ALCOHOL AND DRUG USE AMONG YOUNG PEOPLE

Youth Friendly Doctor Program
Rural Health West Aboriginal Health Conference 2017

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Drug and Alcohol Youth Service (DAYS)
The adolescent brain
Figure 2.1. Aboriginal and Torres Strait Islander population, by age group — 2008 and 2014–15
Overview of Presentation

- Types of psychoactive drugs
- Statistics – Young People
- Reasons for drug use
- Engagement / Health Screening
- Assessment of Drug Use
- Brief Intervention / Motivational Interviewing
- Steps in Practice + Referrals
- DAYS
- Questions / Case Studies
What is a drug?

A drug is a substance, other than food, which is taken to change the way the body and/or mind function. Psychoactive drugs – affect the CNS.
What are the main drug types?

• Depressants
• Stimulants
• Hallucinogens
• Others/Mixed
Depressants

• Slows down the CNS
• Affect concentration and co-ordination
• Larger quantities may cause unconsciousness – death
• Include
  – alcohol, barbiturates, benzodiazepines, cannabis, gammahydroxybutyrate (GHB), promethazine
  – opioids – heroin, morphine, codeine, methadone, oxycodone, buprenorphine, fentanyl, pethidine
  – “Lean” - codeine, promethazine, benzodiazepine
What is Cannabis?

• Delta9 tetrahydrocannabinol (THC)
  – Psychoactive – activation of the endogenous cannabinoid system
  – Highly lipid soluble
  – Depressant/hallucinogenic properties

• Impact on cognition/mental health – acute vs chronic
  – Increased risk of affective disorders and psychosis
A Visual Guide to Cannabis Quantities

- Half Gram
- Gram
- Eighth Ounce
- Quarter Ounce
- Half Ounce
- Ounce
- Half Gram

Note: Size dependent on flower density
For more info: leafly.com/knowledge-center
Withdrawal

- A process of physical and psychological adjustment to a drug free state
- Can involve physical and emotional distress
- Wide range of withdrawal symptoms
- Broadly speaking, clinical presentations tend to be opposite to the effects of the drug
- If effect of a certain drug is to sedate and relax then withdrawal may result in anxiety and agitation
Depressant Withdrawal

- Anxiety, tremor, sweating
- Increased PR, BP, RR
- Hypersensitivity to stimulation e.g. noise, bright lights
- Nausea and vomiting
- Diarrhoea
- Opiate withdrawal signs include runny nose, watery eyes and goosebumps
Cannabis withdrawal

Figure 7: Symptoms and duration of cannabis withdrawal

Source: NSW Health (2008, p.44)
Alcohol withdrawal

Figure 3–3
Progress of alcohol withdrawal syndrome
Source: NSW Health (2000, p. 41)
Benzodiazepine withdrawal

Figure 5: Symptoms and duration of benzodiazepine withdrawal
Opioid withdrawal

Stage I: Up to 8 hours
- Anxiety
- Drug craving

Stage II: 8–24 hours
- Anxiety
- Insomnia
- GI Disturbance
- Rhinorhea
- Mydriasis
- Diaphoresis

Stage III: Up to 3 days
- Tachycardia
- Nausea, vomiting
- Hypertension
- Diarrhea
- Fever
- Chills
- Tremors
- Seizure
- Muscle spasms
Stimulants

• Speeds up the CNS
• Make a person feel more awake, alert, and confident
• Increase talkativeness, libido
• Dilate pupils, increase heart rate, body temperature, blood pressure, jaw clenching, cardiac/pulmonary toxicity
• Reduce appetite, sleep disturbance, weight loss, agitation/anxiety/psychosis/depression, poor teeth/skin
• Includes - amphetamines (speed, ice, meth), dexamphetamine, cocaine, ecstasy (MDMA), nicotine, caffeine
What is meth?

• **Amphetamines/Methamphetamine**
  - derived from phenylethylamines;
  - structural similarities to adrenaline

• **Acts indirectly to cause release of**
  - dopamine, norepinephrine, epinephrine, and serotonin
  - Can result in a sympathomimetic toxidrome
Stimulant Withdrawal

- Depression, tiredness, lack of energy
- ‘Crashing’ – a period of low energy levels and lethargy following use.
- Increased appetite
- Depressed mood state
- Restlessness and agitation
Amphetamines

“Run Crash Run” cycle

**Speeding phase**
- Using ++
- No sleep
- No food
- Paranoia
- ?Psychosis

**Level of arousal**

**Early Withdrawal phase**
- Aggression
- Mood swings
- Irritability
- Sleep disorder
- Cravings

**Crash phase**
- Tiredness
- Eating+++ (Day 3)
- Irritability

**Speeding phase**
- Using ++
- No sleep
- No food
- Paranoia
- ?Psychosis

**Crash phase**
- Tiredness
- Eating+++ (Day 3)
- Irritability
Amphetamine withdrawal

- Is thought to be longer than alcohol/heroin in the acute phase, and with an exceptionally long protracted phase.
DECREASED BRAIN FUNCTION IN METHAMPHETAMINE ABUSER

Healthy Control  
Drug Abuser

Methamphetamine abusers have significant reductions in dopamine transporters.
Figure 2. Partial Recovery of Brain Dopamine Transporters in Methamphetamine (METH) Abuser After Protracted Abstinence

Normal Control  METH Abuser (1 month detox)  METH Abuser (14 months detox)

Hallucinogens (psychedelics)

• Distort a person’s perception of reality
• Sense of psychological euphoria and well being
• Increased activity, talking, laughing
• Dilated pupils, jaw clenching, sweating
• Loss of contact with reality
• Irrational or bizarre behaviour, paranoia, psychosis, may experience “flashbacks”
• Includes - LSD, ketamine, magic mushrooms, PCP, DMT, mescaline, THC and MDMA
Others/mixed

- **Solvents/Volatile substances**
  - Petrol, paint, aerosol spray cans, glue, correction fluid

- **Other inhalants**
  - Nitrous Oxide, amyl nitrate, butane

- **rapidly absorbed into the blood stream**
  - euphoria, laughing, hallucinations, delusions, confusion/disorientation
  - Drowsiness, slurred speech, decreased coordination, headaches, nausea, diarrhoea, nose bloods, cardiac arrhythmia
## Approximate prices

<table>
<thead>
<tr>
<th>SUBSTANCE</th>
<th>MEASURE</th>
<th>METRIC EQUIVALENT</th>
<th>APPROXIMATE COST (PERTH, 2017)</th>
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<tbody>
<tr>
<td>HEROIN Or METHAMPHETAMINE</td>
<td>Weight or Gram</td>
<td>1g</td>
<td>$600-$800</td>
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<tr>
<td></td>
<td>Half weight</td>
<td>0.5g</td>
<td>$350-$400</td>
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<tr>
<td></td>
<td>One quart</td>
<td>0.25g</td>
<td>$200</td>
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<td></td>
<td>Street Q</td>
<td>0.2g</td>
<td>$150</td>
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<td></td>
<td>One point</td>
<td>0.1g</td>
<td>$100</td>
</tr>
<tr>
<td></td>
<td>An ounce</td>
<td>28g</td>
<td>$8000</td>
</tr>
<tr>
<td></td>
<td>An eight ball OR</td>
<td>3.5g (1/8 oz)</td>
<td>$1500-$2000</td>
</tr>
<tr>
<td></td>
<td>ball</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CANNABIS</td>
<td>A stick</td>
<td>1g</td>
<td>$25-$30</td>
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<tr>
<td></td>
<td>An ounce</td>
<td>28g</td>
<td>$350</td>
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</table>
ASSAD Survey 2014

• Australian School Students Alcohol and Drug Survey
  • Every three years, school students in Western Australia are surveyed to find out about their drug use.
  • Asked about how often they consume alcohol, tobacco, other illicit and licit drugs - how much they use, how they use and their attitudes to alcohol and other drug use.
  • Data collected since 1984.
  • The most recent survey included 3,305 young people aged from 12 to 17 years from 46 randomly selected government, Catholic and independent schools across the State.
  • More information on these surveys is available at: www.dao.health.gov.au.
Figure 2: Prevalence and recency of illicit drug use for students, 2014

- Any illicit: Past week 6.3%, Past month 10.0%, Past year 17.0%, Lifetime 19.5%
- Cannabis: Past week 5.6%, Past month 9.9%, Past year 16.4%, Lifetime 19.2%
- Tranquilisers*: Past week 3.2%, Past month 5.3%, Past year 13.4%, Lifetime 19.9%
- Inhalants: Past week 4.9%, Past month 10.4%, Past year 16.0%
- Amphetamines*: Past week 1.1%, Past month 1.6%, Past year 2.8%, Lifetime 3.5%
- Ecstasy: Past week 3.3%, Past month 1.8%, Past year 31.1%, Lifetime 3.6%
- Hallucinogens: Past week 0.9%, Past month 1.2%, Past year 2.7%, Lifetime 1.3%
- Steroids*: Past week 1.3%, Past month 1.6%, Past year 2.4%, Lifetime 3.0%
- Cocaine: Past week 1.2%, Past month 1.3%, Past year 1.9%, Lifetime 2.5%
- Heroin and other opioids: Past week 0.0%, Past month 1.0%, Past year 1.7%, Lifetime 2.1%

Legend:
- Past week
- Past month
- Past year
- Lifetime
Figure 1: Prevalence and recency of alcohol use for students aged 12 to 17 years, 1984 to 2014
Figure 1: Trends in the use of at least one illicit drug, 1996 - 2014
Prevalence and Recency of Cannabis use 2008 ASSAD – age 12-15 years
### Figure 2.3: Proportion of daily smokers, lifetime risky drinkers and illicit drug users, people aged 14 or older, by selected characteristics, 2013

<table>
<thead>
<tr>
<th>Category</th>
<th>Daily smoking</th>
<th>Risky drinkers (lifetime)</th>
<th>Illicit use of any drug</th>
<th>Cannabis</th>
<th>Misuse of pharmaceuticals</th>
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<tr>
<td>Major cities</td>
<td>11.0</td>
<td>16.7</td>
<td>14.9</td>
<td>9.8</td>
<td>4.5</td>
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<tr>
<td>Remote/very remote</td>
<td>22.2</td>
<td>34.9</td>
<td>18.7</td>
<td>17.6</td>
<td>6.6</td>
</tr>
<tr>
<td>Lowest SES</td>
<td>10.9</td>
<td>15.6</td>
<td>15.9</td>
<td>10.3</td>
<td>5.6</td>
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<tr>
<td>Highest SES</td>
<td>4.7</td>
<td>18.4</td>
<td>15.0</td>
<td>10.0</td>
<td>3.3</td>
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<tr>
<td>Indigenous people</td>
<td>31.6</td>
<td>22.7</td>
<td>24.3</td>
<td>19.0</td>
<td>6.9</td>
</tr>
<tr>
<td>Homosexual/Bisexual</td>
<td>23.5</td>
<td>28.8</td>
<td>38.6</td>
<td>28.8</td>
<td>11.3</td>
</tr>
<tr>
<td>Employed</td>
<td>13.9</td>
<td>22.6</td>
<td>16.8</td>
<td>11.9</td>
<td>3.3</td>
</tr>
<tr>
<td>Unemployed</td>
<td>22.8</td>
<td>18.8</td>
<td>24.5</td>
<td>18.5</td>
<td>7.3</td>
</tr>
<tr>
<td>Total (people aged 14 or older)</td>
<td>12.8</td>
<td>18.2</td>
<td>15.0</td>
<td>10.7</td>
<td>3.3</td>
</tr>
</tbody>
</table>

- Green circle: Decreased from 2010
- Purple circle: Increased from 2010

Monitoring trends in the prevalence of petrol sniffing in selected Australian Aboriginal communities 2005-2014

Figure 2-1: Number of people sniffing in 17 communities 2005-06 to 2013-14

<table>
<thead>
<tr>
<th></th>
<th>2005-06</th>
<th>2007-08</th>
<th>2011-12</th>
<th>2013-14</th>
</tr>
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<tbody>
<tr>
<td>Total</td>
<td>647</td>
<td>287</td>
<td>98</td>
<td>78</td>
</tr>
</tbody>
</table>

Trends in individual regions are more varied, reflecting local factors, including the progressive regional rollout of LAF, which commenced in 2005.
Figure 5-2: Trends in total number of people sniffing petrol, by region
Figure 5-3: Total number of people sniffing in selected communities, 2005-06 to 2013-14, by age-group
WA Waste Water Analysis

Methylenedamine Consumption (doses/week/1,000 people)

- Bunbury
- Kalgoorlie
- Broome
- Geraldton
- Perth Metro

Data from Jul-15 to Apr-17
Reasons for Drug Use

• To experiment/out of curiosity/to have fun
• Peer pressure or to create a sense of belonging
• Boredom
• To “block out” problems
• Identity
• Reaction against authority
• “self medication” for anxiety/depression/stress
• Social environment
### Risk Factors vs Protective factors

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Domain</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Aggressive Behavior</td>
<td>Individual</td>
<td>Impulse Control</td>
</tr>
<tr>
<td>Lack of Parental Supervision</td>
<td>Family</td>
<td>Parental Monitoring</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Peer</td>
<td>Academic Competence</td>
</tr>
<tr>
<td>Drug Availability</td>
<td>School</td>
<td>Antidrug Use Policies</td>
</tr>
<tr>
<td>Poverty</td>
<td>Community</td>
<td>Strong Neighborhood Attachment</td>
</tr>
</tbody>
</table>

*Preventing Drug Use among Children and Adolescents*
Factors contributing to illicit drug use among Aboriginal and Torres Strait Islander people

- **Historical factors**
  - European colonisation, loss of traditional lands and customs, social and economic exclusion, stolen generation, intergenerational trauma

- **Social Factors**
  - Education, Employment, Income
  - Complex Trauma
  - Boredom/Peers
  - Family/Community – can be protective
  - Barriers to Access
Treatment Approach with Young People

• Provide the young person with treatment options/be collaborative
• be multidimensional e.g. psychological, accommodation, education/training
• include the family
• be flexible in approach – alternative mediums
• address co-morbid mental health issues
• provide practical coping strategies
• include harm reduction strategies
Importance of Intervening

- Reduce risks – early intervention
- Impact on longitudinal trajectory of AOD problems
- Provide them with a positive help seeking experience
Confidentiality

• Major concern for a young person
• Legal right for competent adolescents “mature minor”
• Competence – ability to understand the consequences of what is being discussed
• 3 main exceptions
  – At risk of harming themselves or suicide
  – Risk of harming someone else
  – At risk of being harmed by someone else or hx of sexual abuse
HEADSS Screen

• H - Home
• E - Education
• A - Activities and Peer relationships
• D – Drug Use + Alcohol
• S – Sexuality
• S – suicide, self harm, depression/psychosis, safety
Considerations when working with Aboriginal and Torres Strait Islander Young Persons

• Who is the best person for the young person to talk to?
  – Indigenous, Male, Female – would they like a support person?
• Introduce yourself by first name/share information about yourself
• Find out where the young person is from?
• Try to make a connection before asking about drug use
• It may be that silence is ok, limited eye contact is ok
• Extended family is important + involving indigenous support
• Develop trust over time, learn about the local community, customs, and language
Brief Wellbeing Screener

Any problems with...

Family worry
Tip: Is there anything with family you are worried about?

Feeling anxious, nervous or jumpy

Gunja, grog, sniffing, tobacco or other drugs

Too much energy, can't slow down
Tip: Some people have times when they have too much energy, they talk all the time and think too fast. This may be a 'manic' episode.

Being alone, not mixing well with others
Tip: Is this more than usual?

You should ask for help from your health centre if you are having some or big worries about any of these problems. You can also link in with family members, community groups, spiritual or cultural mentors and/or traditional healers.

www.nt.gov.au/health
Brief Wellbeing Screener

Or problems with...

Feeling sad inside, no interest in doing things

Mixed up thoughts, paranoid or silly thinking
Tip: Some people think people are going to hurt them, that they have special powers or that other people can hear their thoughts.
Thinking like this is common when someone has a psychotc illness.

Hearing voices or seeing things

Thoughts of suicide or self-harm

Violent, strange or silly behaviour

You should ask for help from your health centre TODAY if you are having some or big worries about any of these problems. You can also link in with family members, community groups, spiritual or cultural mentors and/or traditional healers.
Assessing Drug Use

• Rapport/Engagement
  – Introduce yourself to the young person first

• Advise that it is best to see the young person alone (unless support person/parent requested)

• Discuss
  – Reasons for enquiring
  – Benefits of accurate information
  – Confidentiality/Privacy

• Be non-judgmental/do not lecture
Drug Use Assessment

• Pattern of Use
• Degree of Dependence
• Impact of Use
• Readiness to Change
Patterns of drug use

- Experimental
- Occasional
- Recreational
- Regular
- Dependent
Assessing Pattern of Drug Use

- Quantity and frequency of use, time of day
- Mode of use
- Environment of use
- Last period of use
- Recent periods of abstinence
Dependence/Substance use disorder

- **Tolerance** – needing to use more of a drug to get the same effect
- **Withdrawal** - unpleasant symptoms when ceasing
- **Impaired Control** - A persistent desire to use and unsuccessful efforts to control use
- **Social Impairment** - Important activities are given up or reduced
- **Risky use** - Continuing use despite knowledge of physical or psychological problems
DSM 5 Substance Use Disorder Criteria

The DSM-5 defines a substance use disorder as the presence of at least 2 of 11 criteria, which are clustered in four groups:

1. **Impaired control:** (1) taking more or for longer than intended, (2) unsuccessful efforts to stop or cut down use, (3) spending a great deal of time obtaining, using, or recovering from use, (4) craving for substance.
2. **Social impairment:** (5) failure to fulfil major obligations due to use, (6) continued use despite problems caused or exacerbated by use, (7) important activities given up or reduced because of substance use.
3. **Risky use:** (8) recurrent use in hazardous situations, (9) continued use despite physical or psychological problems that are caused or exacerbated by substance use.
4. **Pharmacologic dependence:** (10) tolerance to effects of the substance, (11) withdrawal symptoms when not using or using less.*

* Persons who are prescribed medications such as opioids may exhibit these two criteria, but would not necessarily be considered to have a substance use disorder.

*mild* (2–3 criteria) to *moderate* (4–5 criteria) and *severe* (6 or more criteria)
Assessing Impact of Drug Use

• Illness & Disease including mental health problems and loss of fitness
• Accidents and Injuries involving self or others inc. MVA
• Violence & Crime including fights and legal problems
• Family and Social Disruption including family disputes or accommodation problems
• Workplace and Economic Concerns including educational/employment problems and financial difficulties; and
• any other identified impacts
Stages of Change

Figure 15 - The stages of change
Brief Intervention

• Pro-active approach to detecting and intervening in hazardous and harmful substance use
• Assessment of young person’s substance use
• Assess readiness to change
• Provide feedback, information and structured advice
• Goal setting + further engagement
• Typically 5-20 mins
Motivational Interviewing (MI)

- Express empathy
  - reflective listening, make affirmations, non-judgemental approach, does not mean the problematic behaviour is condoned

- Develop discrepancy
  - identify discrepancies between current behaviour and future goals
  - Pros and cons of substance use and change/ quitting

- Roll with resistance

- Support Self Efficacy
Combine with Stages of Change model

• **Precontemplation (not ready)**
  - Raise doubt, increase perception of the risks and problems
  - Harm reduction strategies

• **Contemplation (getting ready)**
  - Weigh up pros and cons of change, identify reasons for change + risks of not changing
  - Increase confidence in ability to change

• **Preparation (ready)**
  - Clear goal setting, help develop a realistic plan

• **Maintenance (sticking to it)**
  - Help identify strategies to prevent relapse

• **Relapse (learning)**
  - Opportunity to learn, help renew process
Strategies examples

• Educate about possible withdrawal symptoms
• Avoid high risk situations
• Spend time with people who do not use drugs
• Expect there will be urges –
  - before using
    Delay / Distract / De-catastrophise/ De-stress
    Call a support person
• Plan ahead
• Gradually cut down before quitting
What are the **good** things about using?

- 
- 
- 

What are the **not so good** things about using?

- Feel sad, angry or nervous
- Feel sick
- Feel paranoid and anxious
- No money
- Poor memory
- Health problems
- Cause family fights
- Don’t want to work

What keeps us strong?

**Physical**
- Eating well
- Keep exercising
- Drink lots of water

**Family, Social and Work**
- Money
- House
- Cars

**Spiritual and Cultural**
- Music
- Dance
- Culture

Things that make changing difficult...

- My friends won’t support me
- Bored, nothing else to do
- Having trouble sleeping
- Worry and stress

Who keeps us strong?

- Healthy and happier
- Kids and family happy
- More money for food, clothes, car

Good things about changing...

- 
- 
- 
Steps – in practice

- **Engagement** - discuss confidentiality, be culturally appropriate
- **HEADSS screen/715**
- Opportunistic brief intervention/motivational interviewing
- Ceasing drug use not likely to be the young person’s agenda
- If drug use – assess dependence, readiness to change, mental health ?anger mx ?anxiety mx
- General lifestyle advice – exercise, nutrition, sleep, relax
- BBV +/- other bloods/STI testing if appropriate
- Negotiate goal setting with follow up
The next visit

- The next visit - “how have you been?”, “how did you go with your plans?” - find a positive
- Ongoing assessment/education + Motivational interviewing,
- Mental Health plan/K10/Wellbeing screen
- Consider referral/Collaboration
  - Local programs, AADS, Headspace, Regional CADS, CAMHS, DAYS, Private psychologist, Teen challenge, Bush mob
- Don’t forget the family
- Lifestyle advice
- Negotiate a plan/strategies and follow up
Role of medication

• Detoxification medication – often not needed
  – Benzodiazepines – only in a controlled environment and used in cases of dependence
  – Symptomatic medication – eg metoclopramide

• NRT

• Alcohol relapse prevention
  – Lack of evidence
  – Naltrexone, acamprosate, disulfiram

• Opiate Replacement

• Consider Naloxone
Regional Alcohol and Drug Services

• Wheatbelt Community Alcohol and Services
• South West Community Alcohol and Drug Services
• Great Southern Community Alcohol and Drug Services
• Midwest Community Alcohol and Drug Services
• Goldfields Community Alcohol and Drug Services
• Pilbara Community Alcohol and Drug Services
• Kimberley Community Alcohol and Drug Services
Useful Websites and Resources

- www.strongspiritstrongmind.com.au
- drugaware.com.au
  - Strong spirit strong mind
  - Parent and family drug support line – (08) 94425050
  - Alcohol and Drug support line – (08) 94425000
  - Meth helpline – 1800 874 878
- www.menzies.edu.au
- www.healthinfonet.ecu.edu.au
- headspace.org.au
- cannabissupport.com.au
- www.adf.org.au
- www.mhfa.com.au
The Drug & Alcohol Youth Service

is a partnership between
Mission Australia and Next Step.

The service provides individuals and their families with a comprehensive range of alcohol & other drug service.
Case Management, Withdrawal & Respite and Residential Rehabilitation services are provided for young people aged 12 to 18 years with some flexibility up to the age of 21 yrs.
Service Range

- Comprehensive Assessment
- Case Management
- Individual counselling
- Medical Assessment & review
- Clinical Psychological services
- BBV screening and immunisation
- Group programs
- Aboriginal and Youth Mentor
- Opiate and alcohol pharmacotherapy
- Parent and family counselling
- Complimentary Therapies
- YPOP
- Assessment & Counselling in detention
- Liaison & shared care with external agencies
Community Support

- Clients can be seen on an outpatient/community basis.
- Most appointments are made at the Hill Street site, but there is some limited capacity for outreach appointments.
- The case manager coordinates the client’s treatment including:
  - Establishing treatment goals and plans
  - Providing 1-1 drug and alcohol counselling
  - Referral to secondary treatment services within DAYS (Medical Nursing, Clinical Psychology, Parental/Family treatment, Mentoring)
  - Liaison with other agencies involved and possible shared care arrangements.
Withdrawal & Respite

- **Aim**: To provide a free, supportive and structured environment which is youth friendly and non-clinical in its approach. Its focus is also to provide both a safe physical and emotional place to withdraw from drugs.

- **5 bed residential facility** which offers 24 hour supervised supportive care for young people requiring a low medical withdrawal service.

- **2 to 3 week program**

- **Holistic treatment approach** including access to a medical practitioner, clinical nurse, clinical psychologists & complementary therapies.

- **Structured program** from a harm minimisation approach including AOD education & information, an opportunity for rest, relaxation & is nutrition balanced. It also includes life skills training and positive leisure activities.
Residential Rehabilitation

- **Aim**: To provide young people with a youth friendly supportive and structured environment to complete a drug and alcohol residential rehabilitation. Its focus is also to provide both physical and emotional safety while they engage in treatment to transition back into the community.

- **10 bed residential facility**

- **12 week program**

- **Holistic treatment approach** including access to a medical practitioner, clinical nurse, mentors & clinical psychologists.

- **Structured Day program** from a harm minimisation approach including AOD education & information, life skills, recreational activities and onsite support from case managers and other staff who can assist with referrals to JPET, accommodation, mental health support services.
Accessing DAYS

Referrals can be made by contacting a duty officer Monday to Friday 12.30 to 4.00pm.

Agencies are encouraged to complete the Integrated Community Drug Service Fax Referral Form.

Where possible the duty officer will contact the young person prior to booking an assessment.

Assessments are generally conducted at 129 Hill St. East Perth. There is limited capacity for community or phone assessments.

If deemed appropriate for the service, young people will be allocated a case manager at daily allocation meetings.

Admission into any of the residential programs will depend on their current wait list.
Rural Referral to DAYS considerations

- Age/Maturity level
- Motivation
- Culture and Lifestyle
- Support Person/Exit Plan
- Drug Use and Exposure to Criminal Behaviour
- Health Review
Table 11. Services by pillar of harm minimisation and type of prevention

<table>
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<tr>
<th></th>
<th>Demand reduction</th>
<th>Supply reduction</th>
<th>Harm reduction</th>
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<tbody>
<tr>
<td><strong>Primary prevention</strong>&lt;br&gt;(preventing the uptake of drugs)</td>
<td>▪ Addressing social determinants&lt;br▪ Recreational activities&lt;br▪ Education&lt;br▪ Health promotion campaigns</td>
<td>▪ Law enforcement</td>
<td></td>
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<tr>
<td><strong>Secondary prevention</strong>&lt;br&gt;(minimising the harms of short-term use; preventing drug dependency)</td>
<td>▪ Brief interventions&lt;br▪ Diversion of offenders&lt;br▪ Education&lt;br▪ Health promotion campaigns&lt;br▪ Primary health care&lt;br▪ Community-based treatment&lt;br▪ Counselling and support services</td>
<td>▪ Law enforcement</td>
<td>▪ Night patrols&lt;br▪ Sobering-up shelters&lt;br▪ Needle and syringe programs</td>
</tr>
<tr>
<td><strong>Tertiary prevention</strong>&lt;br&gt;(reducing harms from chronic use, rehabilitation)</td>
<td>▪ Primary health care&lt;br▪ Community-based treatment&lt;br▪ Residential treatment&lt;br▪ Counselling and support services</td>
<td></td>
<td>▪ Sobering-up shelters&lt;br▪ Needle and syringe programs</td>
</tr>
</tbody>
</table>

Sources: Gray et al. 2008 [11], Gray et al. 2010 [41]
Case Study 1

• Mr & Mrs Green attend your practice with their 14 year old son Billy. They have discovered a small bag of cannabis in his bedroom and want you to ‘treat’ him for drug use.

• How might you respond?
Case Study 2

• Chastity is a 17 year old long-standing patient. She attends on Thursday am concerned that she may be pregnant. The previous weekend she drank heavily and had sex (possibly with two boys) but remembers very little of the incident.

• How might you respond?
Case Study 3

• Rick is a 18 year old who presents to your surgery requesting sleeping pills. He relates to using ‘Speed’ every second weekend and missed school last Monday because he slept the whole day.

• How do you respond?
Thank you