BUDDYS - Building Up Dual Diagnosis in Youth Services

HYDDI our partner service

Homeless Youth Dual Diagnosis Initiative

Youth Dual Diagnosis

Resource Guide

2015

Developed by the Victorian Dual Diagnosis Initiative

Acknowledgements

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Introduction

Working with dual diagnosis and young people

Working with young people who are struggling with co-occurring mental health and alcohol and other drug (AOD) issues presents many challenges. Often these young people are in the pre-contemplative stage of change for both problems in that they may not be aware of the problem or the risks. Alternatively they may be aware of a problem but not yet convinced of the need for change. Or they may be actively seeking change and looking for support. What are some effective approaches and strategies for working with young people and their families to improve their health and wellbeing?

This guide covers key practice areas for supporting young people who have, or may be at risk of, developing a dual diagnosis – that is, a co-occurring AOD problem and a mental illness, which can range in severity from mild to severe.

'Young people' generally refers to the 16-25 age group, although this guide may also be useful for young people that fall outside of this age bracket.

What's in the guide

The guide covers five practice areas, with a case study which is discussed within each topic to illustrate how these areas of care might be applied in practice. Call-out boxes appear throughout, with 'practice wisdom tips'. The five practice areas are:

1. **Adolescent development, drug use and mental health**
2. **The helping alliance**
3. **Young people in their social context**
4. **Harm reduction and working with young people**
5. **Integrated treatment and working with young people**

Each topic is discrete, and together they comprehensively cover practice issues for youth sector staff. There is also a resources section at the end of the guide.

Who it's for

The guide is designed as an introduction for anyone who works with young people who have a dual diagnosis: youth workers, AOD workers, mental health clinicians, community mental health workers, housing workers, homelessness workers and others. We use 'practitioner' as a generic term to cover all these possible roles.

While practice is discussed in the context of Victorian service systems and legal frameworks, the broader points are relevant for practitioners working in other places.

Where it's come from

The guide has been developed by the statewide network, Building Up Dual Diagnosis in Youth Services – 'BUDDYS' – whose members work in the teams that make up the Victorian Dual Diagnosis Initiative (VDDI). It represents the collective practice wisdom of the group and is based on recent evidence regarding young people's mental health and drug use issues and good practice in this area.

About BUDDYS

BUDDYS is a statewide representative group of dual diagnosis and HYDDI (Homeless Youth Dual Diagnosis Initiative) clinicians who work across the Youth Mental Health, Mental Health Community Health Services AOD and homeless sectors. It was established to support practice excellence that leads directly to improved client treatment outcomes through capacity building, and a range of team- and service-based activities. BUDDYS is a leader in the promotion of youth dual diagnosis, service capacity enhancement and collaborative cross-sectoral relationship building in Victoria.

About the VDDI

The Victorian Dual Diagnosis Initiative (VDDI) is a cross-sector (AOD, mental health community support and clinical mental health) initiative funded by the Victorian Department of Health & Human Services. The VDDI's role is to contribute to the further development of mental health and AOD workers', agencies' and sectors' capacity to recognise and respond effectively to people experiencing co-occurring mental health and substance use concerns - dual diagnosis.

Case study: Johnnie

Family, school and social background

Johnnie is 16 and currently lives with his father. His parents separated when he was five, and Johnnie had been living with his mother, stepfather and two younger half-siblings. Because of growing conflict with his stepfather, he moved again when he was 11 to live with his father. His mother had increasing concerns about Johnnie's aggressive behaviour and its impact on his two younger siblings.

Johnnie's father works regular periods of nightshift and Johnnie used to sleep over with his maternal grandparents. Johnnie reports a positive relationship with his grandparents. For the past three months however, he has not been staying with them, partly because his grandmother has been unwell, but also because both grandparents have struggled with Johnnie's oppositional and verbal aggression when they have set rules at home.

Johnnie is enrolled at the local high school, but has not been attending recently. He has either not arrived for the start of the school day or else left at the lunch break, preferring instead to make his way to the local shopping mall where he meets up with a peer group.

Involvement with drugs

Johnnie starting using alcohol and cannabis at the age of 13, and more recently he has started using 'ice' (methamphetamine). His use of alcohol and other drugs began when he started mixing with the group of local teenagers, a couple of whom are involved in street level drug supply of cannabis.

Risk and safety issues

Without effective supervision in the evenings and overnight, Johnnie often goes out with friends and this regularly includes drinking alcohol, using cannabis and sometimes using ice. On three occasions he has been taken by friends, and once by the police, to the emergency department. When intoxicated, especially after using ice, he experienced paranoid ideas which have required medical management at emergency, including close observations to monitor agitation and a poor level of co-operation with the treating team. Treatment with oral antipsychotic medications has been needed to alleviate the acute symptoms of ice intoxication. Once, following the 'crash' after using ice, Johnnie reported to the medical officer of feeling low in mood and having some suicidal thoughts.

Mental health

Johnnie's medical records list a diagnosis of drug induced psychosis and conduct disorder.

He has a history of contact with the youth mental health services regarding symptoms of depression and anxiety, self-harming and suicidal ideation. His contact is often short, and staff reported that he is difficult to engage. Johnnie's mood-related symptoms predate his use of cannabis and ice. His psychotic symptoms are evident when using methamphetamine and appear to resolve quickly with medication. When not using ice, Johnnie does not show signs of psychosis.

Johnnie's mother reports that she has a history of anxiety, which has become worse since Johnnie has stopped attending school regularly and has been going out at night. Johnnie's paternal uncle has a diagnosis of bi-polar affective disorder and Johnnie's parents are worried about his mental health.

Engagement in support and treatment

Johnnie has met with a youth worker several times and although he does not attend weekly scheduled appointments, he will regularly drop in to see the worker. Johnnie reports he would like to return to school and is ambivalent about changing his AOD use. He does acknowledge the use of ice has caused him some problems.

1. Adolescent development, drug use and mental health

As a time of physical, emotional cognitive and social change, adolescence presents many challenges for the young person and those who work with them. It's a time when young people experience change in their transition to adulthood.

For most teenagers the journey through adolescence will be essentially trouble free, excluding the usual challenges which are experienced through this period. For a small number of adolescents the presence of a dual diagnosis will make this a much more difficult journey. This transition may include experimenting with all sorts of behaviours, including using alcohol and other drugs. It is also a time when mental health problems may develop. For these reasons, it is important to think of the impact of AOD use and mental health problems in terms of a young person's future development and functioning. If 'normal' development is interrupted by mental illness or drug use, subsequent developmental milestones may not be reached.

> *"Risk taking…is an important way that adolescents shape their identities, try out new decision making skills, and develop realistic assessments of themselves, other people, and the world"*
> *Developing Adolescents: A reference for professionals. The American Psychological Association 2002.*

The impact of alcohol and other drugs

The fact that the brain is still developing makes adolescence a particularly vulnerable period for the development of substance use disorders.

Until around the age of 25, the prefrontal cortex is still maturing. This part of the brain is responsible for regulating the capacity to make sound decisions, accurately assess situations and control impulses. Young people are still developing their capacity to make sound judgements and to anticipate any negative consequences of their actions especially while taking part in pleasure seeking activities that have an element of risk attached. When alcohol and other drugs are part of this - mix means further impaired judgment and decision making

Working with adolescents needs a different approach

We need to think differently about interventions around AOD use for young people, compared with adults, because their patterns of drug use are different and they may not seek help as readily.

> *Adolescence is a time when dual diagnosis problems may show themselves, so we have a real opportunity for early intervention.*

In the early experimental stage of substance use less than half of teenagers half of teenagers drink alcohol, and few use illicit drugs. Among those adolescents who do use alcohol and other drugs, a binge pattern of use is most common. Dependence is less likely at this stage, and most have no problems at this early age.

Despite these challenges, young people do have the ability to learn and engage in education and health support.. Helping young people develop some basic mastery gives them the foundation to develop further competences. These basic skills can be crucial in understanding behaviour and motivation, and building the ability for change. Behaviour-based 'skills training' is a simple and effective way to assist young people develop into healthy adults.

> *Almost universal among young people with a dual diagnosis is a history of childhood trauma and history of family-related issues.*

Johnnie`s case

Johnnie showed emerging difficulties at the age of 11 and was using alcohol and other drugs at 13 – in early adolescence – with themes related to disinhibited behaviour.

Thinking about Johnnie

- What are Johnnie's developmental dual diagnosis tasks and challenges?
- Considering the importance of both attachment and trust in relation to Johnnie's family of origin, what importance might his parent's separation have had for Johnnie?
- Johnny says he would like to return to school. How would using a strengths-based approach when working with Johnnie assist him to achieve this goal?
- What factors are most likely involved in Johnnie's poor impulse control?
- What are the known mental health and social consequences when adolescents start substance use in early adolescence?

Approaches to treatment

There are a range of possible approaches to helping the young people with dual problems.

I'm a good book!
Motivational Interviewing with Adolescents and Young Adults. Written by
Sylvie Naar-King & Mariann Suarez. 2011

Engagement in treatment is essential in order to begin the conversation about substance use and mental health issues. Engaging includes the practitioner accurately understanding what stage of change the young person is at. For the young person in the Precontemplation or Contemplation stage, Motivational Interviewing skills are helpful.

CBT (Cognitive Behavioural Therapy)

CBT is a type of psychological treatment that is shown to be helpful for young people experiencing anxiety and depression. As the evidence shows; it is frequently the case that young people with a dual disorder will have these symptoms either prior-to their drug use, or as a result from their drug use. CBT comes from the idea that thoughts elicit feelings, which elicit actions (e.g. drug use as a means of coping with negative thoughts about themselves). CBT aims to provide alternative thinking patterns that ultimately change their behaviours. This approach also works best when they make use of practical exercises outside of sessions, and in the 'real world'. CBT can also work with the young person's mental health problems and their drug use problems at the same time, as these problems are co-occurring.

A helpful set of resources can be found on the following site:

www.therapistaid.com/therapy-worksheet/cbt-practice-

Supportive community based mental health care case management or recovery support practitioners

Specific AOD counselling (including residential detox or rehabilitation)

Engagement with a local CMH Service for specialist psychiatric care.

Self-regulation of cognition and emotion

Self-regulation is a critical skill that underlies mindful, intentional, and thoughtful behaviours. It refers to intentional behaviour.

Self-regulated young people can delay gratification and suppress their impulses long enough to think ahead to the possible consequences of their actions or to consider alternative actions that would be more appropriate. Self-regulation is not limited to the social-emotional domain; it can also apply to cognitive behaviours, such as remembering or paying attention.

Link thoughts and feeling, set goals

For Johnnie, possible points of intervention that involve self-regulation are his suicidal feelings and his ice use.

Using a similar method to problem solving, we could help Johnnie 'connect the dots' between his actions or behaviour. This would start with psycho-education around effects of ice, how it makes people feel and how long it takes to come down. We can help Johnnie to understand that he can control the way he feels through his behaviour – whether it is helpful or unhelpful – and understand the consequences of that behaviour. It may be helpful to make use of a substance use and mood diary, to link the pattern of use to the pattern of thoughts and feelings.

Another helpful strategy is teaching goal setting, helping Johnnie to set and achieve goals to develop his own sense of mastery of his world. Goal setting is an important skill in building self-efficacy and works on basic problem solving skills.

Key points

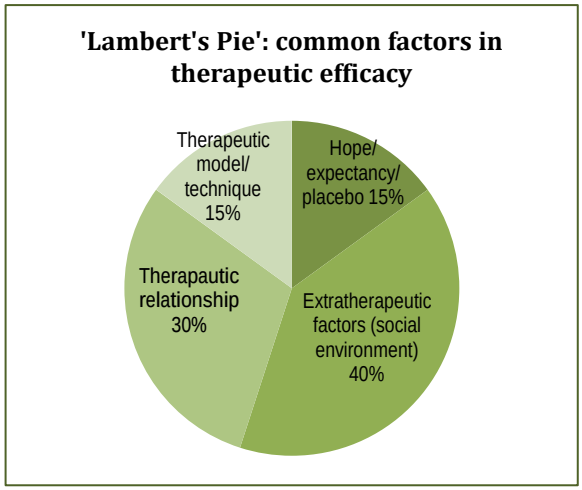
- Because it is still developing, the adolescent brain is especially vulnerable to the effects of AOD use.
- Problems arising from young people's AOD use are likely to be related to binge use and risk-taking, rather than dependence.
- Young people who might be experiencing problems related to their AOD use are less likely to seek assistance as a result of a strong need to conform to peer group expectations lack of knowledge about getting help, or because they are in Precontemplation and unaware of the harms of AOD use

2. The helping alliance

Effective dual diagnosis intervention with young people depends on much more than good knowledge of youth mental illness and substance use. As with any helping relationship the most important variable for success is forming a good helping alliance (or therapeutic relationship).

The **therapeutic relationship**, also called the helping alliance or the working alliance, refers to the relationship between the practitioner and the young person. It is the means by which the practitioner and young person hope to engage with each other, and effect beneficial change in the young person.

No matter what approach or therapeutic models we might use in our work with young people, a considerable body of research has shown that most approaches work about equally well and that the model or technique is not the most important factor. What is important is the therapeutic relationship which contributes around 30% to treatment outcomes. This is illustrated in 'Lambert's Pie' [4], which shows the common factors in therapeutic efficacy (see diagram).



Thinking about the case study of Johnnie

- What might be some specific challenges associated with engaging Johnnie?
- Who else could we enlist to support our engagement effort?
- What actions might we take that could facilitate Johnnie's engagement?

Tips for practitioners to building a strong helping alliance:

- **Listen**: make time just to hear the young person's story – what has been happening, what they think and feel about their situation
- **Show respect**: this is a fundamental ethic in provision of human services
- **Set boundaries**: boundary-setting with young people is very effective. They need to know times you are available, what is appropriate behavior in the office, what you can and can't do etc.
- **Be consistent**: as a basic element of human respect, displaying consistency can model this behaviour to the young person as well as showing them that we have a genuine interest in their wellbeing
- **Be 'human'**: acknowledging to young people that as service providers we can be emotional, stressed and busy shows it not to be a sign of weakness, but rather a normal human trait
- **Use humour**: many young people associate a sense of humour with genuineness and trustworthiness
- **Involve the family, where appropriate**: family members can be potential allies in treatment, and we know that treatment retention is higher for young people if the parent feels that treatment is valuable and that the young person's health is improving. (refer Practice Area 3)
- **Be honest**: young people have had enough of dishonesty in their lives
- **Be non-judgemental:** easy to say but hard to do when you can see a young person's behavior taking them down a destructive path
- **Be genuine:** young people can sense when you are not being genuine
- **Be curious:** don't take an expert position but ask lots of questions to help with understanding

***Maintain Optimism**: Often neglected by health professionals, maintaining a spirit of hope and optimism is extremely important.*

Be flexible and 'youth-friendly': Flexibility when making contact is common practice (when, and whether by phone, text, email, or face-to-face). Engaging young people with mental health and AOD services may mean home visits or meeting in 'neutral' environments such as cafes or shopping centers in order to avoid the stigma associated with these services.

Focus on what's relevant to them in their world: Focusing on problem-solving and agreeing on joint goals can be much more effective than focusing on diagnostic issues. For example, assisting a young person with anxiety, stress, concentration difficulties, or poor sleep is more likely to build engagement than offering diagnostic labels. Similarly, discussing strengths as well as difficulties may make a young person's attendance and engagement more likely than if the focus is solely on pathology.

Adopt appropriate interventions: Appropriate interventions take into account the young person's developmental stage and the phase of their recovery. The motivational interviewing literature can be useful in providing advice on how to engage young people who may not necessarily be help-seeking. This model advocates for 'rolling with resistance' rather than becoming involved in unhelpful debates.

Practice challenge: When engaging the young person is difficult

We know from practice wisdom that young people struggling with complex issues including dual diagnosis are the hardest to engage. There may be a variety of reasons for this including lack of trust, fear or anxiety which may be related to their experience of complex trauma while growing up. As well, the impact of their dual diagnosis can play havoc on their day-to-day functioning. For example, what some practitioners might describe as "treatment resistance" might be purely related to the impact of depression/anxiety and/or substance use intoxication/withdrawal
One should also not underestimate the impact of cognitive impairment or learning difficulties in this cohort. Other things to consider include having an awareness that for some young people motivation fluctuates regularly, even hour to hour. As well, young people having insight into their problems should not be assumed by practitioners.

Mental illness and substance abuse issues do not tend to discriminate and as such we may have personal or professional experiences that have impacted upon the way in which we work with young people struggling with a dual diagnosis. Further to this, due to the complexity of young people with a dual diagnosis practitioners can at times feel frustrated and overwhelmed by such presentations and this too can impede us from providing the best treatment possible. As professionals, therefore, it is essential that we take the time to reflect on our own values and attitudes

It is important to think of the impact that our own values, beliefs, attitudes and personal experiences have on our overall engagement and work with young people with a dual diagnosis.

With all these practice challenges to contend with one will need to give careful consideration to how best to engage a young person in working towards a different future. So what to do? Some ideas you might find useful include:

- Be creative: if something is not working try something different
- Be adaptable: don't continue to do the same old thing but adapt your style of working to suit the needs of the young person
- Be persistent: don't give up
- Be assertive: don't wait for the young person to come to you. We need to be proactive and actively follow-up
- Be useful: do something that the young person might appreciate such as providing practical assistance
- Be collaborative: spend time with the young person and/or their family in order to understand their explanatory models, that is, why things are the way they are
- Ask about past treatment experiences: taking time to discuss their experiences of service involvement can provide valuable insight into what young people and their families have found helpful and unhelpful
- Explain the process: that is the when, where, how and why of what is going to happen
- Provide information

- Ask the young person what they would like you to do if they miss an appointment
- Where possible, make every contact as positive experience
- Where appropriate, and with the young person's permission, communicate with the young person's support network
- Be mindful of the stage of change for both substance use and mental health problems and respond accordingly
- Try to engage on different topics. Perhaps the young person isn't ready to talk to a worker about their mental illness or drug use, but will talk about other areas of their life. Perhaps there are issues outside of the obvious problem. Have they got money, suitable accommodation? What do they do with their day? Are they interested in getting involved in a new activity? Supporting young people in what they want to achieve shows them we are listening, that we want to support them, which may in turn increase their confidence in talking to us about other things.

Supporting young people in what they want to achieve shows them that we are listening, that we want to support them and that we can.

The helping relationship: Johnnie

Factors that might affect engagement

To consider the best approach to engage with Johnnie, let's first look at key factors that might influence engagement:

- Johnnie has experienced some stressors growing up, including the separation of his parents at five years of age and conflict with his step-father
- He is known by his family to become aggressive
- Mental health services have found Johnnie hard to engage, with contacts being time limited
- The youth worker has found Johnnie's attendance at appointments sporadic, although when he shows up the youth worker has found him willing to discuss his situation

Shaping our style of engagement

We can use what we know of these factors to shape how we engage with Johnnie.

Non-confrontational

Confrontation will most likely result in a negative reaction or disconnection from Johnnie, especially given his conflict with his step-father and supposed lack of trust in some adults. Therefore a 'slowly, slowly' approach will be more likely to succeed. This includes a harm minimisation approach concerning his AOD use and mental health issues.

Opportunistic

Scheduling appointments may also prove difficult and suggesting Johnnie 'drop in' when he needs to could lead to development of a better helping alliance on his terms. It might be useful to take Johnnie's presentations to the emergency department as opportunities to engage, particularly for gaining assessment information.

Working with what he wants

Working with what he wants is a good place to start. The case study indicates that Johnnie would like to return to school, and this should become the priority for contact with Johnnie, to show him you have heard his wishes and have hope that he can succeed.

Key points

- Building rapport and developing a strong therapeutic relationship are paramount when working with young people.
- Successful engagement is critical to effective intervention and/or treatment.
- One of the best things we can do is listen, learn about what is important to the young person and use this to provide support and help them achieve their goals.
- Family members can be a great support for young people in treatment so it is important that, when appropriate, they are supported and kept informed of treatment, provided that the young person is agreeable to this.

3. Young people in their social context

Working with young people who are struggling with co-occurring mental health and AOD issues can be challenging, especially if the young person is unwilling to engage in treatment for either issue. Knowing that there are other parts of a young person's social environment where we can have an influence, which in turn may indirectly impact the young person's mental health or drug use in a positive way, , can help provide us with hope and a sense of direction.

Thinking about Johnnie

- Who in his family might benefit from our contact, ultimately leading to a better outcome for Johnnie?
- What areas of Johnnie's life might we be able to influence that could have an indirect impact on Johnnie's wellbeing?
- Who else is there in Johnnie's social environment that might be useful to engage?

Working with a young person's family / carers

Who are they?

Family, in this context, is defined in the broadest possible sense to include extended family which and significant others. It can be anyone including parent/s, siblings, extended family, carers, friends and others who are significant in the young person's life.

Family inclusive practice

What is family inclusive practice?

This is an approach and way of thinking that recognises the role of family in a young person's life.

It is important that young people are recognized as being part of a family system and social network – that those family members and significant others can be involved in assessment and treatment, and may have support needs of their own.

Why is this good practice?

It's important to consider families affected by independent and co-existing mental health and drug and alcohol problems for two important and related reasons: first, family members in these circumstances show symptoms of stress that warrant help in their own right; and second involvement of family members in the treatment of their significant other with mental health and/or drug and alcohol problems can enhance positive outcomes [5].

Most young people will have a strong biological and emotional connection to their family of origin, whether or not they are still living at home. We don't necessarily need to see the family face-to-face, but it is important to remember that the family plays a key role in adolescent development and also in the success or otherwise of treatment.

Is family inclusive practice effective?

Research shows that ongoing positive family connections are protective against a range of health risk behaviours. Involving family in treatment – directly, indirectly or as a consideration – improves the prospects for the young person and their family.

Family inclusive practice improves dual diagnosis outcomes and family functioning.

Keeping the family in mind can:

- improve dual diagnosis outcomes and family functioning
- assist with encouraging the young person into treatment and improve potential outcomes
- lead to the reduction and impacts of harm
- reduce relapse rates and family distress levels, which in turn creates opportunities for the young person to recognise problematic behaviours
- provide an opportunity to find out the support needs of the family [6]?

Types of family inclusive practice

Family inclusive practice can be categorised into three broad types:

- working with family members to promote the engagement of young people into services
- involving families and others in assessment and treatment plans
- providing services directly for family members [7]

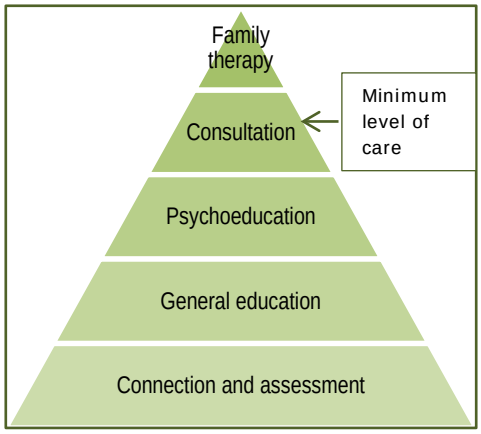
Each of these types has different aims and will bring a distinct focus to engagement with families. It is important that both practitioners and services determine how, why and to what end they are engaging families.

The pyramid of family care

One of the challenges for practitioners wishing to incorporate 'family' into their work is their assessment of their own skills, confidence and knowledge. The Pyramid of Family Care (see diagram) [8] is a useful model which provides guidance about different opportunities which lead

to family members receiving the support they need. This can also have a beneficial effect on treatment outcomes for the young person who is struggling with dual diagnosis.

Based on Maslow's hierarchy of need, the pyramid is highly applicable to many different work settings. Conceptualising family inclusive practice as a continuum of possible responses makes improving engagement with families, according to each practitioner's/service's capacity, both practical and feasible. The tasks of engaging, providing education and collaborating with most families are well within the scope of most practitioners.



Some ideas for practitioners

It is essential for families to obtain information that they can understand, as well as support and practical assistance to enhance their own wellbeing and day to day management of the young person. Practitioners can help the families of young people by:

- including carers in relevant aspects of the young person's treatment if possible including involvement in the development of the care and relapse prevention/management plan
- explaining medication effects with an emphasis on drug interactions
- describing the expanded model of change to promote understanding of relapse of both disorders and ambivalence to change substance use
- describing the effects of typical substances on mental health particularly symptoms of psychosis, effects on mood and anxiety
- advising the family of local support groups or services

The tasks of engaging, providing education and collaborating with most families are well within the scope of most practitioners.

Finding out about a young person's world

The family: genograms

A genogram or family tree is a useful tool to gather information about a young person's family. This visual representation of a family can help identify patterns or themes within families that may be influencing or driving the young person's current behaviour. Most young people really enjoy this opportunity to talk about their family history, and it can work as a good tool to further build trust and rapport. At the same time we need to be aware that some young people may find seeing a visual picture of the state of their relationships confronting, particularly if the majority of relationships in their life at present are conflictual or distant. It is important to use this tool sensitively and only in cases where it is likely to be useful to help promote healthy change and development of more positive relationships in the young person's life.

For more information on genograms:

- *Child and Family Snapshot* www.dhs.vic.gov.au/about-the-department/documents-and-resources/forms-and-templates/child-and-family-snapshot-practitioner-field-tool-and-genograms, p. 4
- Simple Guide to Genograms *www.strongbonds.jss.org.au/workers/families/genograms.html*

Others in their world: ecomaps

An ecomap is another useful tool for gathering further information about a young person's other significant social relationships, how strong the connections are, and whether they are supportive or stressful for the young person.

For more information on ecomaps:

- Simple Guide to Eco-Maps http://www.strongbonds.jss.org.au/workers/cultures/ecomaps.html

Addressing the young person's social environment

Risk and protective factors

Preventing dual diagnosis and the underlying problems means reducing the risk that accompanies early adversity, and enhancing the benefits that result from common protective factors, at least in part and as much as is possible.

Many of the young people we work with have risk factors they are exposed to far outweigh any protective factors that may buffer the impact of those risk factors: hence they experience dual diagnosis. While there are many parts of a young

person's past and present life where we can have little influence, there are still many other life domains where we can work with the young person to maximize the potential for a positive outcome.

Social and economic inclusion

Research on the factors influencing mental health and substance use outcomes provides us with some insights into potential areas of influence. If we are not able to work with the young person on their dual diagnosis, we should endeavor to impact on any of the areas listed:

- social and community connectedness
- stable and supportive environments
- a variety of social and physical activities
- access to nurturing, affectionate and secure relationships with adults
- access to work and meaningful engagement
- access to education
- access to adequate housing
- access to money
- involvement in pro-social peer groups
- positive personal achievements [9-12]

Practice challenges and management

Confidentiality and its limitations

There are many laws covering the issue of privacy and confidentiality, but in general we are required to keep most of what young people tell us confidential. As we know, confidentiality is rated very highly, is considered very important by adolescents and is crucial to practice. Young people have a right to confidentiality, and where it is limited, to have those limits explained. Clarity regarding confidentiality policies and practices needs to be established.

> We must routinely seek a young person's consent before providing information to parents/carers.

Where a young person's mental health is concerned, the *Mental Health Act* allows information to be disclosed to family, primary carers and guardians if the information is reasonably required for the young person's ongoing care.

Practice suggestions

- Be clear about who the client is – the young person or the family?
- Ensure discussion about confidentiality occurs in the first session
- Explore the young person's concerns and fears about confidentiality
- Reassure the young person that some information can be kept confidential although might be important to share some information with the family to improve their care
- Document any consent to share information with the person's family, partners or carer
- Use the pyramid of family care as a guide to what can be shared with family without breaking confidentiality
- Consider other services that may support the family

Often young people opt for confidentiality because they don't know how to bring up sensitive information. You might like to offer some help with how to word what they would like their family member to know. You might even like to practise saying it with them. Practitioners need to respect the decision of the young person if they choose not to have their family involved. Be sure, however, to revisit the issue at a later time.

Family stress

In some cases involving family members of young people may not always be appropriate, helpful or possible as it may add to family stress. There are times when a young person can't rely on their family's support; or family members themselves may contribute to the stressors the young person is experiencing (e.g. through abuse, homophobia, parents' mental health and/or drug issues); or they are no longer residing with their family of origin.

Practice suggestions

- Reconnect young people with more appropriate family members, or alternatively, with other significant adults who can provide the elements and safety net for emotional development
- Despite family separation it may still be helpful to keep the family in mind. While the impact of dual diagnosis on families can be significant and result in relationship breakdowns, gradually repairing this damage, as part of the therapeutic process can be very beneficial for both the young person and the family – unless of course safety is an issue
- Families are generally trying to do their best with the resources and skills they have at the time. Assisting them (if appropriate) to develop a better understanding of the issues and equipping them with the skills to manage it can assist both the family members and young person
- Manage expectations – families and carers should be advised at the earliest opportunity about the type, level and nature of support the service can provide.
- Families from culturally diverse backgrounds may require additional support or have cultural specific needs so it is important to explore this further with the young person

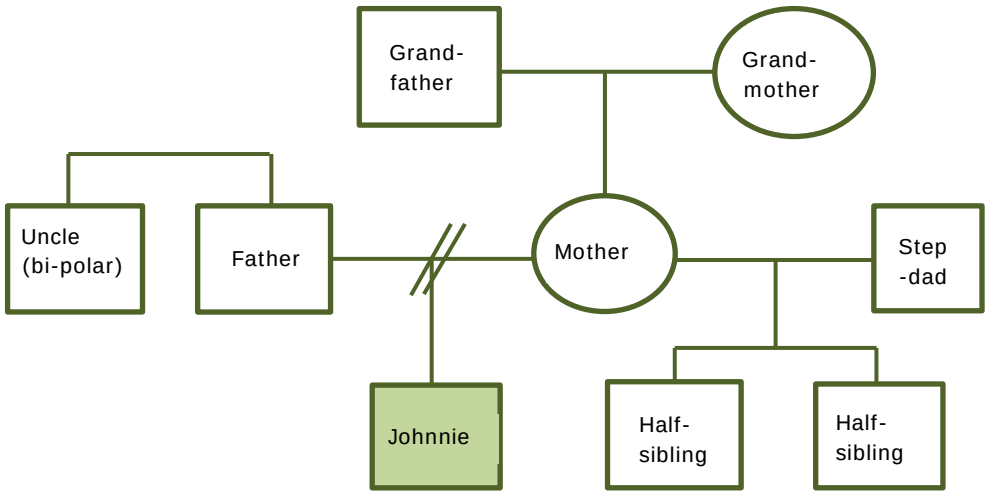
and/or family as to what supports may be available/required.

Engaging family and others: the case of Johnnie

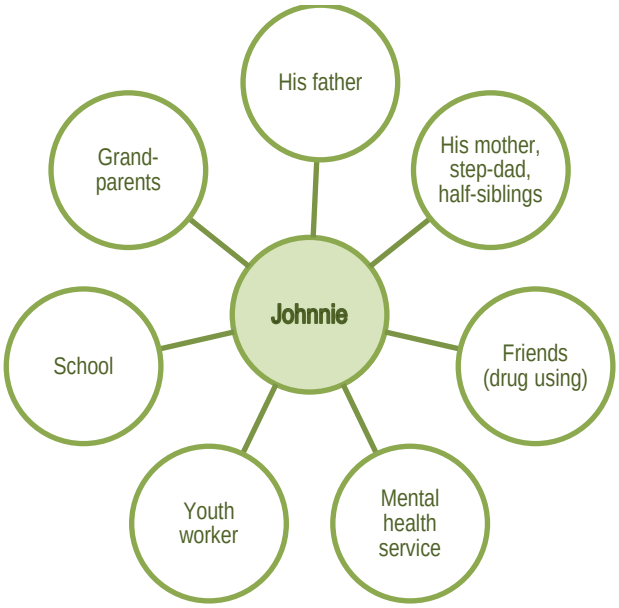
Johnnie's family, school and peers are all parts of his social environment where we can have an influence.

- Johnnie is connected to his family, who want to support him. How can we support Johnnie's dad and grandparents to provide him with a stable, secure living environment?
- Johnnie says he would like to return to school. What needs to be done to facilitate this and maximize his ongoing attendance?
- Johnnie's use of alcohol and other drugs is part of a pattern of mixing with other teenagers who use. What do we know, or can we find out, about Johnnie's interests and what he is good at? Is there some activity that Johnnie can participate in where he mixes with non-using peers?
- What support services are available to provide help for families where a member has a dual diagnosis?

Genogram for Johnnie



Ecomap for Johnnie



Key points

- Young people need to be recognised as being part of a family system and social network.
- Research shows that ongoing positive family connections are protective against a range of health risk behaviours.
- Involving family in treatment – directly, indirectly or as a consideration – improves the prospects for the young person and their family.
- A genogram or family tree and an ecomap are useful tools to gather information about a young person's family and other significant social relationships.
- Stable housing, engagement in a meaningful activity and a pro-social peer group are just a few of the important variables influencing outcomes for young people struggling with a dual diagnosis.

4. Harm reduction and working with young people

AOD Use in Australia

Harm reduction does not always sit comfortably with everyone who works in health and welfare. Some are concerned that it seems to be condoning behaviour that we know leads to poor health and is potentially dangerous.

Benefits of harm reduction

- *Harm reduction is effective in reducing risks associated with AOD use*
- *A harm reduction approach is also effective in engaging people in treatment [13]*

Alcohol and other drugs are a normal part of Australian community life. People use them to celebrate special events, have fun, participate in social activity and some people report that it can help alleviate psychological distress. We have a strong culture of drinking alcohol, and illicit drug use is not so very unusual. Experimenting with alcohol and other drugs during adolescence is common and for some it is a rite of passage. It is important to note, however, that it is not as common as many – including adolescents – think School data call out box

Young people are unlikely to be seeking to change their alcohol or other drug use, and harm reduction is best practice with this group of pre-contemplators.

While many of us might prefer that young people lead drug-free lives, we know that some young people will use alcohol or other drugs at some time. We know that forbidding use will most likely mean the young person disengages, and also force the alcohol or other drug use underground which may cause more severe problems, such as binge using or transmission of blood-borne viruses.

We also know that young people are less likely than older people to be seeking to change their AOD use.

Thinking about Johnnie

- What are some of the harms associated with Johnnie's AOD use?
- How might we go about talking with Johnnie about these risks?
- What would we want to talk about?
- What are some strategies that Johnnie could implement that would reduce some of these harms?

Public health policy

Public health policy in Australia supports harm reduction as a strategy when managing alcohol and drug use in the community. Examples of this include programs such as methadone maintenance, needle and syringe exchange programs and the Sydney medically supervised injecting center.

> Harm reduction involves any strategy that reduces the risk and /or social harm associated with drug use.
>
> Lintseris and Spry-Bailey, 1998

"The harm reduction approach accepts that the use of drugs is a part of life, that many people use drugs for their psychoactive effect and that on most occassion the drug is enjoyable" – source turning point clinical treatment guidelines for aod clinicians

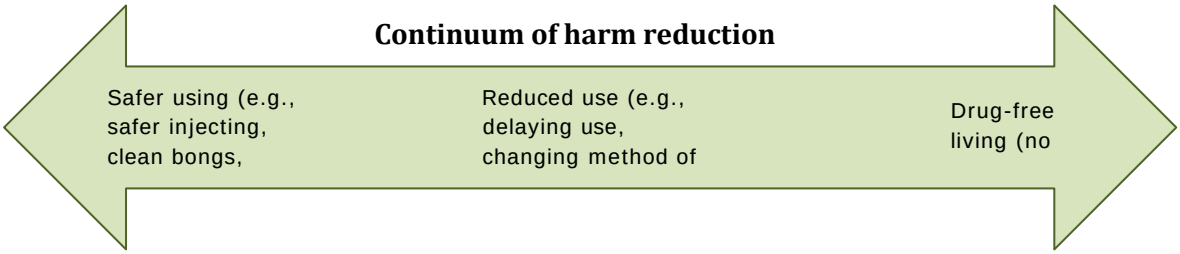
Harm reduction involves any strategy that reduces the risk and /or social harm associated with drug use (Lintseris and spry-bailey, 1998 – turning point) call out box.

Practitioners often experience the tension of those advocating abstinence, whilst acknowledging AOD use among young people.

Harm Reduction

Many young people we work with do not wish to cease their drug use and some may not wish to change their consumption patterns at all.

While harm reduction does incorporate drug-free living or abstinence at the level of the individual, it is considered on a spectrum that includes safer using or reduced use as achievable and worthwhile goals, as illustrated on the continuum of harm reduction (see diagram).



Harm Reduction in Practice

The practice of harm reduction involves the following

- A harm reduction approach which recognises that AOD use cannot always be prevented, and instead works to reduce its harmful effects.

Successful harm reduction practice is non-confrontational, and instead:

- Takes an educational and supportive approach
- Supports conversations that encourage the client to engage in discussion about their AOD use
- Supports the client's curiosity about their own behaviour, decisions and responses that provide opportunities to reflect about ambivalence for change.

'Harm reduction begins with acknowledging that AOD use can be fun and for many is a normal part of community life.'

The practitioner's aim is to:

- Educate young people, their family and wider social networks about the risks of AOD use and to increase knowledge of strategies to reduce harm.

Exploring Practical Strategies

A drug education approach involves talking with the young person about what they use, how they use it, time of day, with whom and so on. If they can describe their patterns of use and the results, we can share our knowledge of the least harmful ways of using. This can be particularly relevant for those dual diagnosis clients who are yet to gain full insight into their mental health issues and the impact their AOD use may be having on their symptoms.

Risks

Following a conversation with a young person about their drug use, it is important to consider any potential risk that may be associated with their AOD use.

A key aspect of harm reduction work is education about risks associated with use of particular drugs, and offering strategies for safer use. Polydrug use (the use of two or more drugs) is common and which may involving combining various drugs including ecstasy (MDMA), cannabis, alcohol, amphetamines and prescription. In the case of Johnnie and his drug use, there are many kinds of drug interactions which need to be considered. Johnnie's use of cannabis, alcohol and methamphetamine increases the risk of harm, including lowered impulse control and conflict with others.

It is also important to consider and understand the interaction between the young person's drug use and their mental health issues, so we can provide information and suggest practical ways to deal with this interaction.

Harm Reduction Resources

The practitioner may use a variety of information materials including handouts, pamphlets and websites and many of these useful tools can be found in the appendices of this document.

Motivational enhancement approaches are effective in identifying and supporting the young person's interest in change. If they wish to make changes to their AOD use, relevant areas to explore are patterns of family AOD use and available sources of support.

Worker attitudes

Worker values and attitudes towards AOD use can have a significant impact. We need to consider in

YoDAA (Youth Drugs + Alcohol Advice) is a helpful online resource for young people, family/carers and professionals
www.yodaa.org.au

advance how we would feel about sending a young person to a needle and syringe program or educating them about safer injecting. Would we prefer to be encouraging them to cease or reduce use, particularly if they had a mental illness? Our attitudes need to be checked against what the client wants and is ready to achieve.

Differences in doing harm reduction with young people and adults

Although the principles of harm reduction are the same regardless of age, there are some important differences to consider when choosing the most appropriate strategies for young people.

Because young people may not have a strong sense of 'future' and be limited in their ability to think before they act, harm reduction strategies need to be practical and focussed on the immediate reduction of harm.

Communication and engagement

Education about risks associated with particular drugs is central to doing harm reduction, and because young people are more likely to experiment with a wide variety of drugs, information about drug interactions can be important. At the same time, however, the direction of the conversation depends on how the young person wants to, or is able to communicate. If they're someone who is well engaged and communicative, detailed information about drug interactions might be appropriate. If, on the other hand the young person doesn't talk much and engagement is harder, discussion of harm reduction strategies may need to be more general.

'Harm reduction strategies need to be practical and focused on the immediate reduction of harm.'

Patterns of use

Young people are more likely to binge on alcohol and other drugs and take risks. A whole range of harms come with binge use, but the young person might be able to perform adequately between binges and therefore not be able to 'see' the harms. Rather than offering information about the cumulative impact of AOD use on their bodies, it is more effective to focus on the immediate or social consequences of their use, such as unsafe sex, falls, fights, embarrassment and so on.

Relations with peers

The influence of peers in young people's AOD use and acceptance of mental illness can be pivotal in the change process. Young people will typically find it hard to be different from their peers and can struggle with harm reduction strategies that rely on self-disclosure of their problems to their friends.

'Before During and After'

A way of encompassing all the above elements of harm reduction work with young people is to use a template such as the 'Before, During and After' tool.* It provides a simple framework for structuring harm reduction discussions with young people and can also work as an engagement tool.

To use the tool, ask the young person to consider what they will do before, during and after they use. Taking each of these stages in turn, together you can develop strategies they can apply to reduce the harm from alcohol or other drug use and reduce its impact on their mental health. The young person can take away notes from the discussion in the form of a reminder card or sheet of paper they can keep in their pocket and refer to.

In order for young people to change their AOD use, ambivalence needs to be resolved

To begin, ask the young person about their using patterns and help them to elicit their own responses around keeping safe. Some prompting questions may include:

- 'Have you thought about what you will do before/during/after you go out that can keep you as safe and healthy as possible?'
- 'What strategies will you use?'
- 'Would you like me to help you come up with some potential strategies?'

During the discussion you can jot down some ideas, as shown in the example below.

You can use the information gained in this exercise throughout your work with the client. It can be a powerful reflective tool for them to think about all the elements that go into their AOD use and the many and varied impacts that their use may have on their mental health.

The following is an example for ***anxiety and cannabis use.***

* Developed by Simon Kroes, Nexus Dual Diagnosis Advisory Service (a service of the VDDI), St Vincent's Hospital Melbourne.

Before	• Find out more about the possible interaction between cannabis and anxiety • Have a good night's sleep • Eat a meal • Know who you are going out with • Limit your money • Set aside money for the trip home, arrange to have someone come and pick you up • Make sure you get the drugs from someone you trust • Identify trigger for use /using too much • Think about what to do if you do get anxious / paranoid / irritable
During	• Try a small amount at a time • Think about whether the drug is increasing your anxiety / paranoia / irritability • Smoke joints instead of bongs • If you use bongs, clean them regularly • Have a break between smokes • Eat healthy snacks • Don't mix your drugs including alcohol and pills
After	• Drink fluids • Take multi vitamins, eat some healthy foods • Get some sleep • Avoid stressful people and situations • Reflect on how your recent using and the effect it had on your anxiety • Talk to someone you trust about your experience

Practice challenges

Harm reduction and families

It is crucial to engage with the family and explain the purpose and logic behind harm reduction. Most families just want their loved one to be well and this commonly equates to stopping use and stabilising mental health symptoms. So a harm reduction approach may seem counterproductive to them: *'Why aren't you telling him to stop'*; *'You shouldn't be supporting her to use!'* Education for families is therefore as important as education for the young person, and gaining support from the family in implementing harm reduction strategies will greatly assist in their success.

Sitting with risk

A big challenge for practitioners with harm reduction is the dilemma of managing risk.

Practitioners understand that a young person's mental health will improve if they can be drug-free. At the same time, accepting a certain amount of risk in relation to the client's ongoing AOD use is consistent with positive risk-taking to promote recovery, and with a strengths-based model of care, approaches that can lead to better long-term outcomes for clients with a dual diagnosis [15-17].

Strategies that can help with safeguarding the young person's safety include the following:

- Regularly monitor their general health, mental health and AOD use
- Develop a support and recovery contract which includes regular appointments or phone check-ins
- Complete and review safety and crisis planning
- Identify a person the young person is willing to let know when they plan to use
- Ensure clinical supervision for help with managing these situations

Poor engagement

Some young people are not willing to participate in conversations about their AOD use or mental health issues.

Sometimes however, it's not the client who is resisting help; it may be that our approach has interfered with their willingness to engage. It's essential that all practitioners regularly 'check' their values and attitudes towards the young person, especially in complex cases.

> Try to engage the young person in another area that is important to them, such as housing, relationships or social activities.

The most useful tip might be to try to engage the young person in another area that is important to them, such as housing, relationships or social activities.

Harm reduction: the case of Johnnie

What we know

- Johnnie uses alcohol, cannabis and ice *(drug/s of choice, how he uses)*
- Johnnie is pre-contemplative about ceasing alcohol and cannabis but contemplative about his use of ice *(stage of change/ motivation)*
- Johnnie has symptoms of depression and anxiety and has had numerous contacts with mental health services due to suicidal ideation and self-harming behaviour *(mental health diagnosis)*
- Johnnie is currently not on any psychiatric medication and is living in a stressful environment *(medication and reasons for AOD use)*

From the case study information alone we can predict the array of potential harms associated with his AOD use and mental health issues:

AOD / mental health issue	Potential harms
Ice use	• central nervous system (CNS) stimulant • risk of exacerbated mental health symptoms, aggression, violence and psychosis • depletion of serotonin increasing depressive symptoms and anxiety • involvement in crime whilst intoxicated
Cannabis use	• CNS depressant and hallucinogen • exacerbates mental health symptoms, increased anxiety, low motivation, sleep disturbances, altered perception • chest infections, reduced lung capacity
Alcohol use	• CNS depressant • may affect medication • over sedation, altered perception, assaults, anger, injury, falls, hangover
Depression / anxiety	• increased thoughts of suicide and self harm • isolation, poor decision making, development of panic attacks, inability to maintain daily activity
Suicidal ideation	• self-injury, death

We can add to this list after we ask Johnnie more about his AOD use.

What we need to find out from Johnnie

- How does he use cannabis – joints, bongs, cookies?
- How does he drink – bingeing, alone, with peers?
- What does he like about his AOD use and what doesn't he like about it?
- Why did he stop his medication; was it anything to do with his AOD use?

How we could help Johnnie

Work with what he wants

Johnnie has indicated ambivalence about his AOD use, which suggests he is somewhere between pre-contemplation and contemplation. A window of opportunity exists here to begin conversations about Johnnie's use:

- how it is affecting him
- what he likes about it
- what he doesn't like about it

We could use the 'Before, During and After' template to review the potential harms and come up with strategies to manage them, for example:

Before	• How are you feeling? Are you anxious / paranoid / angry / sad? • Is this an impulsive reaction, have you really thought about it? • Do you know the person you scored from? • Have you eaten today? • What other drugs are you intending on taking? How much? In what order? • Do you remember the last time you used? What happened, how did it make you feel, what could you do differently this time to avoid adverse effects?
During	• Are you using in a safe environment? • Does someone know where you are? • How much are you drinking? Slow down your drinking to avoid overdose and over-sedation • Are you smoking pot on top of the other drugs? Smoke joints instead of bongs
After	• Can you give yourself a break now? • Drink non-alcoholic fluids • Eat something healthy • Sleep it off somewhere safe • Avoid rushing out and doing it again until you're rested • How are you feeling? Are you anxious / paranoid / angry / sad? • Talk to someone about the experience and identify any risks you might have taken

Provide him with information and resources

Ice use

Johnnie has acknowledged the connection between using ice and experiencing problems so he might be open to discussing strategies to reduce his use or the harm associated with use.

Firstly it would be useful to have a conversation to learn more about Johnnie's experiences of using ice. The last time he used, where was he, with whom, how much did he use, how did he use it, where did he get it from and what happened afterwards? Most likely Johnnie will feel comfortable telling these stories, particularly if the worker displays good listening skills and a non-judgemental attitude.

You could also ask Johnnie to pick out the best and worst parts of using ice or use a tool like a decisional balance to help him explore his ambivalence. Doing so will also help Johnnie to question his actions and may 'tip the balance' of his ambivalence. To reach this point, it is important to acknowledge the reasons that Johnnie enjoys using ice, and not focus only on the negative aspects.

Some useful harm reduction strategies around ice include:

- Delaying strategies to increase times between use
- scoring from the same known dealer
- having adequate 'come down' breaks between use to try to restore brain chemistry and sleep patterns
- use with people you know and who know about your mental health symptoms

Alcohol use

While acknowledging that Johnnie doesn't want to stop drinking, it's essential to discuss safe levels of drinking, the interaction between alcohol and other drugs, keeping himself safe from violence and risk of accidents when intoxicated. This conversation should be non-judgemental, conversational and educational.

Possible harm reduction strategies:

- identify alcoholic drinks that don't give him bad hangovers or make him aggressive
- introduce other social activities that don't include alcohol

Cannabis use

It might be useful to check Johnnie's knowledge about the influence of cannabis on mental health. Perhaps he could do an internet search on cannabis use and anxiety.

National Cannabis Prevention and Information Centre www.ncpic.org.au provide great resources

Some harm reduction strategies:

- helping Johnnie to change from smoking bongs to joints
- practising use-delaying strategies

The National Cannabis Prevention and Information Centre provides the latest research and cannabis information which includes factsheets and online resources for professionals, young people, consumers, parents and the general population.

And if he's seeking change

If Johnnie is ready for change you could take him to a support group for ex-drug users such as Narcotics Anonymous, SMART recovery or a youth friendly support group.

The influence of peers on young people is powerful, so potentially introducing him to peers who are in recovery can be of immense assistance.

Key points

- The basic principle of harm reduction is to work with the person to minimise the risks associated with their AOD use. This may include reducing the amount used, or changing how it is used and where.
- Developing a good rapport with a young person and communicating non-judgmentally about their AOD use will help them do better in the long run.
- While the principles of harm reduction are the same across all age groups, ways of communicating with young people about harm reduction strategies will be different. Thus it is important for the practitioner to take into account aspects of adolescent development when suggesting harm reduction strategies.
- Some practitioners will be uncomfortable with the idea of 'sitting with the risk' when working with a young person who is continuing to use drugs or alcohol, particularly in a high risk fashion. It is, however, important not to react to this feeling as it can disrupt engagement and place the young person at higher risk.

5. Integrated treatment and working with young people

For young people presenting to a mental health or AOD service, dual diagnosis is considered the expectation rather than the exception (Dr. Kenneth Minkoff, 1998). Despite this many young people miss out on the treatment they need to because services may focus soley on aspects of the dual diagnosis picture at the exclusion of the other. As a result the young person may not have an opportunity to talk about the impact AOD use has on their mental health, or the impact of their mental health on their AOD use.

By failing to take into account both sides of the dual diagnosis presentation, treatment effectiveness is reduced. Under treating is likely to lead to a poorer outcome or disengagement from treatment by the young person and the recovery journey is likely to be much more difficult.

Thinking about Johnnie

- What difficulties might Johnnie encounter if he needs help from different types of service?
- How can we as practitioners help Johnnie receive coordinated help? What difficulties might we encounter?
- What can we do to make our service more responsive to Johnnie's needs?
- What can we do to make our service more responsive to Johnnie's needs overall?
- What support and training might be available to practitioners to assist in providing integrated treatment?

'If we don't screen, assess and develop a collaborative, integrated treatment plan with the client, we're treating only half the problem.'

Treatment difficulties with services from two sectors

Young people with dual diagnosis can encounter barriers when seeking help from more than one service:

- Difficulty attending appointments at a number of services and locations
- Confusion arising from differing treatment philosophies and approaches
- Feeling that they don't fit into either service
- Neither program addressing issues in a unified, comprehensive way that puts the young person's needs at the center

"Treatment success derives from an emphatic, hopeful, continuous treatment relationship, which provides integrated treatment and coordination of care through the course of multi treatment episodes"
Dr. Kenneth Minkoff

Integrated treatment is the approach which is mostly likely to help overcome these barriers.

Integrated treatment

Integrated treatment means addressing the young person's mental health and AOD use issues at the same time.
It is the backbone of the work in dual diagnosis and avoids problems arising from treatment being disconnected. Integrated treatment is consistent with best practice in youth services, including the 'one stop shop' service delivery approach. Where services are provided by different agencies the key to integration is great communication between practitioners, ensuring that all the agencies involved know what the other agencies are doing.

Ways of doing integrated treatment

There are different models for providing integrated treatment:

'A "No Wrong Door" policy means that whether a young person presents to a mental health or an AOD service, their dual diagnosis will be addressed, either within the service or through working with practitioners in a service in the other sector.'

- One practitioner might treat the young person's mental health and AOD use issues at the same time, if they are skilled in both areas
- More commonly, practitioners from separate services in each sector collaborate to provide integrated treatment by agreeing on and working to a treatment plan which addresses both disorders.

Working collaboratively

Successful integrated treatment depends on good collaborative relationships between workers and agencies. If these are already established, then any necessary referral for components of the treatment plan (for example, a mental health review) can be done smoothly, with support for the young person maintained in the process.

Inconsistent delivery of dual diagnosis treatment across services can be as a result of variable capacity in service

A single treatment plan

Integrated treatment plans have a number of common features:

- The young person identifies the issues
- The plan identifies the key agency practitioners engaged with the young person
- The plan clarifies who is responsible for provide aspects of dual diagnosis care.
- Practitioners have agreed mechanisms (inter-agency communications) communication which occurs with the young persons consent.
- The plan is guided by the young person, reflecting a recovery and client-centred focus which is responsive, flexible and holistic

Developing integrated treatment capacity

At the practitioner level

There are actions that can assist with building up the necessary contacts, skills and resources:

- Find out about local youth AOD and mental health services, and key staff positions in these services. In the Victorian context there are both Melbourne metropolitan and rural dual diagnosis teams BOX
- Find out about and regularly attend local AOD and mental health youth networks.
- Participate in and/or initiate case review meetings
- Attend a reflective practice groups
- Attend dual diagnosis training opportunities to increase skills and knowledge in assessment and treatment planning.
- Know how to make supportive and well facilitated referrals with the young person
- Develop ability to review treatment plans with the young person and amend as appropriate
- Learn how to undertake a risk assessment and provide appropriate strategies and actions as required
- BOX All DDx services provide secondary consultation

At agency and system levels

Successful integrated treatment occurs with organizational support at the corporate, service and team base levels. Dual diagnosis capacity building activities underpin the integrated treatment approach. These include access to specific dual diagnosis training courses, workshops, supervision and mentoring.

Don't be afraid to take the lead and arrange a case plan or care team meeting to get all services around the table. Everyone will thank you for it, including the client.

Support at the service system level is also vital. This involves developing infrastructure within mental health and AOD systems to support integrated service delivery, with collaboration and consultation between agencies and programs [18, 19].

Practice challenges and management

KEY POINTS:

Young people with a dual diagnosis may be challenging to engage therefore it is important for the service system to maintain a hopeful and welcoming environment to increase engagement.

Young people accessing both mental health and AOD services may be required to undergo multiple assessments which can then become a potential barrier to engagement. Where possible, a shared recovery plan can reduce the need for ongoing multiple assessments.

At the inter-agency level other services that know the young perons can be helpful to put the pieces of the dual diagnosis puzzle together, leading to a better understanding of the young person and more holistic care. Where appropriate enage with family or significant other.

It is well known that collaborative treatment between agencies and workers leads to better outcomes (18)

Responsibility for risk management

Young people with a dual diagnosis may present with many challenges which may lead to increased risk. These may include acute mental health symptoms such as harm to self or others, or other high risk situations as a result of substance use or intoxication. It is essential that practitioners enquire about these risks and if necessary to communicate with others who are involved in making treatment decisions.

Integrated treatment with Johnnie:

How will integrated treatment assist Johnnie?

Integrated treatment will assist Johnnie to have a integrated treatment plan for recovery.

This plan may include the following:

- Secondary consultation
- Case conference
- Effective recovery plan
- Active outreach to Johnnie so that he is not required to come to services
- Engagement with family

Key points

- Integration means addressing the young person's mental health and AOD use issues at the same time.
- Collaborative treatment between agencies and workers leads to better outcomes.
- If we don't screen, assess and develop a collaborative, integrated treatment plan with the client, we're treating only half the problem.
- To succeed, integrated treatment needs to be supported by agencies and their management. Agreements or memorandums of understanding between agencies may be helpful.
- The bonus of integration is its flexibility and holistic focus.

Resources and references

Websites: young people and dual diagnosis

Reachout (online youth mental health service)	http://au.reachout.com/
Headspace (national youth mental health foundation)	www.headspace.org.au
Youth Beyond Blue (for young people dealing with depression and/or anxiety)	www.youthbeyondblue.com
YODAA (Youth Drug and Alcohol Advice service)	http://yodaa.org.au
Orygen Youth Health (youth mental health clinical program)	http://oyh.org.au
Harm Reduction Victoria	http://hrvic.org.au/the-principles-of-harm-reduction
NCPIC (National Cannabis Prevention and Information Centre)	www.ncpic.org.au

For young people

YSAS Line (Youth Support and Advocacy Service youth outreach teams)	1800 014 446
DirectLine (alcohol & drug counselling and referral in Victoria)	1800 888 236
Headspace	1300 880 218
Kids Helpline	1800 551 800
Koori Connect	1800 993 783
YODAA (Youth Drug and Alcohol Advice service)	1800 458 685
Ice Advice Hotline	1800 423 238

For families

Websites

Family Eclipse Program, Odyssey House	www.odyssey.org.au
Family Drug Help	www.familydrughelp.sharc.org.au
Family Drug Help Sibling Support	www.siblingsupport.org.au
Eastern Drug and Alcohol Service (EDAS) Family Program	www.edas.org.au
Children of Parents with a Mental Illness (COPMI)	www.copmi.net.au
Victorian Mental Health Carers Network	www.carersnetwork.org.au
ARAFEMI	www.arafemi.org.au
Mental Illness Fellowship	www.mifellowship.org
GROW	www.grow.net.au
Carers Victoria	www.carersvic.org.au
The Bouverie Centre	www.bouverie.org.au
Youth Support and Advocacy Service (YSAS) Reconnect	www.ysas.org.au
Ice Website	www.ice.vic.gov.au

Written reource

Mental Health Carers Arafmi Queensland (2003). *Dual Diagnosis: mental illness & substance use. Information and coping strategies for families*. Mental Health Carers Arafmi Queensland, Brisbane.

Resources for practitioners

Online resources to use with young people

Cognitive Behaviour Therapy Self-Help Resources (CBT self-help information, resources and including therapy worksheets on the free downloads pages) http://www.getselfhelp.co.uk/gallery.htm

Psychology Tools (online toolbox of cognitive behavioral therapy resources) http://psychology.tools/

Young people and mental health

Raphael, B. (2000) *Promoting the mental health and wellbeing of children and young people, discussion paper – key principles and directions*, Canberra: National Mental Health Working Group, Commonwealth Department of Health and Aged Care.

Young people and alcohol and other drug use

Addy, D. & Ritter, A. (2000). *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 4. Reducing harm for clients who continue to use drugs*. Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.

Swan, A. & Ritter, A. (2001). *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 7. Working with polydrug users.* Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.

UnitingCare ReGen (2013). *Supporting Evidence – Harm Reduction*. UnitingCare ReGen: Coburg, Victoria. www.regen.org.au/Position_Statements/Harm_Reduction_SupportingEvidence_ReGen.pdf

Lintzeris, N., Spry-Bailey, P. Harm reduction with problem users. in: M. Hamilton, T. King, A. Ritter (Eds.) *Drug use in Australia: Preventing harm*. 2nd ed. Oxford University Press, Melbourne; 2004.

Dovetail Good Practice Toolkit:

> Crane, P., Buckley, J. and Francis, C. (2012). *Youth alcohol and drug good practice guide 1: A framework for youth alcohol and other drug practice*. Brisbane: Dovetail.
>
> Crane, P.(2012). *Youth alcohol and drug practice guide 2: Legal and ethical dimensions of practice.* Brisbane: Dovetail.
>
> Crane, P., Francis, C., and Buckley, J. (2013). *Youth alcohol and drug practice guide 3: Practice strategies and interventions. Brisbane. Dovetail.*
>
> Encompass Family and Community (2014). *Youth alcohol and drug practice guide 4: Learning from each other: Working with Aboriginal and Torres Strait Islander Young People*. Brisbane. Dovetail.

www.dovetail.org.au/i-want-to/open-the-good-practice-toolkit.aspx

Working with families

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The World Health Organisation self Help Guide

http://www.who.int/en/

Youth Drugs and Alcohol Advice

http://yodaa.org.au/

Appendices

Tools for practitioners

THE DECISIONAL BALANCE

	Status quo or option A	Change or option B
Advantages	Good things about the status quo	Good things about change
Disadvantages	Less good things about the status quo	Less good things about change

Follow the arrows in your discussion with the client with emphasis on the less goog things and the good things about change. Select only one drug at a time to discuss.
After arriving at the good things about change -ask ' what will you do now". " I can support you work out a plan to make the change s you have been thinking about"

THE READINESS RULER

The desire in people to make change is common, but making change depends on how important it is as well as the degree of readiness and confidence the person has.

1. How important is it for you to make this change?

1	2	3	4	5	6	7	8	9	10

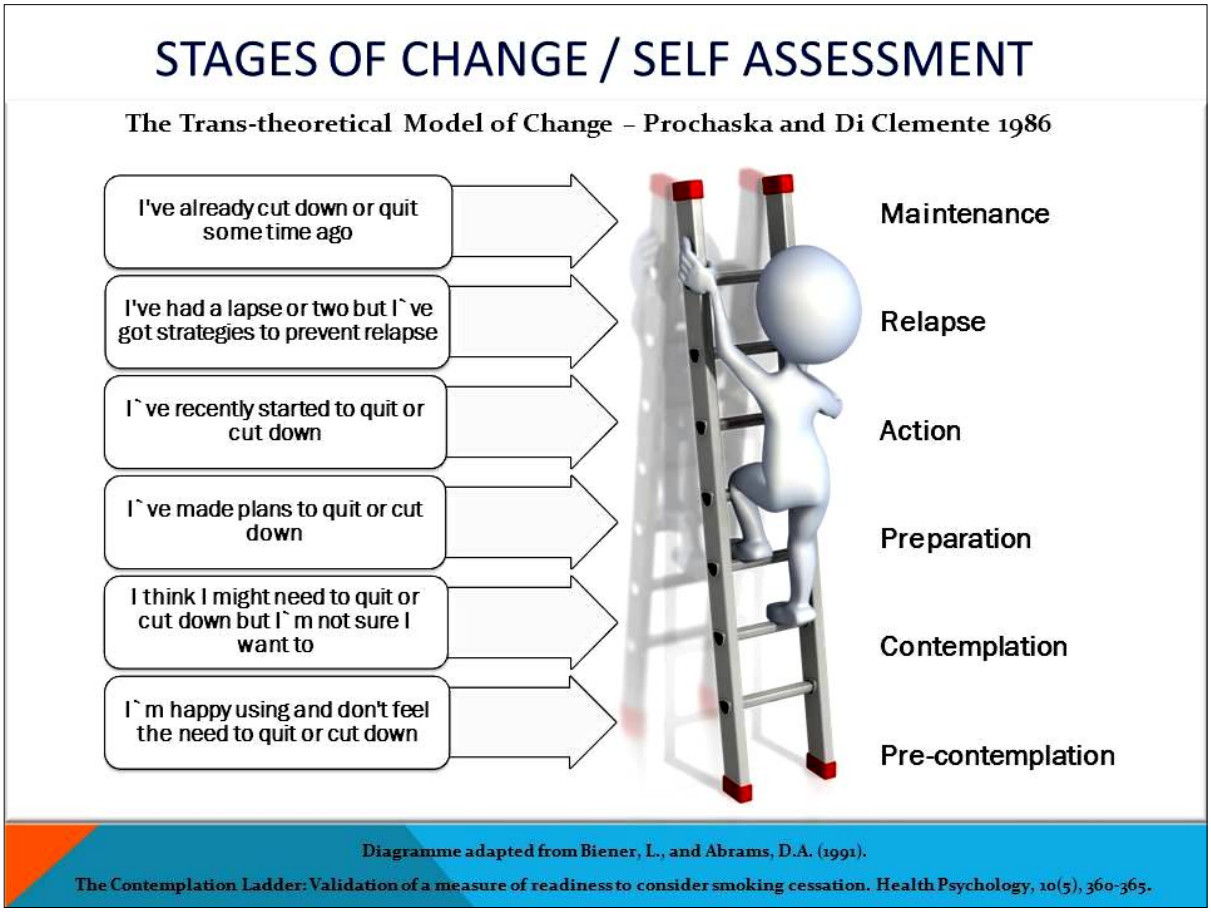
2.How confident are you in your ability to make this change?

1	2	3	4	5	6	7	8	9	10

3.How ready are you to make this change?

1	2	3	4	5	6	7	8	9	10

Ask these questions for each of the rulers
1. Why are you at your current score and not higher or lower on the scale?
2. What would it take for you to get to a higher score?
3. What would it take to make this change even more important to you?


STAGES OF CHANGE / SELF ASSESSMENT
The Trans-theoretical Model of Change – Prochaska and Di Clemente 1986
I've already cut down or quit some time ago
I've had a lapse or two but I`ve got strategies to prevent relapse
I`ve recently started to quit or cut down
I`ve made plans to quit or cut down
I think I might need to quit or cut down but I`m not sure I want to
I`m happy using and don't feel the need to quit or cut down
Maintenance
Relapse
Action
Preparation
Contemplation
Pre-contemplation
Diagramme adapted from Biener, L., and Abrams, D.A. (1991).
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With kind permission from Trevor Shelton Director of CVH at the Heart Foundation WA

REASONS FOR SUBSTANCE USE SCALE

Affix Patient ID If Available

Which substance do you use the most, or causes the most concern for you?

*(Please specify):*_____

	Considering your current use of that substance, how often do you use it for the following reasons? *(For each reason ✍, please ✓ a box that best-fits ☺)*	*Almost never / Never*	*Some of the time*	*Half of the time*	*Most of the time*	*Almost always / Always*	*Scoring / Tallying Columns* A	B	C	D	E
1	To relieve boredom	1	2	3	4	5			C		
2	To make it easier to sleep	1	2	3	4	5			C		
3	To slow down racing thoughts	1	2	3	4	5			C		
4	To be sociable	1	2	3	4	5					E
5	To relax	1	2	3	4	5			C		
6	To be part of a group	1	2	3	4	5		B			
7	To get high	1	2	3	4	5				D	
8	To decrease suspiciousness / paranoia	1	2	3	4	5	A				
9	To forget your worries	1	2	3	4	5			C		
10	Because it's fun	1	2	3	4	5				D	
11	To reduce side effects of medication	1	2	3	4	5	A				
12	Because it makes a social gathering more enjoyable	1	2	3	4	5					E
13	To help you talk to others	1	2	3	4	5		B			
14	To get away from the voices	1	2	3	4	5	A				
15	Because you feel more self-confident and sure of yourself	1	2	3	4	5			C		
16	Because it helps when you feel nervous	1	2	3	4	5			C		
17	Because it's what most of your friends do when you get together	1	2	3	4	5					E
18	As a way to celebrate	1	2	3	4	5					E
19	To decrease restlessness	1	2	3	4	5			C		
20	To help you concentrate	1	2	3	4	5			C		
21	Because your friends pressure you to do it	1	2	3	4	5		B			
22	To be liked	1	2	3	4	5		B			
23	So you won't feel left out	1	2	3	4	5		B			
24	It helps when you feel depressed	1	2	3	4	5			C		
25	To feel more motivated	1	2	3	4	5			C		
26	Because it makes you feel good	1	2	3	4	5				D	
27	Other reason (Please specify):_____	1	2	3	4	5					
A	TOTAL (Qn's 8 + 11 + 14) Factor A =						A =				
B	TOTAL (Qn's 6 + 13 + 21 + 22 + 23) Factor B =							B =			
C	TOTAL (Qn's 1 + 2 + 3 + 5 + 9 + 15 + 16 + 19 + 20 + 24 + 25) Factor C =								C =		
D	TOTAL (Qn's 7 + 10 + 26) Factor D =									D =	
E	TOTAL (Qn's 4 + 12 + 17 + 18) Factor E =										E =

Adapted from Spencer, Castle & Michie (2002); Based on the DMQ by Cooper (1994).

Please Turn Over...

Form developed by Graeme Lamont and Dr. Kah-Seong Loke
c/o Eastern Dual Diagnosis Service – Eastern Health (2011)

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REASONS FOR SUBSTANCE USE SCALE

Affix Patient ID If Available

Scale Ranges:	Never / Almost Never	Some of the time	Half of the time	Most of the time	Almost Always / Always

A = Coping with Positive Symptoms and Medication Side Effects

Factor A Score ⇩

A =

B = Conformity / Acceptance

Factor B Score ⇩

B =

C = Coping with Unpleasant Affect

Factor C Score ⇩

C =

D = Enhancement

Factor D Score ⇩

D =

E = Social Use

Factor E Score ⇩

E =

Scale Ranges:	Never / Almost Never	Some of the time	Half of the time	Most of the time	Almost Always / Always

Adapted from Spencer, Castle, & Michie (2002); Based on the DMO by Cooper (1994).

A = Coping with Positive Symptoms and Medication Side Effects:

This sub-scale acknowledges that substance use can be undertaken as a way of managing suspiciousness and paranoia, or to get away from distressing voices. It is also sometimes used to manage unwanted side effects of psychiatric medications.

B = Conformity / Acceptance:

Substance use in this category reflects peer pressure, and the need to be liked or be part of a group.

C = Coping with Unpleasant Affect:

This reason suggests that substance use is a way of dealing with depression, anxiety, insomnia, boredom and general distress. It is also a way of improving concentration and self-confidence.

D = Enhancement:

This motive reflects substance use as a way of getting high, having fun and feeling good.

E = Social Use:

Substance use is undertaken as a way of celebrating, to make social gatherings more enjoyable and as an activity that is sociable.

Form developed by Graeme Lamont and Dr. Kah-Seong Loke
c/o Eastern Dual Diagnosis Service – Eastern Health (2011)

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Genograms and ecomaps

Genograms

- *Child and Family Snapshot* www.dhs.vic.gov.au/about-the-department/documents-and-resources/forms-and-templates/child-and-family-snapshot-practitioner-field-tool-and-genograms, p. 4
- Simple Guide to Genograms www.strongbonds.jss.org.au/workers/families/genograms.html

Ecomaps

- *Guidelines for a Palliative Approach in Residential Aged Care* www.nhmrc.gov.au/_files_nhmrc/publications/attachments/pc29_guidelines_for_a%20_palliative_approach_in_residential_aged_care_130925.pdf, p. 253
- Simple Guide to Eco-Maps http://www.strongbonds.jss.org.au/workers/cultures/ecomaps.html

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