Training Frontline Workers
Young People, Alcohol & Other Drugs

Section B
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Introduction

Overview

This module explores some of the reasons why young people may use drugs and focuses on the social and economic factors that influence drug use. It also contains information about drug use patterns and legislation and policy relevant to young people and drug use.
1.2 Learning outcomes

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

1. Identify your own personal values and attitudes regarding AOD issues and their implications for working with young people on AOD issues

2. Describe current models used to understand drug-use behaviour

3. Describe patterns and prevalence of drug use by young people

4. Discuss a broad range of factors that can impact on AOD use by young people

5. Outline harm minimisation and other current policies and frameworks that underpin AOD work with young people.

It is suggested 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 the learning 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 requirements for module completion.
Values and attitudes to AOD use

2.1 Significance of values and attitudes

Values are beliefs about what is good and desirable. This includes what we consider good and desirable for ourselves, for others and for the wider community.

Each worker has a unique perspective on the world and has their own set of values. These can often be traced back to our experiences as children and the messages that we get from our parents, friends and society as we grow into adults. As we mature we develop our own attitudes towards life. We discard some parts of our value system and adopt new values.

We bring to the workplace a whole range of life experiences that define who we are. It is neither possible nor desirable to separate ourselves into a ‘work’ self and another ‘social’ or ‘family’ self. We may modify our behaviour to fit work or social situations, but it is not psychologically healthy to alter our whole personality or to split our psyches into separate selves.
Our identity is not fixed but is constantly evolving as a result of our interactions with friends, family, co-workers and clients. We are also influenced by our interactions with employers and with social institutions. For example, people who work in a health environment might absorb ideas about harm minimisation. These ideas are gradually absorbed into our value system and become part of who we are.

The significance of values and attitudes

Note: If you are completing this by distance learning ask two other people for their responses to these questions and compare them to your own. Write your first response and encourage those who assist you to do the same.

Task

Write down three words that describe what you think about young people today.

In one or two sentences describe the role of parents in today’s society.

Write down three words that describe what you think of young people who use AOD.
Being aware of our values and attitudes is important because it helps us to:

- identify why we are doing what we are doing
- identify what the consequences of our actions will be for ourselves or for the young person or colleague
- consider other or better options
- be more aware of the reasons for our responses to situations.
2.2 Values and attitudes to AOD use

Alcohol and drug use in our society is not a neutral issue. It is strongly influenced by the attitudes and values common in society. It is not unusual to pick up a newspaper or turn on the television on almost any given day and hear about or see a story relating to the ‘dangers’ of drug use.

Our beliefs and attitudes have been influenced to at least some extent by the messages portrayed by the media and society more generally. It is important then, that we are aware of our own values and attitudes and the impact that they may have when working with young people.

Some drugs might be more socially acceptable in Western society than others (e.g. coffee or alcohol versus heroin or cocaine), but all of these substances are drugs nevertheless. It is important to realise how pervasive our attitudes are in relation to drugs and drug use.
Rate these statements on a scale of 1 to 10, 10 being the most disturbing to you, 1 being the least disturbing. Use each number once only.

- A man with his family at the beach, drinking from a beer can
- A 14-year-old smoking a joint at a party
- A woman shooting up heroin in a flat with her children playing in another room
- A well-dressed businessman staggering blind drunk out of a major international hotel
- A 13-year-old girl chain smoking
- A young man shooting up heroin in a public toilet
- A 15-year-old girl staggering blind drunk in a local park about to throw up
- A 16-year-old male prostitute soliciting for gay men to get money for drugs
- A senior youth worker taking a dose of Valium during the lunch break
- A drunk young man getting in a car to drive home.

Can you identify any themes coming through? What are they? Can you draw any conclusions about your attitudes? (You may like to compare your responses with those of your friends or colleagues.)
2.3 Values and working with young people

Our values can impact in positive and negative ways when we interact with young people with AOD issues. For example, we may attempt to influence the choices and decisions of young people on the basis of our own experiences, rather than looking at the individual situation of each young person.

Consider your beliefs and values

The aim of this exercise is to consider some of your beliefs and values about young people, which may impact on the way you interact with them.

Read the following statements. Each of the statements will ask you to think about how you perceive the behaviour of young people. Consider whether you strongly agree, agree, are neutral, disagree or strongly disagree with each statement. Draw an ‘x’ on the line to indicate your feelings.

1. Life was easier for young people when you were an adolescent

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

2. Young people only want to spend time with their mates

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

3. Young people have too many options today

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>
4. Young people can’t make good decisions for themselves

5. There is no safe level of drug use for young people

6. It is preferable for a young person to use some substances over others

7. Young people who are voluntary clients are easier to work with than those who are involuntary.

8. The family is a safe environment for young people

9. Young people only think about themselves
Can you identify any emerging themes? For example, do you have strong views on any particular topics or issues? Can you draw any conclusions about your attitudes?

Discuss (with a colleague or learning group) how your values and attitudes might impact on your work with young people. Write down any areas or issues which are problematic.

Write down some strategies you could develop to avoid these issues impacting on the young people you work with.
2.4 Personal values in the workplace

Not only can our values impact on the young people with whom we work, but they can also impact on our relationships with other workers.

Read the following scenario and answer the questions below.

You are working in a government-run youth health centre. Your supervisor has a strong belief in religion and has definite ideas about right and wrong, sin and guilt. She believes that abstinence from using AOD is the only way to be ‘free’ of AOD problems and that this should be the goal of all interventions with young people.

Would you be able to have an effective relationship with this person?

What values does this example bring up for you?
How might your boss’s attitude impact on young people?

• We all have personal values and attitudes that can impact significantly on the way we work with young people

• The nature of work with young AOD users can evoke emotional and personal responses

• Reflecting upon our values and attitudes can assist us develop strategies to manage work with young people

• Developing strategies for managing those responses is critical both for yourself as a worker and for the quality and effectiveness of your work with young people.
3.1 Reasons why people use drugs

For most people, using drugs is just another way of altering consciousness that is not so different from many other recreational activities. However, for the relatively small number of people who develop more compulsive drug-using patterns, drug use is not just about having fun, relaxing or for ‘partying’. It usually serves a deeper purpose (such as helping enhance identity, acceptance, and reducing psychological distress or a sense of alienation).

Human beings have a long history of using substances to alter their consciousness. Ancient tribes made their own mind-altering substances, some of which are still used today.

When working with young people, it is important to understand that for many, drug use is a fairly normal part of growing up, and that the reasons why many young people use drugs is not too different from the reasons why adults might enjoy drinking alcohol or engaging in other non-drug activities.
It is important to understand why young people might choose to use alcohol and other drugs and to consider this in the context of youth and youth culture. Life can be difficult for many young people as they work to define their identities and deal with many of the pressures of adolescence. While adolescence is a period of discovery, fun and achievement, it can sometimes be a confusing time for some young people. Frustration, anger and trauma can result from environmental and individual circumstances. It is therefore, important to consider that AOD use may be due to certain aspects of a young person’s situation, and may be used as a mechanism for coping with such pressures.

Adolescence is also a time of happiness, experimentation, celebration and fun and just as adults derive pleasure from using drugs, so can young people. Sharing an intoxicated time with friends can be a bonding experience. It can heighten a sense of group membership and belonging. Risk-taking is also a normal part of development and experimenting with psychoactive drugs is just one of the many risks that some young people will take during this time of great change.

Comparing adults and young people

Consider the reasons why adults use psycho-active drugs (including caffeine, alcohol, and tobacco) and why young people use psycho-active drugs. Write down the reasons in the table below.

<table>
<thead>
<tr>
<th>Adults</th>
<th>Young people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Consider your responses. Are they very different?

Now consider the reasons given by a sample of drug users for their use of a particular drug (Zinberg).

- To enjoy the effect: 85 percent
- To use for recreation: 57 percent
- To use for relaxation: 54 percent
- To socialise: 46 percent
3.2 Types of AOD use – Schaeffer’s model

Schaeffer outlined five distinct patterns of AOD use:

- experimental
- recreational/social
- situational
- intensive
- compulsive

Schaeffer has developed a model to describe patterns of drug use. In this model (see below) he acknowledges that most people use drugs in an experimental or recreational manner. This is particularly true for young people who often experiment with various substances as part of their growing up.
Drug use by recreational users serves different purposes than drug use by intensive and particularly compulsive users. In other words, recreational users and intensive or compulsive users use drugs for different reasons (Spooner, 1999; Shedler & Block, 1990; Stein, Newcomb & Bentler, 1987).

**Recreational drug use** is more about:

- curiosity
- rebellion
- being social
- having fun
- relaxing
- confidence
- the physical sensations of the drug

**Intensive and particularly compulsive drug use** on the other hand, is more about:

- reducing a sense of alienation
- identity formation
- self-medication
- relieving emotional distress
- improved self-regulation (soothing your emotions)

Recreational users tend to use more to have fun or party while compulsive users are motivated more by deeper psychological processes such as self-medication and providing relief from negative emotions.
ROBERTO AND JULIAN

Roberto and Julian are two 16-year-olds who spend most of their time together. On weekends, they like to party hard and they consume large amounts of alcohol (mainly spirits) every Saturday night. When there are no parties, they usually go to the beach to drink together. Julian usually drinks a lot more alcohol than Roberto, but for both of them, Sundays are spent recovering.

Roberto also uses a variety of substances to get him through the week. He claims that this helps him to cope with his parents and life in general. He does not see his drug or alcohol use as a problem and believes his life is under control.

What are the differences in Roberto and Julian’s AOD use? Which seems to have more of a problem? Why?

Can Julian’s alcohol use be described as purely recreational?
3.3 Dependence

Being dependent on drugs is not very different to being dependent on many other everyday activities such as the television, work or your car. Dependence exists on a continuum, and a useful way to think about the process of dependence is to relate it to your own relationships.

Dependence

The word dependence means different things to different people.

Most of us will admit that we are dependent on our cars, computers, money, partners or friends.

One definition of dependence is: ‘A state of relying on or being sustained by something’.

When it comes to drug dependence, however, society tends to view it as something quite different from these everyday behaviours. Despite this, a number of authors have argued strongly for it to be considered in the same light.

Dependence is a relatively normal human experience. Most of us are dependent to a greater or lesser extent on something.

Understanding the normality of dependence is important in terms of developing relationships with young people with AOD issues, as well as being able to dispel some of the myths surrounding dependence with your client group, parents and the wider population.

In the absence of the thing that we are very dependent on we often experience negative feelings and become quite uncomfortable. We think about the thing/object/person a lot, and we often orient our behaviour towards getting it back.

Experiencing negative feelings in the absence of drugs is considered one of the hallmark features of drug dependence.

This understanding is important in terms of developing an empathic relationship with a young person, and also for helping parents and other key stakeholders understand what it is like to be strongly attached to, or dependent on a substance.
Assessing your own dependence

Write down a list of five things or people you depend on. Remember to include things like technology (e.g. T.V., radio, mobile phone) and food/favourite items/pets.

1. 
2. 
3. 
4. 
5. 

Using a scale of 1-5, rate each item according to how much you think you depend on it. If you think you depend on something a lot, or feel that it is a big part of your life it should be rated at 5.

1. 1 - 2 - 3 - 4 - 5
2. 1 - 2 - 3 - 4 - 5
3. 1 - 2 - 3 - 4 - 5
4. 1 - 2 - 3 - 4 - 5
5. 1 - 2 - 3 - 4 - 5

Think about how you would react if this item or person were unavailable to you. How would you feel? How would you cope? Take the time to write down some of your thoughts in the space below.
3.4 Models that help us understand AOD use in society

Models of drug use

Throughout history people have tried to understand the concept of drug use and why some people become dependent or addicted to certain drugs and why some don’t. Many theories have been developed over time that provide us with explanations of drug use. Some of these theories have been developed into models which is a way of defining a problem or situation so that it can be more easily understood.

The following models have been most influential in developing drug policies and drug treatment historically and are still used in Australia. These models influence the way people work with young people and other individuals who have drug problems. You may be able to relate to some models better than others and identify models that underpin your agency’s approach to drug use.

Moral model

During the eighteenth and early nineteenth centuries addiction was viewed as a sin. Drug-dependent people were considered morally weak, and addiction was seen as a fault of one’s character. Under the influence of this model, users were punished with whippings, public beatings, stocks, fines, and public ridicule being relatively common. (In some British towns people were made to walk around wearing nothing but beer barrels.) Spiritual direction was also a common treatment. Jail sentences were another form of punishment and at the turn of the century many more drug users were put in mental hospitals as the jails became full.
**Disease model**

The disease model assumes that the origins of addiction lie within the individual him/herself. This model adopts a medical viewpoint and suggests that addiction is a disease or an illness that a person has. It believes that:

- Addiction does not exist on a continuum – it is either present or it isn’t.
- Addicted people cannot control their intake of a given substance. Once they consume some of the substance (such as one drink of alcohol) they are powerless to stop themselves having any more and are overtaken by almost irresistible cravings when they cannot have it.
- The disease of addiction is irreversible. It cannot be cured and can only be treated by lifelong abstinence.

Alcoholics Anonymous (AA) is based on the disease model. Given the popularity of disease models, it is worth examining their advantages and disadvantages in greater detail.

**Advantages** of disease models include:

- drug use becomes a health issue and not just a legal issue
- allows ‘addicted’ people to understand their behaviour.
- offers a treatment approach (abstinence) that works for some people
- removes some of the shame often felt by people affected by addiction.

**Disadvantages** of disease models include:

- removes responsibility from the user
- offers only one course of treatment (abstinence) which is not suitable for all people, particularly young people
- not supported by a large amount of evidence.
Psycho-dynamic model

This theory originated with Sigmund Freud and is still used today as a way of treating people with drug problems. The basic philosophy behind the psycho-dynamic model is that we can link problems to our childhood and how we cope (or don’t cope) as adults. In other words, drug use or misuse may be an unconscious response to some of the difficulties individuals may have experienced in childhood. This philosophy forms the basis of many counselling approaches which aim to gain insight into an individual’s unconscious motivations and try to enhance their self-image.

Social learning model

Prior to the 1970s, substance dependence was understood purely in terms of a physical reliance on a substance and the experiencing of withdrawal symptoms in its absence. Russell (1976) introduced the idea that dependence is not only chemical but also behavioural and social in nature. It is based more on the user’s thoughts about the substance, and what it is like to be ‘under the influence’ of the drug itself.

The key points of the social learning model can be summarised in the following way:

- Anyone who engages in an activity that they find pleasurable is at risk of developing dependence on that activity.

- Dependence is a learned behaviour that results from conditioning, modelling and thinking about the substance.

- Dependence on an activity/drug or person exists in degrees. The greater the dependence then the greater the negative feelings experienced in the absence of the activity.

- Dependence is a normal facet of human behaviour. It only becomes a problem when the individual experiences a number of negative consequences as a result of their behaviour, but continues to do it anyway.

- A sense of compulsion, of wanting to engage in a behaviour (such as drug use), but knowing that one really shouldn’t, is the hallmark of addictive behaviour. People talk about a sense of having handed over control to the drug/person/object.
• In wanting to do something very much but knowing that one shouldn’t, behaviour becomes erratic. ‘Bingeing’, ambivalence, secrecy, unreliability, rationalisations and vows of abstention are common.

• Addictive behaviours are only terminated when the individual makes the decision that the costs of continued use are vastly greater than the benefits.

**Socio-cultural model**

This model has become popular in the last 15 years. Unlike other models it focuses on society as whole and not just on individuals. This model is based on the idea that the type of society in which people live has an impact on their drug use. In particular, this model makes links between inequality and drug use. It suggests that people who belong to groups who are culturally and socially disadvantaged are more likely to experience substance abuse problems. It also recognises that society labels users of certain substances as deviant, thereby creating further problems.

Because this model links substance abuse to the conditions of the wider society, the solution to ‘drug problems’ revolves around changing the social environment, rather than treating individuals. This involves developing ways to address poverty, poor housing and discrimination.

**Public health model**

In Australia this approach was launched at the National Drug Summit of 1985. The summit resulted in the National Campaign Against Drug Abuse and later the National Drug Strategy 1992–1997 and 1998–2003. This model continues to guide treatment and prevention programs in Australia. It is an integrated approach and identifies three key factors and the relationships between them.

1. **The agent** – characteristics and effects of the drug itself

2. **The host** – characteristics of the individual or group of users

3. **The environment** – the context of the drug use.

This approach is reflected in the **Interaction model**.
This model is based on the philosophy of **harm minimisation**. This means that we accept that drug use is a reality within our society and that trying to stamp it out is an unreachable goal. The goal therefore is to reduce the harms brought about by certain types of drug use through the following range of intervention approaches.

- **Primary prevention** - The aim is to ensure the problem does not occur in the first place. This may be achieved through:
  - community development
  - drug education
  - media-based strategies

- **Secondary prevention** - The problem is identified in its early stages and intervention is applied to stop further progress of possible problematic drug use.

- **Tertiary prevention** - This is when the problem is considered serious and may be affecting the individual’s health, finances, relationships and/or legally. Treatment may include counselling, hospitalisation etc.

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**Models of drug use**

A group of around 12 young people (mainly boys) aged between 14 and 17, meet each Saturday night in an isolated section of the local park and get drunk.

There have been a lot of complaints from neighbouring residents and some of the young people involved drive cars to and from the park.

You are a local Youth worker and have been requested to handle this complaint. Using the following tables, summarise how you would deal with this situation according to the assumptions of the models of drug use presented in this topic.
Throughout history various models of drug use have been developed:

<table>
<thead>
<tr>
<th>Model</th>
<th>Central Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moral Model</td>
<td>Views addiction as a sin or a moral weakness</td>
</tr>
<tr>
<td>Psychodynamic Model</td>
<td>Asserts childhood traumas are associated with how we cope or do not cope as adults</td>
</tr>
<tr>
<td>Disease Model</td>
<td>Argues that the origins of addiction lie in the individual him/herself</td>
</tr>
<tr>
<td>Social Learning Model</td>
<td>Suggests that dependence behaviours are learned, exist on a continuum and consist of a number of behavioural and cognitive (thought) processes</td>
</tr>
<tr>
<td>Public Health Model</td>
<td>Drug use seen as the interaction between the drug, the individual and the environment</td>
</tr>
<tr>
<td>Socio-cultural Model</td>
<td>Argues that substance abuse should be examined in a wider social context and can be linked to inequality</td>
</tr>
</tbody>
</table>

Distance learners should take time now to reflect on their learning, check in with their facilitator and determine their progress.
4.1 Legal drug use by young people

Substantial community and political concern about illicit drug use among young people has resulted in government actions such as drug summits and funding to address these issues. However alcohol and tobacco – two legal drugs – are also very popular. Young people are using alcohol and tobacco at high rates even before they reach 18 when they are legally able to buy and consume them.
Alcohol and tobacco use among young people

What might be some of the reasons that many young people tend to use legal drugs such as alcohol and tobacco as their drugs of choice?

(Write your answer here, then check the possible answers on the next page.)
Possible answers include:

- relative low cost
- easy availability
- modelling by parents and peers
- marketing
- fear of illicit drugs
4.2 Comparing AOD use patterns of young people and adults

The three most popular recreational drugs in Australia are alcohol, tobacco and cannabis, generally in that order. This is true for both young people and adults.


Table 1: Lifetime use of the drug

<table>
<thead>
<tr>
<th>per cent</th>
<th>Alcohol</th>
<th>Tobacco</th>
<th>Cannabis</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>50</td>
<td></td>
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<td>40</td>
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<td>30</td>
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<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This table suggests that if young people start to use alcohol and tobacco before they are 20 they are likely to keep using these drugs when they become adults. The table also suggests that cannabis use is slightly higher among young people than in the general population.
Factors associated with smoking

The level of tobacco smoking among young people remains a major problem in Australia despite a generation of effort and funding from state and national governments to prevent them from taking up smoking. While there was a reduction in youth smoking rates in the 1980s, smoking rates have risen again since the early 1990s. Smoking is the largest cause of preventable illness and death in Australia. People who start smoking in their teens smoke at a heavier level and are less likely to quit in adulthood. Children of smoking adults are more likely to smoke.

Smoking is strongly associated with social factors, and people from the following groups more likely to smoke:

- lower socio-economic regions
- unemployed
- blue collar workers
- residents of rural areas

Task

What might be some of the reasons that people from certain groups are more likely to smoke?
4.3 Tobacco and alcohol use among young people

Tobacco use

Males and females of all ages have similar patterns of tobacco use.

Table 2: Tobacco use, 14–29-year-olds 2001 (percent)


a) Never smoked more than 100 cigarettes or the equivalent amount of tobacco.

b) Ex-smoker: smoked at least 100 cigarettes (manufactured and/or roll your own) or the equivalent tobacco in their life, but reported no longer smoking.
Alcohol use

Significant numbers of young people consume alcohol on a regular basis, with females consuming less than males.

Table 3: Alcohol use, 14–29-year-olds, 2001 (percent)

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14-19</td>
<td>20-29</td>
</tr>
<tr>
<td>Never consumed a full glass</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>Occasional, less than weekly</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Never consumed a full glass</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Occasional, less than weekly</td>
<td>10%</td>
<td>20%</td>
</tr>
</tbody>
</table>


Men of all ages drink more alcohol than women. However, young people drink significantly more than the general population.
Table 4: Amount of alcohol usually consumed: proportion of recent drinkers aged 14-29 years, by age and sex, compared to all ages.

<table>
<thead>
<tr>
<th>Drinks per week</th>
<th>0</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk Males</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low risk Females</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Risky Males</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Risky Females</td>
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<td></td>
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<tr>
<td>High risk Males</td>
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<tr>
<td>High risk Females</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

Table 5: Consumption by age and sex

<table>
<thead>
<tr>
<th>14-19 years</th>
<th>20-29 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstainer</td>
<td>Abstainer</td>
</tr>
<tr>
<td>Low Risk</td>
<td>Low Risk</td>
</tr>
<tr>
<td>High Risk</td>
<td>High Risk</td>
</tr>
</tbody>
</table>

Where do young people drink?

What are the most likely places for young people to consume alcohol?

(Write your answer here, then check the possible answers on the next page.)
The top five places where young people consume alcohol are:

1. at parties
2. at a friend’s house
3. at home
4. at licensed premises (e.g. clubs and bars)
5. in cafes and restaurants.

- Young women (14–18-year-olds) are more likely to drink at parties, at clubs, at work and in educational institutions (e.g. universities), than are young males. This suggests a more social aspect to their drinking.

- Young men of the same age are more likely to drink at home, in cars and at friend’s houses. However, the most common place for both males and females to drink is at parties.

- Adults are more likely to consume alcohol at home.

What do young people drink?

Young men (14–18-year-olds) drink mainly beer and spirits, whilst young women drink a high proportion of pre-mixed drinks such as UDL, coolers and spirits. Young people tend not to drink wine.

Reflection

Do the facts and figures presented in the tables and graphs in this section fit with your experience of working with young people in your area? What similarities exist? What differences can you identify and why might these differences exist?
Many of the statistics indicate that young women are catching up with young men in their use of cigarettes and alcohol. Is this reflected in your work with young people? Can you suggest some reasons why this might be happening?

Over the past 10 years the level of advertising for alcohol and cigarettes has been greatly reduced. Does advertising still have a significant effect on young people? Why?

Once you have written down your responses discuss them with your colleagues or in a group.
4.4 Marketing of alcohol and tobacco to young people

Alcohol
Advertising for alcohol products remains legal in all forms of media although there are some restrictions. Clearly the manufacturers of alcoholic drinks are trying to make their products appear attractive to young people. People who drink are usually beautiful, sophisticated, sexy and popular – attributes considered very important to young people.

Task

Identify some commercials that target a younger market.

A

(Write your answer here, than check they possible answers on the next page.)
Tobacco

Young people are particularly vulnerable to advertising and marketing. They want to look and act cool. Advertising for tobacco products has virtually ceased in Australia. Sponsorship of sport is one of the remaining ways for tobacco companies to openly market their products. Promotions where attractive young women offer free cigarettes also occur, although this is usually limited to licensed venues.

Tobacco companies now take advantage of one of their last refuges: the retailer selling the tobacco. Called ‘point of sale’ advertising, retailers such as corner shops and service stations often display advertising as well as a large wall of cigarette packets which become de-facto advertising. It seems that tobacco companies are also paying for ‘product placement’ of their brands in films and television to get around the laws and to market their products to young people, who are big filmgoers.

Advertising restrictions vary across Australian states and territories. Some do not allow any ‘point of sale’ advertising and cigarettes are kept under the counter.

Task

Look at cigarette retailers in your area. What restrictions apply?

Possible answers include:

- Archers
- Bacardi Breezes
- Midori Illusions
- Stolleys
4.5 Drug-related deaths and harm among young people

Deaths

Nearly one in five deaths in Australia is drug-related. In 1998, it was estimated that 17,671 Australians died as a result of harmful drug use and over 18,500 Australians would be hospitalised for conditions resulting from harmful drug use.

Tobacco and alcohol were responsible for over 93 percent of death-related mortality and morbidity. Tobacco and opiates figure significantly in the death rates (as the primary cause of death) for adults, while alcohol features much more strongly in the death rates for young people.

Table 6 outlines drug-related deaths among 15−34-year-olds with a comparison of deaths among those over 35.

Table 6: Drug-related deaths 1998
(not including suicide/accidental poisoning)
Harm consequences

Alcohol and other drug use results in health problems in a very large number of young people in Australia (Alcohol in Australia 2001; National Action Plan on Illicit Drugs, 2001).

Some of the AOD-related health consequences for young people are summarised below:

- road traffic injuries
- assault
- depression and self-harm
- cognitive impairment (brain damage)
- overdose (especially with heroin use)
- blood-borne disease such as Hepatitis C and HIV.

Note: Young males have much higher rates of alcohol-related health problems compared to females.
4.6 Information sources on AOD use

Young people arrested for crime have high rates of AOD use. There is a particularly strong link between alcohol and crime. A significant proportion of the following crimes are committed by offenders affected by alcohol at the time of the offence (Williams, 1989):

- murder
- assault – including domestic violence against women
- sexual assault of adults
- theft
- drink driving

Both the perpetrators and victims of alcohol-related violence tend to be young men, with most offences taking place late on Friday and Saturday nights, in or near licensed venues. Alcohol-related violence is also more common in rural communities.

Building a profile of your community

In the following series of exercises you will build a comprehensive picture of the young people and drug issues in your local area. You will need to find out about which drugs are used, where they are used and by whom.

Sources of community information

Think about the sort of information you need to find. Make a list of organisations and services in your local area that might gather relevant statistics.

(Write your answer here, then check the possible answers on the next page.)
Possible sources of relevant data include:

- police data on the extent of drug use and drug-related crime
- hospital and other health services data on drug overdose and other drug-related health problems
- Coroner’s Court data on drug-related mortality
- Ambulance Service data on non-fatal overdose
- alcohol and other drug agency data, such as treatment and referral statistics
- needle and syringe program data
- local court data on drug offences
- school information on student drug use, truancy and so on
- local media stories on drug-related issues in the community.

Community location

Where is your community located?

Research shows that young people from outside capital cities in Australia are more likely to drink alcohol heavily than their city based peers (Williams, 1999). This is probably related to a well entrenched heavy drinking culture in the bush, especially among young men. Rates of tobacco use are also higher in rural areas (National Action Plan on Illicit Drugs, 2001).

It is important to note that while these differences in alcohol and tobacco use are significant, the differences in the rates of use between city and country based young people are not large.

When you are examining the statistics for your area, try to keep a look out for differences with the general population. If you live in a regional or isolated area, try to compare your findings with those of a major city.
Community cultural make-up

What is the cultural makeup of your community? (You can usually get this information from your local council, library or the Australian Bureau of Statistics)

Does your community include many Indigenous Australians? How does the proportion of Indigenous people in your local community compare to the figures for Australia generally? What are the implications (e.g. agency staffing) for your work?

The cultural make-up of your community is obviously very important and will impact on the drug choice of young people in your community.

For example, there is considerable evidence that there are higher rates of smoking tobacco and harmful use of alcohol among Indigenous Australians, compared to other Australians. There are also higher numbers of non-drinkers among the Indigenous population than the broader population. (Drug Statistics, 2000)

While there is a reasonable amount of information available on AOD use among indigenous Australians overall, there is much less information regarding the use of AOD among young Indigenous people. This is partly due to the relatively small numbers of young Indigenous people, as compared to non-Indigenous young people.

While there is a lack of scientific data collected on a large scale, petrol sniffing has been acknowledged as a major problem for some Indigenous communities – especially in rural areas – for over 20 years.
Culturally and linguistically diverse (CALD) groups

Does your community include young people from culturally and linguistically diverse groups?

As with indigenous populations, there is little data available on AOD use among young people from CALD groups. Research conducted in the 1990’s by the Drug and Alcohol Multicultural Education Centre in NSW found that there are some distinct differences in AOD use among people (including young people) from cultures where the first language is not English.

**Alcohol**

- Overuse of alcohol in Australia is much less common among people from CALD groups compared to Australian-born and English-speaking migrants (Alcohol in Australia, 2001).
- CALD communities which do tend to drink alcohol regularly (e.g. Italian and Spanish) are more likely to drink in a less harmful pattern (wine daily with meals), compared to the Australian and English tradition of binge drinking in order to get drunk.
- Alcohol overuse is not common among Arabic, Chinese and Vietnamese speaking communities.

**Tobacco use**

Research by the Drug and Alcohol Multicultural Education Centre in New South Wales found:

- smoking is highest among Arabic speakers (at a higher rate than the general community)
- males in this group are much more likely to smoke than females, but this gender difference reduces with younger people.
- smoking was lowest among Chinese speaking communities, again with women smoking at much lower levels than men.
Young people with psychological disorders

The results from the Australian Survey of Mental Health and Well Being (1997) Australian Bureau of Statistics indicate that people (including young people) with psychological disorders are more likely to abuse alcohol and other drugs. Among young people in treatment for drug and alcohol abuse, there is a high prevalence of psychological disorders including:

- depression
- anxiety
- conduct disorder
- personality disorders
- attention deficit hyperactivity disorder (ADHD)
- schizophrenia
- post-traumatic stress disorder (PTSD)

It must be noted that many homeless young people have not been diagnosed and use AOD to self-medicate.

Information sources

*From your local Area Health Service, find out how many young people in your local area suffer from the disorders listed above.*

Drug information sources

*What sort of drugs are used by young people in your area?*

There are a large number of resources available for accessing information about patterns and prevalence of AOD use in the general community. **Survey reports** are a good source of information about drug use. Surveys are conducted by a variety of organisations on a regular basis.
Obtaining survey reports

Most survey reports can be downloaded from the Internet. For example, the Australian Drug Foundation (www.adf.org.au/drughit/stats/) has a comprehensive list of links to sites where surveys can be viewed and printed. Likewise, most state health departments supply data on AOD use which can often be accessed on their websites.

The librarian at your local library or at your workplace will assist you in obtaining paper copies if you do not have access to the Internet.

Other sources of information

In addition to survey reports, there are many other sources of information about drug use which including:

- Australian Bureau of Statistics (ABS) which conducts and publishes numerous studies relating to patterns and prevalence of AOD use
- mortality and morbidity (death and sickness) data from state and federal health departments
- Australian Institute of Criminology
- police arrest data
- ambulance data
- methadone client urine testing data
- the National Drug and Alcohol Research Centre (NDARC) publishes regular reports on the use, availability and price of illicit drugs
- Australian Institute of Health and Welfare publishes reports on the health of Australians
- Australian customs reports on illicit drug seizures
- Australian Intravenous League (Ivy League) www.aivl.org.au
4.7 Crime and AOD use

Illicit drug use among the general population

The following table has been included as an example of the information that is available.

Table 7: Summary of drug use in the preceding 12 months: proportion of the population aged 14 years and over, Australia wide, 1998

<table>
<thead>
<tr>
<th>Substance</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana/cannabis</td>
<td>30%</td>
</tr>
<tr>
<td>Pain-killers/analgesics</td>
<td>25%</td>
</tr>
<tr>
<td>Tranquilisers/sleeping pills(a)</td>
<td>15%</td>
</tr>
<tr>
<td>Steroids</td>
<td>10%</td>
</tr>
<tr>
<td>Barbiturates(a)</td>
<td>5%</td>
</tr>
<tr>
<td>Inhalants</td>
<td>5%</td>
</tr>
<tr>
<td>Heroin</td>
<td>2%</td>
</tr>
<tr>
<td>Methadone(a)</td>
<td>2%</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>1%</td>
</tr>
<tr>
<td>Cocaine/crack</td>
<td>1%</td>
</tr>
<tr>
<td>LSD/synthetic hallucinogens</td>
<td>1%</td>
</tr>
<tr>
<td>Ecstasy/designer drugs</td>
<td>1%</td>
</tr>
<tr>
<td>Injected illegal drugs</td>
<td>1%</td>
</tr>
<tr>
<td>Ever used any illicit drug</td>
<td>1%</td>
</tr>
<tr>
<td>None of the above</td>
<td>10%</td>
</tr>
</tbody>
</table>


(a) For non-medical purposes.
Patterns of cannabis use

Like adults, the most popular illicit drug among young people is cannabis. Cannabis is used much more widely than other drugs by young people (except at ages of under 14, where inhalant use is more popular) probably because of its easy availability and low cost factors which have a strong impact on drug use.

Cannabis use and young people in Australia

Young people:

• are more likely to smoke hydro cannabis with a bong (water pipe), while older Australians tend to use joints

• tend to smoke stronger potency cannabis (hydro or head), while older adults tend to smoke leaf, which is less potent.

• report that they obtain cannabis from friends or acquaintances, as opposed to a street dealer (85-90 percent).

Note:
The level of cannabis use declines in people over 25.

Q Where are young people most likely to smoke cannabis?

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

In order of popularity:
• friend’s house
• parties
• own home
• public places – e.g. park, beach
• car

Other illicit drug use

When young people use drugs, they tend not to inject – they are more likely to smoke, swallow, snort or inhale. Injecting drugs appears to be a barrier for many young people.

Next to cannabis, the most popular illicit drugs for young Australians are:
• inhalants – especially among those under 16
• benzodiazepines (prescribed sedatives)
• amphetamines – which are usually snorted
• ecstasy – taken as a tablet
• hallucinogens (aka trips) – LSD is usually dissolved on a tiny piece of paper which is swallowed.

Injecting drug use

Injecting drug use has increased significantly in recent years, but remains relatively rare among the general population of under 20’s in Australia. Less than 1.4 percent of 14–19-year-olds injected illicit drugs in 2001.

Lifetime injecting rises to almost 7 percent for Australians 20-29 years, still well below rates of cannabis use. While the rates of injecting drug use remains relatively low in mainstream youth culture, injecting drugs can result in serious harms, including overdose, Hepatitis C and criminal activity (to finance the cost of drugs).
Heroin

In recent years there has been much community concern about the level of heroin use and overdose. This concern has been reflected and/or fuelled by attention by the media and by politicians. Drug Summits have been held in NSW and Western Australia in the late 1990s and early 2000s.

With the level of concern that has been shown, one would expect that the use of heroin among young people would be very high. This is not true. Use of heroin among 14–19-year-olds, that is used at least once in a lifetime is 0.7 percent for males and 1.1 percent for females. A slightly higher incidence is prevalent for 20–29-year-olds showing males use at 5.2 percent and females at 2.0 percent in the year 2001.

Comparing your workplace experience

Does the information contained in this module fit with your experiences with young people? What substances are commonly used by the young people you know or work with? (Discuss some ideas with your colleagues or in groups.)

Complete profile of your community by bringing together all the information you have collected and putting it in a folder. It will give you a clear picture of your local community and it will be useful in supporting your arguments for new or more appropriate services.
• Legal drug use such as alcohol and tobacco consumption among young people is very common and remains a major problem in Australia

• The media portrays alcoholic beverages as being sexy and sophisticated and aims to target a young population, contrary to tobacco advertising which has ceased throughout Australia

• Nearly one in five deaths in Australia are drug-related. Some AOD-related health consequences for young people include road traffic injuries, assault, depression, overdose and infectious diseases

• Statistics claim there is a strong link between alcohol use and crime in young people

• Statistics indicate that young people with psychological disorders are more likely to misuse alcohol and other drugs and have a higher prevalence of psychological disorders.
Topic 5

Factors influencing AOD use by young people

5.1 Systems model

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

A useful way of understanding how young people’s experiences and environment affects them is to look at them through a systems approach.

A systems approach assumes that no aspect of behaviour occurs in isolation without the wider context in which it occurs. In other words, when we try to understand young people, we must consider the individual, their family, the wider community and society as a whole as well as how they interact with each other. Even subtle changes in one part of the system impacts on other parts and can also affect relationships between various systems.
Think about your own adolescence. What kinds of systems impacted on the way that you experienced life? Think about another adolescent that you knew. What kinds of systems impacted on their life?

Systemic youth-focused framework

In applying a systems approach to working with young people we need to acknowledge the following assumptions.

- Young people are normal and deal with challenges in ways similar to other people in society (e.g. some well and 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, beliefs and myths about young people can often determine the way in which they are treated by adults. For example, young people are viewed differently in different cultures.
- Young people are not a homogenous group. Although young people experience some common developmental issues, their backgrounds, experiences and cultures are as diverse as the rest of the population.
- Young people make choices and actively participate in our society. They are not victims of a dysfunctional society, family or peer group.
Other factors that influence young people are:

- developmental stages (differences between a 13-year-old and a 19-year-old, individual differences in reaching developmental milestones)
- socio-economic status (where they are placed in the structure of society),
- culture (the culture they identify with, and their cultural practices)
- gender (biological and social experiences related to that gender)
- sexuality (their sexual identity)
- educational background (type of education, the school they attended and educational experiences)
- family background (foster care, state wards, blended family, single-parent family, traditional family, extended family etc)
- physical attributes (disability or impairment, tall, short, dark-skinned, light-haired etc)
- peer culture (values and beliefs of friends and peers)
- cohort (people who were born in the roughly the same era. Values, beliefs and behaviours of one cohort can be vastly different from those of another).
- interests (hobbies, passion).
5.2 Applying a youth-related systems approach to young people

Approaching young people from a systemic model requires treating each young person as an individual. The aim of the worker is to remain curious about that young person and to find out as much as possible about their background, influences, values, attitudes, passions, interests, goals and abilities.

A systems approach assists workers to be non-judgemental in their approach, seeing each young person as unique rather than part of a group of people with a label while at the same time understanding the influences in that young person’s life.

This approach encourages workers to ask open questions and explore all the facets of the young person’s life. It helps them develop an understanding and respect for each individual young person’s experiences.

Using a systemic approach means engaging with young people in a positive and respectful way being aware of power issues within the helping relationship.

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**Case Study**

*Sam*

A young man *(Sam)* attends your centre. He has dreadlocks, make-up and feral attire. He looks like he has been using a substance.

**Q**

*What are your assumptions about Sam?*

**A**
What would you like to find out about Sam?

What are some ways that you think you may engage with this young man?
The youth-focused systems approach provides a framework for understanding a range of adolescent behaviours. It helps us to understand the context of young people's AOD use by indicating the broad range of factors that affect their lives.

The following diagram illustrates the factors that can influence a young person. Each of the factors involves a complex array of influences and situations which can serve as 'protective' or 'risk' factors in a young person’s life. The kinds of risk or protective factors present in a young person's life can influence the health and wellbeing outcomes for that individual.
SAM

Remember Sam? He is 18 years old and is living in a refuge in the city for young people who identify as same-sex attracted. He left home when he was 15 due to domestic violence in the family. His mother was born in Vietnam and his father is of Anglo-Australian background. Sam has one younger brother. His family of origin are from a working class background.

Sam attended the local state school until year 10. He has limited contact with his family but has a rich network of friends of all ages in the gay community. He was sexually assaulted at the age of 10 by a family friend. He told his father who physically assaulted him for making up stories. He has experienced anxiety, depression and suicidal feelings since the assault. He has not sought counselling about his experiences and has been using alcohol and other drugs since the age of 14 mainly as a way of self-medicating.

Consider the following questions:

What are your assumptions about Sam now?

What would you like to find out about Sam? (Use the diagram on the following page to think about the factors that influence Sam.)

How do you think you could help Sam?
YOUTH-FOCUSED SYSTEMS APPROACH

Risk and Protective Factors

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

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

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

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

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

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

Mature People, Society and AOD - Learner’s Workbook
Distance learners should take time now to reflect on their learning, check in with their facilitator and determine their progress.

- A systems approach is a useful way of understanding how a young person’s experience and environment affects them.

- Factors that influence young people include developmental stages, socio-economic status, culture, gender, sexuality, educational, family, physical, peer culture, cohorts and interests.

- A frontline worker should find out as much as possible about a young person’s background. This can be achieved by applying a youth-focused systems approach framework.

- Once a worker obtains some background information from the young person it is necessary to establish which influences are protective or risk factors.
6.1 What is harm minimisation?

Harm minimisation aims to address alcohol and other drug issues by reducing the harmful effects of alcohol and other drugs on individuals and society. Harm minimisation considers the health, social and economic consequences of AOD use on both the individual and the community as a whole. It has been a key policy of Australian state and federal governments since the 1985 launch of the National Campaign against Drug Abuse and the subsequent National Drug Strategy.

Earlier in this module you looked at values and attitudes to AOD use and patterns of AOD use both by young people and society in general. As with all work on AOD issues, certain values and beliefs underpin the harm minimisation approach.
The harm minimisation approach

The harm minimisation approach is based on the following:

- 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 to different types and patterns of AOD use
- A range of approaches can be used to respond to these harms.

You have already explored a range of models that are used to help understand drug use. Harm minimisation is based on the public health model. According to this approach, AOD use is viewed as the result of the interaction between the following three components: the individual; the social, economic, cultural and physical environment; and the drug itself. Strategies to reduce harm related to AOD use are therefore focused on these three interacting components.

Adapted from Zinberg’s Interaction Model of Drug Use
We can also link the harm minimisation approach to the youth-focused systems approach discussed in Topic 5. The systems approach expands on the public health model by providing a greater emphasis and depth to the environmental factors involved. It increases our awareness of the broader societal and cultural factors, the interactions between different parts of the system and the impact these have on young people and their behaviours. It helps us to see that interventions to reduce harm can be directed at different parts of the system.

Goals and strategies for harm minimisation are wide ranging. The approach is broad enough so that the goals of safer drug use, controlled use and abstinence can all be accommodated.

**Task**

Does your agency have a policy on harm minimisation? If so, briefly outline the policy. Reflect on any harm minimisation strategies that you currently use in your work with young people. Do you think these strategies work well for the young people that you work with? Consider the reasons for your response.

(Write your answer here, then check the possible answers on the next page.)
Harm minimisation strategies can be categorised into three areas:

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

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

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

Suppose that a new illicit drug called Mafu has become a problem in your community. It is a type of amphetamine with a range of negative side effects and has been the cause of sudden death in number of new users. You have been appointed to lead the taskforce in tackling the Mafu issue. What factors would you consider in attempting to reduce the harm associated with using Mafu?

(Write your answer here, then check the possible answers on the next page.)
Possible factors to be considered include:

- the different patterns of use discussed in Schaeffer’s model (i.e. experimental, recreational, social, regular and dependent)
- who is your target group and what you want to achieve
- types of strategies you could use – harm reduction, demand reduction, supply reduction
- different parts of the system that you could target.

In terms of the workplace, what additional harm minimisation strategies could be used with the young people that you work with?

What factors in your workplace could assist you in applying some of these new harm minimisation strategies? How could you make use of these to help you to implement harm minimisation strategies?
What factors in your workplace may be obstacles to you applying harm minimisation strategies with the young people that you work with? How can you try and overcome some of those obstacles?

• Harm minimisation aims to address alcohol and other drug issues by reducing their harmful effects on individuals and society.

• Harm minimisation is based on the public health model, in which AOD use is seen as an interaction between the drug, the individual and the environment.

• Harm minimisation can be categorised into three areas:
  - harm reduction
  - supply reduction
  - demand reduction.
Current policies and legislation guiding AOD work

Overview of current national drug policies and programs

Australia has a range of drug policies and programs that have been developed over the years. The development of legislation and policies should be viewed as an ongoing process that has been influenced by various factors such as changes in government and changes in community values and attitudes. Changes in staff at policy making levels can also influence the direction and purpose of policies and programs.

The National Drug Strategy, launched in 1985 was the starting point for a range of policies based on a harm minimisation approach. These policies have had a significant impact on the everyday work of frontline workers, especially in the way they interact and intervene with young people.

www.nationaldrugstrategy.gov.au
www.drugs.health.gov.au
www.adin.com.au
www.adca.org.au/
www.nationaldrugstrategy.gov.au/nids
www.ceida.net.au
The development of national alcohol and drug policies in Australia featured the following key initiatives:

1985  Launch of the National Campaign Against Drug Abuse
1991  Development of the National Drug Strategic Plan
1993  Launch of the National Drug Strategy
1996  Launch of the National Public Health Partnership

**National Drug Strategic Framework**

The National Drug Strategic Framework provides a national policy framework to reduce the harm caused by drugs. It identifies eight priority areas for action:

1. Increasing the community’s understanding of drug-related harm
2. Building partnerships
3. Links with other strategies
4. Supply reduction
5. Preventing use and harm
6. Access to treatment
7. Professional education and training
8. Research data and development

The National Drug Strategy Household Survey series is the data source used to monitor trends and evaluate the progress of the National Drug Strategy. These surveys provide data on behaviour, knowledge and attitudes relating to drug use among young people aged 14 years and over.
Diversity of approaches to drug issues in Australia

As well as the National Drug Strategic Framework, Australia has developed a range of policies and programs that aim to improve the health, social and economic outcomes for both the community and the individual. These include:

- Prevention efforts which employ the use of social marketing campaigns and the distribution of information products
- Community development projects
- Peer education programs and school-based drug education
- Efforts to help people cease their use and/or help prevent the most harmful consequences of using drugs
- Efforts aimed at disrupting both the supply of illicit drugs entering Australia and the production and distribution of illicit drugs within Australia.
Policies and programs are developed at a national level and provide a nationwide approach to drug issues in Australia. However, each state government has its own programs and policies and these also reflect the political aims and aspirations of the government in power. For example, the NSW Government spent considerable time trialling the use of safe injecting rooms. Policies and programs relating to drug use vary widely from state to state.

Collecting information about your state

*Using some of the information sources you collected in building your community profile, locate and describe some of the policies and initiatives of your state government over the past 20 years? (A great deal of information is available on the web. You should try looking at the site for your state government.)*

Do these policies impact on your day-to-day work? *In what ways?*
7.3 Key stakeholders in the AOD sector

Changes in policy usually result in new or different programs being introduced at a local level. For example, if your organisation adopts a harm minimisation approach, this may result in a whole range of interventions, such as the provision of condom machines or the provision of information about the safe use of illicit substances. Changes in policy therefore have a flow-on effect to many people in the community.

Can you think of some key stakeholders in your local community?

(Write your answer here, then check the possible answers on the next page.)
Some examples of stakeholders include:

- alcohol and other drug workers
- police
- residents
- drug users or their representatives
- lawyers
- local government officers
- youth workers and the young people they work with
- hotel licensees
- pharmacists
- school teachers
- general practitioners
- traders
7.4 Legislation that impacts on work with young people

Areas covered by legislation

Many laws impact on our work with young people. These include laws regulating:

- drugs – legal or illegal status
- mandatory reporting – if you suspect that a child is being physically, emotionally or sexually abused
- confidentiality and privacy legislation – to protect the confidentiality of young people
- duty of care – to reduce or limit the amount of harm or injury to your clients
- OH&S – ensures workers operate in a safe environment to prevent injuries or hazards in the workplace.

Laws regulating drugs

All drugs are regulated to some extent by laws, which can have particular ramifications for young people.

Drug-related laws act as a form of control of drug use and comprise an important part of the harm minimisation approach (in terms of demand reduction and supply control). Psychoactive drugs have legal, illegal or restricted status. In some instances, however, certain substances are illegal for certain people (alcohol for anyone under the age of 18), or in certain places.
Cannabis as a case study

The laws relating to cannabis vary from state or state. Find out about the cannabis laws in your state, and summarise the key points. (The internet is useful for finding current information. Log on to: www.druginfo.nsw.gov.au/druginfo/Legislation.html)

Mandatory reporting

In NSW the Children and Young Persons (Care and Protection) Act 1998 requires all community services and health workers to contact their Community Services Department if they have concerns for the safety, welfare or well being of a child. The Act differentiates between children (under 16) and young people (16-17 years). This is an important distinction to make, as it recognises that older adolescents may be physically and emotionally mature and heading towards financial and social independence.

In most states, you must let your community services department know if you suspect that a child is being physically, emotionally or sexually abused. Mandatory reporting means that you don't have a choice. The law says you must make a report.

Some states (e.g. New South Wales) requires that criminal record checks are undertaken on people who wish to work with children and young people.
Confidentiality and Privacy Legislation

The law generally requires workers to protect the confidential information of their clients. There are certain laws that strengthen clients’ protection. For example, the Commonwealth Privacy Act 1988 and the Privacy and Personal Information Act 1998 (NSW) state that an individual’s personal and family history cannot be divulged to other organisations without their consent and that these records must be kept in a secure place.

The Freedom Of Information Act 1982 states that young people have the right to request access to their personal records. Workers should be careful to be accurate and concise in their client records and avoid recording their assumptions about clients or opinions that are not based on evidence.

Duty of care

As a worker, you have a legal and moral responsibility to keep your clients safe from harm while they are using a service. This responsibility is known as ‘duty of care’.

Workers’ responsibility to reduce or limit any harm or injury can sometimes seem overwhelming. For example, your responsibility to one party (for example, your employer) might conflict deeply with your responsibility to your clients. It helps to remember that duty of care is a balancing act.

Sources of harm

Q Suggest some ways in which a young person might come to harm in your organisation?

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

- Physical injury (from an unsafe environment)
- Physical injury (as a result of violence from other young people or workers)
- Sexual abuse (by another person or a worker)
- Infectious disease
- Misinformation

There are several aspects to duty of care:

**Legal** - What does the law require you to do?

**Professional/ethical** - What do other workers expect us to do?

**Organisational** - What does your organisation, and its funding body, say you should do?

**Community** - What do the parents of our clients and other community members expect you to do?

**Personal** - What do your own beliefs and values suggest you do?

You need to balance the safety of the young person against other concerns such as:

- safety of other people/your personal safety
- other rights that young people have (e.g. the right to privacy)
- aims of the service (e.g. to empower young people)
- limits of your organisation (e.g. money and other resources).
**SULA**

*Sula* visits your centre on a regular basis for counselling. One day she arrives and is clearly very unwell. You think she needs medical attention but she says that she does not want to see a doctor. Are you carrying out your duty of care if you call the doctor yourself?

**What do you think is the right course of action?**

**What would you consider to reach your decision?**
Occupational health and safety (OH&S)

OH&S legislation exists to ensure that workers can operate in a safe environment. Organisations have an obligation to maintain equipment and to put into place strategies to prevent injuries and control hazards in the workplace. This includes adequate provision for the disposal of hazardous waste materials. OH&S legislation also requires organisations to make arrangements for worker’s compensation and obliges them to have detailed emergency plans in the event of a fire or security breach.

Agencies are required by law to develop their own policies to deal with these issues. These policies should also relate to the mental health and wellbeing of workers as stress and burnout are an important consideration for people working in the community services and health fields.

Check the policy and procedure manual at your workplace. Does it contain specific policies relating to preventing and managing stress at your workplace? If not, why not?

What steps could you take to make sure these policies are developed and/or put into action?
Distance learners should take time now to reflect on their learning, check in with their facilitator and determine their progress.
Topic 8

Issues that have shaped the AOD field

8.1 AOD issues

The AOD field is dynamic and fluid and is constantly being shaped by a variety of forces. It is important to be aware of these in order to understand why certain changes have, or have not, happened and to keep abreast with key issues.

In this topic you will examine the key factors that have shaped the sector and focus on a major AOD issue that affects young people in your area and the response to it.
Key factors

Key factors affecting the AOD sector include politics, funding, philosophies, factional battles, research findings, personalities, changes in drug availability and changes in the demographics of people who use. Importantly, all of these factors are interrelated and impact on each other.

Politics

Politics plays a major role in the AOD field. This factor is changeable, however, as it is subject to the philosophical ideas of the government. For example, while the Labor government in Western Australia recently stated that they support consideration of a heroin trial on principle, the Liberal party is opposed to the idea. Because drug issues do not win votes, government policies tend to follow perceived public opinion rather than shape it (Saunders & Marsh, 1999). Consequently, there are numerous instances where governments have failed to follow the recommendations of research in favour of doing what the general public wants. For example, harsher drug-related penalties have been introduced in response to public demand, despite the fact that research shows that the threat of legal consequences fails to deter many users of illegal drugs.

Funding

Heavily impacted by the political agenda, public concern and visibility of the issues, funding exerts a significant influence in the AOD field. For example, given the recent concern raised by families and parents of drug users, more funding has been directed into initiatives targeting this population. As a result, there has been a swing towards increased service provision and research relating to parent and family-based interventions.

Personalities

The personalities of key players in the field have a significant influence on directions taken, funding and community attitudes. If a very vocal and visible but conservative key figure in the field talks about the dangers of harm reduction and pushes for stronger zero tolerance, there may be a corresponding change in policy direction in terms of education, community-based programs, as well as in community attitudes.
Factional battles

For many years, the AOD field has been characterised by factional battles. Perhaps one of the most well known relates to harm reduction versus zero tolerance or ‘abstinence only’ based approaches. While the harm reduction model has become widely accepted, in the early 1990’s there was an uproar when it was suggested that perhaps the community should accept drug use as a fact, and seek to reduce the harm associated with it (Single, 1995) rather than focusing all of our efforts on stopping drug use altogether. A number of people suggested that such a policy was both unethical and untenable and that the only ‘right’ way to approach drug use was to advocate abstinence and support the ‘war on drugs’.

Another famous (or perhaps infamous) factional battle is still going on between proponents of the disease model of addiction and social learning theorists. Such battles influence the AOD field through the manipulation of research topics, community attitudes (through political and media agendas), treatment regimes and even education and training programs.

Drug availability

Drug availability changes according to time and place, not only influencing what people use, but determining research, treatment and professional education and training. For example, recently there was a noticeable reduction in the availability of heroin and a corresponding increase in the availability of methamphetamine and cocaine. Not only has this temporarily altered the nature of drug use and drug-related problems most commonly experienced by drug users (for example, a decrease in overdose and increase in drug-related psychosis) but it has also had wider ramifications for the field as a whole.

The nature of some treatment programs has changed, and in particular the role of pharmacotherapies has been reduced. There has been a decrease in requests for methadone and naltrexone, and an increase in psycho-social treatments and alternative medical responses for stimulant-related problems (Towers, 2002). In line with this trend, there has been a change in the focus of some professional education and training programs, as well as funding for new research programs.
To demonstrate the interaction between the various factors that influence the AOD field, it is interesting to note some of the sources of this change in drug availability. Increasingly, the world is becoming a global village, with the illicit drug trade being one of the largest global industries. World events such as wars, natural disasters, and even changes in weather patterns can significantly alter drug use around the world. For example, when the Taliban came to power in Afghanistan, growing the opium poppy was banned. As a result, the quantity of heroin available in Australia was reduced significantly. At the same time, the manufacture of methamphetamine in Burma increased resulting in an increase in amphetamine availability in Australia. Following the defeat of the Taliban in Afghanistan, changes in heroin availability are thought to be imminent.

Philosophies

Current popular perceptions of drug users and the nature of addiction are important in terms of responding to drug-related issues. For example, in the eighteenth and nineteenth centuries drug users and excessive drinkers were perceived to be moral deviants who lacked willpower and were making a conscious choice to ‘behave badly’. The most appropriate treatment was punishment and most appropriate prevention program was the threat of punishment and the strengthening of moral fibre and ‘good moral values’.

In contrast, the pharmacological model demanded a different response. Both prevention and treatment involved the eradication of the ‘demon drink’ (or other substances). The disease model advocated a more humanistic approach that put addiction into the health realm, whereas the social learning model advocates a multidisciplinary, systemic approach to both treatment and prevention.

Research

The AOD sector is influenced to a large extent by research findings and the strong links between research, practice and education. Australia, in particular, emphasises evidence-based practice, which involves the integration of research and clinical wisdom into education, prevention and treatment. This program follows the evidence-based model in that both research and the experiences of other key stakeholders such as clinicians and clients support its teachings.
For example, until quite recently it was believed that abstinence was the only treatment option for people with addiction-related problems. Research by the Rand corporation and Sobell, Sobell and Davies suggested that controlled drinking (as opposed to abstinence) was an option for some people. While this caused an uproar in the field at the time (and a significant factional battle in which the Sobells were wrongly accused of falsifying data - Heather & Robertson 1989), such treatment outcomes are now well accepted for some populations (such as young people).

**Demographics of drug users**

Who is actually using what also plays a big role in terms of research directions, community attitudes and treatment responses. For example, the National Drug Household Survey (1998) shows that increasing numbers of young people are using drugs at a younger age. This means that greater emphasis is being put into treatment and prevention and education designed specifically for working with young people (such as this training program). Research also shows that, contrary to popular opinion, there are a large number of young professionals who use illegal drugs on a recreational (and sometimes not so recreational) basis (Dale, 2002). As a consequence, some harm reduction and community-based interventions have been developed to target this population.

**Community attitudes**

Largely shaped by the media, community attitudes influence political agendas and funding bodies. In turn, this impacts on the directions in the AOD field. In addition, the more subtle and insidious influences of community attitudes are directly felt by drug users themselves, families and workers in the field. This can shape people’s drug-using patterns (in terms of increasing secrecy of use etc), and also their approach to and experience of treatment. Since alcohol and drug use is so much in the public eye, it is natural that community attitudes are among the most influential of the factors that shape the context of the AOD sector.
Media

The role of the media in terms of shaping community attitudes and political agendas has been mentioned many times in this module. Since we live in such a media-driven society, the media has the power to shape attitudes and responses to AOD issues positively (highlighting the need for funding, giving people good information on AOD use) and negatively (sensationalizing and demonizing drug users and failing to present accurate information and balanced points of view).

Investigating a local AOD issue

Identify a specific issue that you consider is important relating to AOD use by young people in your local community. Select an issue that has generated some interest in the local press.

Examples include:

- the introduction of an alcohol free zone in your main street or at the local beach
- the closure or opening of a needle exchange facility
- the opening of a youth drop-in centre in an area known for drug trading
- fears of the local community about the use of a particular drug (e.g. amphetamines, heroin)
- perceived links between local crime and drug use by young people

What is your issue?
Who are the key stakeholders in this issue? (Who is affected by the issue? Who will have something to say about the issue? Describe their role or their interest in the issue.)

What do your local newspapers have to say about the issue? Can you identify any themes? (Remember to read the letters to the editor as well as the editorials.)

What do your work mates think about the issue? Are they of one opinion or are there a variety of views?
What do you think about this issue? Have you always felt this way or have your views been influenced by the young people with whom you work or your co-workers?

What social, cultural or economic factors impact on this issue? Does the issue relate to a particular group of young people? How does this group compare socially, culturally and economically with the rest of the community?

What research findings exist about this issue? (Use your library or the Internet to find out what is known about the issue or how it has been dealt with in other communities.)
How have the key stakeholders in your community responded to this issue? Does the response of your local community fit with a harm minimisation approach, an abstinence model, or some other model? Can you identify why?

Does this issue impact on your organisation? Has it responded in any particular way?

In your opinion, how should this issue be dealt with? Can you identify any possible blocks to your solution? (Consider local politics, funding limitations and the impact on young people)
Can you think of any strategies for overcoming these obstacles?

The AOD sector is a dynamic and fluid area that is constantly changing as a result of:

- politics
- funding
- philosophies
- factional battles
- research findings
- personalities in the field
- changes in drug availability
- changes in the demographics of people who use

All these factors are interrelated and impact on each other in the AOD sector.
9.1

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

- Identify your own personal values and attitudes regarding AOD issues and their implications for working with young people on AOD issues
- Describe current models used to understand drug-use behaviour
- Describe patterns and prevalence of drug use by young people
- Discuss a broad range of factors that can impact on AOD use by young people
- Outline harm minimisation and other current policies and frameworks that underpin AOD work with young people.

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

As you can see, the AOD sector is constantly being shaped by a variety of influences. Topic 8 gives you an idea of the breadth of issues important to the AOD sector.

This module has highlighted the important role of economic, political and social factors in determining AOD use as well as our responses to it. Models for understanding AOD use have been presented and explored as well as patterns of use and legislative and policy responses to AOD issues. Our own personal responses to AOD issues have also been examined.
9.3 Self-reflection activity

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.

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

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

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

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


**Websites**

An excellent website, with details descriptions of major disorders and links to many high quality mental health and AOD-related sites

www.mentalhealth.com

Australian Institute of Criminology


Australian Institute of Health and Welfare

www.aihw.gov.au

Commonwealth Department of Health and Ageing


Drug and Alcohol Multicultural Education Centre

www.damec.org.au

Drug Arm (This site is particularly focused on youth issues):

www.drugarm.org.au
Drug Info Clearinghouse – The drug prevention network
druginfo.adf.org.au

National Drug Strategy
www.nationaldrugstrategy.gov.au

National Drugs Campaign
www.drugs.health.gov.au

National Illicit Drug Strategy (NIDS)
www.nationaldrugstrategy.gov.au/nids

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

The Australian Drug Foundation (ADF)

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

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

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

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

Useful summaries of youth AOD use in WA and nationally

The Centre for Youth Drug Studies is within the ADF:
Abstinence | Refraining from drug use.
Binge | A lengthy episode of very heavy drinking that produces extreme intoxication.
Cognitive | A person’s thought processes.
Community | A broad group of people (who may live close together, but do not necessarily live in the same area), who share common social structures and goals and engage in a wide range of activities in an interdependent, mutually advantageous, and empowering manner.
Compulsive drug use | Frequent daily doses and experiencing withdrawal symptoms.
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 which involves changes in mood or behaviour due to alterations in brain function.
Drug dependence | Anyone who relies on and regularly seeks out 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.
Experimental drug use | Single or short-term use of a drug.
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.
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<th>Key terms (continued)</th>
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<tr>
<th><strong>Harm-reduction</strong></th>
<th>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.</th>
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<tbody>
<tr>
<td><strong>Health promotion</strong></td>
<td>The process of enabling people to improve their health</td>
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<td><strong>Intensive drug use</strong></td>
<td>High doses – binge.</td>
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<td><strong>Intersectoral collaboration</strong></td>
<td>Coordination of interventions by agencies from different sectors or industries</td>
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<tr>
<td><strong>Intervention</strong></td>
<td>A purposeful activity designed to prevent, reduce or eliminate AOD use at an individual, family or community level.</td>
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<tr>
<td><strong>Intoxication</strong></td>
<td>Any alteration whatsoever in our perception, mood, thinking processes and motor skills as a result of the impact of a drug(s) on our central nervous system.</td>
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<tr>
<td><strong>Overdose</strong></td>
<td>The use of a drug in an amount that causes acute adverse physical or mental effects. Overdose may produce transient or lasting effects and can sometimes be fatal.</td>
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<tr>
<td><strong>Poly-drug use</strong></td>
<td>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.</td>
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<tr>
<td><strong>Prevention strategies</strong></td>
<td>Interventions which aim to prevent people from taking up drugs (e.g. reducing tobacco sales to minors) and to prevent those using AOD from using AOD in a harmful way (e.g. promoting safe levels of drinking).</td>
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<tr>
<td><strong>Protective factors</strong></td>
<td>Those factors that enhance the coping abilities of a young person thus increasing active participation in community activities and decreasing susceptibility to adverse consequences.</td>
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<tr>
<td><strong>Psychotherapy</strong></td>
<td>Non-pharmacological treatment of psychiatric disorders utilising a wide range of strategies, from simple education and supportive counselling to insight-oriented, dynamically based therapy.</td>
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### Key terms (continued)

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td><strong>Recreational drug use</strong></td>
<td>Controlled use in a social setting.</td>
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<tr>
<td><strong>Resilience</strong></td>
<td>This is the ability of an individual to face particular difficulties (such as abusive situations, living in poor conditions and having a non supportive family), yet not necessarily go on to develop problem/risk behaviours. It describes the capacity of a person to respond in a positive way to the risks, stresses, and adversities of life.</td>
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<tr>
<td><strong>Risk taking</strong></td>
<td>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, having unprotected sex while intoxicated).</td>
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<tr>
<td><strong>Stakeholders</strong></td>
<td>An individual or group who holds an interest or stake in the issue under investigation.</td>
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<tr>
<td><strong>Stimulants</strong></td>
<td>Drugs that speed up the brain and nervous system.</td>
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<tr>
<td><strong>Withdrawal symptoms</strong></td>
<td>Symptoms that can occur when a person using a drug over a prolonged period reduces or ceases use.</td>
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