youth Action Policy Association (Vic)

This project was funded and supported by the National Illicit Drugs Strategy through the Australian Government Department of Health and Ageing.
The Materials

The final product, provided for distribution on CD-Rom, consists of:

- a facilitator and learner guide for 12 modules,
- a support text for workplace learning.
- Overhead transparencies using Microsoft PowerPoint for each module to support facilitators who choose face-to-face delivery.

Each document has been provided in

- Acrobat (pdf) format to ensure stability
- A Microsoft Word version to enable organisations to amend, add and customise for local needs

The primary user would be a facilitator/trainer/training organisation that would distribute the learning materials to the learners. They can be used in traditional face to face or through a supported distance mode.

Materials have been prepared to allow direct colour laser printing or photocopying depending on the size and resources of the organisation. It is not envisaged that learners would be asked to print materials.

Assessment

Where assessment of competence is implemented training organisations are reminded of the basis principles upon which assessment should be based:

Assessment is an integral part of learning. Participants, through assessment, learn what constitutes effective practice.

Assessment must be reliable, flexible, fair and valid.

- To be reliable, the assessment methods and procedures must ensure that the units of competence are applied consistently.
- To be flexible, assessment should be able to take place on-the-job, off-the-job or in a combination of both. They should be suitable for a variety of learning pathways including work-based learning and classroom based learning.
- To be fair, the assessment must not disadvantage particular learners
- To be valid, the assessment has to assess what it claims to assess.
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Training Frontline Workers: Young People, Alcohol and Other Drugs

Background

The project Training Frontline Workers – Young People, Alcohol and Other Drugs is part of a broad strategy to support the educational and training needs of frontline workers. The training and support needs of frontline workers not designated as alcohol and other drug workers to enable them to work confidently with young people on illicit drugs is well recognised. This project attempts to meet this need. It was funded by the Australian Government Department of Health and Ageing under the National Illicit Drug Strategy (NIDS).

Target occupational groups

This training resource has been developed specifically for the following groups of frontline workers:

- Youth workers
- Accommodation and crisis workers
- Counsellors (including school-based)
- Primary and community health and welfare workers
- Juvenile justice workers
- Teachers
- Police
Approaches to service delivery

The development of the resources brings together two approaches to service delivery:

- work with young people
- alcohol and other drug work

The two approaches which underpin these resources are summarised as follows:

Working with young people

A **systems approach** is the most appropriate model to understand and work with young people. A systems approach assumes that no aspect of behaviour occurs in isolation, rather it occurs within a wider context. In other words, to understand young people we need to consider the individual, their family, the wider community and society as a whole as well as how they interact with each other.

The systemic youth-focused approach assumes that:

- Young people deal with challenges in ways similar to other people in society (some well, others not so well). Young people develop their coping strategies and skills by learning from others around them, through their own personalities and through trial and error.

- The term ‘youth’ is a social construction. Societal values and beliefs about young people determine the way in which they are treated within society (for example, young people are viewed differently in different cultures).

- Young people are not an homogenous group. Although young people share some common developmental issues, their backgrounds, experiences and cultures are as diverse as the rest of the population.

- Young people participate actively in their lives, make choices, interact with others, initiate changes and participate in our society. They are not passive victims of a dysfunctional society, family or peer group.
The following social justice principles guide work with young people:

- **Access**: equality of access to goods and services
- **Equity**: overcoming unfairness caused by unequal access to economic resources and power
- **Rights**: equal effective legal, industrial and political rights
- **Participation**: expanded opportunities for real participation in the decisions which govern their lives.
**Alcohol and other drug work**

**Harm minimisation** is the most appropriate approach for working with alcohol and illicit drug issues. The goal of harm minimisation is to reduce the harmful effects of drugs on individuals and on society. Harm minimisation assumes that while we cannot stop drug use in society, we can aim to reduce the harm related to using drugs. Harm minimisation has three components: harm reduction, supply reduction and demand reduction.

A variety of drugs, both legal and illegal, are used in society. There are different patterns of use for drugs and not all drug use is problematical.

Large proportions of young people try alcohol or other drugs, including illicit drugs, without becoming regular or problem drug users.

Drug use is a complex behaviour. Interventions that try to deal with single-risk factors or single-risk behaviours are ineffective.

Drug use represents functional behaviour for both young people and adults. This means that drug use can best be understood in the broader context of the lives of the young people using them. Any interventions need to take the broader context into account.

**Training approach**

These training resources are based on the following principles:

- Training is consistent, supports a national qualification and provides a pathway to a qualification.

- Training is based on adult learning principles. It should:
  - build on learners’ existing knowledge, skills and experience
  - utilise problem-based learning and skills practice, and
  - develop critical thinking and reflection.

- Training is to be flexible and available through a variety of methods. Examples include workshops, self-directed learning, distance learning supported by a mentor/facilitator and work-based learning.
- Work-based learning provides participants with the opportunity to reflect on current work practices, apply their learning to the work situation and to identify opportunities for organisational change and development in their workplaces.

- A key learning strategy of the resources, supported by individual, group and work-based activities, is reflection: alone and with peers and supervision. To reflect upon and evaluate one’s own work, the types of intervention used and the assumptions they are based on is crucial to working more effectively.

Project resources

The Young People, Alcohol and Other Drugs program aims to provide the core skills and knowledge that frontline workers need to respond to the needs of young people with alcohol and drug issues, particularly illicit drugs.

This training resource, which comprises 12 modules, has been developed to provide a qualification and/or specific units of competence. The resource can also be used as a test or reference document to support the development of a specific knowledge or skill.

Each module (except Module 1) comprises a Learner Workbook and a Facilitator Guide. Each Learner Workbook is a self-contained resource that can be used for both distance and work-based learning or to support face-to-face learning (including workshops).

Relationship to the Community Services Training Package (CHC02)

The training modules were initially developed to support four units of competence from the Community Services Training Package (CHC99). These were:

- CHCYTHA Work effectively with young people
- CHCAOD2A Orientation to the alcohol and other drugs sector
- CHCAOD5A Provide support services to clients with alcohol and other drugs issues
- CHCAOD6A Work with clients who are intoxicated.
Following the release of the revised Community Services Training Package (CHC02) in April 2003, the modules were revised to support the following units of competence from the revised Training Package:

<table>
<thead>
<tr>
<th>Unit of Competence</th>
<th>Module</th>
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</table>
| CHCYTH1C Work effectively with young people | • Perspectives on Working with Young People  
• Young People, Risk and Resilience  
• Working with Young People |
| CHCAOD2B Orientation to the alcohol and other drugs sector | • Young People, Society and AOD  
• How Drugs Work  
• Frameworks for AOD Work |
| CHCCS9A Provide support services to clients | • Helping Young People Identify their Needs  
• Working with Young People on AOD Issues  
• Working with Families, Peers and Communities  
• Young People and Drugs – Issues for Workers |
| CHCAOD6B Work with clients who are intoxicated | • Working with Intoxicated Young People |

The twelfth module **Planning for Learning at Work** is designed to support participants in their learning.

The four units of competence listed above contribute to national qualifications in both Youth Work and Alcohol and Other Drug Work and are electives in a range of other qualifications. Since these units by themselves will not deliver a qualification, the additional units listed in the Community Services Training Package Qualification Framework would need to be completed.

To achieve any of the above units a learner must complete all the modules comprising that unit and be assessed by a qualified assessor from a registered Training Organisation. While it is possible to complete individual modules, this will not enable you to achieve a unit of competence. Individual modules will contribute towards gaining the unit of competence and over a period of time all modules needed for the unit could be completed.
Each of the units of competence has a different focus and has been customised within national guidelines to meet the needs of frontline workers in working with young people with illicit drug issues. The modules each provide a learning pathway with stated learning outcomes to help achieve each particular unit of competence.

Since the modules associated with each unit of competence progressively build on each other, they can be delivered and assessed in an integrated manner. This provides learners with a ‘total view’ of the essential theory and required skills for their work roles.
Using the Facilitator Guide

Each Facilitator Guide is a comprehensive teaching tool that contains the information, resources and activities required to meet the learning outcomes of a particular module. It is designed to be used in conjunction with the Learner Workbook for that module which contains detailed information that facilitators may wish to refer to. The Facilitator Guide and the Learner Workbook are suitable for a variety of delivery modes, including face-to-face learning, distance and work-based learning.

The Facilitator Guide is divided into two sections.

**Section A** provides general information about the training resources and guidelines on how to support learners and assist them in developing a learning pathway and plan.

**Section B** provides the facilitator instructions for the module.

The Facilitator Guide provides an overview of the module, the learning outcomes and any links to other modules. It provides a summary of the Learner Workbook content topic by topic and suggested facilitator-led discussions and learning exercises. While an approximate timing of activities is suggested, facilitators are encouraged to use their judgement, taking into account the knowledge and skill level of the learners. Each Guide contains overheads, a glossary and a list of references and resources. Icons are used in both the Facilitator Guide and the Learner Workbook to highlight instructions and activities suitable for work-based learning, application and reflection.

It is recommended that facilitators read both the Facilitator Guide, the Learner Workbook and key references.

Prior to commencing the module with learners, facilitators should be familiar with the:

- Learning outcomes
- Module content by topic area
- Learning activities within each topic
- Structure and flow of the module
- Learner workbook
- References and resources listed
Supporting distance learners

These training resources have been developed with the understanding that learners should not undertake these modules without the support of an appropriately qualified facilitator. This is especially the case for distance learners who undertake their learning outside of a classroom or workshop setting.

Distance learners have specific needs in relation to:

- Isolation
- Conflicting priorities and time pressures.

A variety of strategies may be used to accommodate learner needs and support learning. These include:

- providing alternative activities or additional tasks to achieve the learning outcomes. Some activities may be unrealistic in some locations (e.g. asking learners to visit other agencies when they are in a remote location)
- developing a learning plan to clarify what topics are to be completed, by when and how
- maintaining contact with learners to monitor their progress and assist with learning
- establishing a learning community through group teleconferences, e-mail or list servers to help learners process issues through discussions and ideas/feedback from other learners.
Contact with distance learners

It is important for facilitators to establish and maintain contact with distance learners.

The amount of contact will depend on:

- nature of the topic being undertaken
- learner’s available resources including availability of other learners, mentors or colleagues
- learner’s desire for interactivity
- learner’s motivation and other learning needs.

Developing a learning plan

In order to develop a learning plan with a learner you will first need to identify their learning needs. From these needs you will be able to formulate learning goals and develop a plan to meet these goals. The learning plan should contain details on what will be learned, how it will be learned, by when, what criteria will be used to evaluate the learning and how the learning will be validated. A learning plan is best prepared by the learner with the guidance and support of a mentor or facilitator. Topic 4 in the module Planning for Learning at Work contains detailed information on preparing a learning plan.

Once learner needs have been identified they can be matched up with the units of competence and the resources available.

The following steps will assist you to develop a learning plan with a learner:

3. Assessment of learning needs

This may include analysis of:

- learner’s values
- skills
- strengths and weaknesses
- preferred learning style
- suitability of learner’s work situation as a work-based learning environment (Is there a quiet place to read/write/consider? Are study leave provisions available? Is management supportive of work-based learning?).
4. **Identification of learning goals**

It is important to identify learning objectives both from a learner’s perspective and from an organisational perspective. Those learners who are undertaking learning as part of a process initiated by their organisation may well have different needs and motivations to those learners who have elected or volunteered to undertake further learning. Once established, learning goals can be reviewed against the learning outcomes of the module/s in this resource. This will assist the selection of appropriate modules.

3. **Identify learning resources, supports and strategies.**

Evaluate the availability of the following resources and the learner’s confidence in accessing them.

- people (facilitator, other learners, mentors, supervisors etc)
- resources (e.g. texts/libraries)
- technology (e.g. phones, Internet/e-mail, video-conferencing)

4. **Specify what constitutes evidence of learning**

How will you and the learner know that learning has occurred? Assessment of learning could include a portfolio, case notes, role plays and/or case studies.

5. **Specify target dates**

Specify dates for progress reviews and for module/task completion. Agree on how this will occur.

Target dates for contact with facilitators should specify:

- Informal query or concerns (How can a learner access you if they have a query or concern? For example, e-mail, telephone etc)

- Progress review dates (When will formal contact be initiated to check on progress and how will this be done? For example, by telephone, face-to-face meeting etc.)

- Assessment event due dates (When are assessment events due and how will they be submitted? (For example, by post, e-mail etc)

- Feedback. When will feedback be available on assessment performance and how will that be delivered?
Many learners will want to develop knowledge and skills in a number of areas. Overlapping content across the units has been identified in the individual modules.

**NOTE:** CHCAOD2B provides key underpinning knowledge on AOD work and reflection on personal values and attitudes to alcohol and other drugs. It is recommended that this unit be completed before undertaking the other units in alcohol and other drug work. In particular, the module **How Drugs Work** provides underpinning knowledge about the action of a drug on the individual. It is recommended that learners completing CHCCS9A and CHCAOD6B also complete this module.
DEVELOPING A LEARNING PATHWAY

When you have worked with your learners to identify their skill/knowledge gaps, the following guide may assist you in developing a learning pathway for each learner or group of learners. Learners’ may choose to do one, several or all of the units, depending on their needs.

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<th>If learners want information about young people and ways of working with young people.</th>
<th>If learners want information about the alcohol and other drug sector and a greater understanding of drug use in society.</th>
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<tr>
<td>Explores the stage of adolescence and a range of factors that impact on the development of young people</td>
<td>Looks at ways of understanding drug use in society and by young people in particular and presents an overview of patterns and trends of AOD use by young people. Broad societal factors that influence work on AOD issues are also explored.</td>
<td>Develops skills in identifying alcohol and other drug issues for young people at an individual, group and community level.</td>
<td>Provides information and skills in working with intoxicated young people.</td>
</tr>
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<td>Young People, Risk and Resilience</td>
<td>How Drugs Work</td>
<td>Working with Young People on AOD Issues</td>
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<tr>
<td>Provides a framework for understanding and working with young people</td>
<td>Provides information about drugs and how they act on the body.</td>
<td>Provides skills in working with young people with AOD issues on a one-to-one basis. The emphasis is on young people who are experiencing problems because of their AOD use.</td>
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<td>Working with Young People</td>
<td>Frameworks for AOD Work</td>
<td>Working with Families, Peers and Communities</td>
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<tr>
<td>Provides a broad framework for understanding and working with young people, explores goals of working with young people and the development of specific skills.</td>
<td>Provides an overview of the range of AOD interventions, from prevention through to treatment and explores their relevance to work with young people on AOD issues.</td>
<td>Provides a framework and skills for working with young people on AOD issues at a community and family level.</td>
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<tr>
<td>Young People and Drugs - Issues for Workers</td>
<td></td>
<td>Young People and Drugs - Issues for Workers</td>
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<tr>
<td>Explores a range of issues that workers may encounter when working with young people on AOD issues. These include personal values, ethical issues and issues surrounding confidentiality and accountability.</td>
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Planning for Learning at Work

If learners want advice about planning learning and how to learn
Supporting Distance Learners in Developing a Learning Plan

1. Assessment of learning needs

Learners should be assisted to assess their:
- Values
- Skills
- Strengths and weaknesses
- Learning style
- Learning environment
- Reason for attending
- (e.g. compulsory - organisation initiated or voluntary – individually initiated)

2. Identification of learning goals

- Learners goals (SMART)
- Organisational goals (if applicable)
- Module learning outcomes

3. Identification of learning resources, supports and strategies

Includes availability and confidence to access:
- **People** (facilitator, other learners, mentors, supervisors, colleagues, other professional and services etc)
- **Resources** (texts/references, libraries etc)
- **Technology** (Internet/websites, e-mail, video-conferencing etc)

4. Identification of forms of evidence of learning

5. Specify timeframes and mode of contact

Includes time frames for:
- Informal contact (e.g. if the learner has a query)
- Review of progress
- Assessment events
- Finalising module requirements

Mode of contact could include:
- Telephone call
- E-mail
- Group teleconference (e.g. with other learners)
- Face-to-face meetings

NOTE:
Remember that learning is part of a cyclical process and the development and implementation of the learning plan will form the basis of analysis, reflection and further planning.
Assessment

Example assessments are provided for these resources. However, individual Registered Training Organisations (RTOs) will determine assessments for the modules/units offered. Assessments will be responsive to learner needs and resources available and comply with Australian Quality Training Framework (AQTF) 2001 requirements.

Assessment Principles

Principles upon which assessment should be based include:

- Assessment is an integral part of learning and developing an understanding of what constitutes effective practice
- Assessment must be reliable, flexible, fair and valid
  - To be reliable, the assessment methods and procedures must ensure that the units of competence are applied consistently.
  - To be flexible, assessment should be able to take place on-the-job, off-the-job or a combination of both. It should be suitable for a variety of learning pathways including work-based learning and classroom-based learning.
  - To be fair, assessment must not disadvantage particular learners
  - To be valid, assessment has to assess what it claims to assess.

Facilitator qualifications and knowledge

It is recommended that the facilitator possesses at least:

- the unit of competence or a qualification containing the topic area being taught
- Certificate IV in Workplace Assessment and Training
- experience in the delivery of services to young people

Ideally, a facilitator should also have tertiary qualifications relating to the module being taught.

Under the AQTF (2001) Registered Training Organisations are required to provide appropriately qualified facilitators/trainers.
Resource requirements

Minimum resources required for the different modes of delivery are outlined below. Details of specific resources are contained in each topic.

Face-to-face training requirements

One large room (preferably with break out rooms for small group work) with the following resources:

- Whiteboard and markers
- Overhead projector and screen
- Butchers paper and markers
- Learner Workbook
- Blu tak

Distance learning requirements

- Learner Workbook

Mixed mode delivery requirements

One large room (preferably with break-out rooms for group work) with the following resources:

- Whiteboard and markers
- Overhead projector and screen
- Butchers paper and markers
- Learner Workbook
- Blu tak
The following icons are used in the Learner Workbook and Facilitator Guide to assist you in using the resources.

- **FAC**: Facilitator direction
- **WPL**: Workplace learning activity
- **Case Study**: Case study
- **Task**: Task
- **Writing exercise**: Writing exercise
- **Group activity**: Group activity
- **Links to other modules**: Links to other modules
- **Web resources**: Web resources
- **Video**: Video
- **Question**: Question
- **Answer**: Answer
- **A good point for student to contact facilitator**: A good point for student to contact facilitator
- **Brainstorm**: Brainstorm
- **Suggested time**: Suggested time
- **Overhead transparency**: Overhead transparency
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Young People, Alcohol & Other Drugs

Section B
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Introduction

Overview

In this module learners will be introduced to a range of approaches to working with young people and AOD issues. Prevention, early intervention and treatment strategies are reviewed from a youth-focused systems perspective. This approach acknowledges that young people are influenced by their social environment and that issues related to AOD use are varied.

Not all issues related to AOD use are the result of dependent or heavy regular use. Issues around experimental and recreational use are also important when working with young people. Treatment options are briefly explored along with the range of options for frontline workers in referring young people for individual treatment.
1.2 Learning outcomes

When learners have completed this module they will be able to:

LO Review AOD interventions and their applicability to working with young people on AOD issues

LO Identify strategies to prevent harmful drug use among young people

LO Describe effective interventions for young people with problems related to their AOD use

LO Describe collaborative approaches for working with young people on AOD issues.

It is suggested that you remind learners of these learning outcomes as they work through the module and at different stages ask whether they think they have achieved each of the learning outcomes. This will help them keep track of their progress, and what they still need to learn to successfully complete the module.
1.3 Assessment events

- Provide all learners with information on any assessment activities they might be required to undertake. Ensure that contact is made with distance learners at your earliest convenience.

- Discuss these with learners and provide time for questions, feedback and examples.

- Reflect on assessment events throughout training sessions to enhance learners’ understanding and conceptualisation of what is required. All assessments match Learning Outcomes competencies.

- Suggested assessment events are provided after Topic 8.
Overview

This topic presents a number of frameworks for understanding the range and types of interventions available when working with young people on AOD issues. The youth-focused systems approach provides an overall model for understanding young people in the context of their environments. This model helps learners to understand the multitude of factors that impact on young people’s experience and thus can guide them when developing programs and services.

A range of interventions, from prevention to treatment are presented in this topic as well as the key approaches that underpin AOD work. It is important for frontline workers to be able to successfully match each young person’s needs with the services that can address those specific needs.
2.1 Applying a systems approach to young people and AOD Work

- Young people do not grow and develop in isolation. Events, families, their peers and even the generation they grow up in impacts upon their growth and development.

- A useful way of understanding how young people’s experiences and their environment influences them is to apply a **systems approach**.

- A systems approach assumes that no aspect of behaviour occurs in isolation. In other words, when we try to understand young people, we must consider the individual, their family, the wider community and society as a whole as well as how they interact with each other. Even subtle changes in one part of the system impacts on other parts.

- Learners should refer to the Learner’s Workbook to read the following diagram.

**Youth-focused system approach diagram**

- A youth-focused systems approach is represented in the following diagram which illustrates the factors that influence a young person’s life. Each of the factors involves a complex array of influences and situations which can serve as protective or risk factors. The kinds of risk or protective factors present in a young person’s life can influence the health and wellbeing outcomes for that individual. **Risk factors** might hinder young people’s development and limit their coping abilities thereby increasing the likelihood of social, behavioural and health problems. **Protective factors** enhance social networks and coping abilities, assisting a smoother transition through adolescence.
YOUTH-FOCUSED SYSTEMS APPROACH

Risk and Protective Factors

Local Community Factors
- Population density
- Housing conditions
- Urban/rural area
- Neighbourhood violence and crime
- Cultural norms, identity and ethnic pride
- Opportunities for social development
- Recreational and support services
- Demographic and economic factors
- Connectedness or isolation

Societal and Political Issues
- Laws of society
- Socio-economic climate
- Availability of services
- Social values and norms
- Social/cultural practices and traditions
- Popular culture (e.g. movies and music)
- Government ideology and policies
- Role of media and advertising

School and Peer Factors
- Peer connectedness
- School climate and culture
- School attendance
- Opportunities for social connection
- Norms and values of peers and school
- Friendships and interests
- Educational approach/methods
- School discipline and structure

Family Factors
- Abuse and neglect
- Family dysfunction
- Patterns of communication
- Family income/employment
- Parents’ mental and physical health
- Consistency of connection
- Family values, beliefs and role models
- Family discipline and structure
- Extended/nuclear family
- Family size

Individual Characteristics
- Personality and intelligence
- Gender
- Cultural background
- Physical and mental health
- Social skills and self esteem
- Sexual behaviour/sexuality
- Alcohol and drug use
- Criminal involvement
- Living situation/homelessness
- Values and beliefs

Possible Outcomes
- Nature of relationships
- Health and wellbeing
- Life opportunities (e.g. education and work)
- Criminal and legal consequences
- AOD use and related harm
- Social inclusion or marginalisation

Frameworks for AOD Work - Facilitator's Guide
Using a systems approach means that interventions need to target different factors influencing the young person. As a result, interventions are often targeted more broadly than if just focused on the individual. This involves working with the individual young person, their family and peers, as well as the community and society that they live in. As well as the traditional casework and groupwork interventions, workers will need to use community work approaches for dealing with issues that impact on individual young people.

Ask learners to discuss and list the kinds of services and programs their organisation provides for young people. Then ask them to respond to the following questions in their Learner’s Workbook.

**Q**

*What do these services and programs focus on? (Do they focus on individuals, families, peers, schools, communities or societies?)*

**Q**

*Can you see gaps in the way your organisation approaches working with young people?*
Using a systems approach to understanding AOD use for young people.

- Ask learners to read the following case studies in their Learner’s Workbook.

**BRETT**

*Brett* is 18 years old and living in the inner suburbs of your capital city. He binge drinks alcohol on weekends with his friends when he goes out and occasionally during the week. He recently had a car accident while driving under the influence. Although no-one was hurt in the accident, Brett has done little to alter his drinking behaviour. He has a long-term girlfriend and is completing his mechanic’s apprenticeship.

Brett still lives at home with his parents who are both non-smokers and social drinkers. Brett’s biological mother died when he was three, leaving just Brett and his father. After Brett’s mother died, his father became chronically depressed and withdrew from his family and friends for a number of years. When Brett was eight, however, his father met and married Brett’s current stepmother. Brett enjoyed school, although he was often in trouble for not concentrating or completing assigned tasks.

Currently Brett feels relatively happy with his life. He plays with the local football team, as well as squash once a week. He has been with his current girlfriend for the past two years and is happy in the relationship.

*Using the youth-focused systems model consider those parts of Brett’s life that might increase or reduce alcohol related difficulties for Brett.*

*For each part of the system list at least two factors that might act to reduce or increase the likelihood that Brett will develop alcohol-related difficulties.*

<table>
<thead>
<tr>
<th>Issues affecting Brett’s alcohol use</th>
<th>Societal and Political</th>
<th>Local Community Issues</th>
<th>School and Peers</th>
<th>Family</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase alcohol difficulties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce alcohol difficulties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Learners should discuss their responses with the whole group or complete the table in small groups.
ANGIE

Angie is 12 years old, living in a remote, heavy-drinking community. She began drinking when she was 10, and currently binge drinks with her friends. She rarely attends school, and when she does attend is often in trouble.

Both of Angie’s parents are heavy drinkers, and spend most of their money on alcohol. Consequently, Angie doesn’t eat well and is often hungry. She usually drinks in the local park or in parking lots at night. Older friends usually buy the alcohol, but when this isn’t an option, Angie and her friends can usually steal their supplies from their parents.

Angie spends most of her time with her friends drinking. There are few non-alcohol related activities for young people in the community, so most young people drink to relieve their boredom.

Using the youth-focused systems model consider those parts of Angie’s life that might increase or reduce alcohol related difficulties for Angie.

For each part of the system list at least two factors that might act to reduce or increase the likelihood that Angie will develop alcohol-related difficulties.

<table>
<thead>
<tr>
<th>Issues affecting Angie’s Alcohol use</th>
<th>Societal and Political</th>
<th>Local Community Issues</th>
<th>School and Peers</th>
<th>Family</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase alcohol difficulties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce alcohol difficulties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Again, learners should discuss their responses with large group or complete the table in small groups.
A systems approach to understanding drug use in your area

- This activity can be done in pairs or groups of three.

*Choose one of the most common drugs of choice used by young people in your area. Using the table below list some of the factors that might influence patterns of use of this drug from a systems perspective.*

Drug chosen: ________________

<table>
<thead>
<tr>
<th>System level</th>
<th>Issues affecting drug use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Societal and political issues</td>
<td></td>
</tr>
<tr>
<td>Local community factors</td>
<td></td>
</tr>
<tr>
<td>School and peer factors</td>
<td></td>
</tr>
<tr>
<td>Family factors</td>
<td></td>
</tr>
<tr>
<td>Individual characteristics</td>
<td></td>
</tr>
</tbody>
</table>

- Learners should discuss their responses in the whole group.
2.2 Levels of intervention in working with young people

An intervention is a term used to describe a purposeful activity designed to prevent, reduce or eliminate AOD use at an individual, family, peer, community or societal level. This can range from interventions that target the individual, such as an informal chat between a youth worker and a young person about smoking, to strategies that target the whole population, for example a mass change in state legislation to reduce the availability of alcohol.

Interventions exist on a continuum ranging from prevention to early intervention to treatment and continuing or longer-term care. Interventions can be aimed at different parts of the system as identified in the youth-focused systems approach.

Frontline workers are ideally placed to undertake some prevention and early intervention work with young people. Some workers may also be required to provide support to young people who are intoxicated or have an established AOD problem.

Frontline workers need to be aware of the range of interventions available to assist young people who may be at risk of or who already are experiencing AOD-related problems.

Ask learners to refer to the following continuum line in their Learner’s Workbook and complete the Intervention Grid in class or in their own time as a take-away exercise.
THE AOD–RELATED INTERVENTION CONTINUUM

Prevention

Definition: Intervention that occurs prior to any AOD issues occurring – reducing the potential for future drug-related harm.

Who can conduct? Frontline workers.

Examples: Legislation, Media-based strategies, Drug education/information provision, Changing societal norms in relation to AOD use, Community development around AOD issues.

Early intervention

Definition: Intervention to prevent the presenting issues from developing into a significant AOD problem by enhancing a person's protective factors and reducing the impact of risk factors (reducing both current and future drug-related harm).

Who can conduct? Anyone who comes into contact with young people with AOD issues, primarily frontline workers (e.g. teachers, police, youth workers etc).

Examples: Screening for AOD issues, Drug education, Referral to AOD service or other service, Brief interventions.

Treatment

Definition: Intervention aimed at the small number of young people who can be considered to have significant AOD problems which may be affecting a range of aspects in their lives (e.g. health, relationships, financial, criminal behaviour etc).

Who can conduct? Primarily health workers such as drug and alcohol services.

Examples: Detoxification, Therapeutic interventions (e.g. counselling), Residential facilities, Outpatient treatment, Day programs, Self-help groups, Brief interventions.
Based on your organisation’s services and programs that you identified earlier, indicate in the table below what type of AOD intervention relating to which part of the system you provide to young people.

### INTERVENTION GRID

<table>
<thead>
<tr>
<th>Part of system where intervention occurs</th>
<th>AOD intervention classification</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevention</td>
</tr>
<tr>
<td>Individual (young person)</td>
<td></td>
</tr>
<tr>
<td>Peer/school</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
</tr>
<tr>
<td>Local community</td>
<td></td>
</tr>
<tr>
<td>Society</td>
<td></td>
</tr>
</tbody>
</table>
Find out which agencies in your local area are involved in some type of intervention (from prevention to treatment) in relation to young people and AOD. In the table below indicate which part of the system the intervention is targeting and briefly describe the intervention and its goal.

<table>
<thead>
<tr>
<th>Type of interest</th>
<th>Goal</th>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peers/school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Societal/political</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Are there any parts of the system where no intervention is offered?

Why do you think this might be?

Can you suggest any ways that this gap could be filled?

The answers to these questions could be explored by the group to identify common areas of need.
2.3 Key models in AOD work

There are a number of key approaches to AOD work that underpin all types of interventions in the sector. These approaches and philosophies are covered in detail in the module *Young People, Society and AOD*. They will be briefly reviewed here. It is recommended that you complete the relevant topics in *Young People, Society and AOD* before you proceed with this module.

**Schaeffer’s model – patterns of drug use**

Schaeffer’s model is useful as it demonstrates that not all AOD use is problematic. It divides AOD use into the following five categories:

**Categories of drug use**

1. **Experimental** – The drug use is motivated by curiosity or desire to experience new feelings or moods. This may occur when the young person is alone or in the company of one or more friends who are also experimenting. It normally involves single or short-term use.

2. **Social/recreational** – The drug is used on specific social occasions by experienced users who know what drug suits them and in what circumstances.

3. **Circumstantial/situational** – The drug is used when specific tasks have to be performed and special degrees of alertness, calm, endurance or freedom from pain are sought (for example, truck driving or shift work).

4. **Intensive** – This type of drug use is similar to the previous category, but more intensive. It is often related to an individual’s need to achieve relief or to achieve a high level of performance.

5. **Compulsive/dependence** – Drug use leads to psychological and physiological dependence where the user cannot at will discontinue use without experiencing significant mental or physical distress.
Often young people do not fit neatly into any one theoretical category and may in fact float in and out of different categories depending on the circumstances. For example many young people experiment with AOD in social or recreational settings.

Ask learners to discuss the following question in small groups and discuss their answers in the group as a whole.

*For each of the five terms of use identified by Schaeffer, list three potential harms associated with that pattern of AOD use.* (There may be some overlap between the types of use and associated harms.)

*Work with two or three other colleagues to complete this activity. Then discuss answers with the group as a whole.*
<table>
<thead>
<tr>
<th>Drug Use Pattern</th>
<th>Associated harms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td>2.</td>
</tr>
<tr>
<td></td>
<td>3.</td>
</tr>
<tr>
<td>Recreational/social</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td>2.</td>
</tr>
<tr>
<td></td>
<td>3.</td>
</tr>
<tr>
<td>Situational</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td>2.</td>
</tr>
<tr>
<td></td>
<td>3.</td>
</tr>
<tr>
<td>Intensive</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td>2.</td>
</tr>
<tr>
<td></td>
<td>3.</td>
</tr>
<tr>
<td>Compulsive</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td>2.</td>
</tr>
<tr>
<td></td>
<td>3.</td>
</tr>
</tbody>
</table>
2.4 Harm minimisation

- Harm minimisation is a useful approach because it helps us to focus on the harms associated with young people’s AOD use (and not just on the AOD use itself). We can then design interventions to directly prevent or reduce those harms rather than just trying to reduce or eliminate AOD use.

- Harm minimisation is the current drug related policy in Australia governing all drug-related laws and responses. There are three components of the harm minimisation policy: harm reduction, demand reduction and supply control.

- The concept of harm minimisation rests on the assumption that we cannot stop all people from using illicit substances and that, while people continue to use drugs, some will continue to experience harm. Importantly however, harm minimisation is not restricted to reducing individual levels of harm. It takes a systems approach by considering potential harm to the individual as well as the community as a whole.

- Harm minimisation includes those strategies designed to reduce the harm associated with use, without necessarily reducing use. It involves those strategies (policies and programs) specifically targeted at reducing the harm directly resulting from drug use.

- Some examples of harm reduction strategies include:
  - labelling on cigarette packets
  - needle and syringe exchange programs
  - safe injecting rooms
  - peer education programs
  - methadone maintenance programs
  - labelling on alcoholic beverages.
Ask learners to complete these questions independently in class or as a takeaway activity.

**Q**

*How does your service view harm minimisation? Describe any harm minimisation services or activities carried out by your organisation.*

**Q**

*Does your service have any policies and procedures that promote or hinder harm minimisation principles?*

---

**Summary**

- Young people use AOD for many different reasons.
- The young person’s environment needs to be considered when planning AOD interventions.
- AOD interventions range from prevention to early intervention to intense treatment intervention.
- AOD interventions can be targeted at one or several parts of the system including:
  - Individual
  - Peer/school
  - Family
  - Local community
  - Societal/political
- Harm minimisation is an approach which attempts to alleviate harm from AOD use.
Topic 3

Prevention and early intervention

Overview

In this topic we will focus on population prevention strategies for AOD use in young people and early intervention strategies that target young people who are beginning to experience problems related to AOD use.

We will also look at strategies frontline workers can utilise in promoting prevention and early intervention. These include brief interventions and programming issues.

Key Issues

Population based prevention strategies

Brief interventions

Resources

www.nt.gov.au/health
www.adca.org.au (The Alcohol and Other Drug Council of Australia)
3.1 Population-based prevention strategies

There are a broad range of prevention and early intervention strategies. Some prevention strategies target the whole population - for example, a mass-media, anti-smoking campaign. By their nature, these interventions are a one size fits all type, with no allowance for targeting specific populations. While these programs are usually expensive, they are quite economic when calculated on a cost-per-person basis.

Key strategies

Population-based prevention strategies include:

- legislation
- media-based strategies (including mass media campaigns and reducing the advertising and promotion of alcohol and tobacco)
- drug education (including school drug education).

Ask learners to read each of these individually in their Learner's Workbook.

Legislation

Changing laws can result in a change in AOD use and the environment in which that use occurs. Ask the learners to suggest laws that are aimed at changing AOD use or preventing harm.

Some examples for later discussion are:
- **Alcohol and other drugs law reform** - Many people in the community believe that decriminalising alcohol and other drugs may reduce the harm associated with drug use - for example, a heroin user stealing in order to support a habit. There is also significant support for a trial of heroin on prescription for registered addicts. Alcohol and other drug use is not likely to be prevented as a result of these changes in legislation. These approaches have been considered because they may reduce the harm associated with illicit drug use.

- **Availability of alcohol and tobacco** - As a general rule, the easier it is to obtain and use alcohol and tobacco, the more people will use them. Legislative changes which can reduce alcohol and tobacco use include:
  
  - **Smoking** – Such strategies include banning smoking in restaurants and other public places; and enforcement of laws banning the sale of tobacco to anyone under 18.
  
  - **Alcohol** – Such strategies include limiting the trading hours of licensed venues; responsible service of alcohol; and enforcement of drink-driving laws and their enforcement through random breath-testing. This has been particularly effective and the road toll has been halved as a result.

- **Price of tobacco and low alcohol beer** - When the price of tobacco goes up, some young people appear to decide against taking up smoking and some smokers decide to quit. Public health organisations are often supportive of this strategy as they believe the numbers of smokers will be reduced as a result. In the 1990s the federal government reduced a tax on low-alcohol beer, making it less expensive than full strength beer. The aim was to encourage beer drinkers to choose light beer.
Media-based strategies

- **Mass media campaigns** – These usually involve government-funded, mass advertising campaigns to encourage people to quit smoking, reduce drinking, avoid drink-driving and avoid illicit drug use. A recent federal campaign encouraged parents to talk to their children about drugs.

- **Reducing the advertising and promotion of alcohol and tobacco** – Cigarette advertising was gradually phased out in Australia from 1976, when the famous Paul Hogan *Anyhow* ads on TV were banned along with all other television ads for tobacco products. Advertising for tobacco is now virtually eliminated. Advertising for alcohol products is much more liberal, with self-regulation governing content and placement of advertisements.

Drug education

- **School drug education** – Virtually all schools in Australia provide alcohol and other drugs education from primary school through to late high school. The aim of these programs is to encourage young people to decide *not* to take up alcohol and other drugs. This has been described by critics of current drug education programs as an attempt to 'innoculate' young people against drugs. Over the past decade, most schools have been tentatively moving towards a harm reduction philosophy, which includes the safe use of alcohol, and sometimes illicit drugs.

- **Program-based prevention and early intervention** – All youth services have the capacity to provide prevention and early intervention strategies and approaches in their work. Services that work with young people should have minimising the harm related to AOD use in young people as one of their service goals. Objectives and specific tasks can then be formulated to achieve this goal. For example, a residential youth service could provide informal health promotion information and awareness to residents about AOD use. They could also work with individuals in developing self esteem, assertiveness, communication and problem-solving skills and helping young people develop recreational and leisure interests.
If services make their goals transparent from the outset, much of the work they do could be oriented towards preventing problematic AOD use by young people.

Ask learners to complete the following questions in their Learner’s Workbook and compare their answers with other colleagues.

What are your organisation’s service goals and objectives in relation to working with young people and AOD use?

Can you think of any interventions or strategies that your organisation utilises that would work within a prevention or early intervention framework?

What other kinds of interventions and strategies could you utilise in your workplace to promote prevention and early intervention?
3.2 Brief intervention

What are brief interventions?

- Brief interventions are widely used in AOD work. They are particularly effective for people who do not have a long-term history of heavy AOD use. This type of intervention takes very little time and is usually conducted in a one-on-one situation. It involves making the most of any opportunity to raise awareness, share knowledge and get a young person thinking about making changes to improve their health and behaviours. The intervention can last as little as 30 seconds or may involve a few 5 to 60 minute sessions. Brief interventions often consist of informal counselling and providing information on certain types of harms and risks associated with drug use and/or risky behaviours.

- Brief interventions can be used in a variety of ways, including health promotion, disease prevention, early intervention and as a strategy for dealing with problematic behaviours. While brief interventions are considered to be effective, the outcome will really depend on the young person’s readiness to change or think about the information provided. Brief interventions are easy and effective. They assist young people make their own decisions and provide them with the opportunity to learn about health-related issues in order to make more informed choices.

- Brief interventions recognise that many people can benefit from being given appropriate information at the right time. This option can work particularly well for young people as they are less likely to engage in ongoing counselling sessions and can be erratic and impulsive in their decision-making.
Who can do brief interventions?

- There are a diverse range of ‘frontline workers’ that can utilise the benefits of brief intervention strategies. Some of these occupational groups may include:
  - youth workers
  - accommodation and crisis workers
  - counsellors (school included)
  - primary and community health and welfare workers
  - juvenile justice
  - police
  - teachers
  - clinical counsellors
  - social workers
  - carers.

- It is important to always check how much a young person knows. By engaging in brief interventions with young people you may be able to provide enough information to allow better choices, raise awareness and motivate and support young people to make decisions that are best for them.
When to do brief interventions

Think of a time when you have conducted a brief intervention in your workplace and answer the following questions:

Q What was the situation or circumstance that led to the brief intervention?

Q How was the brief intervention conducted?

Q What was the end result?
Where do brief interventions take place?

_ask learners to take some time to reflect on their own work practice and to recall some instances in which brief interventions occurred while working with young people._

Q Can you think of a time when applying a brief intervention may not be appropriate?

A

- When the person does not wish to engage in conversation and becomes visibly distressed by your questioning
- When a person is in a highly emotional state
- When a person is intoxicated
- When a person is on medication that is mood and/or mind-altering (i.e. methadone or some anti-psychotics).

Distance learners have been advised to make contact with you the facilitator to check their learning progress.
Distance learners have been advised to make contact with you, the facilitator, to check their learning progress.

- Population-based prevention strategies target groups, communities and societies by attempting to change attitudes and behaviours associated with AOD use.

- All organisations working with young people should develop practices that encourage prevention and early intervention of problematic AOD use.

- Brief interventions can be used by frontline workers to provide quick and informal education and awareness about the impact of problematic AOD use.
This topic focuses on community approaches used in preventing problematic AOD use and/or in minimising harm and reducing problematic use. A range of strategies are explored that can be utilised when working with communities.

www.communitypartnerships.health.gov.au
www.turningpoint.org.au
4.1 Community-based approaches

- The prevention interventions we have considered so far are aimed at the whole population. However, there is another set of prevention interventions which targets specific groups and communities. These programs typically focus on groups of people at high risk of developing harm from AOD use, and are tailored to meet their needs. Target groups can be broad (i.e. Aboriginal and Torres Strait Islander peoples) or specific (i.e. young men living in a socially disadvantaged suburb or town).

- Community-based approaches addressing AOD-related problems can incorporate both prevention and other interventions. The goal is generally to prevent the development of AOD problems where possible or reduce the harm associated with AOD use within a particular community.

Community action

- Community action involves people who live, work and raise their families in a community coming together to respond to specific local problems. Some communities choose to focus on local drug-related issues.

Community action strategies

- As part of the National Illicit Drug Strategy the Commonwealth government has funded the Community Partnerships Initiative. This is a community grants program that aims to encourage quality practice in community action to prevent illicit drug use and to build on existing activity occurring across Australia.

- A Community Partnerships Kit has been developed to assist in the development, implementation and evaluation of community prevention projects focusing on illicit drug issues. A copy of the kit is available at www.communitypartnerships.health.gov.au
At a state level the NSW government has established a Drugs and Community Action Strategy to promote:

- Greater community awareness of drug issues
- positive and coordinated action at local and regional levels
- government cooperation with the community
- local solutions for local drug issues
- better links between funding programs and initiatives
- more cooperation at local, regional, state and national levels.

Ask learners to discuss the following question in groups.

Can you think of a community action strategy you? How does it work?

Community work

Community work strategies

- **Holding community alcohol and other drug forums** – These provide opportunities for community members (including alcohol and other drugs users, young people, parents and representatives from local agencies) to discuss drug use in their community.

- **Establishing community drug action teams** – These have been set up for local agencies to meet and develop strategies to work in a coordinated way and to share information and resources to reduce illicit alcohol and other drugs use in local areas of NSW.

- **Liquor licensing accords** – These are agreements between hotel operators, police, local government and health services which aim to reduce alcohol related harm.
- **Lobbying for more treatment funding** – Community action might also include lobbying governments for increased or better focused funding to help address the alcohol and other drugs issues which confront a particular community.

### Community development

Community development initiatives include a range of strategies which are largely targeted at improving the local community factors. Refer back to the youth-focused systems diagram in Topic 2 to review the factors that may be targeted by community development initiatives.

### Community development strategies

Community development strategies are interventions aimed at creating a healthier environment in a community overall. Examples include:

- developing appropriate recreational activities for young people
- improving community resources that affect young people e.g. public transport
- changing community norms about drug use.

- Holding community alcohol and other drug forums
- Establishing community drug action teams
- Liquor licensing accords
- Lobbying for more treatment funding
- Community development initiatives.
About the Goondiwindi area

Goondiwindi is a remote rural area west of Brisbane, Queensland. The population is primarily farming people, with wheat, cattle, cotton and sheep being farmed. The Goondiwindi area includes the Townships of Goondiwindi, Boggabilla and the Aboriginal township of Toomalah. Many people in the community have experienced hardship in recent years due to a number of factors affecting the profitability of farming.

Young people and drug use in Goondiwindi

There is an increase in the use of illicit drugs by young people in the community. This has been observed in an increase in public drunkenness, and an increase in crime related to drug use.

The problem has been exacerbated by the fact that there have been no alcohol and drug service located in the immediate area to address the needs of the population.

Drugs used by young people include alcohol, speed (injected and snorted), and cannabis (smoking).

The Youth Drug Use Prevention Program

The Youth Drug Use Prevention Program was established in January 1999 to develop a range of strategies to respond to drug use by young people in the area.

The project aims to link young people with opportunities for education about alcohol and drug use.

Create opportunities for recreation that provides an alternative to drug use.

Link with Juvenile Justice services.

There was a six month process of networking and establishing community needs.
The project consists of a range of approaches that were developed in response to local needs. These include:

- Accessing local youth groups to deliver alcohol and drug education
- Linking with local schools to deliver alcohol and drug education
- The development and delivery of the ‘To Heal’ program: a 10-week structured education and support program for young aboriginal people who have been convicted of drug-related crime (usually alcohol). The program is aimed at encouraging lifestyle change.
- The Youth Development Initiative: an outdoor adventure education program targeting a specific group of young people at high risk of suffering negative consequences of drug use.
- Delivery of ‘How to Drug-Proof Your Kids’ parent education workshops.
- The ‘Health Station’ alcohol management strategy designed for the B Ball, an annual event notable for excessive drinking by young people and potential for increased risk-taking behaviour such as engaging in unsafe sex, and drink-driving.

Outcomes

Young people have reported an increase in their knowledge about the health impacts of drinking.

The ‘To Heal’ program has had a remarkable impact with very few participants re-offending since participating in the program.

The Youth Development Initiative has had a positive impact with 50 per cent of participants returning to school or TAFE after participating in the program, and less than 10 per cent re-offending in the nine month period since the program was undertaken. Another positive outcome of this program has been an positive impact on family relationships as reported by the Toomalah Community Family Support Worker.

The parents who participated in the ‘How to Drug-Proof Your Kids’ parent education workshops reported feeling more confident and knowledgeable in raising and discussing drug issues with their children.
The ‘Health Station’ at the B&S Ball was a success in a number of ways. It established a health-focus for the event, provided young people water and soft drinks as an alternative to alcohol, distributed free condoms and health information. It established a point of contact for other health services, such as the ambulance service, who were previously reluctant to attend the event due to previous experiences of violence.

**Key Learnings**

It was very important that this project was accepted and owned by the community.

An extensive process was undertaken to present the aims of the project to the community and consider all the ways the project might best address the community needs and involve the wider community.

The program and its activities need to be accessible and visible within the community.’

(For further information on the above contact the Care Goondiwindi Association, PO Box 687 Goondiwindi QLD 4390. Phone 07 4671 3574, fax: 07 4671 4132, email caredal@northnet.com.au)

▶ Learners can complete this activity by working in small groups.

**Q**

**What parts of the system have been targeted by this intervention?**

**Q**

**What categories of interventions were used?** (e.g. prevention, early intervention, treatment). **Give examples.**
What are the advantages and disadvantages (if any) of the approach used?

Name some specific AOD issues that affect the community that you work in.

What types of community approaches are being used to address these?

What other kinds of approaches could be implemented?

What obstacles might you face when implementing these approaches?
• Community-based approaches focus on groups at high risk of developing harm.

• Some community work strategies include:
  – drug forums
  – drug action teams
  – liquor licensing accords
  – lobbying
  – community development.
Topic 5

Peer and family

Working with Families, Peers and Communities
Perspective on Working with Young People

Key Issues

Peer influence
Peer education
Approaches to family work
Case studies

Overview

Peers can be a useful resource as they have a major influence over young people’s behaviour. This topic examines the possibilities of working with peers to support young people in their attempts to change their AOD use. Often this can be achieved through peer-based education programs and working with families.

Resources

www.turningpoint.org.au
5.1 Peer influence

- As young people develop from childhood, through adolescence to adulthood, the people who influence their decision-making change. An understanding of these developmental changes has an impact on the interventions and approaches we use as frontline workers and service providers.

- In childhood, schools and families have a large impact on shaping children’s interests and choices. Peer groups become increasingly important to young people in adolescence as they begin the process of developing their identities, learning about intimacy and relationships and take some steps towards independence.

- However, families continue to provide a backdrop for the developmental issues that young people experience and can impact greatly on how young people see themselves, their behaviours and their values and beliefs.

- It is therefore important to develop some strategies that target peer groups and families when working with young people on AOD issues.
5.2 Peer education

Peer education approaches

▶ Most peer education programs can be described as:

*Providing information about alcohol and other drugs to young people, usually in a group situation that discourages drug use, and encouraging them to pass it on to others in their social network.* (McDonald, 2001)

▶ In the field of drug education, peer-led programs have long been known to be effective in communicating information, changing attitudes and shaping behavioural *intentions*. Actual behaviour *change* through education has proven harder to obtain (Klepp, Halper & Perry, 1986).

▶ Peer education programs vary widely according to the aim of the individual program. The aim may be as simple as increasing knowledge about drug-related issues, or as complex as attempting to change attitudes and behaviour (e.g. making informed decisions and changing behaviour to decrease risks).

▶ Desired outcomes can range from preventing participants from ever using drugs, to delaying onset of use, or changing the behaviour of those already using (e.g. stopping or reducing use or restricting further development of their drug repertoire).

▶ Some programs aim for *cultural change*. This involves providing information so that it is passed on to others, who in turn pass it on to others until there is a change in attitude to drug-related issues throughout the social network.
5.3 Approaches to family work

Defining families

- Defining ‘families’ is difficult. Today family structures vary to such an extent that the conventional ‘Western’ notion of Mum, Dad and the kids now forms less than half of all families in Australia (Bessant, Sercombe & Watts, 1998). Variations include large extended families, single-parent families and an increasing number of ‘blended’ families (where kids of different parentage are raised together after their parents have remarried), and families with adopted or fostered children. Some kids now have parents of the same sex (living in gay and lesbian relationships).

- In view of this varied family theme a broad definition of family seems warranted so that none are excluded or go unrecognised. Perhaps a family should be thought of as any group of people who share interdependently in the daily tasks of living.

- The attraction of a widely encompassing definition of family is that it allows you to think creatively about who to enlist as ‘family’ support for a young person. It is not uncommon for young people in a residential drug program to talk about finding a ‘new family’ when they bond with peers and staff.

Working with families

- Families and concerned significant others (CSO) will require different types of support, intervention and assistance depending on the individual circumstances of the young person.
For example, parents who are worried about the possible drug use of their child are likely to need some basic drug education in order for them to feel more comfortable discussing these issues at home. Families are often troubled by a whole range of issues involving young people and drug issues make up only one aspect of their concerns.

Families who have recently discovered that a young person has been experimenting with certain substances may require information about the effects of a particular drug.

Families who have acknowledged that a family member has an established problem with a particular substance may need the support of other families dealing with the same issue or may need training to help them deal with a crisis situation.

The interaction you have with CSOs may be very limited in your work situation and can sometimes be very brief. However, these short interchanges can often be very effective.

Brief intervention can consist of:

- encouraging the relative to talk about the issues they are facing
- providing relevant information
- counselling in coping strategies
- exploring/enhancing social supports
- advising and helping relatives to make contact with specialist services.

After a brief intervention package was recently trialled by primary health care workers, relatives were less stressed and coped better while the workers felt more confident about their ability to work with families (Copello et al., 2000).
Family support groups

- Another way of supporting families is to link them with other families who are dealing with similar issues. Formal family support groups are run by organisations such as the local health services. Informal networks sometimes develop from these groups as well as from families linked together by a worker.

- These groups allow family members to increase their understanding and to deal with feelings of guilt, shame and anger in relation to the drug use of a family member. It has been observed that within these groups the mothers tend to share their perspectives particularly with other mothers, fathers with fathers and siblings with siblings.

- These are not family therapy sessions (where the young drug-using member of the family attends), but rather groups where members of the families can ventilate their feelings, express their thoughts and draw support from others who have also grappled with excessive drug use in their families.

Families as interactive 'systems'

- The notion of a family as an interactive system is well established and guides most interventions that involve family members (Corcoran, 2000). Systems theory does not view any one member of a family as having the problem, or being the problem. When applied to families systems theory has four main tenets (Corcoran & Basham, 2000):

  1. **There is circular causality.** It is not possible to trace the cause of any member’s current behaviour directly from past events because the behaviour of every family member is continuously influencing every other member. No behaviour of an individual can be understood or influenced in isolation from the behaviour of other family members. Therefore, rather than focus on the past causes of an individual's 'problem', attention should be paid to current communication and reinforcement patterns occurring between all members of the family.
2. **Families have a tendency towards homeostasis** (i.e. to remain in a steady state and to resist change). Therefore, change needs to occur in a planned, step-by-step manner, so that the family does not actively resist. Tangible rewards for change are essential, as families often feel change involves costs and sacrifices.

3. **Symptoms are functional.** Drug use may serve a purpose for both the drug user and a family member. For example, Jane can ‘tune out’ from her mother’s ‘nagging’ when stoned. Her father shouts at her (the only time they relate to each other) as he has difficulty expressing positive feelings towards Jane. Jane’s big brother supplies her with marijuana, and can do what he likes while his parents are absorbed with Jane.

4. **The structure of the family is important in maintaining maladaptive behaviour.** Who is in charge? Who can speak openly to whom? Are some members disengaged from the family? While no single structural pattern has emerged in studies of families with excessive drug use, a preponderance of extremes has been noted. Some families are over-involved in each other’s affairs and feelings (enmeshed), some are under-involved (disengaged), some are very rigid about what behaviours are permitted (with an authoritarian parent), while some are too permissive (anything goes and the kids may be in charge).

   ▶ A number of studies (reviewed by Basham, 2000) have shown that family therapy using a family systems approach can change drug-use patterns.
5.4 Case studies

Ask learners to read the following case study from the Community Partnerships Kit and work through the questions at the end of the case study. They may wish to discuss the questions with their co-workers.

Stepping Stones to Success: A course to guide families through a process of dealing with drug use in the family

About the Program

The Stepping Stones to Success project is a group-based support program for family members affected by drug use in the family. The project is a collaboration between Family Drug Support and DrugNet, WA. The program is run in the Sydney metropolitan area.

The program was developed from the experience of running an unstructured group support program. The potential benefit in developing a more structured closed group process for family members dealing with drug use in the family was recognised.

This program introduces a new model which identifies the ‘stages of change’ for members in the process of coming to terms with and responding to drug use in the family.

The project has redefined ‘success’ for families dealing with drug use. So, rather than the often-stated goal to ‘get off drugs’, success is now viewed as having workable strategies in place.

The program emphasises:

- Personal and interpersonal skills;
- Access to quality support options;
- Taking care of emotional, physical and spiritual wellbeing; and
- Building caring, strengthening family relationships.
The successful implementation of strategies may or may not mean that the drug user(s) in the family is drug-free.

The project also developed a model for program development and delivery. The model includes a framework of philosophies, assumptions, goals and structure.

Participants and facilitators handbooks are also being developed.

Update

The Stepping Stones to Success program model has taken six months to develop. It was then focus tested on family groups and refined according to the feedback received from the focus groups. The participants and facilitators handbooks are currently in production.

For further information contact Family Drug Information and Support Services, PO Box 226 Willoughby NSW 2068 Phone 02 9427 8052, fax 02 9427 1700, email http://www.fds.org.au

- Ask learners to complete the following questions in groups of three and present their responses to the large class.

What categories of interventions were used (e.g. prevention etc)?

What are the advantages of the approach used?

What are the disadvantages of the approach used?
How does your organisation approach working with peers and families?

What are the advantages and disadvantages of working with peers and families in your current work role?

What issues make working with peers and families challenging?

What factors could support you in your work in this area?

What obstacles might you face in implementing these approaches?
Distance learners have been advised to make contact with you, the facilitator, to check their learning progress.

• Peers can be a useful resource in providing accurate information to young people and bringing about social change.

• Peer support groups can provide opportunities for drug users to express their feelings in a supportive environment.

• Peer education programs involve sharing information in both informal and formal ways.

• Families and concerned significant others require different types of support and assistance. Workers can provide this by linking families with others who have similar issues.

• Families may act as an interactive system.
In this topic the issue of ‘best practice’ treatment interventions is raised. Various treatment methods that may be used by frontline workers for working with young people are discussed. While many techniques and strategies, models and methods are available, each individual case requires careful consideration of a number of presenting issues before an intervention can be effectively implemented.

- Learners will be able to identify some of the treatment interventions mentioned in this topic as their own or their workplace’s preferred approach.

- Often young people are influenced by their environments which may have a large impact on their AOD use. Workers should ensure they consider the bigger picture when working with young people.
6.1 Young people and best practice treatment interventions

- In this module, the term *treatment* is used broadly to mean any intervention with an individual, family, group or community currently using alcohol and other drugs in a harmful way. The goals of different treatments will vary. It may be abstinence or it may be to reduce harmful AOD use.

- Interventions for young people should be appropriate to their developmental stage and the ways in which young people use drugs. Young people’s drug use is characterised by:
  - a tendency to use drugs which are most easily accessible, such as alcohol and tobacco
  - polydrug use
  - binge use of drugs, and
  - less entrenched drug use.

- Young people are:
  - more spontaneous
  - less likely to plan ahead
  - more focused on the pursuit of short-term goals
  - influenced strongly by their peers.

- The Best Practice in Alcohol and Other Drug Interventions Working Group (2000) in Western Australia have identified the following elements of effective drug counselling with young people:
  - holistic approach
  - includes the family
  - flexible approach, including outreach
  - provides practical and concrete strategies
works well with other agencies involved with the client
able to recognise psychiatric disorders
uses harm reduction when appropriate.

The WA group also identified the counsellor qualities which are important when working with young people:
understands the stage of adolescence
displays sense of humour
consistent limits
able to relate to young people and parents
sets clear boundaries
allows young people some freedom of choice.

Ask learners to read the following questions in their Learner’s Workbook and present their answers in class or as a take away activity.

**Q** Based on your contact with AOD services and the experiences of the young people you work with, how do the approaches outlined above compare with actual AOD services in your area?

**Q** What strategies could be used to encourage agencies to follow these Best Practice Guidelines?
What type of role (if any) could you or your agency take in supporting agencies to follow these guidelines?

Give two examples of specific changes that might improve AOD services.
6.2 Treatment interventions

Types of treatment intervention

Outreach work

- Outreach workers do not wait for clients with alcohol and other drug problems to come to them – they go out to where the drug users are. For homeless young people, this is often the street. Some of their duties include:
  - linking young people with health and welfare services
  - case management
  - needle and syringe programs
  - home detoxification
  - information and advice on drug use.

Individual alcohol and other drug counselling

- This is usually carried out by a counsellor specialising in alcohol and other drug treatment over a number of one-hour sessions. Many counsellors have qualifications in psychology, social work or nursing; some have personal experience in alcohol and other forms of drug dependence. There are a variety of models of alcohol and other drugs counselling including cognitive behavioural therapy (CBT), psychodynamic and gestalt therapies. CBT, which helps the person to learn different ways to think and behave, is now a dominant model of counselling in Australia.
Self-help groups

- Alcoholics Anonymous and Narcotics Anonymous are self-help organisations which support people who have decided to stop alcohol and/or drug use forever. The fellowships are based on the 12 Steps (a program of personal and spiritual growth) and attendance at meetings where members share their stories of addiction and recovery. The number of members of AA and NA under 20 is relatively small. Perhaps this is because they are at an early stage in their drug-using career, or because the groups may not target young people.

Detoxification centres

- These are units where people who are physically dependent on alcohol and other drugs can withdraw under supervision with support and medical intervention if required. Most clients stay for about one week – the time taken to detoxify from most drugs. These programs usually include counselling to prevent relapses, and referral to other services such as rehabilitation and individual counselling.

Rehabilitation centres

- Young people tend not to attend residential services in high numbers compared to older adults. In general, clients of these agencies are people with the most severe alcohol and other drug problems.

- These centres provide the most intensive of all alcohol and other drug treatment programs. Alcohol and other drug-dependent clients are offered a 1-to-12 month stay following detoxification. (Some programs also offer detoxification prior to rehabilitation). Clients without stable housing or primary relationships are more likely to accept this option.
Many centres offer:

- development of personal strategies to cope with stressful situations without alcohol and other drugs
- introduction to 12-step fellowships such as Narcotics Anonymous
- living skills training including communication, financial management and self-care
- understanding of the underlying factors associated with their own alcohol and other drug use
- training and work programs.

One of the difficulties young people encounter is access to rehabilitation programs as many areas do not offer programs for young people, and there are often long waiting times. Some programs require an upfront payment, which is an additional barrier.

**Halfway houses**

Often linked to rehabilitation or detoxification centres, these are supervised houses in the community where people with serious alcohol and other drug problems can obtain support while getting on with their lives.

**Needle and syringe programs**

In these programs, injecting drug users are provided with sterile injecting equipment and information on how to avoid blood borne viruses such as HIV and Hepatitis C. Some of these programs also offer case management and counselling services to this marginalised and difficult-to-reach client group.
Pharmacotherapies

Pharmacotherapy involves the use of medication to assist people to cease their use of specific drugs of abuse. There is an increasing menu of medication options for young people with AOD problems. These interventions are more effective when offered as part of an overall treatment program which includes counselling and social support.

Ask learners to discuss the following question within the group.

Which of the above interventions best suits your current workplace?
6.3 Counselling models used in AOD work

The following are the most common counselling therapies used in AOD work.

- **Cognitive behavioural therapy (CBT)** – where the client learns strategies to change thoughts and behaviours related to AOD use. CBT is now a dominant model of counselling in Australia.

- **Psychodynamic** – where the client develops an understanding in how and why the AOD problem began, often associated with childhood and/or family issues.

- **Narrative approaches** – where the client is helped to understand the story (or narrative) of their life, adopts a new perspective, and writes another script (usually metaphorically) for the future.

- **Family therapy** – assumes that the whole family is involved in the development of the young person’s AOD problem, and should be involved in the counselling.

- **Solution-focused counselling** – where the counsellor assists the young person identify their goals. These goals are then broken down into manageable objectives and specific tasks. The counsellor helps the young person track how difficulties developed.

- Cognitive behavioural therapy
- Psychodynamic
- Narrative approaches
- Family therapy
- Solution-focused counselling
Stages of change

In the early 1980s, James Prochaska and Carlo DiClemente (among others) developed a model to explain the process of change in the context of substance use and dependence. Based on their research of ‘self-changers’, the stages-of-change model forms part of a broader conceptual framework known as the Transtheoretical Model (Prochaska & DiClemente, 1982; 1986).

This model recognises that different people are in different stages of readiness for change. It is important not to assume that people are ready for or want to make an immediate or permanent behaviour change. By identifying a person’s position in the change process, a worker can more appropriately match the intervention to the client’s stage of readiness for change.
STAGES-OF-CHANGE MODEL

Precontemplation
Precontemplation
Precontemplation

Contemplation
Contemplation
Contemplation

Preparation
Preparation
Preparation

Action
Action
Action

Maintenance
Maintenance
Maintenance

Lasting Exit
6.4 Motivational interviewing

- Motivational interviewing is a therapeutic approach that was originally developed in the alcohol and other drug field by William Miller and Stephen Rollnick (Miller, 1983; Miller & Rollnick, 1991).

- It is an interpersonal style of interviewing designed to assist clients to explore and resolve ambivalence, and to increase motivation for change.

- Motivational interviewing utilises the principles and practices of client-centred counselling to encourage the client to move through the stages of change and to make personal choices along the way. Client resistance is viewed as evidence of conflict or ambivalence, and is met with reflection rather than a confrontational style (Rollnick & Miller, 1995).
The treatment provided by pharmaceutical (drug) products is called pharmacotherapy. In this topic it will refer to the treatment of problem drug use by the use of other drugs.

The use of pharmacotherapy is much debated as problematic drug use involves many complex personal and social issues. Well used, pharmacotherapy can enable some stability and control over compulsive use and with proper support, address other problem areas (e.g. legal, employment).

<table>
<thead>
<tr>
<th>Heroin</th>
<th>Methadone</th>
<th>opiate substitute used mainly as maintenance treatment</th>
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<tbody>
<tr>
<td></td>
<td>Naltrexone</td>
<td>used for rapid opiate detox and to prevent relapse</td>
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<td></td>
<td>Buprenorphine</td>
<td>longer acting sublingual alternative to Methadone</td>
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<tr>
<td>Alcohol</td>
<td>Antabuse</td>
<td>makes client ill if they drink alcohol</td>
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<td></td>
<td>Campral</td>
<td>reduces cravings to drink</td>
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<tr>
<td></td>
<td>Naltrexone</td>
<td>reduces cravings to drink</td>
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<td>Tobacco</td>
<td>Nicotine replacement therapy</td>
<td>reduces cravings to smoke</td>
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<td></td>
<td>Zyban</td>
<td>reduces cravings to smoke</td>
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</table>
Visit to an AOD agency

- Learners are encouraged to arrange a visit (or phone) an AOD treatment centre with the facilitator’s assistance and answer the following questions based on their contact with the agency.

  **Q** Who are the agency’s client groups? (What is their intake criteria?)

  **Q** What are the most common drugs used by young people attending the centre?

  **Q** What approaches are used when treating young people?

  **Q** What is the percentage of young people attending the centre?
Pharmacotherapy – Not a magic pill

Pharmacotherapy is sometimes seen as a ‘magic pill’ for alcohol and other drug dependence, but the gains made by these approaches tend to be fairly modest in most cases.

Q Why are these pharmacotherapy interventions less effective than some workers and many clients expect?

Q How can they be used more effectively?

FAC

Ask learners to complete the questions in groups and then present their answers to the whole group.

If there is time ask the learners to explore popular press reports of any of the pharmacotherapies listed in the table above.
6.6 Working systemically with treatment issues

- It is important to remember when working on treatment issues with young people that their AOD use happens in the context of their environments. Many times young people participate in treatment programs only to return into the environment that created the AOD use.

- It is imperative that the approaches we take are multi-layered. Treatment interventions are important in the context of the bigger picture. They are part of an entire network of services and interventions available to young people who have issues with their AOD use. One of the most important facets of working with young people is developing a network of interventions and strategies to protect them from harm. Topic 8 will look more closely at developing collaborative work practices.

Summary

- Treatment interventions target people who use AOD in a harmful way.
- Different types of treatment interventions for young people: from counselling to detoxification.
- Treatment is one part of a system of services and interventions.
As discussed earlier in this module young people are influenced by a number of different factors such as individuals, family, peers and school, communities and society as a whole.

It is therefore important to develop collaborative workplace practices. Frontline workers should be able to provide a wide range of options and referrals for young people to access. This can be done through sharing information, resources and ideas with other people, colleagues, agencies and services.
7.1 Working with other systems

As we saw in Topic 2, young people are influenced by a number of different factors. These factors are related to:

- individual
- family
- peers and school
- community
- society.

Collaborative work practices involve identifying and working with people/workers who also have contact with the young person.

There are many ways that we can include collaborative work practices in our approaches to working with the young person.
Developing collaborative practices

- Ask learners to list some ways that they do or could work collaboratively with families, peers and schools, communities and the broader society. Refer learners to their Workbook to complete the following table. This is best done in groups or as a whole class.

<table>
<thead>
<tr>
<th>System</th>
<th>Collaborative Practices</th>
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<tbody>
<tr>
<td>Families</td>
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<td>Peers and schools</td>
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<td>Communities</td>
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<td>Societies</td>
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- Working collaboratively with the macro-systems (community and society) can appear to be more difficult than working with families and peers. It is important to understand some of the broader issues that young people face in order to develop appropriate interventions that target these areas. Collaborative practices with macro-systems might mean advocating on behalf of a group of young people about an issue that affects them.
Think of an issue that adversely affects young people in your community. In what ways could you advocate on their behalf to policy makers and people in power? What would stop you from doing this?

Some actions include:

- Work collaboratively with other youth workers in your area on areas where young people face the same issues
- Run a community meeting to ask local residents and young people’s opinions on the issue
- Encourage young people to speak up about their issues to people in power.

When you work systemically in a collaborative fashion you need to encourage young people to inform you about their needs. It is your role to ensure that those needs are passed on to and acted upon by bureaucrats, policy makers and politicians. Therefore, collaborative work practice with macro-systems involves needs assessment, research, lobbying, consciousness-raising and challenging current processes and systems. The role and skills of advocacy are covered in more detail in the module Working with Young People.
7.2 Working collaboratively with other agencies

- Young people are often involved with a number of agencies which play an important role in providing them with a safety net. This may have a positive effect in that young people develop links with a number of support networks. On the other hand it may have a negative effect if workers operate at cross purposes with each other. For example, one worker might be working with mental health issues while another is working with AOD issues. These issues may directly affect each other and yet the interventions may not treat the young person as a whole.

- This is one of the reasons why it is important to work collaboratively with other agencies who have dealings with a particular young person.

- Ask learners to discuss the following question with their colleagues.

  What are some other reasons why collaborative work is helpful in working with young people?
7.3 Coordinated interventions

Case management

Many young people with AOD problems are assisted by a range of AOD and other interventions, which are often provided by more than one agency. The coordination of interventions is often carried out by one agency which is the key agency for the client. The coordination of services by one agency (which is recommended), is sometimes described as case management. A wide range of agencies, including welfare agencies, AOD services and youth services could carry out this role for young people with AOD issues. When agencies are working in partnership, it is important that they communicate effectively with each other regarding the client’s progress and with client consent.

The goals of coordinating interventions include:

- Meeting clients’ needs holistically, not just AOD needs
- Providing regular client contact and follow up to prevent clients from ‘falling through the cracks’
- Ensuring efficient provision of services
- Preventing duplication of services
- Advocating for clients.

Recall one young person you have worked with who had a number of issues. Was there a ‘case manager’? How could you have worked with other agencies more effectively to assist that young person?
7.4 Professional conduct and collaborative work practices

- Working collaboratively means sharing information, resources and ideas with other people. This presents some professional dilemmas and issues for frontline workers with regard to:
  - rights and responsibilities
  - confidentiality
  - duty of care
  - ethics.

Dilemmas in collaborative work practices

*Ask learners to think about an instance when working with another agency caused an ethical or professional dilemma for them. Where did the dilemma stem from? How did they approach it? What other ways could they have approached it? They may discuss their answers with other colleagues.*

- If learners are interested in pursuing these issues further, the module *Young People and Drugs – Issues for Workers* details many of these issues.
Collaborative work with local services

- Ask learners to refer to their Workbook to complete this activity working in groups.

- **List the services you might be able to develop links with in your local area** (e.g. welfare, education, employment, legal, health and recreational/leisure). **What ways could you work collaboratively with these services?** (e.g. case planning meetings, joint projects, networking etc).

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7.5 Making referrals - partnerships for treatment interventions

Making referrals is an important aspect of working collaboratively with other services. One worker or agency is unable to provide all the services that a young person may require. Therefore, being able to make appropriate referrals is a skill that workers need to develop. The following case study considers some of these collaborative approaches.

ELLIE

Ellie is a 17-year-old pregnant young woman living in a rural community. She and her family are strongly connected to a local church. She has been drinking alcohol heavily in a binge fashion for about one year. In recent months she has been missing school and her drinking has increased. Last week Ellie was arrested for stealing alcohol from a bottle shop, and is due to appear in court in a month.

List five types of agencies which could have a role in helping Ellie to deal with her problems. What role/s can they play in Ellie’s case?

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<thead>
<tr>
<th>Agency to assist Ellie</th>
<th>Agency’s role</th>
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Learners should discuss their responses with the large group and provide relevant feedback.

- Developing partnerships with young people is an important aspect of working with them.
- Working with other agencies is an important part of providing a comprehensive service for young people.
- Frontline workers need to develop skills in working collaboratively with other agencies in a multi-disciplinary fashion.
- Professional issues are involved in collaborative work practices. These include an awareness of rights and responsibilities, confidentiality, duty of care and ethics.

- Partnerships with young people
- Work with other agencies
- Collaborative skills
- Ethical and professional issues.
At this point you should reflect with the learners on their learning experience and together assess whether the following learning outcomes have been met:

- Review AOD interventions and their applicability to working with young people on AOD issues
- Identify strategies to prevent harmful drug use among young people
- Describe effective interventions for young people with problems related to their AOD use
- Describe collaborative approaches for working with young people on AOD issues.
8.2 Summary of Contents

- This module has presented an overview and framework for working with young people on AOD issues. These issues are varied and include issues related to experimental and recreational use and, for a small percentage of young people, issues related to problematic and dependent use.

- The youth-focused systems model has been presented as a way of understanding drug use by young people. Key models in AOD work were introduced to provide a framework for understanding the range of AOD interventions.

- A range of strategies was presented and reviewed and included prevention and community approaches, early intervention and a range of treatment interventions including peer and family work, counselling approaches and pharmacotherapies.

- Finally the value of working collaboratively with other agencies has been explored and strategies to facilitate working relationships between agencies presented.
8.3 Self-reflection activity

- Ask learners to take some time to reflect on what they have gained from this module and complete the following questions. Allow time for feedback and discussion.

What aspect of this module do you feel is most relevant and useful in your work practice?

What kinds of issues has this module raised for you in your work?

Have you identified any further learning needs as a result of completing this module?

If so, what are some ways you can achieve these learning needs?
Overview

- The suggested assessment events for this module have been mapped to the unit of competence CHCYTH1A and correspond with the learning outcomes listed at the beginning of this module, Frameworks for AOD Work. Over the course of this program learners could be required to complete one of the following assessments:

Event 1: Report and presentation

Part A - Report

Write a report (800–1000 words) outlining a range of treatment approaches that are available to young people with alcohol and other drug problems. Describe the treatment services that you think best meets the needs of most young people with AOD problems that you have contact with, and support your answers.

In your responses think about the following key areas:

- Range of services needed
- Types of drug problems experienced and duration of the problem
- Needs of young people
- Family and community supports available
- Harm minimisation
- Treatment approaches that engage young people

Part B – Presentation

Conduct a 15-20 minute presentation on your written report and findings, briefly discussing each key issue. Make sure you introduce yourself, your topic and what it is you will be presenting. You may wish to use charts, overheads, diagrams, collages or any other form of media to support your presentation.
Assessment criteria

- The following key areas are to assist you and the learners in providing a guide for marking the assessment for this particular unit:

  - Demonstrates ability to describe in detail a range of treatment approaches that are available to young people with AOD problems; provides evidence of how these treatment services meet young people needs
  
  - Demonstrates ability to prepare and conduct a timely presentation that is orally and visually clear, concise and creative
  
  - Demonstrates a good understanding of the assessment question and addresses the key areas provided.
References


Websites

Evidence based Practice Indicators for Alcohol and Drug Interventions (2000) The Best Practice in Alcohol and Other Drug Interventions Working Group
www.wa.gov.au/drugwestaus

Narcotics Anonymous
http://www.naoz.org.au

Alcoholics Anonymous
http://www.alcoholicsanonymous.org.au

Australian Drug Information Network
www.adin.com.au
www.communitypartnerships.health.gov.au
www.turningpoint.org.au

Fact sheets - What is Drug Prevention for Workers
- Drug Prevention Strategies
These are available from The Drug Prevention Network
http://druginfo.adf.org.au

Drug Info Clearinghouse – The drug prevention network
http://druginfo.adf.org.au

The Australian Drug Foundation (ADF):

Centre for Youth Drug Studies is within the ADF:

The Alcohol and Other Drug Council of Australia (ADCA):
www.adca.org.au/

The National Drug and Alcohol Research Centre (NDARC): www.med.unsw.edu.au /ndarc/

The Centre for Education and Information on Drugs and Alcohol (CEIDA): www.ceida.net.au/

The Network of Alcohol and Drug Agencies (NADA):
www.nada.org.au

Drug Arm (This site is particularly focused on youth issues):
www.drugarm.org.au
<table>
<thead>
<tr>
<th>Key terms</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Abstinence</td>
<td>Refraining from drug use.</td>
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<tr>
<td>Ambivalence</td>
<td>Having mixed feelings about something (e.g. stopping drug use)</td>
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<tr>
<td>AOD</td>
<td>Alcohol and other drugs.</td>
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<td>Brief intervention</td>
<td>An intervention that takes very little time which are usually conducted in a one-on-one situation.</td>
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<tr>
<td>Case management</td>
<td>Coordination of services for a client carried out by one agency.</td>
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<tr>
<td>Cognitive behavioural therapy (CBT)</td>
<td>A counselling technique where the client learns strategies to change thoughts and behaviours related to AOD use.</td>
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<tr>
<td>Dual diagnosis</td>
<td>The phenomenon of someone experiencing both an AOD problem and a psychiatric disorder.</td>
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<tr>
<td>CSO</td>
<td>Concerned significant other. This includes family members, the close friends of a young person and sometimes, workers.</td>
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<tr>
<td>Community</td>
<td>A broad group of people (who do not necessarily live in the same area), who share common social structures and goals and engage in a wide range of activities in an interdependent, mutually advantageous, and empowering manner.</td>
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<tr>
<td>Drug dependence</td>
<td>Anyone who relies on and regularly seeks out the effects of a drug can be considered to be dependent on that drug to some degree. Drug dependence occurs when a drug becomes central to a person’s thoughts, emotions and activities. A dependent person finds it difficult to stop using the drug or even to cut down on the amount used. Dependence has physiological and psychological elements.</td>
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<tr>
<td>Harm minimisation</td>
<td>Harm minimisation is the primary principle underpinning the National Drug Strategy and refers to policies and programs aimed at reducing drug-related harm. It encompasses a wide range of approaches including abstinence-oriented strategies. Both legal and illegal drugs are the focus of Australia’s harm minimisation strategy. Harm minimisation includes preventing anticipated harm and reducing actual harm.</td>
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<td><strong>Key terms (continued)</strong></td>
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<tr>
<td><strong>Harm reduction</strong></td>
<td>Harm reduction aims to reduce the impact of drug-related harm on individuals and communities. It includes those strategies designed to reduce the harm associated with drug use without necessarily reducing or stopping use.</td>
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<tr>
<td><strong>Health promotion</strong></td>
<td>The process of enabling people to improve their health. It involves a range of activities that are focused on building health public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health issues.</td>
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<tr>
<td><strong>Intersectoral collaboration</strong></td>
<td>Coordination of interventions by agencies from different sectors or industries.</td>
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<tr>
<td><strong>Interventions</strong></td>
<td>An activity designed to prevent, reduce or eliminate harmful AOD use in an individual, family, or community. It includes prevention and treatment focussed strategies.</td>
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<tr>
<td><strong>Motivational interviewing</strong></td>
<td>A technique to increase the client’s motivation to reduce their alcohol and other drug use.</td>
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<td><strong>Narrative therapy</strong></td>
<td>A counselling technique where the client is helped to understand the story (or narrative) of their life, takes a fresh look at their life, and writes another script (usually metaphorically) for the future.</td>
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<tr>
<td><strong>Pharmacotherapy</strong></td>
<td>The use of medication to assist people to cease their use of specific drugs of abuse.</td>
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<tr>
<td><strong>Prevention strategies</strong></td>
<td>Interventions which aim to prevent people either taking up drugs (e.g. reducing tobacco sales to minors) or using AOD in a harmful way (e.g. promoting safe levels of drinking).</td>
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<td><strong>Psychodynamic therapy</strong></td>
<td>A counselling technique in which the client develops an understanding of how their AOD problem began (often associated with childhood and/or family issues).</td>
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<td><strong>Protective factors</strong></td>
<td>Protective factors are those factors that enhance the coping abilities of a young person thus increasing active participation in community activities and decreasing susceptibility to adverse consequences.</td>
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<td><strong>Relapse</strong></td>
<td>A return to harmful AOD use after a period of abstinence or moderated use.</td>
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<td>Key terms (continued)</td>
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<td><strong>Resilience</strong></td>
<td>The ability of an individual to face particular difficulties (such as abusive situations, living in poor conditions and having a non supportive family), yet not go on to develop problem/risk behaviours. It describes the capacity of a person to respond in a positive way to the risks, stresses and adversities of life.</td>
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<tr>
<td><strong>Relapse prevention management</strong></td>
<td>A variety of strategies used in intervention to increase motivation for maintenance of change, to identify high-risk situations for relapse, and develop skills to both avoid and manage relapses.</td>
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<tr>
<td><strong>Stages of change</strong></td>
<td>A model of change developed within the AOD field in the early 1980s. The model proposes that change is a process and not a one-off event.</td>
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<tr>
<td><strong>Treatment</strong></td>
<td>A return to harmful AOD use after a period of abstinence or moderated use.</td>
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