Training Frontline Workers

Young People, Alcohol & Other Drugs

Working with Young People on AOD Issues

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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:

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Community and Health Services (Tas)
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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.

Training Frontline Workers

Young People, Alcohol & Other Drugs

Section A

Contents

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

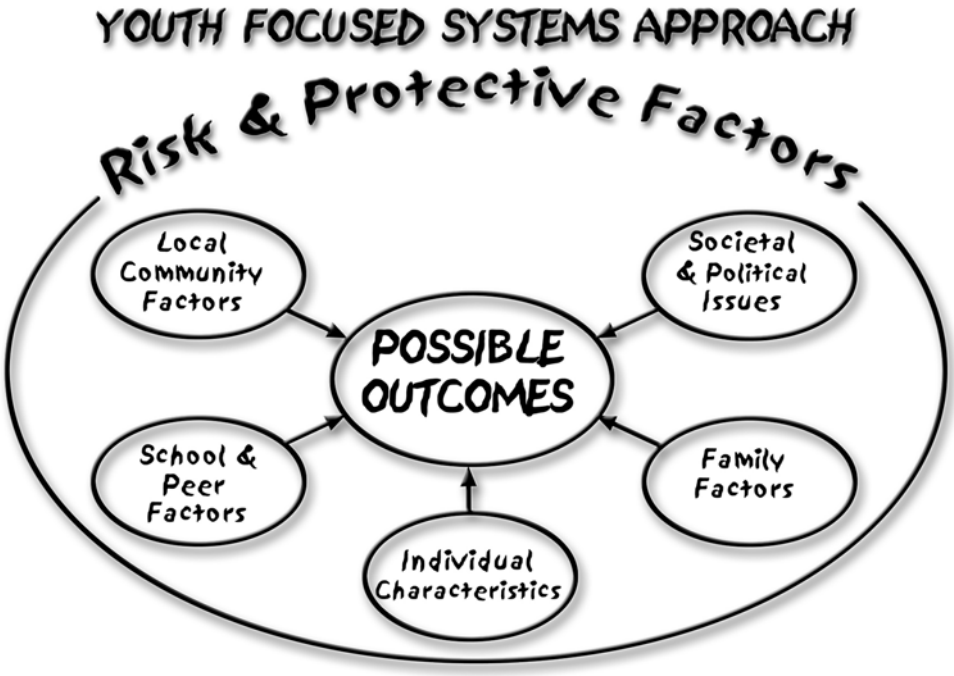
A **systems approach** is the most appropriate model to understand and work with young people. A systems approach assumes that no aspect of behaviour occurs in isolation, rather it occurs within a wider context. In other words, to understand young people we need to consider the individual, their family,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

CHCYTH1A	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:

Unit of Competence	Module
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.

CHCYTH1C Work effectively with young people	CHCAOD2B Orientation to the alcohol and other drug sector	CHCCS5A Provide support services to clients	CHCAOD6B Work with clients who are intoxicated
Elements: 1. Develop a professional rapport with young people 2. Address issues associated with the culture of young people 3. Recognise that youth culture is distinct	**Elements:** 1. Work within the context of the alcohol and other drugs sector 2. Develop knowledge of the alcohol and other drugs sector 3. Demonstrate commitment to the central philosophies of the alcohol and other drugs sector	**Elements:** 1. Assist clients to identify their needs 2. Support clients to meet their needs 3. Review work with clients	**Elements:** 1. Provide a service to intoxicated clients 2. Assist clients with longer-term needs 3. Apply strategies to reduce harm or injury
Focus: • models and approaches of working with a young person • principles underpinning this work • basic skills in working with young people.	**Focus:** • understanding AOD use in society • approaches to AOD work factors.	**Focus:** • helping young people to identify needs in relation to AOD issues • responding to these needs • skills in working with young people on AOD issues, at an individual and a community level.	**Focus:** • assessing, monitoring and responding to the needs of young people who are intoxicated.
Module Sequence 1. Perspectives on Working with Young People 2. Young People, Risk and Resilience 3. Working with Young People	**Module Sequence** 1. Young People, Society and AOD 2. How Drugs Work 3. Frameworks	**Module Sequence*** 1. Helping Young People Identify their Needs 2. Working with Young People on AOD Issues 3. Working with Families, Peers and Communities 4. Young People and Drugs - Issues for Workers	**Module Sequence*** 1. Working with Intoxicated Young People

***In addition to the modules listed learners will need a current First Aid Certificate in order to achieve the unit of competence.**

Developing your learning pathway

Depending on your learning needs you may choose to do one, several or all of the units listed below. The following guide will help you decide which units to undertake.

If you want information about young people and ways of working with young people. UNIT CHCYTH1C	If you want information about the alcohol and other drug sector and a greater understanding of drug use in society. UNIT CHCAOD2B	If you want skills in identifying AOD drug impacts on young people to develop responses to alcohol and drug issues for the young people you work with. UNIT CHCS9A	If you want skills and information to work with young people who are intoxicated. UNIT CHCAOD6B
Perspectives on Working with Young People Explores the stage of adolescence and a range of factors that impact on the development of young people **Young People, Risk and Resilience** Provides a framework for understanding and working with young people **Working with Young People** Provides a broad framework for understanding and working with young people, explores goals of working with young people and the development of specific skills.	**Young People, Society and AOD** 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. **How Drugs Work** Provides information about drugs and how they act on the body. **Frameworks for AOD Work** 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.	**Helping Young People Identify their Needs** Develops skills in identifying alcohol and other drug issues for young people at an individual, group and community level. **Working with Young People on AOD Issues** 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. **Working with Families, Peers and Communities** Provides a framework and skills for working with young people on AOD issues at a community and family level. **Young People and Drugs - Issues for Workers** 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.	**Working with Intoxicated Young People** Provides information and skills in working with intoxicated young people. **If you want advice about planning learning and how to learn** **Planning for Learning at Work**

Many learners will want to develop knowledge and skills in a number of these 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 drug actions on the individual. It is recommended that learners completing CHCCS9A and CHCAOD6B also complete this module.

Developing your learning plan

Before developing your learning plan you will need to have a clear idea of what your learning needs are. A learning need is the gap between what you know and *can* do to what you *want* to know and do. Once you have clarified your learning needs you can develop a plan to help you achieve your learning goals. Your plan should have details about 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. It is recommended that learners develop their plan with a mentor or facilitator.

Goals	What do I want to learn?
Strategies	How am I going to learn?
Resources	What resources will I use?
Evidence guide	What will I show to confirm I have learned it (e.g. case notes, references, supervisor feedback)?
Review date	
Review comments	

The module **Planning for Learning at Work** provides detailed information on identifying your learning needs, developing a learning plan and strategies that will assist you to learn.

Once you have identified your needs you can match them up with the units of competence and the resources available.

Assessment

If part of your learning plan is to achieve particular units of competence you will need to clarify how you will be assessed and by whom. Your facilitator will provide you with information on assessment activities and requirements.

Recognition

If you think that you already have skills and knowledge that are contained in a particular module, you may be eligible to apply for recognition of prior learning. You will need to discuss this with your facilitator who will inform you of the necessary requirements.

Using the Learner Workbook

The Learner Workbook is a comprehensive, workbook-style document. It can be used for distance and work-based learning modes as well as supporting face-to-face learning.

The Learner Workbook provides an overview of the module and the learning outcomes which will help you to plan and guide your learning. The content is divided into topic areas providing information for you to read, topics for research, activities that can be completed alone, in groups or in your workplace. A glossary and a list of references and resources are also provided in each module.

Information for distance and work-based learners – your facilitator's role

It is recommended that these resources be used in *supported* distance mode. This means that learning occurs outside of a classroom workshop setting with the support and guidance of a qualified facilitator. If you are a distance learner it is important for you to clarify your learning needs and what you hope to achieve with your facilitator. This person will help you identify your needs, develop goals, match your needs to the units of competence and the relevant modules and develop your learning plan. Your facilitator will clarify how you will be assessed and by whom and will contact you at prearranged times to assist and support you as you complete the Workbook.

As a distance learner much of your learning is self-directed. This means that you are responsible for setting your own learning goals and organising your learning so that you achieve these goals. The module **Planning for Learning at Work** is a good resource for distance learners. As well as helping you to develop a learning plan, it provides a range of strategies to assist you with self-directed and work-based learning as well as helping you to identify how you learn best.

Managing your learning

Your Workbook contains a range of learning activities. These activities involve self-assessment and will assist you in your learning and your preparation for formal assessment.

The following study links will assist you in managing your learning:

- **Managing time –** You will need to plan time to undertake your learning. This may be a regular time each week or you may prefer to do blocks of learning.

- **Managing activities –** The Workbook contains a range of activities some of which will require you to have access to a phone and a computer and sources of data in the workplace.

- **Managing your learning materials –** Organise your materials so that you can easily keep track of the resources you need.

- **People who can help you learn –** Remember that a range of people can help you with your learning including your facilitator, your supervisor, work colleagues and your peers. These people can provide support, assistance and information and assist you in completing activities such as role plays.

Icons

A range of icons is used in the Learner Guide to assist you in using the resources. The following icons are used:

FAC	Facilitator direction
WPL	Workplace learning activity
Case Study	Case study
Task	Task
	Writing exercise
	Group activity
	Links to other modules
WWW	Web resources
	Video
Q	Question
A	Answer
	A good point for student to contact facilitator
	Brainstorm
	Suggested time
OHT	Overhead transparency

Training Frontline Workers

Young People, Alcohol & Other Drugs

Section B

Contents

Topic 1

Introduction

Overview

In this module you will explore the principles and develop techniques for working effectively with young people with alcohol and/or other drug problems. The emphasis of this module is on working with young people on an individual basis. Approaches that target peers, groups and communities are covered in the module **Working with Families, Peers and Communities.**

This module focuses on young people who are experiencing problems related to their AOD use. As you work through it you will have the opportunity to reflect on your own work with young people and apply your learning within your workplace.

1.2 Learning outcomes

When you have completed this module you will be able to:

- LO Identify AOD interventions suitable for working with young people
- LO Apply the 'Stages-of-Change' model and motivational interviewing to work with young people
- LO Implement strategies for working with resistance and ambivalence with young people
- LO Demonstrate skills in harm minimisation, and brief and early interventions with young people.
- LO Apply relapse prevention and management strategies.

It is suggested that you remind yourself of these learning outcomes as you work through the module. At different stages ask yourself whether you think you have achieved each of these outcomes. This will help you keep track of your progress, and what you still need to learn to successfully complete the module.

1.3 Assessment events

Your facilitator will provide you with information on any assessment activities you might be required to undertake. If you are not provided with assessment information when you commence this module, make sure you ask your facilitator if there are any assessment activities that are a requirement of completion.

Topic 2

Introduction to AOD interventions

- Young People, Society and AOD
- Frameworks for AOD Work

Key Issues

- Harm minimisation
- Schaeffer's model
- Youth-focused systems model
- Integration model

Overview

This topic presents a framework for understanding individually-focused AOD interventions for young people who are experiencing problems due to their use of alcohol and/or other drugs. Frontline workers are ideally placed to undertake some prevention and early intervention work with young people in relation to AOD issues. Some frontline workers may also be required to provide support to young people who have more established AOD problems

A number of approaches underpin alcohol and other drug work, many of which have been covered in other modules. We will briefly review them here to identify how they can help us to understand and implement AOD interventions. The youth-focused systems approach will also be presented as it provides a framework for understanding young people and their behaviour.

If you have completed the module **Helping Young People Identify their Needs** you will have already covered harm minimisation, Schaeffer's model and the youth-focused systems approach. You may wish to review them here before you proceed to Topic 3.

2.1 Harm minimisation

Harm minimisation is a useful approach because it helps you to focus your assessment on the range of factors that are contributing to the harms associated with young people's AOD use (and not just on the AOD use alone). You can then design interventions to prevent or reduce those harms *directly* not just by trying to reduce or eliminate AOD use.

Harm minimisation is the current drug-related policy in Australia governing all drug-related laws and responses. Harm minimisation considers the health, social and economic consequences of AOD use in relation to the individual and the community. It has been a key policy of Australian state and federal governments since the National Campaign Against Drug Abuse was launched in 1985.

Three key areas

Harm minimisation strategies can be categorised into three areas:

- **Harm reduction –** These strategies are aimed at reducing the harm from drugs for both individuals and communities and do not necessarily aim to stop drug use. Examples include needle syringe services, methadone maintenance, brief interventions, and peer education.

- **Supply reduction –** These strategies are aimed at reducing the production and supply of illicit drugs. Examples include legislation and law enforcement/

- **Demand reduction –** These strategies are aimed at preventing the uptake of harmful drug use. Examples include community development projects and media campaigns.

The harm minimisation approach is based on the following premises:

- Drug use, both licit and illicit, is an inevitable part of society
- Drug use occurs across a continuum, ranging from occasional use to dependent use
- A range of harms are associated with different types and patterns of AOD use
- A range of approaches can be used to respond to these harms.

The concept of harm minimisation rests on the assumption that we cannot stop all people from using illicit substances. However, 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 and considers potential harm to the community as a whole as well as the individual.

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, limits and controls on gambling, needle and syringe exchange programs, safe injecting rooms, peer education programs, methadone maintenance programs, labelling on alcoholic beverages.

The concept of harm minimisation is not well understood or accepted in the wider community as many people believe that in attempting to reduce the harm associated with drugs, we are condoning drug use. The approach recognises that drug use is occurring both legally and illegally and our aim is to try to keep people safe or as safe as possible through harm minimisation strategies. These strategies aim to educate young people so that they are able to make informed decisions and choices.

WPL

'Harm minimisation in my service'

Q ***What are three ways in which your organisation attempts to reduce the harm associated with AODs?***

A ***1.***

2.

3.

WPL

Q ***What ways could your organisation further contribute to harm minimisation among young people who use AODs?***

A

Q ***Identify two harm minimisation strategies within your organisation.***

A ***1.***

2.

Q ***How are they implemented?***

A

2.2 Schaeffer's model

In the context of identifying a young person's needs it may be useful to reflect on Schaeffer's model which reminds us that not *all* young people's AOD use is inherently problematic. In our assessments with young people we need to be able to distinguish between different patterns of AOD use and intervene appropriately depending on the type of use identified.

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

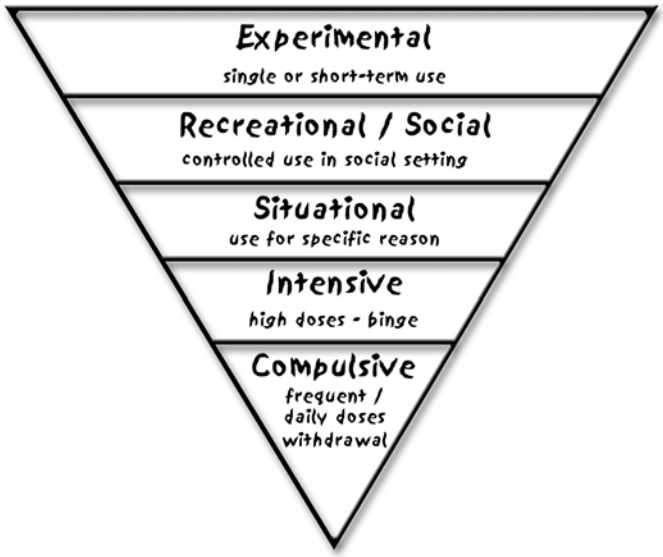
- **Social/recreational use –** Drugs are used on specific social occasions by experienced users who know what drug suits them and in what circumstances (e.g. ecstasy use by experienced users at dance parties, or alcohol with a meal).

- **Circumstantial/situational use –** Drugs are used when specific tasks have to be performed and special degrees of alertness, calm, endurance or freedom from pain are sought. (e.g. truck driving, shift work or studying for exams).

- **Intensive use –** This 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. It can also involve binge AOD use, where there is excessive use of a substance at one time. The pattern of binge use may be occasional, or may relate to specific situations.

- **Compulsive/dependent use –** Drug use leads to psychological and physiological dependence where the user cannot at will discontinue use without experiencing significant mental or physical distress. Drug use is central to the user's day-to-day life.

When a person is physically dependent they develop withdrawal symptoms when the drug is not taken. Psychological dependence occurs when the drug is central to a person's thoughts, emotions and activities. Drug users in this category have a strong urge to use despite being aware of the harmful effects.



Schaeffer's Model - Patterns of Drug Use

Even though not all use is problematic, there may still be harms and consequences associated with any pattern of AOD use.

Task

Potential harms associated with Schaeffer's list

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

A *(Fill in the table, then check your answers on the next page.)*

Drug use	Potential harms
• Experimental	
• Recreational/social	
• Situational/circumstantial	
• Intensive	
• Compulsive dependency	

A **Possible answers include:**

Experimental – Lack of knowledge, experience and low tolerance could lead to accidental overdose or risk-taking behaviours.

Recreational/social – Peer influences, tendency to get lost in the moment, excitement, using too much or uncertainty about the concentration of the drug could lead to accidental overdose or risk-taking behaviours.

Situational/circumstantial – Not coping or using to cope could lead to risk behaviours, accidents etc.)

Intensive – Accidents, overdose, legal/financial issues.

Compulsive/dependency – Health problems, relationship issues, legal/financial issues, accidents/overdose.

Task

Q **Provide two examples of patterns of drug use evident among the young people you work with.** *(Ensure confidentiality of young person is maintained and false names provided.)*

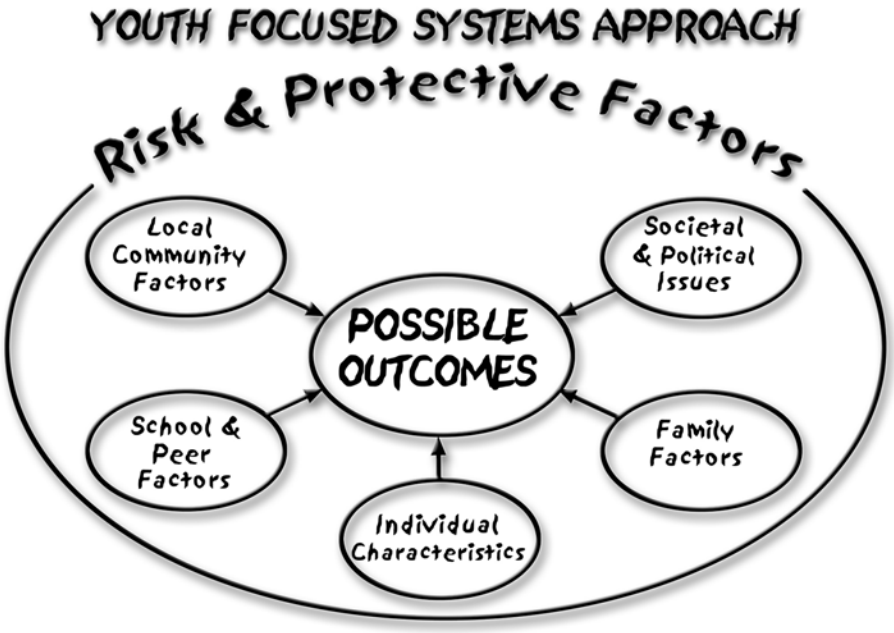
A

2.3 Youth-focused systems model

In applying a broader perspective on drug use and harm minimisation, a young person's drug use can be viewed within a holistic context. The youth-focused systems approach is a useful framework as it helps you to take into account a broad range of factors that impact on young people and their AOD use. Sometimes our tendency is to focus solely on the AOD use, without taking into account the **context** of that use (e.g. family, peer and/or community factors) which can be very important influences on a young person's pattern of AOD use.

This module will deal largely with interventions aimed at **individual factors**. However, it is important to be aware of the other aspects of the system, even when dealing with the young person in a one-on-one context, because those factors may influence the outcomes that you are trying to achieve with the young person. No-one exists in isolation.

The following diagram 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. These factors can influence the health and wellbeing outcomes for that individual.



Identifying possible outcomes for young people

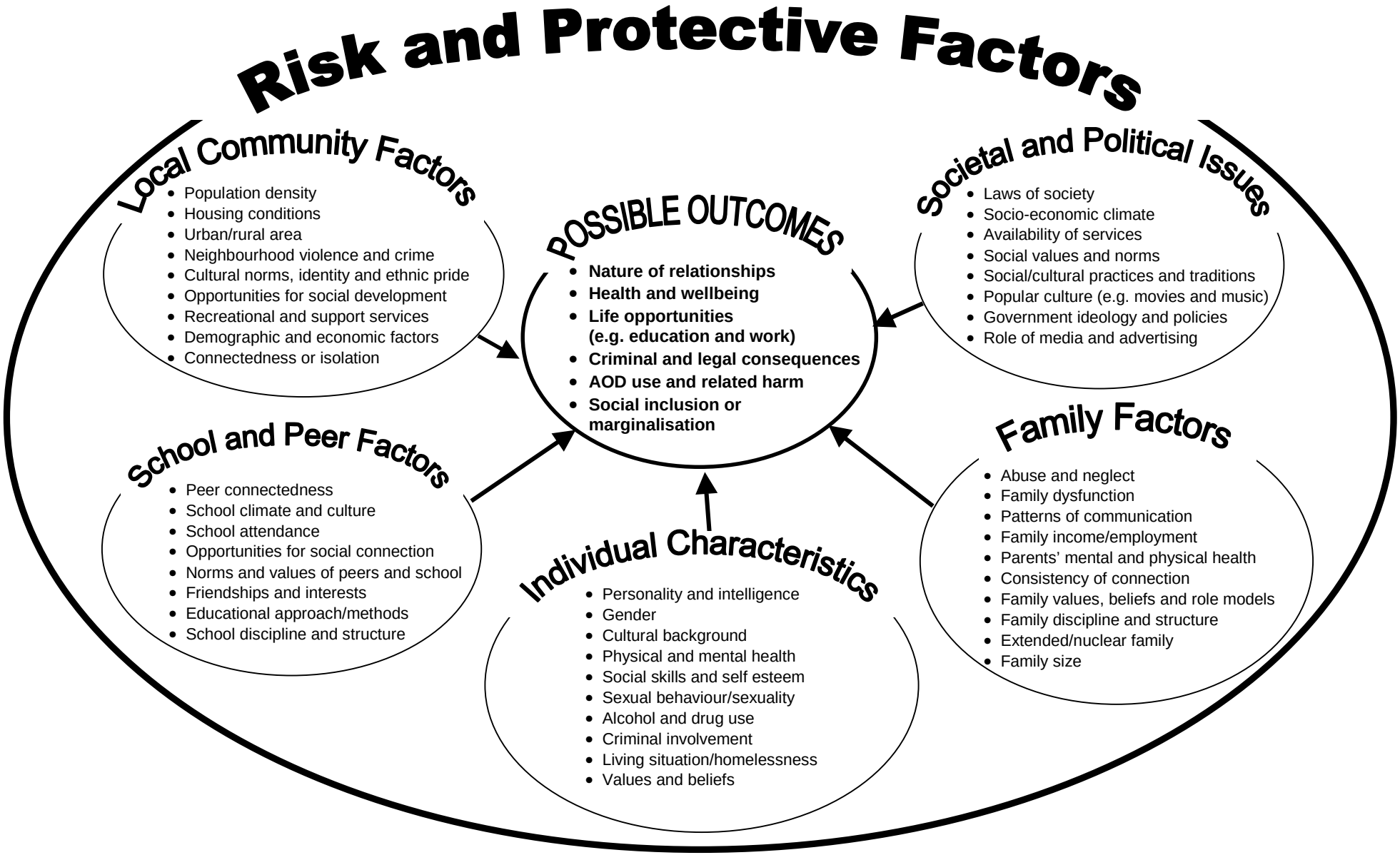
Q ***What are some of the possible influences on a young person and their AOD use? Consider your responses in accordance with the categories in the above model.*** *(e.g. individual characteristics – physical health, values beliefs, family factors, abuse and neglect, etc).*

A

Q ***Review the youth-focused systems model on the next page. Were your suggested outcomes similar to those listed in the model?***

A

YOUTH-FOCUSED SYSTEMS APPROACH

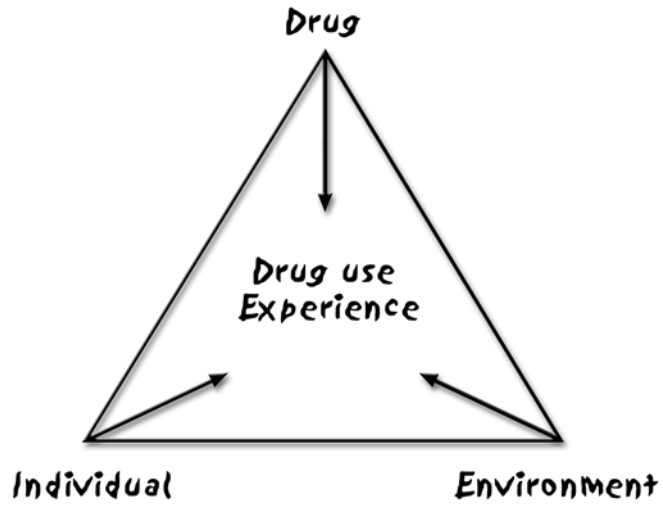


2.4 Interaction model

Zinberg's (1984) Interaction model provides a simpler version of the youth-focused system approach. It is also useful when trying to understand the relationship between different factors that impact on the drug-using experience. The model identifies three factors:

- The drug (i.e. the properties of drug(s) consumed)
- The set (the individual characteristics of the user)
- The setting (the environment in which the intoxication is occurring).

In recent times the model has been adapted and the above factors are often referred to as drug, individual and environment.



Adapted from Zinberg's Interaction Model of Drug Use

Summary

- Harm minimisation focuses on reducing harms from AOD use, not the use itself.
- Not all young people experience problems from their drug use.
- The context of the young person must be considered.
- The context of drug use must be considered.

Topic 3

Understanding change

Key Issues

- Understanding change
- Communication 'roadblocks'
- The Stages-of-Change model
- Applying the Stages-of-Change model to working with young people
- Identifying and responding to a young person's readiness to change

3.1 Understanding change

The change process

Change is something we are all familiar with. It can be easy or difficult depending on what it is that we want to change and what that change might mean in the broader context of our lives. In the work context we adapt to a changing environment and make adjustments constantly, often without even realising it. We learn new policies, procedures and ways of doing things. Other, more personal or lifestyle-related changes such as giving up smoking, leaving a relationship or deciding to get up early in the morning to exercise can be far more difficult both to achieve and sustain.

We know that smoking is linked to lung cancer or that we should exercise more in the interests of good health but knowledge alone is not enough to achieve behaviour change, especially when it comes to lifestyle changes. We can also be ambivalent about change – that is, we can have strong reasons for making change and strong reasons against making change. It is important to note that ambivalence is a normal human condition and it is central to decision-making in relation to change.

Natural and assisted change

Having acknowledged that many changes require a significant effort, it is also true that change can happen naturally. In fact it is possible that most change in drug-using behaviour, for example, has always occurred outside of formal treatment. This type of change seldom happens overnight, but rather involves the slow process of change that also applies to those who receive treatment (Prochaska, DiClemente & Norcross, 1997). Many of those who naturally recover also experience lapses back to drug use, as do those who receive treatment.

Even if we do manage to achieve some change, whether naturally or assisted, we are still susceptible to some slip-ups. After all, it is through our mistakes that we can learn where we need to put our efforts if the change is to be maintained in the long term.

Remember that most young people do not have established patterns of use. However, where use is established, it is important to draw on the lessons from the research on natural change to assist our efforts to help young people change their AOD-use patterns.

Key features of natural change

The common ingredients of natural change are:

- **finding a new reference group to identify with** and belong to that does not have an AOD focus
- **finding (or rediscovering) a purpose in life** and activities that are not compatible with heavy AOD use (which is often related to the previous action)
- **dramatic and humiliating events associated with AOD use**
- **'maturing out' from heavy use** in which heavy drug use has gradually been replaced by other priorities, commitments and obligations
- **developing new personal relationships that are not compatible with heavy AOD use** or **trying to salvage existing relationships** (responding to pressure from family and friends to give up)
- **financial and/or legal problems**
- **health concerns**
- **work problems**
- **advice from friends and families**
- **pregnancy.**

3.2 Communication 'roadblocks'

Communication about AOD use can be a difficult process. Substance use and misuse can involve a two-sided conflict between wanting and not wanting to engage in the behaviour. That is, people can be ambivalent about change. Too much focus by someone (e.g. counsellor, GP, family member) on the negatives of using drugs or possible positives associated with change can often lead to 'yes but' arguments and a reinforcement of the opposite side.

Ideally, every communication event about possible behaviour change should be as effective as possible. However, there are times when workers may find themselves using less effective communication responses, particularly if there is perceived resistance from a young person. This in turn can lead to high levels of frustration in workers.

Following are 12 common examples of less-than-ideal approaches to communication which are referred to as roadblocks. They were originally proposed by Thomas Gordon, the developer of 'Parent Effectiveness Training' (PET) but they are just as applicable to the worker-young person relationship. None of the 12 roadblocks listed are 'right' or 'wrong'. They are responses that may be less effective when talking to a young person about their drug use.

Twelve communication roadblocks

Roadblock	Examples
1. Ordering, directing, commanding	'Don't say that.' 'You've got to face up to reality!' 'You have to do something about your drug use!'
2. Warning or threatening	'You're really asking for trouble!' 'If you go down that road you'll be sorry!'
3. Giving advice, making suggestions, providing solutions	'Have you thought about…?' 'What I would do is…' 'Why don't you…?'
4. Persuading with logic, lecturing, arguing	'The facts are…' 'Statistics show…' 'Yes, but…'
5. Moralising, preaching or telling someone what to do	'You should go to rehab.' 'The best thing you could do is get a job.' 'You really ought to…'
6. Disagreeing, judging, criticising or blaming	'It's your own fault.' 'Don't you think you ought to think of others?' 'Surely there's more to do than smoke dope.'
7. Agreeing, approving, praising	'I think you're absolutely right.' 'That's how I would feel if I were you.'
8. Shaming, ridiculing or labelling	'That's a silly way to think.' 'You really ought to be ashamed of yourself.' 'How could you do such a thing?'
9. Interpreting or analysing	'Do you know what the real problem is?' 'You don't really mean that.'
10. Over questioning or probing	'What makes you feel that way?' 'Why?'
11. Reassuring, sympathising, consoling	'Things aren't really that bad.' 'Don't worry – you'll look back on this in a year and laugh.' 'Things will turn out OK, you'll see.'
12. Withdrawing, distracting, humouring, changing the subject	'Let's talk about that some other time.' 'Oh, don't be so gloomy! Look on the bright side.' 'You think you've got problems! Let me tell you about …'

Often the above responses are made by well-meaning workers and although there are no hard and fast right or wrong answers, they can be roadblocks to effective communication with young people.

WPL

Recognising the roadblocks

Q ***Choose at least two of the 'roadblocks' and recall two professional situations where you have used these communication blockers.***

A

Q ***Describe the circumstances surrounding the situations that may have led to a 'roadblock'. Record or discuss the factors that may have contributed to the situation.*** *(They may have been factors within yourself, your client, other staff member or within the environment.)*

A

Q ***Devise two examples of alternative skills or statements that you could have employed in the above situations.***

A

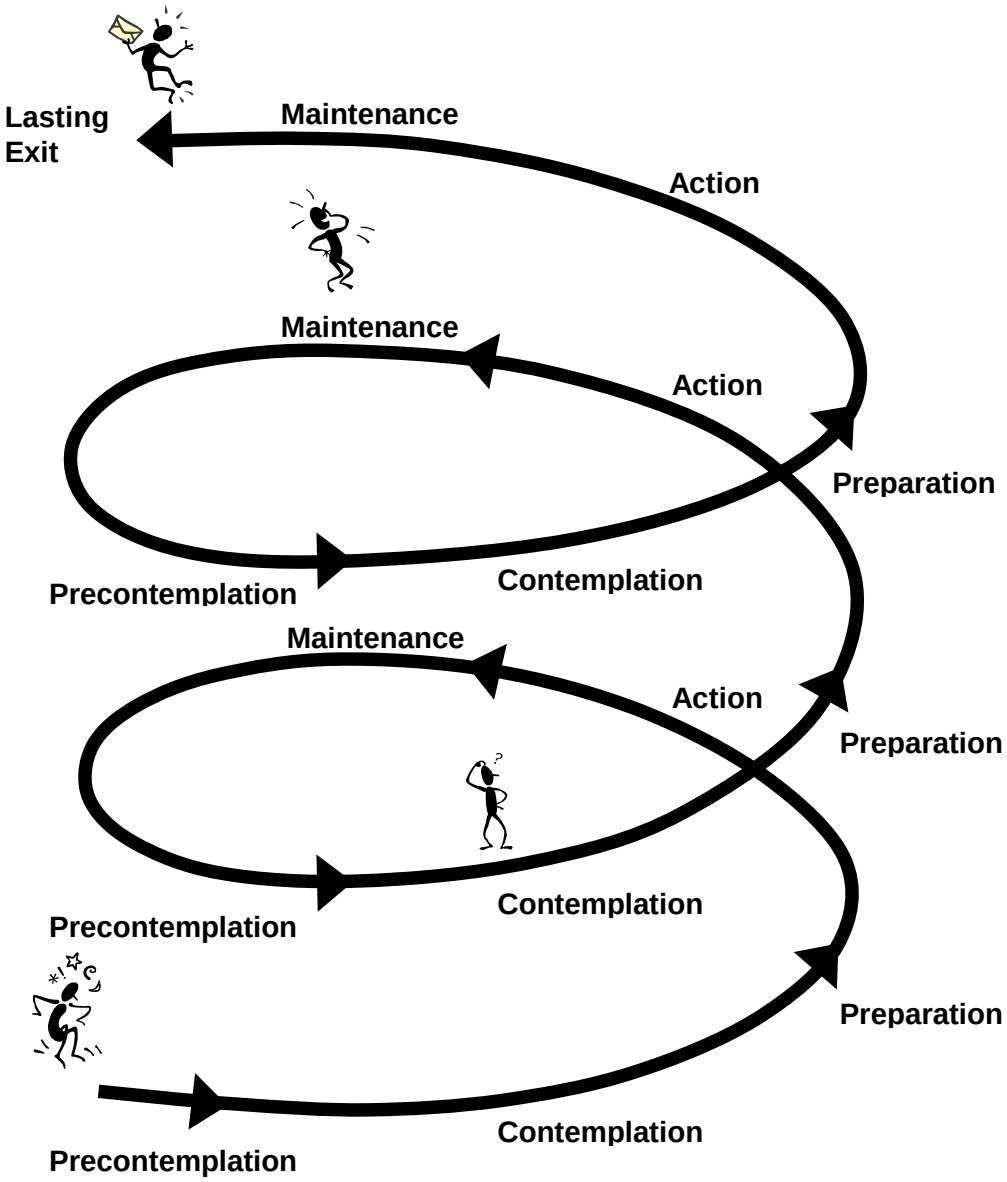
3.3 The Stages-of-Change model

Traditionally, changing AOD use was viewed as a single event rather than a process. This often involved only one possible outcome: total cessation or abstinence. This view does not take into account the small steps towards cessation that a person might make and the achievement that those smaller steps might represent (such as reducing the number of cigarettes smoked in a week). Young people who did not change their substance use in this way were viewed as being resistant and unmotivated.

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 young person's stage of readiness for change.

STAGES-OF-CHANGE MODEL



The five stages of change:

	People in this stage
1. Precontemplation	Not thinking seriously about changing and tend to defend their current AOD use patterns. May not see their use as a problem. The positives or benefits, of the behaviour outweigh any costs or adverse consequences so they are happy to continue using.
2. Contemplation	Able to consider the possibility of quitting or reducing AOD use but feel ambivalent about taking the next step. On the one hand AOD use is enjoyable, exciting and a pleasurable activity. On the other hand, they are starting to experience some adverse consequences (which may include personal, psychological, physical, legal, social or family problems).
3. Preparation	Have usually made a recent attempt to change using behaviour in the last year. Sees the 'cons' of continuing as outweighing the 'pros' and they are less ambivalent about taking the next step. They are usually taking some small steps towards changing behaviour. They believe that change is necessary and that the time for change is imminent. Equally, some people at this stage decide not to do anything about their behaviour
4. Action	Actively involved in taking steps to change their using behaviour and making great steps towards significant change. Ambivalence is still very likely at this stage. May try several different techniques and are also at greatest risk of relapse.
5. Maintenance	Able to successfully avoid any temptations to return to using behaviour. Have learned to anticipate and handle temptations to use and are able to employ new ways of coping. Can have a temporary slip, but don't tend to see this as failure.

Relapse

During this change process, most people will experience **relapse**. Relapses can be important for learning and helping the person to become stronger in their resolve to change. Alternatively relapses can be a trigger for giving up in the quest for change. The key to recovering from a relapse is to review the quit attempt up to that point, identify personal strengths and weaknesses, and develop a plan to resolve those weaknesses to solve similar problems the next time they occur.

Relapse is a factor in the action or maintenance stages. Many people who change their behaviour decide for a number of reasons to resume their drug use or return to old patterns of behaviour. Research clearly shows that relapse is the rule rather than the exception.

A note about lapse versus relapse: A **lapse** is a slip up with a quick return to action or maintenance whereas a relapse is a full-blown return to the original problem behaviour.

Task

Reflecting on change using the Stages-of-Change model

Q ***Choose a behaviour from your own life that you have changed or attempted to change (related to smoking, exercise, diet, caffeine intake, career direction, etc.) Note down the process you went through using the Stages-of-Change model and record relapses and slip-ups.***

A

Q ***What strategies did you use in making that change? For example, did you set yourself short-term and longer-term goals?***

A

Case Study

Identifying the stage of change

SARAH, JAMES, SAMMIE AND GRACIE

Sarah *is a 16-year-old girl who has been using speed for about two years. She uses speed intravenously, having originally snorted it for the first 12 months. On assessment, Sarah tells you that she has been trying to cut down on her speed use and has even had a period of two weeks where she didn't use it. She appears to be 'speeding' when you meet with her.*

James *is a 14-year-old boy who smokes cannabis and tobacco. On assessment of his cannabis use, he states that he can 'take it or leave it'. He tends to smoke with friends on the weekend. James smokes cigarettes whenever he can afford them. He also drinks alcohol to the point where he 'blacks-out' about once a month.*

Sammie *is an 18-year-old male who has been using heroin for about three years. He smokes heroin on a daily basis and also takes Valium or Normison if he can't get any heroin. Sammie has been caught breaking and entering on a number of occasions. His family are very worried about his drug use and the trouble he is in. Sammie has no desire to detox from heroin use. He states 'It's a hassle sometimes, but at least I don't inject it'.*

Gracie *is a 17-year-old female who is involved in a Drug Court program. She has a history of poly-drug use and has worked as a sex worker. Gracie has been trying to stay off cocaine and speed. She continues to drink heavily a couple of times a week and also takes street benzos as she says this helps her to sleep. Gracie's latest urinalysis reveals cannabis, benzodiazepines and amphetamines. She is pretty worried that she will be taken off the Drug Court Program and she states she really wants to stay out of trouble.*

Q ***Which stage of readiness for change seems to fit each young person?***

A *(Write your answer here, then check the possible answers on the next page.)*

A

Sarah	-	Preparation
James	-	Precontemplation
Sammie	-	Precontemplation
Gracie	-	Action

3.4 Applying the Stages-of-Change model to working with young people

Adolescence is a time of great change and risk-taking behaviour that can include some experimentation with drugs. Remember that there are different patterns of drug use (Schaeffer's model) and that young people for the most part fit within the experimental/recreational patterns of use. Although the Stages-of-Change model was developed using adult experiences, it is useful for understanding behaviour change in general. It is probably most relevant for work with young people with established patterns of AOD use.

The youth-focused systems model indicates that a young person's readiness to change may be influenced by other factors in the system. For example, peers may be pressuring a young person to keep using or a young person's family may have expressed their lack of confidence in a young person's ability to change. Keep this in mind when assessing readiness for change.

3.5 Identifying and responding to a young person's readiness to change

The Stages-of-Change model is primarily of use when dealing with people with established patterns of AOD use. Remember that this model may not fit all people all of the time, but is helpful in identifying a young person's readiness for change.

There are a number of ways of determining a young person's stage of change and readiness for action. It is important to use basic counselling skills including the use of open-ended questions, reflective listening, summarising and confirming the young person's views. One of the simplest tools for assessing readiness for change is to ask someone to indicate their response on a 10-point scale. (See Tool 1, The Ten Point Change Scale on the following page.)

Ask the young person to mark on the scale how they currently feel about changing their AOD use. It is likely that the young person will feel differently about different drugs so it may be worth using the tool with each of the drugs they use.

This approach can provide a framework for having a structured conversation with a young person about their drug use. The 'score' has subjective meaning for each young person and can also be a good base measure to return to at a later time (upon review of a case plan for example). Remember that some responses are more effective than others in initiating a conversation about the possibility of change as indicated in the section about communication roadblocks.

Some examples of questions you could use in response to the young person's position on the scale are provided. Remember that the focus of the conversation is not to convince the young person to change behaviour, but to help them consider the *possibility* of change and perhaps move along the stages of change. The wording of your questions and an empathic response to resistance and ambivalence are extremely important.

TOOL ONE - THE TEN POINT CHANGE SCALE

Not Considering Change **Thinking About Changing** **Already Changing**

0 1 2 3 4 5 6 7 8 9 10

If their mark is on the left end of the line

Goal for conversation:
To encourage the young person to think about the possibility of changing behaviour. Young people at this end of the scale can appear argumentative or in 'denial' and the natural tendency is to try to 'convince' them which usually provokes resistance and can be a roadblock to communication.

Some useful questions might be:

'What would have to happen for you to decide that your AOD use is a problem?'

'*What warning signs might tell you to start thinking about changing?*

'What things may happen if you continue to use …?'

'What have other people said about your drug use?'

'How might your use of … have stopped you from doing other things you want to do?'

'What are some of the hassles that your …. use may have caused?'

If their mark is somewhere in the middle

Goal for conversation:
To encourage the young person to examine the 'pros' and 'cons' of changing

Some useful questions might be:

'What are some of the reasons you might like to make a change to your….. use?'

'What might be some of the advantages in not using …?'

'If we were to bump into each other on the street in six months time, what do you think you would you like to tell me about your life at that point?'

If your mark is on the right end of the line

Goal for conversation:
To encourage the young people to explore factors that can support their decision to change.

Some useful questions will be:

'Pick one of the barriers to change and list some things that could help you overcome this barrier.'

'Pick one of those things that could help and decide to do it by …… (write in a specific date).'

'If you've taken a serious step in making a change:

-'What made you decide on that particular step?'

-'What has worked in taking this step?'

-'What helped it work?'

-'What could help it work even better?'

-'What else would help?'

-'Can you break that helpful step down into smaller steps?'

'Pick one of those steps and decide to do it by ……. (write in a specific date).'

Role Play

Starting a conversation about change using the ten-point change scale

The following role-play activity will provide you with an opportunity to practise using the ten point change scale as a tool for facilitating a conversation about the possibility of change. Remember that this is a constructive learning opportunity and its success will depend on the way you provide and take on feedback.

Working in groups of three, each participant takes a turn in the following roles:

- ***the school counsellor***
- ***the young person***
- ***the observer***

Read the following:

- ***Role play scenario***
- ***Debriefing sheet***
- ***Observer worksheet***
- ***Reflection sheet***

Allow approx. 10–15 minutes for the role play and a minimum of five minutes for debriefing. The observer will manage time and the debriefing process.

If you are undertaking this task as a distance learner take on the role of the worker and complete the role play with a co-worker or friend. Make sure that you complete the Debriefing Sheet and the Reflection Sheet. You can complete the Observer Worksheet as a self-evaluation task if you are unable to find an observer for your role play.

Role play scenario

Troy *is a 14-year-old male who was recently found drinking alcohol on school grounds. When confronted about it by a teacher, he became extremely argumentative and aggressive and was suspended as a result. Troy has a history of getting into trouble at school for missing classes, failing to complete homework and general rudeness to teachers. A number of teachers have reported being concerned about Troy's health and wellbeing, and have stated that they were sure that they had smelt alcohol on his breath on several different occasions. They have also noticed a deterioration in his school work as well as his general demeanour.*

Troy has admitted that he has been drinking 'quite a lot' and sometimes by himself to get away from things. However, he doesn't see that there is a problem with his drinking, and believes that the teachers should mind their own business. He doesn't really see the point in school because he isn't doing well anyway although he did want to at least finish high school.

The school counsellor has been asked to speak with Troy about his alcohol use and the other problems that have been arising at school.

The counsellor's aim is to:

- ***start a conversation about how Troy feels about the possibility of changing his alcohol use using the ten-point change scale as a tool***
- ***determine what stage of change might be consistent with Troy's current state***
- ***respond appropriately to Troy's elected position.***

Role Play Debriefing Sheet

Those taking the observer role are responsible for facilitating the debriefing.

1. Ask the person who played ‘the worker’ to state their response to the role play – what they think they did well and what could be done differently next time.

2. Ask the ‘young person’ to give constructive feedback to the worker stating how they responded to their approach. (What was helpful, and not so helpful, including verbal and non-verbal aspects of worker's approach.)

3. Give the worker an opportunity to comment or seek any further feedback (e.g. ‘How was it for you when I ……. ?’)

4. Ask the young person and worker role players to stand physically move away from their seating position and shake off the role. State their real name and two qualities about them which are different from the role they played.

5. Observers then give constructive feedback to the worker. Finish by restating what strengths the worker demonstrated.

All group members then identify the key learning points of the role play.

Task

Role Play Observer Worksheet

Starting a conversation about the possibility of change using the ten-point change scale

Feedback on school counsellor's response to the situation	Yes	No	Comment
Approached the young person in an appropriate way (e.g. introduced themselves, non-threatening and non-judgemental)			
Raised the issue of concern: episodes of being alcohol affected. (This should be factual focusing on incidents at the school.)			
Introduced the ten-point scale of change and clearly explained to Troy what was required of him.			
Responded appropriately to Troy's elected position on the scale using at least one open-ended question to explore why he positioned himself at that point on the scale.			

Reflection Sheet

Task

Reflect on what you have just learnt and write down your thoughts to the following questions:

Q ***What went well in the role play and what didn't go so well?***

A

Q ***What constraints might you come across in this type of situation at work?***

A

Q ***What steps could you take in your workplace to apply what you have learnt in this topic?***

A

Summary

Lifestyle change is a difficult task. The Stages-of-Change model provides a framework for assessing and working effectively with young people.

Key points about the Stages-of-Change model:

- Change is a process, not a single event
- People may go around the cycle of change many times before achieving control
- A young person's resistance may be a sign that the worker has overestimated their readiness for change.

The ten-point change scale can be a useful tool for starting a conversation focusing on how the young person feels about the possibility of changing their AOD using behaviours.

Distance learners should take time now to reflect on their learning, check in with their facilitator and determine their progress.

Topic 4

Motivational interviewing

Key Issues

- Introduction to motivational interviewing
- Working with ambivalence in young people
- Working with resistance in young people

Resources

4.1 Introduction to motivational interviewing

Issue of motivation

The issue of motivation is often raised in discussions about young people and also in relation to AOD use. Although it is an important concept in the behaviour change context, it is difficult to define. Workers' perceptions of motivation may differ, not only from each other but also from that of the young person.

The main idea of motivational interviewing is to purposefully create a conversation around change, without attempting to convince the person of the need to change or instructing them about how to change.

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). Previous approaches to the treatment of addiction behaviours tended to view continued substance use as evidence of inherent personality defects, such as denial.

Article "What is motivational interviewing", (Rollnick & Miller, 1995)

This approach utilises the principles and practices of person-centred counselling to encourage the young person to move through the stages of change and to make personal choices along the way. A young person's resistance is viewed as evidence of conflict or ambivalence and is met with reflection rather than a confrontational style (Rollnick and Miller, 1995).

In this topic we will be discussing some of the fundamental aspects of motivational interviewing and some techniques that may be helpful for you in your work with young people. It is not, however, a comprehensive course in motivational interviewing as this requires far more information and skills which are beyond the scope of this module.

WPL

What is motivational interviewing?

Please read the article 'What is motivational Interviewing?' (Rollnick and Miller, 1995) before answering the following questions:

Q ***Reflect on the points made in the article under the subheading 'The Spirit of Motivational Interviewing'. How do these ideas compare with your current work with young people?***

A

Q ***How might motivational interviewing be used in your work with young people?***

A

Key principles of motivational interviewing

The following are the key principles of motivational interviewing.

Express empathy

- Acceptance facilitates change
- Skilful reflection is fundamental
- Ambivalence is normal

Develop discrepancy

- Awareness of consequences is important
- A discrepancy between present behaviour and important goals will motivate change

Avoid argument

- Arguments are counterproductive
- Defending breeds defensiveness
- Resistance is a signal to change strategies
- Labelling is unnecessary for change

Roll with resistance

- Momentum can be used to good advantage
- Perceptions can be shifted
- New perspectives are invited but not imposed

Support self-efficacy

- The belief in the possibility of change is an important motivator
- The young person is responsible for choosing and carrying out personal change
- The young person should present arguments for change

4.2 Working with ambivalence in young people

One of the underlying premises of motivational interviewing is that all behaviour is motivated. There is no such thing as 'unmotivated' behaviour. It therefore assumes that people may be motivated to change and at the same time have strong motivators to stay the same. The more a young person is involved with drug use and the associated lifestyle issues, the greater the chance they will feel some conflict about making a significant change to their drug use and avoid making that change. That is, they may be ambivalent about changing their patterns of use. Understanding and working with a young person's ambivalence is a central element of motivational interviewing.

As mentioned earlier, ambivalence is a normal, human condition which is central to decision-making. A good comparison is with relationships. Most people have felt ambivalence about an intimate relationship. Again, the greater the involvement in the relationship, the stronger the ambivalence is likely to be. Similarly, the greater the involvement with drug use, the stronger the ambivalence is likely to be.

Working with this ambivalence (rather than ignoring it or denying it) can be one of the keys to assisting young people in moving through the change process.

4.3 Working with resistance in young people

Resistance in young people

Resistance in young people can be one of the most challenging and frustrating issues to deal with and often occurs when freedom of choice is being threatened. In the Juvenile Justice context, for example, coercion into treatment can be a clear source of resistance! Where possible, encourage the young person to reflect on the choices they have and involve them as much as possible in the decision-making process. Reflection and expression of empathy can also help the young person to talk about their loss of choice.

Resistance can be an expression of the young person thinking, 'Hey hang on, I'm not with you, I don't agree'. One of the defining characteristics of motivational interviewing is the way a worker views and deals with resistance. A young person's resistance is viewed as an interpersonal, contextual dynamic rather than a personality trait or the result of a disease state. The reframing of a young person's resistance is one of the key factors in the motivational interviewing model.

Key issues in working with resistance

- The worker's style can be a powerful determinant of the young person's resistance and motivation to change
- Argument tends to provoke resistance
- Young people may respond to confrontation by presenting the reasons against change
- When resistance is provoked, young people tend not to change
- Resistance may be a message from the young person that you do not understand them or their situation
- Motivation emerges from the interaction between the young person and the worker
- Motivation can be increased by using a variety of strategies.

One of the goals of motivational interviewing is to avoid eliciting and reinforcing any resistance or reluctance a person may express. This is known as **'rolling with resistance'**. Research suggests that the approach taken with a young person can either increase or decrease resistance. There is also good evidence to suggest that levels of a young person's resistance can predict outcomes (See Miller and Rollnick, 1991).

Reflection can be used to *reduce* resistance and can also be employed as a way to work with, rather than against, the energy of resistance.

Some examples are:

- Simple acknowledgement of the young person's disagreement, emotion or perception can permit further conversation rather than defensiveness.

- Reflecting back what the young person has said, exaggerating the point but with a quiet, understated tone. If successful, the young person may back off a bit and might articulate the other side of the ambivalence.

- Acknowledge what the young person has said and include the other side of the issue, with the aim of increasing ambivalence.

In relation to AOD issues, resistance is most likely to occur when there is a mismatching between the young person's stage of change and the approach being taken by the worker. One of the worst ways to work with someone who is not ready to look at the issues at hand is to confront them.

Responding to resistance

Task

For each of the statements below, spend a few moments considering the possible sources of the resistance. Based on what you have just learned about working with resistance, generate two responses to each of the following statements.

'Who are you to tell me what to do? What do you know about smack? You've probably never even tried dope!'

1.

2.

'I don't have to talk to you. I'm only here 'cause I have to be!'

1.

2.

'I couldn't change even if I wanted to. My father always said I'd be no good.'

1.

2.

Task

'I don't use any more than my friends. They aren't being hassled!'

1.

2.

'The law sucks! Everyone knows that alcohol causes far more problems than marijuana. Besides, they're trying to legalise it now.'

1.

2.

'Things are different now than when you were a kid. There's nothin' else to do except smoke cones!'

1.

2.

The person responds to any question with either silence or 'I dunno'.

1.

2.

WPL

Sources of resistance in your work with young AOD users

Q ***Why might you encounter resistance as a worker with young people who use AOD?***

A

Q ***List three examples of resistance that has arisen in your interactions with young people who use AOD.***

1.

2.

3.

Q ***What aspects of your role and the way young people may view it might contribute to resistance?***

A

Q ***Are there any aspects of your own work style that may contribute to a young person's resistance?***

A

Summary

- Motivational interviewing is an intervention technique that purposefully creates a conversation about change, without attempting to convince the person of the need to change or instructing them about how to change.
- Working with ambivalence, rather than ignoring or denying it, can assist young people in moving through the change process.
- Reflection can be a useful technique to work with resistance.

Topic 5

Some motivational interviewing techniques for working with young people

Key Issues

- Introduction to some motivational interviewing techniques
- Good things/ less good things
- Looking forward/ future directions
- Worst-case scenario/ best-case scenario

5.1 Introduction to some motivational interviewing techniques

Motivational techniques

Many different techniques are associated with the motivational interviewing approach. As mentioned previously, a comprehensive coverage of all possibilities is beyond the scope of this module. However, you will be provided with several techniques that are useful when working with young people with AOD issues. You may well have used some of these techniques in your work with young people, perhaps in relation to difficult behaviours or another issue. The techniques presented here can be used in addressing behaviour change generally, but this module will focus specifically on behaviour change in response to AOD-related problems.

The strategies can be used alone in short conversations with young people or in combination within more lengthy or in-depth interactions, depending upon the setting in which the worker is placed.

The techniques include:

- **Pros and cons for making change or staying the same (also known as decisional-balancing):** a young person is asked to identify some of the good and less good things about making change and staying the same

- **Looking forward/future directions:** a young person is asked to consider what life might be like for them in the future

- **Worst-case scenario/best-case scenario:** a young person is asked to think of what the worst and best-case scenarios might be like for them.

5.2 Good things/ less good things

This strategy, known as decisional-balancing (Saunders and Wilkinson, 1990) represents the 'heart and soul' of motivational interviewing. It is an essential strategy for building and exploring ambivalence about current drug use and the possibility of changing drug use.

An exploration of the two sides of the young person's substance use serves a number of purposes. The strategy:

- helps to build rapport
- helps assess how the young person feels
- assesses readiness for change
- assesses other dimensions (e.g. triggers for relapse if change were to occur)
- when the good things and less good things are written down it provides a visual representation of the situation.

Resistance is minimised when you start with the positive things about a young person's substance use and then talk about the 'less good things', rather than start with 'problems' or 'concerns'. This allows the young person to identify areas of concern without feeling that these are being labelled as a big problem. It also assists the young person to develop some perspective on their situation. It can be useful to write down the good things/less good things so that a visual picture of the situation develops.

Begin by expressing empathy for the young person's position. Try to elicit from the young person the benefits and costs of their alcohol or drug use. This strategy is a useful way of assessing the stage of change and the degree of ambivalence.

Be careful not to presume that the costs or 'less good things' related to substance use are a source of great concern to the young person. Terms such as 'problem' or 'concern' are often best avoided. Rather, the aim of the strategy is to explore young people's feelings about their substance use. They, rather than you, identify potential problem areas.

The wording of your questions exploring the pros and cons or good and less good things about using is critical at this point. Poorly-phrased questions or statements can lead to increased resistance in a young person.

Task

Good things and less good things about drug use

A useful tool for recording the information gathered during a discussion of the good things and less good things about staying the same or changing (decisional-balancing) is shown below:

Q

Using smoking marijuana as an example, answer the following questions, by completing the table.

- ***What might be some of the positives of smoking marijuana?***
- ***What might be some of the possible negatives associated with smoking marijuana?***
- ***What might be some of the positives of not smoking marijuana?***
- ***What might be some of the negatives associated with changing marijuana smoking?***

A

Tool 2: 'Good things/less good things' table

	Good things	Not so good things
Continue drug use		
Reduce/stop drug use		

Hint: Consider effect on finance, friendships, relationships, health, work, legal issues etc.

Reflection

Task

Q ***In terms of the Stages-of-Change model, in which stage/s do you think this tool might be appropriately used with a young person? Why?***

A *(Write your answer here, then check the possible answers on the next page.)*

A This tool may be useful at the beginning of conversation with a young person as it can assist in developing rapport and avoids discussing drug use as a 'problem'. The good/less good things strategy can also be used when young people are thinking more about change (in the contemplative/action phases). You may ask the young person to describe the good things about their current (or past) efforts to change and some of the less good things. Remember the goal is always to facilitate or lead movement to the next stage-of-change without forcing the young person.

Q ***In terms of the ten-point change scale, at which end of the spectrum do you think this strategy might work best?***

A *(Write your answer here, then check the possible answers on the next page.)*

A This strategy is probably most useful in the lower half of the scale where people are either not considering, are beginning to consider or have tried to make small changes (0-5).

WPL

Q ***In your own work with young people, outline some situations in which this tool might be useful.***

A

Q ***What might be some barriers to using this tool with the young people you work with or in your workplace?***

A

Q ***What are some strategies that might assist you in overcoming those barriers?***

A

Task

Good things/less good things (decisional-balancing)

Spend some time with a young person and ask for the following information.

Q ***'What are/were some of the good things about your use of alcohol/drugs?'***

A

Q ***'What are/were some of the not-so-good things about your use of alcohol/drug(s)?'***

A

Q ***'What are some of the good things about making a change to your drinking/drug use?'***

A

Q ***'What are some of the not-so-good things about making a change to your drinking/drug use?'***

A

Discuss with the young person what it is like to have the opportunity to discuss the positives and negatives of using substances and changing substance use.

5.3 Looking forward/ future directions

Helping a young person to imagine a different future is another approach to discussing change.

Some questions that you could use in this strategy are:

'How do you think things might be different for you once you turn 18?'

'If you were to become a parent, how might your drug use fit in with that role?'

'What would be the best possible result that you could imagine, if you were to make a change?'

'If we were to bump into each other on the street in six months time, what do you think you would you like to tell me about your life at that point?'

'If you did make a change to your drug use, how would you like things to turn out?'

Reflection

Q ***In terms of the Stages-of-Change model, in which stage/s do you think the looking forward strategy might be appropriately used with a young person? Why?*** *Remember the goal is always to facilitate or lead movement to the next stage of change if the young person is ready.*

A

Q ***In terms of the ten-point change scale, at what point on the scale do you think this strategy might work best?***

A

5.4 Worst-case scenario/ best-case scenario

It can be useful to ask young people to consider 'worst-case' and 'best-case' scenarios in response to change.

Some questions that you could use in this strategy are:

'If you were to stop using heroin, what do you imagine would be the worst things that could possibly happen?'

'If you were to keep using heroin, what do you imagine would be the best things that could possibly happen?'

These questions could be varied to include the 'worst-case' and 'best-case' imaginings around change and staying the same.

Task

Q ***In terms of the Stages-of-Change model, in which stage/s do you think the best-case strategies might be appropriately used with a young person? Why?*** *Remember the goal is always to facilitate or lead movement to the next stage of change if the young person is ready.*

A

Role Play

Continuing a conversation about change using some motivational interviewing techniques

The following role-play activity will provide you with an opportunity to practise using the three motivational interviewing techniques (good/less good things, looking forward/future directions and worst-case/best-case scenario) for facilitating a conversation about the possibility of change. Remember, this is intended to be a constructive learning opportunity and its success will depend on the way you provide and take on feedback.

Working in groups of three, each participant takes a turn in the following roles:

- ***the school counsellor***
- ***the young person***
- ***the observer***

Read the following:

- ***Role play scenario***
- ***Debriefing sheet***
- ***Observer worksheet***
- ***Reflection sheet***

Allow approximately 15-20 minutes for each role play including the debriefing. Allow time for role changeover. The Observer will manage time and the debriefing process.

If you are undertaking this task via distance learning complete the role play with your co-workers. Complete the Debriefing Sheet and the Reflection Sheet and use the Observation Worksheet as a self-evaluation task if you are unable to find an Observer for the role play.

Role play scenario

Troy *(the 14-year-old male from the previous scenario) has admitted that he has been drinking quite a lot, sometimes by himself, to 'get away from things'. However, he doesn't see that there is a problem with his drinking and believes that the teachers should mind their own business. He doesn't really see the point in school because he isn't doing well anyway although he did want to at least finish high school.*

Troy says that he sometimes thinks about changing his drinking behaviour, but then things 'get on top' of him and he tends to have a strong urge to drink more often which he says makes him feel better. He also likes having a good time drinking with his mates. He rates himself as being somewhere between 3 and 4 on the scale and seems to be ambivalent about change at this time.

The school counsellor has been speaking with Troy about his alcohol use and the other problems that have been arising at school.

The counsellor's aim is to:

- ***determine what stage of change might be consistent with Troy's current state***
- ***respond to Troy's elected position on the scale appropriately***
- ***respond appropriately to ambivalence***
- ***roll with any resistance from Troy (e.g. using reflection)***
- ***use one or more of the techniques outlined to provide Troy with an opportunity to explore some of the pros and cons of changing.***

Role Play Debriefing Sheet

Those taking the observer role are responsible for facilitating the debriefing.

6. Ask the person who played 'the worker' to state their response to the role play – what they think they did well and what could be done differently next time.

7. Ask the 'young person' to give constructive feedback to the worker stating how they responded to their approach. (What was helpful, and not so helpful, including verbal and non-verbal aspects of worker's approach.)

8. Give the worker an opportunity to comment or seek any further feedback (e.g. 'How was it for you when I ……. ?')

9. Ask the young person and worker role players to stand physically move away from their seating position and shake off the role. State their real name and two qualities about them which are different from the role they played.

10. Observers then give constructive feedback to the worker. Finish by restating what strengths the worker demonstrated.

All group members then identify the key learning points of the role play.

Role-play Feedback Sheet

Starting a conversation about the possibility of change using the ten-point change scale

Provide feedback on school counsellor's response to the situation	Comment
Communicated in a non-threatening and non-judgemental manner	
Dealt with any resistance from Troy by responding empathically and using reflection where necessary	
Approached Troy's apparent ambivalence appropriately	
Used one or more of the techniques described to continue the conversation about the possibility of change with Troy: • Good things/less good things • Looking forward/future directions • Worst-case scenario/best-case scenario	

Reflection Sheet

Task

Reflect on what you have just learnt and write down your thoughts to the following questions:

Q ***What went well in the role play and what didn't go so well?***

A

Q ***What would be some constraints that you may come across in this type of situation at work?***

A

Q ***What steps might you take in your workplace to apply what you have learnt in this topic?***

A

Summary

Motivational interviewing:

- is one way to work with some people, some of the time, in some situations
- is an approach that aims to work with people at their own pace, and addresses the need for change
- uses a quiet, eliciting style rather than directive approach
- has application in both specialist AOD and other settings
- is useful in brief interventions.

Some useful motivational interviewing techniques for working with young people include:

- good/less good things
- looking forward/future directions
- worst-case/best-case scenarios.

Distance learners should take time now to reflect on their learning, check in with their facilitator and determine their progress.

Topic 6

Brief interventions

Working with Intoxicated Young People
Helping Young People Identify their Needs

Key Issues

- Brief interventions – a definition
- Range of brief interventions
- How to carry out brief interventions
- Counterproductive assumptions
- Applying brief interventions

Resources

www

6.1 Brief interventions – a definition

Most frontline workers will be familiar with 'brief intervention' as an approach for working with young people. By 'brief intervention' we mean implementing an intervention that takes very little time. Brief interventions are usually conducted in a one-on-one situation and can be implemented anywhere on the intervention continuum.

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.

Brief interventions are therefore a much less 'traditional' form of intervention option and can be a useful tool for working with young people, who may be impulsive and erratic in their decision-making. The focus of many brief interventions is harm reduction and safer drug use.

www.nt.gov.au/health

It involves making the most of an opportunity to raise awareness, share knowledge and get a young person thinking about making changes to improve their health and behaviours. The intervention can be brief and 'opportunistic', lasting as little as 30 seconds, or extending over a few sessions lasting 5-60 minutes. Brief interventions often consist of informal counselling and information on certain types of harms and risks associated with drug use and/or risky behaviours.

Frontline workers have a responsibility to raise health issues and related behaviours with the young people they are working with.

The aims of brief intervention are to:

- engage with those young people not yet ready for change
- increase the young person's perception of real and potential risks and problems associated with AOD use and associated practices.
- encourage change by helping the young person to consider the reasons for change and the risks of not changing.

Brief interventions utilise many of the skills already covered in this module such as motivational interviewing, problem solving, decisional-balancing and goal setting and requires an understanding of the process of change.

6.2 Range of brief interventions

Brief interventions can take many forms and can occur in a variety of settings.

Examples of brief interventions include:

- Informal discussions around drug use in a youth drop-in centre
- Telephone services such as Kids Helpline
- One-to-one counselling opportunities in the context of a youth program (e.g. during assessment, or when a young person seeks advice about AOD issues)
- Self-help manuals or workbooks provided by a school counsellor or youth worker
- AOD education in a group setting in a Juvenile Justice centre.
- Computer-based or on-line quizzes and questionnaires around drugs and drug use
- School-based peer-intervention programs
- Provision of harm reduction information in general practice or hospital accident and emergency settings.

When to carry out brief interventions

WPL

Brief interventions can take place almost anywhere and anytime. Take some time to reflect on your own work practice and think about when and where brief interventions have occurred while you were working with young people.

Q ***Are there times when it may not be appropriate to undertake a brief intervention?***

A *(Write your answer here, then check the possible answers on the next page.)*

Possible answers include:

- When the person does not wish to engage in conversation and becomes visibly distressed or angry by your questioning
- When a person is in a highly emotional state
- When a person is extremely intoxicated and will gain little benefit from any conversation or intervention until they begin to sober up
- When a person is on medication that is mood/mind altering (i.e. methadone or some anti-psychotics).

Prepare a case study example recalling a workplace scenario where a brief intervention occurred and include the following information (ensuring all names remain confidential.)

1. ***When did the brief intervention take place?***
2. ***Where did it take place? Provide a brief overview of the environment, location, if any others were involved.***
3. ***What was the goal of the intervention?***
4. ***How was the brief intervention conducted? What strategies did you use?***
   - ***Were any harm minimisation strategies discussed?***
   - ***Were any referrals made?***
   - ***Was another time arranged to meet with the young person to discuss issues further?***
   - ***How long did the intervention take?***
5. ***What would you do differently?***

6.3 How to carry out brief interventions

Brief interventions require good communication skills. It is therefore important that you:

- Assess the situation first. Is the environment safe or hostile?
- Assess the young person's level of intoxication or level of attention
- Listen to what a young person has to say
- Notice what they haven't said or what they do not wish to talk about
- Observe how they react
- Empathise with them and their situation
- Consider what you may already know about them
- Talk in a non-threatening manner
- Avoid lecturing.

At the very least, brief interventions will ensure that the young person will go away with some information, advice and point of contact or referral for ongoing support and/or information.

Do not assume that the young person has a lot of information. It is important to always check to see how they know. By engaging in brief interventions with young people you may be able to provide enough information to allow them to make better choices, raise their awareness, and motivate and support young people to make decisions that are best for them.

Role Play

This role play provides you with an opportunity to consider your skills in brief intervention. Remember that this is a constructive learning opportunity and its success will depend on the way you provide and take on feedback.

Working in groups of three, each participant takes a turn in the following roles:

- ***school counsellor***
- ***the young person***
- ***the observer***

Read the following:

- ***Role play scenario***
- ***Debriefing sheet***
- ***Observer worksheet***
- ***Reflection sheet***

Allow approximately 15-20 minutes for each role play including the debriefing. Allow time for role changeover. The observer will manage time and the debriefing process.

If you are undertaking this task as a distance learner take on the role of the worker and complete the role play with a co-worker or friend. Make sure that you complete the Debriefing Sheet and the Reflection Sheet. You can complete the Observer Worksheet as a self-evaluation task if you were unable to find an observer for your role play.

Role play scenario

Matt *is a 16-year-old male in Year 11 at school. His parents have recently called the school counsellor, concerned because he is drinking large amounts of alcohol on weekends with his friends. More recently he has begun arriving home early on Sunday morning (after a Saturday night out) extremely intoxicated, to the point where he vomits and has difficulty speaking or even walking.*

A few weeks ago, Matt arrived home later than usual (minus his eyebrows because they were shaved off by his mates after he had 'passed out' after drinking too much), and talked about using marijuana. Although Matt's parents accept 'heavy drinking' as a relatively normal part of growing up, they are concerned that Matt's drinking is becoming more frequent and he is now using an illicit drug. They also suspect that he may be using other substances as well. Whenever they have tried to discuss their concerns with Matt, or impose limits on his going out, he becomes extremely agitated and tells his parents that they don't understand and that they are being over-protective. Matt believes that he is just doing what his mates do, and that there is nothing wrong with his behaviour.

The school has noticed no recent decline in his grades. Although Matt has never been a top student, he has consistently obtained B/C grades and has always planned on going to university to study business. Indeed, as long as his current grades are maintained, he may achieve this goal (although in order to do so it is important that his grades do not fall).

The school counsellor undertakes a brief intervention with Matt.

Role Play Debriefing Sheet

Those taking the observer role are responsible for facilitating the debriefing.

1. Ask the person who role-played 'the worker' to state what they felt they did well and what could be done differently next time.

2. Ask the young person (role player) to give constructive feedback [to the worker stating what was helpful, and not so helpful, including verbal and non-verbal aspects of worker's approach.

3. Give the worker an opportunity to comment or seek any further feedback (e.g. 'How was it for you when I ……. ?')

4. Ask the young person and worker role players to stand physically move away from the role's seating position and shake off the role. State their real name and two qualities about them which are different from the role they played.

5. Observers then give constructive feedback to the worker. Finish by restating what strengths the worker demonstrated.

All group members then identify the key learning points of the role play.

Role Play Observer Worksheet

Brief Intervention

Feedback on school counsellor's initial response to young person	Comment
Maintained communication with the young person in an appropriate way, (non-threatening and non-judgemental manner, used open-ended questioning)	
Checked to see if it is an appropriate time to conduct a brief intervention, bearing in mind confidentiality issues and ethical conduct?	
Identified the young person's stage of change and responded appropriately	
Provided relevant information to young person regarding drug use and/or harm reduction strategies and information for referrals to appropriate agencies and/or treatment services	
Provided the young person with relevant information regarding health risks of drug use	
Communicated clearly and calmly at all times	
Explained to the young person what their options are, and discussed their choices, needs, safety	
Explored possible risk and protective factors outlined in the youth-focused systems model	
Provided the young person with relevant information regarding health risks of drug use	

Task

Reflection Sheet

Reflect on what you have just learnt and write down your thoughts to the following questions:

Q ***What went well in the role play?***

A

Q ***What didn't go so well?***

A

Q ***What would you do differently next time?***

A

Task

Q ***What constraints might you come across in this type of situation at work?***

A

Q ***What steps might you take in your workplace to apply what you have learnt in this topic?***

A

6.4 Counterproductive assumptions

Rollnick and Mason (1995) identified some assumptions that health, welfare and other workers can make when working with people with alcohol and/or other drug problems, particularly in brief contacts. These also apply to work with young people. The following 'dangerous' assumptions are NOT wrong, but can negatively impact on brief interventions.

- This person *ought* to make a change
- This person *wants* to make a change
- This person's health is a prime motivating factor for change
- If the person decides not to change, the intervention has failed
- People are either motivated to change or not
- *Now* is the right time to consider change
- A tough approach is most effective
- I'm the expert. He or she must follow my advice.

Q ***Describe some negative assumptions made in your workplace? How do these affect your work?***

A

6.5 Applying brief interventions

WPL

Reflect on any brief interventions that you currently use in your work with young people who are using alcohol and/or other drugs.

Q ***Are there areas or skills you would like to improve? If so, what are they?***

A

Q ***If you are not currently using any brief interventions can you think of any opportunities or situations where you might be able to introduce them in your work?***

A

In the next week or two identify a specific situation at work where you can practise implementing brief interventions. Read over your notes again before you apply this learning.

Reflection

Reflect on the following after working with a young person on harm reduction.

Q ***What worked well?***

A

Q ***What didn't work so well?***

A

Q ***What would you do differently next time?***

A

Summary

Brief interventions:

- don’t require ongoing formal counselling sessions
- make the most of small opportunities
- can occur at any time in your work with young people
- can provide information quickly when it’s most needed
- can increase a young person’s acceptance of information.

Topic 7

Working with young people to determine a plan of action

Key Issues

- Negotiating a plan of action using problem-solving and goal-setting skills
- Problem-solving and setting goals

Resources

7.1 Negotiating a plan of action using problem-solving and goal-setting skills

When working with young people through the process of change it is important to help set realistic and achievable goals.

Jarvis, T., Tebbutt, J. & Mattick, R. (1995).

Goal-setting skills

Goal-setting is a process which is readily embraced and regularly undertaken. However, for many, goal setting is not a developed skill or technique. Encouraging young people to set goals and to work towards achieving them can be an important part of the process of changing AOD use. Workers must remember that as young people are spontaneous and still going through major developmental changes, their goals can change dramatically from day to day. Do not assume that you know what is best for the young person. Allowing young people to explore their own identities and goals is often a crucial part of the process in negotiating a plan of action.

When setting goals with young people, it can be useful to explain that goals are like directions on a road map. They are the landmarks that can help to plot the way to a future. In order to plan 'action', a goal must be pictured. A young person may be side-tracked very easily if there is no clear vision, purpose and ownership of the plan of action.

Beginning the process

Goals are related to a person's values, beliefs and dreams. For a young person to see a need to set goals, it is important to elicit their current beliefs and values as well as their future hopes and plans.

Questions that may assist in the process include:

- What sorts of things are important to you?
- What is the one most important thing in your life, that you would miss the most?
- What sort of person would you like to be?
- If things worked out in the best possible way for you, what would you be doing in one year from now?
- What are some of the good things your friends and family say about you?
- How does your drug use (or you as a drug user) fit in with your plans for the future?

The last question is helpful to possibly identify discrepancy and elicit self-motivational statements.

It can also be useful to explain that goals can be short-term or long-term. Short-term goals are things that you can achieve in a day, a week or a month. Encouraging a young person to start with small goals, such as getting out of bed at a particular time, or joining a sports team can enhance the likelihood of success.

Setting small steps will empower a young person. The steps can be as simple as attending a treatment session. If young people are achieving small goals they will be more likely to aim for and achieve longer-term goals. It is important for them to be able to see progress. You should commend them for talking with you.

If a young person is unsure of what they want to achieve, ask them to take some time to think about it and write down a list of goals on a piece of paper. Stipulate that these goals can be as wildly ambitious or as modest as they like. When they have written down their goals it is a good idea to discuss with them which ones they believe they are most likely to achieve in the short term, then identify which goals they believe are most likely to be achieved in the longer term.

Using the SMART Approach

Using the acronym SMART (Specific, Meaningful, Assessable, Realistic, Timed) can assist you to help to set concrete and achievable goals.

SMART

Specific

Meaningful

Assessable

Realistic

Timed

- **Specific –** Goals that are vague or unclear are hard to reach. Specific targets need to be reached, thus creating a greater sense of achievement. Examples of vague goals might be *'I want to get fit'* or *'I want to smoke less dope'.* While fitness can be a desirable goal, this is often vague and difficult to assess when it is achieved. A more specific goal might be *'I want to go to a gym for one hour three times a week'* or *'I want to stop smoking cones during the week. I will only smoke cones on the weekend'.*

- **Meaningful –** Since the young person is the one who has to put in the hard work, change may take a great deal of personal effort. It is obviously important that goals are of personal relevance. While goals may involve other people, they need to fit closely with a young person's values, beliefs and personal desires.

- **Assessable –** In order for the young person to continue to change, it is important that they can see when a set goal has been achieved. Making a goal assessable means that it is also flexible if it is not reached. Stipulating a time frame for achievement as well as setting specific short-term goals can make the goal more assessable.

- **Realistic –** People involved in the process of making a significant change may have high expectations of what they can achieve. Significant others may also have high expectations of the outcomes. Setting unachievable goals may set the young person up for a sense of failure with the possibility that they may give up on the process. An example of an unrealistic goal might be *'I'm going to buy a sports car for my next birthday'.* This may be unrealistic if the young person does not have any savings or a job. While it is important to have long-term desires and goals, setting smaller milestones is more realistic and less prone to failure. A realistic goal might be *'I am going to go to get a job by the end of the month. I plan to save $20 a week'.*

- **Timed –** Goals need to have a timeframe attached to them. It is said that for younger people *'Goals are dreams with a deadline!'* In order to assess goals, it is important to set a date for review, for example their next birthday, the next holiday or the end of the year. Setting a timeframe for goals also increases the possibility of success and allows for revision.

Questions that may assist with setting goals within the SMART framework can include:

Make a list of goals for the day.

Make a list of goals for this week.

Make a list of goals for this month.

Make a list of goals for your year.

Make a list of goals for five years.

What will be your next (first) step now?

What will you do in the next one or two days (week)?

Have you ever done any of these things before to achieve this? What will you need to do to repeat these things?

Who will be helping and supporting you?

On a scale of 1 to 10, what are the chances that you will achieve your next step? (Be hesitant about accepting anything under a 7. The initial goal or next step may need to be more achievable).

WPL

Practising goal-setting

Select a young person to work with for this exercise. If necessary, choose a young person from your family or your community.

Using the key ideas discussed above, spend 15 minutes assisting the young person to set one short-term and one longer-term goal.

When you have finished, reflect on the usefulness of the process.

Q ***Did the young person find the exercise useful?***

A

Q ***Do you think the young person will follow through on the goals set? If so, why? If not, why not?***

A

Q **What particular factors might need to be taken into consideration when assisting young people with goal-setting?**

A

7.2 Problem-solving and setting goals

Problem-solving techniques are an essential part of working with young people with AOD-related concerns. While such techniques may often be used to assist a young person to take action with regard to their drug use, problem-solving approaches can also be applied in the reduction of drug-related harm. For problem-solving techniques to be of value, the young person has to have some level of concern about the perceived problem. The stage of readiness for change will have an impact on the timing and approach a worker might take in regard to using problem-solving strategies.

Task

Problems – What problems?

Q ***Drawing on the information presented earlier in this module, what are some of the factors that workers need to be aware of when using a problem-solving approach with young people in the AOD context?***

A

Problem-solving styles

Young people vary in the manner in which they approach problems and make decisions. They may have good decision-making (coping mechanisms) styles that may sometimes be helpful, yet at other times be potentially harmful.

Problem-solving approaches can be influenced by a range of factors such as young person's developmental stage, the example set by parents or significant others and personal beliefs. AOD use can also influence a person's problem-solving ability. For example, if a young person is intoxicated, clear decisions are less likely. As well, if a young person is dependent upon a substance, it is possible that their decision-making style will be more compulsive.

Workers can assist young people with their problem solving by helping them to identify their style of decision-making and by exploring their strengths and deficits. Past experiences of problems faced, decisions made and the consequences can also be explored.

Problem-solving training

Assisting a young person to develop problem-solving strategies is central to working through the process of change with them. Whether a young person is considering the possibility of change, actually attempting to change or trying to maintain change in their drug use, problem-solving training is an important part of the process.

Problem-solving training aims to help the young person to:

- recognise when a problem exists
- generate a range of possible solutions
- decide on the most appropriate option and determine a plan for enacting it
- evaluate the effectiveness of the selected option.

Problem-solving worksheet

A useful tool for working with young people through the process of problem-solving and decision-making has been developed by Jarvis, Tebbutt and Mattick (1995). It can also be used for young people to work through on their own.

Example 1: Problem solving worksheet

Stage 1: My problem is:

I smoke dope because it makes me feel good and I have more confidence when I socialise with my mates! Mum and Dad are really getting on my back lately because they think that I am not doing so well at school and that I spend too much time in my room smoking and not enough time doing school work. It's fun to hang out with my mates and smoke.

Stage 2: Brainstorm possible solutions:

- Join a sports team or start a sports team with mates
- See if your mates can come over and study with you
- Hang out with your mates less during the week and see them on the weekends
- Get a tutor to help with your study
- Cut down on your smoking during the week
- Fail school
- Get Mum or Dad to help you with your study
- Study out in the kitchen
- Try and smoke less on social occasions

Stage 3: Pros and cons of each solution:

Possible Solution	**Pros**	**Cons**
Study with mates	Get work done together	End up doing nothing
Fail at school	Continue to smoke	Get left behind
Join a sports team	Hang out with mates	Don't get to smoke

…. And the choices are:

Join a sports team and study with mates

Stage 4: What's my plan?

How?	Find out times and days of sports, organise study days
When?	Start on Monday after the weekend
Where?	At school and at home
With whom?	Friends from school

Example 2: Problem solving worksheet

Stage 1: My problem is:

When I smoke dope I end up doing nothing. But smoking dope helps me to sleep. If I don't smoke late at night I can't get to sleep at all. Then I want to sleep all day.

Stage 2: Brainstorm possible solutions:

- Stay awake all night
- Watch TV until I fall asleep
- Have a hot bath
- Drink Milo and hot milk
- Force myself to stay awake all day
- Read a boring book
- Take sleeping tablets

Stage 3: Pros and cons of each solution:

Possible solution	Pros	Cons
Stay awake all night	Will eventually get tired	Will give up and smoke
Watch TV	Something to do	Could keep me awake
Have a hot bath	Relaxing	Boring

…. And the choices are:

<u>Have hot baths and drink Milo and hot milk</u>

Stage 4: What's my plan?

How?	Get mum to buy some stuff for the bath and some Milo
When?	Start on Sunday night after the weekend
Where?	At home
With whom?	Tell mum what I'm going to do

Task

Applying problem-solving skills

Using the case example of 'Joe', develop a problem-solving worksheet. Write down key questions and statements you could use to get responses from Joe to get involved in the process.

Case Study

JOE

Joe *is a 14-year-old boy who has been caught smoking marijuana at school for the second time. He is being threatened with exclusion from school unless he agrees to see the AOD counsellor. Joe only smokes marijuana when he is with Peter and Fran as they are his good friends. Joe's parents have demanded that he not see those friends any more and have told him he will be sent to a boy's-only boarding school if he is expelled from his current school.*

Summary

- Assisting a young person to set realistic and reachable goals can be an important step in the process of taking action for change.
- Once it is clear what a young person aims to achieve by making a change, concrete help with problem-solving and decision-making can be necessary.
- Setting goals, solving problems and making decisions are all part of the process of change.

Topic 8

Relapse prevention/ management

Key Issues

- Relapse prevention/ management

8.1 Relapse prevention/ management

Relapse prevention and management is the main goal when trying to reduce or eliminate drug use – the path through the stages of change is not smooth for a young person, or for anyone. However there are number of relapse-prevention and management strategies that can be used.

The term **relapse** is well established and is used in this module. However, the word 'lapse' is often used. Relapse implies a total reversion to heavy drug use and a sense of failure. **Lapse** has less negative connotations, and emphasises the everyday nature of slipping-up when trying to change behaviour. Lapses can be minor and temporary. **Relapse management** is the term used for working with a young person to prevent or reduce the impact of a 'lapse' before heavy drug use becomes re-established.

Even when a young person is extremely motivated to change their lifestyle and drug use, it is probable that they will encounter situations that encourage drug use. This may be due to the way they are feeling (low mood, anxiety, craving for the drug) and/or circumstances that are conducive to drug use (e.g. friends pressurising them into using, stress in relationships or at work).

What approaches do you take when working with a young person who is trying to change, but lapses?

Relapse (lapse) prevention and management

There are some essential ingredients of relapse (lapse) prevention and management. These include the following:

- **Acknowledging that a lapse is a normal experience and should not be viewed negatively**. Peers/friends are not likely to have any difficulty with this concept, but family members and workers often equate a lapse with the 'beginning of the end'. Both the young person and their families should be helped to adopt an attitude that lapses provide opportunities for learning how to avoid further lapses.

- **Strengthening the motivation to change throughout the change process**. Discuss with the young person (at a time that feels right for them) the need to revisit the pros and cons for maintaining change.

- **Identifying high-risk situations** (that include factors both internal and external to the young person). High risk factors for young people will not uncommonly include their friends and families under certain circumstances. It will help enormously if others can be aware which of their behaviours help protect against relapse and which serve as triggers. For example, a common trigger is monitoring the young person's every movement, so that they feel they are not trusted or sufficiently independent. This is a sure recipe for resentment and secretiveness, which is associated with relapse.

- **Developing coping strategies and skills to avoid high-risk situations and to deal with them when they are unavoidable**. One of the foremost strategies to cope with high-risk situations is to turn to prearranged supportive people such as friends and family members. Help the young person discover and participate in non-drug related alternative behaviours with friends and family to combat a possible lapse.

- **Developing coping strategies and skills to deal with lapses.** Again, if the worker, friends and family do not overreact, they can be invaluable in helping to terminate a lapse.

- **Recognising and implementing changes to the young person's environment and lifestyle** to minimise the frequency of high-risk situations and to strengthen their commitment to change.

- **Positive self-talk: the young person can be helped to develop a phrase or two to repeat to themselves when tempted to use (or go beyond their limit).** This phrase should be positive in tone so that it also helps to build their self-esteem (e.g. *'I've gone without before, so I can do it again'.*). It would be useful for a friend or family member to help the young person develop their phrases, and could share in this process by occasionally repeating it aloud to the young person when they indicate they are feeling vulnerable.

- **Problem-solving skills** (see Topic 7). Enlisting family and friends in problem-solving will greatly increase the range of solutions to choose from.

- **Relaxation skills**. Change is stressful! Being able to relax will help to maintain change and face challenges. Craving for a drug is a very stressful experience. One of the ways of countering cravings is by relaxing and thereby reducing arousal levels. Some friends/peers, family members and situations will be an aid to relaxation, others definitely will not! There is no one way of achieving relaxation. Relaxation can also follow arousal associated with exciting risk-taking activities.

- **Anger and depression management**. Negative mood is associated with relapse, so mood needs to be monitored and dealt with before it builds up to a crisis. Anyone close to the young person (including the worker) can often detect the early stages of trouble brewing. They can also be the targets of anger, and so conflict resolution skills offer a huge advantage.

- **Coping with craving**. Young people and their supporters should be made aware that craving is normal and can be outlasted. Distraction is often useful, but the young person may also want a quiet space to retreat to until the craving subsides.

- **Identify the build-up to relapse**. Lapses usually occur at the end of a long chain of small decisions rather than happening 'out of the blue'. Marlatt & Gordon (1997) call them 'apparently irrelevant decisions' that result in a drift into a lapse. Identifying the early stages of the slide is very important.

Task

A work situation

Select a young person you are working with and in point form jot down their issues and characteristics. Choose a particular situation or issue that they may have raised and, from the range of strategies above, draw up a plan to deal with it.

Motivational interviews and relapse drills

When you become aware that a young person has 'lapsed' a useful tool to revisit is **Motivation Interviewing** (Topics 4 and 5). Informal discussion aimed at re-establishing the young person's motivation to maintain change may well help prevent relapse (as long as he or she welcomes the discussion – don't force it if you sense resistance).

Remember, this process is about developing a positive perspective and reinforcing the positives of maintaining change. Emphasise that a 'lapse' is not a failure.

After you have re-established a positive attitude in the young person emphasise again that a lapse is not a failure. Explain that they can use the experience to learn how to avoid further incidents.

Ask them to recall the incidents that led up to their 'lapse'. Where were they? Who were they with? What were they doing? How were they feeling? Do they know what provoked those feelings?

The young person, with your help, can build up a picture of the situation, thoughts and feelings that preceded their 'lapse'. Think about other such situations. Were they similar? What do these situations have in common?

Consider each of these factors. Encourage and support the young person to devise strategies to deal with each of them. What can they do to avoid the situation developing? They should be specific*: 'I will call this person'; 'I will go to that place'.*

Remember the problem solving exercise in Topic 7. The solutions were definite and precise, not general – and possible actions were planned well in advance.

Maintaining change

Long-term maintenance of change often requires significant changes to a young person's lifestyle, such as:

- establishing social contacts that are not AOD centred (new friendships/peer group)
- establishing new leisure activities and hobbies that are not AOD centred
- living in a new place to avoid a familiar group of heavy users
- working in a new location to avoid heavy drug using scenes.

Note: If a young person continues to relapse a referral to a specialist drug and alcohol worker is essential.

Topic 9

Summary and conclusion

9.1

At this point you should speak with your facilitator and together assess whether you can:

- Identify AOD interventions suitable for working with young people
- Apply the ‘Stages-of-Change’ model and motivational interviewing to work with young people
- Implement strategies for working with resistance and ambivalence with young people
- Demonstrate skills in harm minimisation, and brief and early interventions with young people.
- Apply relapse prevention and management strategies.

If you have any concerns about meeting these learning outcomes you should speak further with your facilitator.

Before you contact your facilitator, complete the Reflection Activity in this topic.

Remember that if you want to know more about any of the topics covered in this module, a range of references are provided at the end of this module.

You could also contact your local health service or youth service for further information.

9.2 Summary of contents

This module has focused on strategies for working effectively with young people with alcohol and other drug concerns. The usefulness of brief interventions, particularly in non-AOD settings was explored. A range of brief intervention techniques was introduced with a focus on when brief interventions may or may not be appropriate.

The Stages-of-Change model was introduced which focuses on matching the young person's readiness for change to different strategies. Methods for measuring readiness were provided.

The principles and practice of motivational interviewing were outlined as an approach that has been proven to be effective for engaging young people in the process of change. Strategies for working with ambivalence and for encouraging change conversation were introduced. As well, approaches for working with any resistance that might arise when working with young people were discussed.

The place of goal-setting and problem-solving in the change process was discussed. Questions for eliciting goals were introduced as well as a framework for assisting young people to set achievable goals. Problem-solving and decision-making styles were raised. Techniques for increasing problem-solving skills in young people were addressed.

Finally it was noted that young people do not progress smoothly through change. The worker must assist the young person to learn from past lapses and to set goals to manage future ones.

Remember, continued relapses means you should refer the young person to a specialist.

It is important to remember when working with young people with AOD issues that some things work for some people some of the time in some situations. Finally, it may also be useful to remember that change is a journey, not a single event. Assisting young people early in the journey increases their chances of reaching their destination.

9.3 Self-reflection activity

Task

Take some time to reflect on what you have gained from your learning. You may wish to share your insights with other learners or colleagues, if possible.

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

A

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

A

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

A

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

A

References

Hando, J., Howard, J. & Zibert, E. (1997). *Risky drug practices and treatment needs of youth detained in New South Wales Juvenile Justice Centres*. Drug and Alcohol Review 16 (2), 137-145.

Jarvis, T., Tebbutt, J. & Mattick, R. (1995). *Treatment Approaches for Alcohol and Drug Dependence: An Introductory Guide.* Sydney: Wiley.

Miller, W.R. & Rollnick, S. (1991). *Motivational Interviewing: Preparing people to change addictive behaviour.* New York: Guilford Press.

Spooner, C., Mattick, R. & Howard, J. (1996). *The nature and treatment of adolescent substance abuse.* Monograph No.26. National Drug and Alcohol Research Centre, Sydney.

Toumbourou, J.W. (2002). *Drug Prevention Strategies; a developmental setting approach.* Prevention Research Evaluation No 2, Sept 2002 (available from Drug Info Clearinghouse – druginfo.adf.org.au).

Bien, T.H., Miller, W.R. & Tonigan, J.S. (1993). *Brief interventions for alcohol problems: A review.* Addiction, 88, 315-336.

Miller, W.R. (1998). *Why do people change addictive behaviour?* Addiction, 93, 163-172.

Miller, W.R. & Heather, N. (1998). (Eds.) *Treating addictive behaviours: Processes of change (2nd ed).* New York: Plenum Press.

Monti, M., Colby, S.M., Barnett, N. P., Spirito, A., Rohsenow, D. J., Myers, M., Woolard, R., & Lewander, W. (1999). *Brief intervention for harm reduction with alcohol-positive older adolescents in a hospital emergency department.* Journal of Consulting and Clinical Psychology, 67, 989-994.

Monti, P.M, Colby, S.M., & O'Leary, T.A. (eds.)(2001). *Adolescents, alcohol, and substance abuse: Reaching teens through brief interventions,* New York, Guilford.

Nelson-Jones, R. (1997). *Practical Counselling and Helping Skills.* (4th ed). London: Cassell.

Noonan, W.C. & Moyers, T.B. (1997). *Motivational Interviewing.* Journal of Substance Misuse, 2, 8-16.

Prochaska, J.O., DiClemente, C.C & Norcross, J.C. (1997). *In search of how people change: applications to addictive behaviours*. In Marlatt, G.A. & VandenBos, G.R. (eds) *Addictive Behaviours.* (pp.671-696). Washington DC: American Psychological Association.

Rollnick, S., Mason, P. & Butler, C. (1999). *Health behaviour change: A guide for practitioners.* New York: Churchill Livingstone.

Rollnick, S. and Miller, W.R. (1995). *What is motivational interviewing?* Behavioural and Cognitive Psychotherapy*,* 23, 325-334.

Stephens, R. S., Roffman, R. A., & Curtin, L. (2000). *Comparison of extended versus brief treatments for marijuana use.* Journal of Consulting and Clinical Psychology, 68, 898-908.

Websites

The Motivational interviewing website is very useful for latest research and articles:
www.motivationalinterview.org/index.shtml

The Australian Drug Foundation (ADF):
www.adf.org.au/index.htm

Centre for Youth Drug Studies is within the ADF:
www.adf.org.au/cyds/index.html

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/*

Drug Arm (This site is particularly focused on youth issues):
www.drugarm.org.au

A practical guide to the stages of change and working with ambivalence:
www.habitsmart.com/tip2.htm

The National Institute on Drug Abuse (NIDA), USA:
www.nida.nih.gov/

The National Institute of Alcohol and Alcohol Abuse (NIAAA), USA: *www.niaaa.nih.gov/*

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

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

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

The Australian Drug Information Network:
www.adin.com.au

Key terms

Abstinence	Refraining from drug use.
Ambivalence	Conflicted feelings towards someone or something. Understanding and working with a young person's ambivalence is a key component of the motivational interviewing model.
AOD	Alcohol and/or other drugs
Brainstorming	A technique that can be used when assisting a young person with problem-solving. A range of ideas are generated by the a young person and the worker which are then more fully explored.
Brief intervention	An intervention that takes very little time. Brief interventions are usually conducted in a one-on-one situation.
Central nervous system (CNS)	Brain and spinal cord.
Depressants	Drugs that slow down the brain and central nervous system.
Drug	Within the context of this course, a drug is a substance that produces a psycho-active effect.
Drug dependence	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.
FRAMES	An acronym standing for Feedback, Responsibility, Advice, Menu, Empathy and Self-efficacy. This framework highlights the key elements of a particular style of brief intervention.
Hallucinogens	Drugs that act on the brain to distort perception (i.e. sight, taste, touch, sound, smell).

Harm minimisation	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.
Harm reduction	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.
Intervention	A purposeful activity designed to prevent, reduce or eliminate AOD use at an individual, family or community level.
Motivational interviewing	A therapeutic style developed in the AOD field in the early 1980s as an alternative to the more confrontational approach used in some sectors of the treatment field. The aim of motivational interviewing is to build on a young person's own motivation and encourage choices for change.
Poly-drug use	The use of more than one psycho-active drug, simultaneously or at different times. The term 'poly-drug user' is often used to distinguish a person with a varied pattern of drug use from someone who uses one kind of drug exclusively.
Relapse	A return to drug use after a period of deliberate abstinence or controlled use.
Relapse prevention/ management	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.
Resistance	Inter or intrapersonal conflict that can manifest within or between a young person and a worker.
Risk-taking	Refers to risks that could be associated with AOD use, apart from the drug use itself. In an assessment, involves identifying factors such as sharing injecting equipment, being intoxicated in dangerous places (e.g. near a railway track), or having unprotected sex while intoxicated.

Rolling with resistance	One of the principles of motivational interviewing. Rolling with resistance refers to the idea of going with, rather than against any resistance that may arise when working with young people.
Self-efficacy	Refers to a person's sense of self-mastery, that is, the extent to which a person believes he or she has the ability to carry out and achieve a given task and reach the desired goal.
Self-motivational statements	One of the key strategies used in motivational interviewing. Key questions are asked with the aim of encouraging change conversation.
Stages-of-Change model	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.