SUPPORT MANUAL

FOR DEALING WITH SUBSTANCE USE ISSUES

IN AN OUT OF SCHOOL SETTING

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Researched and compiled by The Learning Curve Institute on behalf of The National Youth Council of Ireland

Foreword

In recent years, significant developments have taken place with regard to drug prevention across the statutory, community and voluntary sectors. Following the publication of the second Support Pack in 2003, we saw the review of the National Drugs Strategy 2001-2008 and the subsequent publication of an interim Drugs strategy for 2009-2016. This current strategy is an interim strategy until the publication of a broader Substance Misuse Strategy which is envisaged to include alcohol.

To take account of these developments, I am delighted to introduce this revised edition of the Support Manual for Dealing with Substance Use Issues in the Out of School Sector. This manual takes consideration of recent policy developments both in the area of Substance Misuse and the Youth Work Sector.

We have endeavoured to put together a resource manual which is practical, informative and comprehensive. This manual offers a practical framework that identifies youth organisations as having a critical role in addressing substance use issues with young people in 3 areas:

> **Developing Policies procedures and guidelines for Substance Use issues in youth organisations**
> **Prevention of Substance Use in youth organisations**
> **Information on Intervention approaches for youth organisations**

It is my sincere hope that this manual will continue to be a valuable resource for youth organisations dealing with substance misuse issues and will consequently make a positive contribution to the lives of young people.

Siobhan Brennan
Senior Project Officer

National Youth Health Programme
National Youth Council of Ireland.

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Introduction

The issues stemming from substance use in contemporary Irish society are a continuing source of concern for policy makers, communities, law enforcement agencies and a range of professional practitioners. Since the publication of the original NYCI manual in 2003, significant changes have taken place in Ireland. These changes are evident in the spheres of substance use policy development, economics, in society in general and within the discipline of youth work.

It remains unclear what the full impact of the current economic downturn will be on substance use and service provision. It is clear, however, that in light of increasing austerity measures, services for those who attempt to engage with people who use substances are increasingly under pressure. With this in mind their remains a need for youth services to continue to play an important role in engaging and supporting young people at risk of, or currently using substances.

This support manual is intended to serve as a practical resource and reference guide for those who are involved in the youth work sector. It advocates for a holistic understanding and approach to the issue of substance use and young people.
This manual also advocates that issues relating to substance use and young people should not be viewed solely as a specialist area requiring input from experts, but rather should be viewed as being within the realm of good youth work.

This manual provides an overview of substance use in Ireland, theories of substance use, information on youth work and its substance use interventions and prevention. It also provides an overview of recent policy development in Ireland in this regard. It aims to enhance the skills of community youth workers in providing effective substance use education and support that is need-specific. It is anticipated that this manual and the accompanying training will stimulate interagency co-operation, encourage comprehensive service provision, and provide added value in the area of youth work and substance use prevention in line with best practice guidelines.

In order to assist the reader in furthering their understanding of the topics covered, references and relevant reading material have been cited where necessary and compiled in Appendix 3 at the end of this manual.

These references have been listed in a chapter by chapter basis to aid the reader in finding the relevant reading or resources.

***Please note the term "Staff" used throughout the manual refers to Staff/Volunteers/Club Leaders.
The term "project" refers to youth project/clubs/groups.*

01

SELECTED THEORIES OF SUBSTANCE USE AND YOUNG PEOPLE

* Selected theories of substance use and young people

INTRODUCTION

Traditionally, adolescence has been described as a period of dramatic change, characterised by biological changes, transitional periods, increased autonomy and independence. Adolescence is also considered a period where young people are at increased risk of engaging in what are termed 'high risk behaviours', including substance use. It should be noted that most young people who engage in substance use will stop by early adulthood.

FACTORS ASSOCIATED WITH SUBSTANCE USE

Factors associated with young people and substance use are many. While we will consider them here, it should be noted that this list is by no means definitive and that these factors can contribute individually, collectively or cumulatively to substance use:

Functional substance use:
Young people may use substances for reasons such body image issues. All substance use can be viewed at some level as "functional" in that it serves a purpose, whether that is to feel better, feel included, improve perceived peer status, feel less shy etc.

Risk taking:
It may be expected that some young people will engage in risky behaviour at times. This risky behaviour can be viewed as functional in some respects. For some young people risk taking may be an attempt to gain status or demonstrate a level of maturity. Risk taking may be used as an attempt to fit in with a group or sometimes simply for the "buzz".

Predisposition:
This suggests (although remains to be conclusively proven) that genetic or psychological characteristics determine if a young person will use substances.

Experimentation:
This is where a young person may use a substance or substances in an exploratory way. Perhaps as a result of curiosity or as stated above, initial use may be for the same reasons as mentioned under "Risk taking", (i.e. status, show maturity, fitting in or just for a "Buzz".)

Gender and Age:
The age that a person first uses substances can be an important indicator of future substance use. In general young men are more likely to experiment with substances. It is worthy of note, however, that young women are more at risk of harm when they engage in substance use.

Hedonism:
Put simply hedonism can be described as the pursuit of pleasure. This pleasure seeking behaviour is usually a calculated and conscious behaviour.

Peer Pressure and Peer Preference:
The Peer Pressure theory suggests that the "norms" that exist within the group's identity can exert pressure on group members to conform. Therefore, substance use is perceived as normal behaviour in a group. Members, who do not use, can feel pressurised to use.

Peer preference suggests that, by choice, young people will seek out a group that shares their views and values. For example, if a young person likes the idea of drinking alcohol socially, they are likely to seek out a group of like-minded peers.

Social Norms:
This theory is expanded on later in this manual and is related to how people often overestimate the numbers of their peer group who do, or don't, engage in certain behaviours. Based on this assumption, people may engage in the behaviour; aiming to conform to what they believe to be normal behaviour.

Availability:
The easier it is to obtain a substance, the easier it is to engage in substance use. Where substances are easy to obtain it is more likely that substance use will occur.

Familial, Social and Environmental Factors:
If a young person lives in an environment which is high in risk factors and low in protective factors, they are at greater risk of engaging in substance use. For a fuller description of these risk and protective factors, please see "Vulnerability to substance use" below.

> If a young person lives in an environment which is high in risk factors and low in protective factors, they are at greater risk of engaging in substance use.

Self-medication:
Some young people may use substances to alleviate current pressures or feelings they are experiencing. In its simplest form, consider the notion that an individual is presented with an issue or task and knows that by ingesting a substance the issue or task will be easier to deal with e.g. "I feel overweight, but if I use amphetamines I won't want to eat as much so will get slimmer", or, "I am much skinnier than the other lads, but I know that if I use steroids I'll soon catch up".

VULNERABILITY TO SUBSTANCE USE

Risk factors are those factors which can place young people at a greater risk of engaging in substance use.

Protective factors are those that ameliorate the risk of engaging in substance use.

These factors are explored more comprehensively in the coming pages.

Vulnerable and disadvantaged children and young people under the age of 25 who are at risk of misusing substances include:

> Those whose family members engage in substance use
> Those with behavioural, mental health or social problems
> Those excluded from school
> Young offenders
> Looked after children
> Those who are homeless
> Those involved in commercial sex work
> Those from some black and minority ethnic groups.

(National Institute for Health and Clinical Excellence, March 2007)

RISK & RESILIENCE FACTORS

The NACD Risk and Protection Factors for Substance Misuse among young people report was published in 2010 by Hasse & Pratschke. In this report several risk and protective factors were identified, and include;

> Personal characteristics and attitudes of the young person
> The parental and home environment
> Factors relating to the educational centre or school
> The use of substances within the peer group
> Characteristics of the neighbourhood in which the young people resides

There is an abundance of theories attempting to answer the question of why young people use substances founded in perspectives ranging from the biological, the psychological and the sociological.

The following section will provide an overview of some of the dominant theories of substance use and its causes drawn from a range of disciplinary perspectives.

MODELS OF ADDICTION

Over the years many different understandings of why people develop and maintain addictions have been described. In some cases these models are contradictory while some others are outdated and offer little information on how best to support those affected by addiction. Some of the models described here reflect the moral and social tolerances of their era and although they may be viewed in an academic sense as being outdated, they still warrant inclusion, as remnants of these theories can still be encountered in modern Irish society.

The Moral Model:
This model presents a view of addiction as something which people choose. This "choice" is seen as a moral deficit or evidence that an individual is sinful. As a method to correct this tendency to "sin", punishment is seen as an appropriate corrective measure.

The Disease model:
This model puts forward the notion that addiction is a disease of the brain. As such, medical treatments should be sought in an effort to find a cure. The disease model clearly sees addiction as a loss of control and views life-long abstinence as the only acceptable treatment goal.

The Genetic Model:
The Genetic Model is based on the idea that addiction is a condition which is hereditary and therefore must have a genetic base. Work continues in this area in an effort to find indisputable evidence of this link. It is widely accepted that a genetic link is indeed possible, but the notion that genetics may play a contributory role rather than a causative role is currently easier to argue.

The Social Learning Model:
Social Learning Theory stems from the development of behaviourism and a belief that behaviour is shaped through an individuals' interactions with both their environment and their engagement with and observations of others. Social Learning Theory highlights social modelling as having a role in how people think and behave. Substance use is seen as an acquired habit which has been learned and as such; dependence on substances can be un-learned. This model views substance use as ranging along a continuum and therefore both abstinence and control of the substance use are seen as acceptable treatment goals.

The Bio-psychosocial model
The bio-psychosocial model sees "addiction" as a behaviour which can be complex and has several components, which are;

> Biological,
> Psychological,
> Sociological, and
> Behavioural

Addictive behaviour is thought as differing from other behaviours as the individual may present a strong desire to continue using and also may identify as having lost control of his or her substance use.

SOCIAL NORMS THEORY

There is a growing body of evidence supporting the role of prevention approaches that challenge young people's incorrect beliefs about their peers' substance use. The social norms approach is one such example. It is described as a preventative intervention which provides accurate normative feedback in an effort to correct misperceptions of normals.

Social Norms approaches differ from conventional preventative interventions. This is because it has been argued, that when traditional substance use prevention programmes emphasise problem behaviours without highlighting the 'actual' healthy norms, the target group risk adopting erroneous beliefs that substance use is more prevalent than it actually is. This then contributes to, rather than alleviates the problem it is trying to solve.

There is a growing body of evidence supporting the role of prevention approaches that challenge young people's incorrect beliefs about their peers' substance use.

A Social Norms approach seeks to understand what constitutes normal behaviour within a group and then seeks to feed this back to the group emphasising the positive elements of non-use.
(National Social Norms Institute)

POSITIVE YOUTH DEVELOPMENT (PYD) (NATIONAL CONFERENCE OF STATE LEGISLATURES, 2010)

> PYD assumes that all young people possess "strengths and assets", and these assets have the potential to contribute towards the development of themselves as well as their families and the societies within which they live.
> PYD focuses on efforts to increase protective factors while reducing risk factors "through structured activities that focus building skills and increasing competencies in various contexts".
> The PYD model "uses positive socialisation to build on youths strengths" in order to improve health and well-being and prevent high risk behaviours including substance use.
> "An additional key element of PYD is to increase support for youth in their homes, schools and communities by providing opportunities to build relationships with caring adults and pro-social peers".
> "The overarching goal is to create a safe environment for engaging youth in positive relationships and activities instead of focusing on 'fixing' youth problems".

> "The PYD Model replaces the deficit view of adolescence and sees all adolescents as having strengths (by virtue at least of their potential for change)".

This perspective suggests that increases in well-being are possible for all youth through aligning the strengths of young people with the developmental assets present in their social and physical ecology.
(NCSL, 2010).

DEVELOPMENTAL ASSETS MODEL

The model has gradually developed from work which was concerned with deficits which negatively affect resilience, into one which places high emphasis on young people's strengths, skills and possibilities in defining and understanding how young people are both influenced and are influencers of the context within which they exist.

This model is built around 40 developmental assets defined as the building blocks that are crucial for promoting healthy youth development and well-being. Developmental assets are separated into internal and external assets and are categorised into 8 different types as presented in the tables overleaf *(Search Institute, 1990)*

EXTERNAL ASSETS

Support
01 Family Support - Family life provides a high level of love and support.
02 Positive Family Communication - Young person and parents communicate positively and young person can seek support and advice from parents.
03 Other Adult Relationships - Young person receives support from 3 other non-parent adults.
04 Caring Neighbourhood - Young person experiences caring neighborhood.
05 Caring School Climate - School provides a caring, encouraging environment.
06 Parental involvement in schooling - Parent(s) are actively involved in helping the child succeed in school

Empowerment
07 Community values youth - Young person perceives that adult community members value young people.
08 Youth as resources - Young people given useful roles.
09 Service to others - Young person provides service to the community for one hour or more per week.
10 Safety - Young person feels safe at home, in school and in their community

Boundaries and Expectations
11 Family Boundaries - Family provides clear rules and expectations with appropriate consequences. Family monitors young person's whereabouts.
12 School Boundaries - School provides clear rules and consequences.
13 Neighbourhood Boundaries - Neighbours take responsibility for monitoring young people's behaviour.
14 Adult role models - Parents and others model positive behaviour.
15 Positive peer influence - Young person's best friends model positive behaviour.
16 High expectations - Parents and teachers encourage young people to achieve.

Constructive Use of Time
17 Creative activities - Young person spends one or more hours a week engaged in creative activities (music, art etc.).
18 Youth Programmes - Young person spends three or more hours engaged in clubs, sports or other organisations both in school and in the community.
19 Religious/Spiritual community - Young person spends one or more hours per week taking part in religious or spiritual activities.
20 Time at home - Young person does not "hang out with friends with nothing to do" for two or fewer nights per week.

INTERNAL ASSETS

Commitment to learning
21 Achievement motivation - Young person is motivated to do well at school.
22 School engagement - Young person is actively engaged in learning.
23 Homework - Young person does at least one hour of homework every school day.
24 Bonding to school - Young person cares about their school.
25 Reading for pleasure - Young person spends three hours or more reading for pleasure each week.

Positive Values
26 Caring - Young person values helping others.
27 Equality and Social Justice - Young person values these concepts.
28 Integrity - Young person stands up for their beliefs.
29 Honesty - Young person remains honest, even in difficult situations.
30 Responsibility - Young person accepts and takes personal responsibility.
31 Restraint - Young person believes in the importance of restraining from activities outside family boundaries and expectations.

Social Competencies
32 Planning and decision making - Young person is able to plan ahead and make choices.
33 Interpersonal competence - Young person possesses empathy, sensitivity and friendship skills.
34 Cultural competence - Young person has knowledge of and is comfortable with people of differing cultural, racial and ethnic backgrounds.
35 Resistance skills - Young person can resist negative peer pressure.
36 Peaceful conflict resolution - Young person seeks to resolve conflict in a non-violent way.

Positive Identity
37 Personal power - Young person feels they have control over things that happen to them.
38 Self-esteem - Young person reports having a high level of self-esteem.
39 Sense of purpose - Young person feels that their life has purpose.
40 Positive view of personal future - Young person is optimistic about their personal future.

(Search Institute, 1990)

Summary

This chapter sought to provide an overview of some of the dominant theoretical perspectives underpinning approaches to intervention and prevention in adolescent substance use. Drawing from neuroscience, psychology, sociology and health promotion it is evident that adolescent substance use is a complex phenomenon incorporating a broad range of factors.

This highlights the need for inter-disciplinary approaches to addressing the issue of substance use and young people. Practice and policy initiatives must be cognisant of these factors and the theoretical frameworks that underpin them in order to fully address the complexity of adolescent substance use in a holistic manner and to promote the health and well-being of young people in Irish society.

SUBSTANCE USE IN IRELAND

02

SUBSTANCE USE IN IRELAND

* Substance use in Ireland

PREVALENCE OF SUBSTANCE USE AMONG IRISH YOUNG PEOPLE

The term prevalence refers to the proportion of a population who have used over a particular time period. In general population surveys, prevalence is measured by asking respondents in a representative sample drawn from the population to recall their use.

The three most widely used recall periods are:

> Lifetime (ever used a substance),
> Last year (used a substance in the last twelve months), and
> Last month (used a substance in the last 30 days).

Provided that a sample is representative of the total population, prevalence information obtained from a sample can be used to infer prevalence in the population.
(National Advisory Committee on Drugs, 2012).

The following data taken from the above research gives a brief indication as to what young people used in the 2010-2011 period covered.

It is fundamentally important to note that with all illegal substances, a marked reduction is evident over the three recall periods. This is important as it indicates that not all young people who use a substance will continue to use throughout their lifetime. Alcohol and Tobacco use however, remains high across all age groups and across all recall periods.

15-24 year olds	Ever used	Used last year	Used last month
Any drug	27.3%	15.1%	5.8%
Cannabis	25.9%	12.9%	5.4%
Ecstasy	5.7%	1.1%	0.2
Magic Mushrooms	3.5%	1.0%	0.0%
Alcohol	83.2%	81.7%	65.9%
Tobacco	46.1%	35.1%	29.2%

(NACD, 2012)

Although current data indicates incremental decreases in some key areas when compared to previous data, it is recognised by the authors of this research that this is most likely due to a decrease in people's disposable income in the current economic climate.

For an indication of how Irish young people's substance use behaviour compares, in general, to that of our European counterparts the School Project for Alcohol and other Drugs (ESPAD) conduct a European school based study seeking to chart differences in substance use patterns amongst European 15-16 year-olds. However, as this study is conducted exclusively with school going young people, there is a lack of research on how substance use in an out of school setting is experienced across Europe.

SUBSTANCES USED AND THEIR RELATED HARMS

When exploring the harms associated with various substances available in Ireland it is important to understand that the legal status of substances which cause harm does not necessarily reflect the risk of harm to the user or to those around them.

When exploring the harms associated with various substances available in Ireland it is important to understand that the legal status of substances which cause harm does not necessarily reflect the risk of harm to the user or to those around them.

It is recognised that ingesting any substance which has the potential to cause harm carries with it a risk. Despite this, many people choose to use a substance, even if they are fully aware of potential negative consequences.

Some substances appear to command more media attention than others. One such substance is Ecstasy, which has, for many years, been described in popular media as a substance which causes addiction and is extremely dangerous. Although people can come to harm and can die as a consequence of taking ecstasy; in comparison, consuming alcohol carries a higher risk of dependence and harms. The issues which surround the use of alcohol have however begun to feature more prominently in recent media coverage.

The following graph illustrates the risks associated with twenty popular substances in terms of harms to the user and harms to those around the user. The risks associated with each substance have been assessed in terms of fourteen areas of harm. (Nutt et al, 2007).

The extent to which a substance is likely to cause harm depends on multiple factors, many of which are explored in greater detail elsewhere in this manual. However in order to understand the potential for any substance to cause harm it is essential to assess the amount of the substance being used, the frequency of use and the context of usage.

Legend:
- Drug-specific mortality (CW 5-1)
- Drug-related mortality (CW 6-4)
- Drug-specific damage (CW 4-1)
- Drug-related damage
- Dependence (CW 5-7)
- Drug-specific impairment of mental functioning (CW 5-7)
- Drug-specific impairment of mental functioning (CW 5-7)
- Loss of tangibles (CW 4-5)
- Loss of relationships (CW 4-5)
- Injury (CW 11-5)
- Crime (CW 10-2)
- Environmental damage (CW 3-8)
- Family adversities (CW 8-9)
- International damage (CW 3-8)
- Economic cost (CW 12-8)
- Community (CW 3-2)

ZINBERG'S SET AND SETTING

Central to this widely accepted theory is the belief that an individual's experience of any substance use is reliant on the interaction of three key factors as follows;

SET
(Individual characteristics, age, sex, mood, etc.)

SETTING
(location, familiarity, feeling of security, etc.)

THE SUBSTANCE
(Previous experience, substance purity, route of administration, etc.)

(Zinberg, 1984)
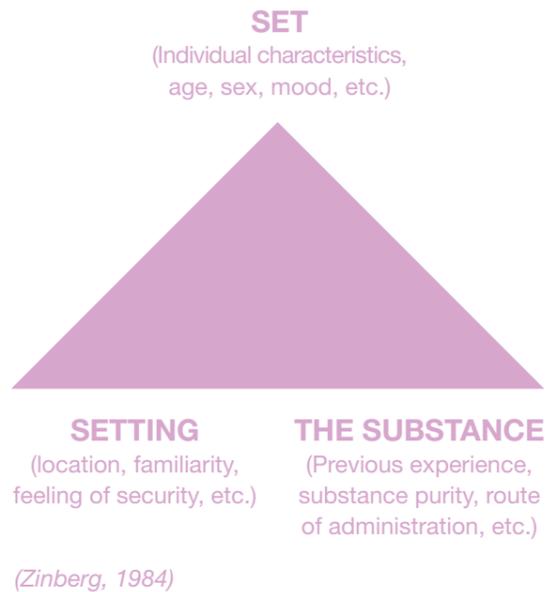
The factors listed above as well as others mentioned, are thought to have a significant influence on the experience an individual is likely to have as a result of the substance they have chosen to use.

These three factors should be considered as interrelated. Therefore they should not be viewed in isolation.

These factors are likely to influence both the individual's motivations for using, and also the effect of the substance on them.

LEVELS OF SUBSTANCE USE

It is important to acknowledge that many people who experiment with substances do not naturally go on to become addicted. Substance use should be viewed as ranging along a continuum, with varying levels of use and hence varying degrees of associated problems. It should be noted that while it is possible for a young person's substance use to escalate, this escalation will be dependent on many complex and often intertwined factors outlined in the previous section. It is also worth noting that Irish statistics indicate that it remains most likely that, for most young people, substance use is a stage which is either grown through or intermittently engaged in. A young person may progress along the continuum, but may also revert back to previous levels of use.

experimental recreational dependent problematic

Experimental substance use may develop into recreational substance use or it may merely cease when the user has satisfied their curiosity.

Experimental use:
Experimental substance use is described as being short-term and often a peer group activity. It tends to be exploratory with an irregular pattern of use and is dependent on many factors including availability, context, peer group associations, and current trends or fashion. Experimental substance use may develop into recreational substance use or it may merely cease when the user has satisfied their curiosity. Such novice use carries specific risks in terms of the young person lacking knowledge about the effects of certain substances.

Recreational substance use:
Recreational substance use refers to the use of substances where enjoyment is the key factor. Such use happens on a regular basis and a perceived social function is often attributed to this type of use. The recreational user often feels that they have control over their use of substances. Use can range from occasional to heavy use but the user is not dependent on the substance. Recreational substance use is generally discriminatory with regard to the type of substance used and the context in which it is taken. It is often seen as part of" "normal" activity, conforming to various social and sub-cultural rules and expectations" *(Malinowski. A, 1987).*

Recreational substance use refers to the use of substances where enjoyment is the key factor.

Dependent substance use:
Dependent substance use is strongly associated with compulsion, either physical or psychological. It is more likely to be a long-term activity with the user, in most cases, unable to control his substance use. Dependence is associated with increases in the amount and frequency of the substance use. This level of substance use is usually a solitary or small group activity and is frequently accompanied by emotional, psychological and social problems as well as physical illnesses.

Problematic substance use:
This type of substance use can be either recreational or dependent. Therefore, it is not necessarily the frequency of the use that is the main issue or problem, but the effect the substance use has on the life of the user. That is to say, a person may experience direct or related psychological, legal and physical (e.g. contracting hepatitis or H.I.V.) problems as a result of substance use but this need not lead to dependence.
(www.drugsalcohol.info)

It is often difficult to positively ascertain whether, and to what extent, a young person is using substances as the signs associated with substance use can often be identical to those evident following normal human activities or emotions.

RECOGNISING SUBSTANCE USE

It is often difficult to positively ascertain whether, and to what extent, a young person is using substances as the signs associated with substance use can often be identical to those evident following normal human activities or emotions.

Therefore these 'signs' should be assessed and cross referenced with other changes in behaviour. These possible indicators can be categorised in three areas:

1. **Physical signs**
2. **Behavioural signs**
3. **Drug-taking paraphernalia**
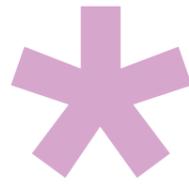
PHYSICAL SIGNS

These can vary according to the type and extent of the substance consumed.
The following signs are specific to the category of substances taken:

A: Stimulant Drugs

(amphetamines, cocaine)

- increased pulse rate
- increased blood pressure
- agitation
- lack of coherent speech or talkativeness
- dilated pupils
- loss of appetite
- damage to nasal passages (sniffing)
- mouth ulcers
- fatigue after use

B: Ecstasy

Ecstasy is a stimulant. However it also possesses mild hallucinogenic properties and thereby in addition to the above it can also cause:

- increased temperature
- possibly excessive sweating
- very dry mouth and throat
- hallucinations and heightened perceptions which make users more tactile
- uncoordinated (jerky) movements
- repetitive movements - many users wanting to dance
- clenched jaws / grinding teeth
- uncontrolled jaw movements caused by muscle spasms
- occasional nausea on initial use
- fatigue after use with possible muscle pain
- weight loss

C: Hallucinogen

(LSD, Magic Mushrooms) These effects can vary depending on the amount taken or if it was taken in conjunction with another substance. Signs include:

- relaxed behaviour
- agitated behaviour
- dilation of pupils
- uncoordinated movements

PHYSICAL SIGNS

D: Cannabis

Cannabis can have the effect of a depressant or mild hallucinogen, depending on situational factors. Signs of use include:

- tendency to laugh easily
- becoming talkative or giddy
- more relaxed behaviour (chilling out)
- reddening of eyes
- hunger (the munchies)
- speckled burn holes in shirt or jumper

E: Heroin

Heroin is a pain killer. As a depressant it can cause:

- slowing down of breathing and heart rate
- suppression of cough reflex
- itchy skin
- runny nose
- lowering of body temperature
- pupils of the eye become small
- craving for sweet things

F: Solvents

Solvents include, gas, glue, aerosols, correction fluids and thinners. Signs of solvent use include:

- usual signs of intoxication
- possible odour on clothes and breath
- if using glue, redness around mouth and nose
- possible stains on clothes
- persistent coughing with a runny nose and eyes

BEHAVIOURAL SIGNS

Again, depending on the individual's level and modality of substance use certain behavioural signs will become cumulatively more visible.

These include:

- sudden changes in mood
- bouts of excitable and overactive behaviour
- evasiveness and secretive behaviour
- amotivation
- lethargy
- irregular sleeping patterns
- loss of appetite
- changes in priorities
- absenteeism
- defensiveness
- erratic productivity in work
- confusion - lack of judgement
- irritability and aggression
- changes in appearance or grooming

3. Drug-taking paraphernalia

- rolled up notes
- twists of paper (wraps)
- small bottles, pill boxes
- cigarette lighter
- cigarette papers
- torn up cigarettes
- roaches (crude filter used in cannabis cigarette)
- burnt tinfoil
- make-shift smoking pipe
- burnt spoons
- the actual substances
- syringes
- cling film, foil and small plastic bags used to package small quantities of substances

(www.drugsalcohol.info)

03

YOUTH WORK AND SUBSTANCE USE

* Youth work and substance abuse

YOUTH WORK

Irish Youth Services have traditionally been the front runners in the provision of substance use education and training. In 2001, the Youth Work Act secured a statutory footing for Youth Work practice. Within the Act, youth work is defined as a:

"…planned programme of education designed for the purpose of aiding and enhancing the personal and social development of young person's through their voluntary participation, and which is

a) Complementary to their formal, academic or vocational education and training; and b) Provided primarily by voluntary Youth Work organisations"

(Youth Work Act, 2001, Part 1, Section 3)

Youth work is above all an educational and developmental process, based on young people's active and voluntary participation and commitment. It is often defined as 'non-formal education'. Youth work is for all young people, with particular focus on those aged 10 to 25 from all aspects of Irish life, urban, rural, all nationalities and social classes. (NYCI, www.youth.ie)

The Youth Work Act 2001 defines a young person as: "a person who has not attained the age of 25 years." (2001:6), the World Health Organisation (WHO) shares a similar view and classifies young people as being between 10 and 24 years of age. However the WHO is more specific in its distinction and identifies to categories of young people: youth and adolescents. Specifically, youth are characterised as being between 15 and 24 years while, adolescents are conceived as being between 10 and 19 years of age.

ETHICS IN YOUTH WORK

At this point it may be salutary to explore some ethical considerations specific to Youth Work. Ethics play a fundamental role within youth work practice. In the context of youth work, ethics is about:

> Carrying out duties with integrity and in line with one's professional responsibilities and duties (e.g. adherence to principles of professional practice or agency guidelines).

> Developing practitioner's abilities to recognise ethical considerations, to reflect and act upon issues and consequently be able to justify such action.

The (UK) National Youth Agency (2000) produced "Statement of Principles of Ethical Conduct for Youth Work", revised in 2004; while recognising that youth work takes place in many varied settings and that it would be impossible to produce a concrete set of rules to follow these principles of ethical conduct can be summarised as follows;

ETHICAL PRINCIPLES

Commitments of youth workers to practice ethically:

1. To engage respectfully with young people, to value each young person and refrain from negative discrimination.

2. To respect, advocate and promote a young persons right to make independent decisions and choices. A caveat to this is when there are concerns for the welfare or legitimate interests of the young person or others are at risk.

3. Promote and ensure the welfare and safety of all young people. Enabling them to learn through engaging in a diversity of educational activities.

4. To advocate for social justice and the civic engagement of young people, through the promotion of respect for diversity and by challenging discrimination.

Professional principles

Youth workers have a commitment to:

1. To be cognisant of the boundaries between their personal and professional life. An awareness of achieving a balance between a caring and supportive relationship with young people while maintaining appropriate professional distance is fundamental to youth work practice.

2. Recognise the need to be accountable to young people, their caregivers, colleagues, funders, wider society and others with a relevant interest in youth work practice.

3. To engage in upskilling and professional development to maintain and expand their skills and competence to perform their duties.

4. To engage in employment within organisations where these principles are transparently discussed, evaluated and upheld.

(NYA, 2004)

PRINCIPLES OF GOOD PRACTICE

The National Quality Standards Framework for youth work (NQSF) was launched in 2010. The aim of these standards is to inform the provision and on-going development of quality youth work. Five core principles form the building blocks of the NQSF and in turn effective youth work service provision:

> Young Person-Centered: Recognising the rights of young people and holding as central their active and voluntary participation
> Committed to ensuring and promoting the safety and well-being of young people.
> Educational and Developmental
> Committed to ensuring and promoting equality and inclusiveness in all its dealings with young people and adults
> Dedicated to the provision of quality youth work and committed to continuous improvement.

(NQSF, 2010)

All organisations that are in contact with or providing services to children have an overall corporate duty and responsibility to safeguard children. It is incumbent on organisations to ensure that their Child Protection and Welfare policies and procedures are compliant with national legislation and guidance

04

YOUNG PEOPLE, FAMILIES AND SUBSTANCE USE

* Young people, families and substance use

INTRODUCTION

Research in the context of Irish families indicates that experiences within the family can have significant and diverse impacts on the well-being of children and adults.
(McKeown & Sweeney, 2001).

Children are reliant on their family by virtue of their physical and psycho-social needs, their economic welfare and well-being. If a parent is engaged in substance use this may place a child in jeopardy. It is important to note that parental substance use alone does not automatically place a child or young person in immediate danger. Factors such as the type of substance used, the amount used and others are contributory factors. Children of problematic substance users are reportedly at increased risk of a range of difficulties, impacting on many domains of their lives, including: poor mental health, interpersonal skills, educational attainment and engaging in substance use.

Research also indicates that protective factors within families play a critical role and are attributed to a decreased risk of substance use by young people (Horgan, 2011). Based on the findings of this NACD report (Horgan, 2011) this section will provide an overview of the potential effect of problematic parental substance use on children and young people.

THE FAMILY AS A SYSTEM

The systems perspective proposes several key concepts related to how we understand families and their functioning:

> The family is more than the sum of its parts
> Changes in any one part of the system impact directly or indirectly on the entire system
> Subsystems are rooted within the larger family system
> Families exist within a larger socio-environmental context
> Families are comprised of different generations.

(National Institute on Alcohol Abuse and Alcoholism)

FAMILIES AND SUBSTANCE USE

It is a widely held belief that problematic substance use places individuals at an increased risk of social marginalisation and exclusion leading to an increased risk of challenges such as unemployment, educational disadvantage, exclusion from health services, poor housing and homelessness. In general, families where problematic substance use is a factor display decreased levels of functioning, have a more negative perception of their environment emphasising a lack of cohesiveness. They also display lower levels of responses of warmth and caring, and higher levels of unresolved conflict and arguing. Moreover, the effects of problematic substance use within family units may impact across generations. The intergenerational effects of problematic substance use can be detrimental to the role modeling process, a sense of trust and concepts of normative behaviour which in turn can damage interpersonal relationships across generations.

> In general, families where problematic substance use is a factor display decreased levels of functioning, have a more negative perception of their environment emphasising a lack of cohesiveness.

The following is a list of the primary factors thought to be affected by problematic substance use difficulties within families:

> **Rituals:** The manner in which families celebrate significant religious/family occasions i.e. Christmas/birthdays

> **Roles:** As one family member develops a substance use problem, a redistribution of roles can occur. Other family members may take on increased responsibilities i.e. financial, discipline, housework etc.
> **Routines:** Difficulties can emerge when the behaviour of the family member engaging in substance use becomes unpredictable. This can create difficulties for families in planning or committing to routines
> **Communication:** Substance use can seriously impair effective communication between family members
> **Social Life:** Families tend to become increasingly socially isolated owing to issues in explaining to others that a family member has a substance use problem. This may be resultant from or social stigma and the unpredictability associated with substance use
> **Finances:** Financial difficulties can develop as a result of a reduction in income (e.g. resulting from loss of job) and spending of income on substances rather than more necessary items
> **Relationship and Interactions:** Increased risk of neglect and violence

> The importance of the relationship between parent and child for the healthy development of children has long been acknowledged

The importance of the relationship between parent and child for the healthy development of children has long been acknowledged. Within the family system several patterns of interaction have been identified which are likely to be present in a family where problematic substance use is a factor:

> Negativism: Communication between family members may be negative, usually delivered via complaints and criticism. Positive behaviour is generally ignored and attention is sought and attained through a crisis incident. Such negativism may prove reinforcing to the substance misuse.
> Parental inconsistency: A lack of consistency in care-givers disciplinary practices can cause confusion for children.
> Parental denial: Where the child or young person is aware of a substance use issue, but the parent does not acknowledge the substance use or its effects on the child.
> Miscarried expression of anger: Children or parents may use substances as a means of coping with repressed anger. When anger is expressed, the child may internalize this anger as criticism.
> Self medication: Using substances as a coping mechanism for emotional and psychological distress.
> Unrealistic parental expectations: For example if a child is not encouraged and supported to complete homework, yet the parent still expects high grades

(Velleman & Templeton, 2007)

CHILDREN AND PARENTAL SUBSTANCE USE

Problematic substance use is affected by and affects all family members, in particular children. Children of parents who engage in problematic substance use are at an increased risk of experiencing a range of issues across the varying facets of their lives, including: mental health difficulties, impaired social skills, low educational achievement and engagement in substance use. The longer children and young people are exposed to parental substance use, the higher the risk of a detrimental impact.

PARENTING AND SUBSTANCE USE

Literature clearly shows that problematic substance use has a negative impact on parenting skills and level of parental attentiveness towards the young person (Templeton et. al., 2006).

The quality of a child's immediate care-giving environment can be seriously undermined by parental substance use and other factors.

Problematic substance use can impair a parent's judgment and capacity to ensure the care and supervision of their child. Parents whose substance use is problematic are more likely to be socially isolated, spend less time with their children and engage in inconsistent disciplinary practices.

It should be noted that when substance use as a problem occurs alone or without the complication of other risk factors, parents may be in a position to fulfill their parenting role (Gilchrist and Taylor, 2009).

Research has clearly shown that young people living in adverse circumstances exhibit remarkable strengths and adaptive capacity or resilience (Masten, 2011). These strengths should be built on where possible.

Youth work is identified as having an important role in enhancing the friendship and support networks of children and their families by engaging with extended family members and fostering links between children, families and community resources (Dept of Health and Children, 2011). Studies indicate that children who have access to practical guidance/advice and positive emotional feedback are more likely to be strengthened in their resilience and coping capacity (Dolan, 2007).

Some initial studies provide us with insights into what children report as helpful in the context of parental substance use which include information and recognition and support from professionals (Velleman and Templeton, 2003). While Bell (2002) reports that what young people are asking for is to engage in a trusting relationship with someone who treats them with respect, is non-judgmental and gives them time by listening to them, being available, reliable and concerned.

Studies indicate that children who have access to practical guidance/advice and positive emotional feedback are more likely to be strengthened in their resilience and coping capacity.

SUMMARY

It is important that children of substance users are not assumed to be maladaptive or pathological. Equally it is important to see the children of substance users as having needs in their own right, not just as having needs which are secondary to the presenting substance use issue within the family.

05

DEALING WITH SUBSTANCE USE RELATED INCIDENTS

* Dealing with substance use related incidents

INTRODUCTION

In order to understand what a substance use related incident is, it is worthwhile considering the following statement as a foundation for this chapter.

An incident should be considered substance use related when there is suspicion, evidence or concern relating to the use of substances.

The contents of this chapter are intended to offer Youth Groups or Projects guidance in dealing with substance use related situations. The Misuse of Drugs Act(s) 1977 (Section 19) places a responsibility on anyone concerned with the management of a property, land, vessel, or vehicle to ensure certain offences do not take place. Section 19 of this Act states that if any illicit drug preparation, use, sale or supply takes place, the people in control of the premises are deemed culpable, through their implied knowledge, until they can prove otherwise. While this may be a complex area of Irish law, simple steps can be taken in order to protect the young people who participate, the volunteers and workers, and the management of any premises used to facilitate youth work.

It should be acknowledged that due to the individual and complex dynamics of substance use related situations it would be impossible to provide detailed guidance that addresses all possible contexts and incidents. Instead what is included in this chapter is a framework (Appendix 2, "Decision making form") which will offer groups and projects a means to analyse each situation they may face; as it arises and choose the most appropriate course of action to take according to the situation. The correct course of action will be determined by your organisations policy and implemented by those responding to the incident.

PREVENTION OF INCIDENTS

It is important to note however that several steps should be considered as preventative measures and steps which can provide a measure of planning prior to any such incident occurring. The development of a relevant and up-to-date substance use policy is one such recommended measure. Such a policy should be viewed as a "living document" and as such should ideally be reviewed at planned intervals.

The following suggestions are intended as measures which should be considered essential;

>   Having a well-designed and up-to-date substance use policy. This policy would ideally be developed with input from workers, managers; young people and where appropriate their parents or guardians. Information on how to develop such a policy is contained in chapter 7 of this manual.
>   Ensuring all members of staff and young people are fully informed of the content of this substance use policy and are cognisant of their responsibilities set out within this policy.
>   Appropriate supervision, team meetings or peer support structures are in place and utilised effectively as a means to discuss current or potential substance use issues.
>   Appropriate training should be made available to staff and volunteers relating to substance use.

The following suggestions are intended to offer measures for consideration, which may, should an issue occur, provide guidance in dealing with the incident:

>   Create links with your local Gardaí. Even if this is simply to introduce your project and its ethos.
>   Create links with your local substance use service. It can be useful to understand what supports or training may be provided locally.
>   Create links with your Local or Regional Drugs Task Force. It may be useful to establish what supports or services are offered and also become aware of any sources of funding available should your group or project decide to engage in any substance use specific work.

BEFORE DURING AND AFTER A SUBSTANCE USE RELATED SITUATION

In order to frame the context within which substance use related incidents occur, and to prepare ourselves for dealing effectively with situations as they arise it may be useful to break an incident into parts focusing on before, during and after an incident. At all stages of any substance use related incident the values of youth work as stated in this manual remain relevant. Of particular relevance is the statement that "youth work starts where young people are at" (www.youth.ie). For some young people the place where they are at may be one which involves the use of legal and/or illegal substances. At all stages of a response, young people should not be labeled; and conscious effort put into avoiding terms such as drug user etc. as such terms increase the risk of a young person being defined by their behaviour instead of being defined by their potential.

> At all stages of any substance use related incident the values of youth work as stated in this manual remain relevant.

Before an incident;

>   The appropriate use of team meetings and supervision should ensure that the environment of the club or project allows for sharing of concerns between staff and mangers/senior workers, where necessary, so as to ensure that whatever actions taken are not carried out by one worker in isolation.
>   Deciding on a course of action together as a team is always preferable as it provides support to the workers engaged in the incident and also allows a consistent approach to be employed in future incidents as they occur.

During an incident;

>   How a worker or volunteer responds initially to a situation can influence the escalation or safe conclusion of any incident.
>   The appropriate use of team support during an incident should be encouraged although care needs to be taken here too as it is important not to allow a series of "Chinese whispers" to circle around within a team with the potential to damage the reputation or standing of a young person.
>   While engaging with a young person around a substance use related incident the same skills and work approach will most likely be used as they would in so many other youth work scenarios. The values underpinning youth work practice should guide and inform your decisions and approach.
>   In general the use of "I statements" are considered more effective in expressing concerns and communicating effectively. E.g. "I am concerned about…"
>   At no point should any worker or volunteer place themselves at risk of harm.
>   Potential risks or harms for the young person or people and the group or club at large should also be central to the way situations are dealt with, and associated risks minimised where possible.
>   If there remains a risk of harm to any young person or worker it may be necessary to involve the Gardaí or other emergency services.
>   Informing parents may also be necessary and is considered good practice if the young person is a minor.

After an incident;

>   How to respond after an incident will be largely dependent on the nature of the incident and how it concluded.
>   Staff involved should be offered the appropriate supports.
>   Information about and access to relevant appropriate supports should be made available to the young person/s involved.
>   Substance use related incidents may bring up issues for the larger group or club as

a whole. These must be addressed using a sensitive and supportive approach. Some issues raised may be appropriate to deal with in a group setting, however some may not.

> Encourage staff or volunteers to reflect on the incident and the measures taken to deal with it in a supportive way.
> Reflection is very useful in envisaging how else we could have responded, and in considering what potential responses could have been utilised.
> Reflecting on your club or groups substance use policy in light of an incident may assist in the development of a more robust or user-friendly draft of the policy, making future incidents easier to respond to and become more supportive both from the perspective of workers and young people.

RECORDING OF SUBSTANCE USE RELATED INCIDENTS

As with all work in a youth work setting, accurate recording of work completed is important for many reasons. These reasons may be viewed as benefits for the three parties in any incident;

> Young person- under the Data Protection Act (2003) any "data subject" (anyone who is subject to their information being stored) has the right to access this information.
> Worker- accurate recording of incidents demonstrates worker competence and is evidence of compliance with legal and organisational policy or expectations.
> Organisation- accurately and regularly maintained records of completed work and its effectiveness is an essential part of good practice. Accurate and up to date records of work also provide an element of protection against future litigation and can provide justification for any decisions made.

Youth workers and organisations/clubs must be cognizant of and adhere to their responsibilities in relation to data protection. There are a number of key considerations in relation to data protection, sometimes referred to as 'The Golden Rules' and are as follows;

All Data Controllers must:

> Obtain and process the information fairly
> Keep it only for one or more specified and lawful purposes
> Use and disclose it only in ways compatible with the purposes for which it was initially given
> Keep it safe and secure
> Keep it accurate and up-to-date
> Ensure that it is adequate, relevant and not excessive
> Retain it no longer than is necessary for the specified purpose or purposes
> Give a copy of his/her personal data to any individual, on request

For further information in relation to data protection, contact the Data Protection Commissioner. (www.dataprotection.ie).

Youth workers and organisations/clubs must be cognizant of and adhere to their responsibilities in relation to data protection

06

CURRENT POLICY AND LEGISLATIVE CONTEXT IN IRELAND

* Dealing with substance use related incidents

INTRODUCTION

The discipline of youth work aims to engage and support young people in a variety of contexts and settings. Promoting health amongst young people remains central to this work. It is recognised that the promotion of health needs to be flexible in its approach in order to respond to the variety of specific needs which may need to be addressed. The national context within which this work currently takes place is outlined in this chapter and looks briefly at the policy and the legislative Acts governing youth work practice in Ireland. Specifically those relevant to working with substance use related issues in a youth work setting.

CURRENT NATIONAL POLICY CONTEXT

'Your Health is Your Wealth' – A public health policy framework for a healthier Ireland. The objective of this document is to promote and develop a high-level policy framework for the Irish public health sector, for the period 2012 to 2020. It seeks to engage relevant leaders and policy makers across governmental sectors and departments and wider society. This collaborative approach is in recognition that, many of the causes of poor health and well-being require more than a response from the health sector alone. Rather it highlights that improving the publics' health is the responsibility of all sectors of society, and requires a collaborative approach. Within its remit, the policy aims to identify practical ways to promote interagency working between sectors. A central focus of the policy is directed towards identifying ways to keep children healthy; improve the health of the workforce; and support positive ageing and encourage a greater participation of those with disabilities and mental health issues. National Drugs Strategy (interim) 2009-2016. A review of the National Drugs Strategy 2001–2008 took place in 2007. The primary aim of the review was to examine the progress and impact made under the current Strategy and to offer recommendations to inform the new Strategy

for the period 2009–2016. A Steering Group was established and chaired by the Department of Community, Rural and Gaeltacht Affairs.

The strategy again acknowledges the complexities of substance use and therefore involves actions pertaining to many areas of life, these actions are then charged to the various relevant bodies for execution. In order to manage this work at local and regional levels 10 regional and 14 local Drugs Task Forces were established. Each Task Force works from an ethos of partnership within the local area between statutory, voluntary & community sectors inclusive of public representatives. The structure seeks to support the development of effective, targeted, responses drawing from the knowledge and experience of various sectors in the locality in informing service design and provision. Moreover, they aim to facilitate inter-agency co-operation and improve the co-ordination of service provision.

During the consultations to inform the current strategy many calls were made to include alcohol within the remit of the national drugs strategy. A recent report submitted by the Steering Group on a National Substance Misuse Strategy and was published by the Department of Health. This report makes recommendations relating to how the issues specifically associated with alcohol consumption can be addressed within the current structures although it has not yet led to a new national strategy.

RELEVANT LEGISLATION IN IRISH YOUTH WORK

The Youth Work Act was enacted in December 2001. The Youth Work Act, 2001 coupled with the National Youth Work Development Plan, 2003-2007, provided clarity on the definition of Youth work in Ireland. As mentioned previously, Section 3 of the Youth Work Act, 2001 defines youth work

RELEVANT LEGISLATION IN IRISH SUBSTANCE USE WORK

The Misuse of Drugs Act 1977 and its subsequent amendments is a key piece of illicit drug legislation. This legislation outlines what substances are considered illegal or controlled and also outlines activities which constitute offences under the Act. The Act outlines the powers of Gardaí and penalties for committing offences.

Child Protection and Welfare

The area of Child Protection and Welfare is undergoing significant change at the time of publication of this manual. It is critical that workers ensure that they are familiar with relevant National legislation and guidance in this regard at all times.

> It is critical that workers ensure that they are familiar with relevant National legislation and guidance in this regard at all times.

FURTHER INFORMATION AND RESOURCES

Child Protection and Welfare Practice Handbook
http://www.hse.ie/eng/services/ Publications /services/Children/ childprotectionandwelfarepracticehandbook.html

Children First National Guidance.
http://www.hse.ie/eng/staff/Resources/hrppg/ Children_First_2011_–_National_Guidance_for_ the_Protection_and_Welfare_of_Children.pdf

Misuse of Drugs Act 1977.
http://www.irishstatutebook.ie/1977/en/act/ pub/0012/index.html

Steering Group Report on a National Substance Misuse Strategy, February 2012. Department of Health
http://www.dohc.ie/publications/pdf/Steering_ Group_Report_NSMS.pdf?direct=1

The Youth Work Act 2001.
http://www.irishstatutebook.ie/2001/en/act/ pub/0042/index.html

The National Drugs Strategy (interim) 2009-2012 Department of Community Rural and Gaeltacht Affairs.
http://www.drugsandalcohol.ie/12388/1/DCRGA_ Strategy_2009-2016.pdf

'Your Health is Your Wealth' – A public health policy framework for a healthier Ireland.
http://www.dohc.ie/issues/your_health_your_ wealth/

07

POLICY DEVELOPMENT

* Policy development

INTRODUCTION

This manual has covered a broad range of factors relating to the responses of youth organisations to the issue of substance use. However, it is imperative that youth work organisations develop guidelines, policies and protocols specific to their service. This will provide clarity and guidance to staff, enabling them to provide a genuine and comprehensive response. The practice of staff and organisations must be informed by and targeted at specific local needs and in take consideration of thee organisations ethos.

For the purposes of this section the use of the term 'organisation' is intended in its broadest sense. It incorporates all youth organisations, groups, clubs and projects.

This chapter will provide a framework for organisations, workers and volunteers to:

> clarify and reflect on their current approach to issues of substance use at local level;
> Identify and explore the specific needs of the organisation in addressing substance use issues;
> consider and provide for the needs of individual staff (paid and volunteers) in working with young people around issues of substance use. Specifically, the safety and security of staff must be ensured and staff must feel supported in their role.
> To be cognisant of and aware of procedures and requirements regarding matters of confidentiality, legal issues and referral;
> To actively engage in the development, dissemination and monitoring of policies specific to their own working environment.

This section aims to facilitate organisations in reflecting and critically analyse where they are at in the context of substance use service provision. Consultation is a key factor associated with effective policy development and implementation. If a consultation process does not occur or is not given adequate time and depth, the likelihood is that the policy will not be effectively implemented within the organisation.

THE NEED FOR POLICY DEVELOPMENT

Policy Development is important for the following reasons:

> To enable organisations to reflect their ethos and position in the work they do;
> To encourage good practice;
> To assist in meeting the needs of young people, support workers, leaders, volunteers, and managers within the organisation, as well as the needs of the organisation itself;
> To meet the specific needs of the organisation's target groups;
> To provide a framework for inter-agency co-operation;
> To enable organisations to reflect the needs and aspirations of the community in which they work;
> To provide consistency in how to respond to substance use issues.

A PROCESS FOR POLICY DEVELOPMENT

This Section aims to provide a step-by-step framework for organisations to follow or adapt, where appropriate, when developing their own policy. Organisation should be taken to mean workers (either paid or voluntary), management and young people. Therefore, a 'whole' organisational approach is required.

It is imperative that if the policy formation process is to be comprehensive then representatives of the wider body of young people should be included. This phase is crucial in offering the young people the opportunity to participate, thereby increasing the chances of collaboration and, in turn, progressing the policy in practical terms.

It is imperative that if the policy formation process is to be comprehensive then representatives of the wider body of young people should be included.

STEP-BY-STEP APPROACH TO DEVELOPING A SUBSTANCE USE POLICY

It is important when developing a policy document to be as comprehensive as possible. Therefore it is useful to follow a step-by-step process.

STEP 1:
Clarify the present position with the organisation:

a. Define the ethos of the organisation
b. Review existing policies and legislation
c. Explore the existing levels of knowledge regarding local substance use
d. Explore the substance use work undertaken by the organisation to date and its perceived strengths and weaknesses.

At the preliminary stages of this process, the merits of a health-enhancing environment should be emphasised to the workers and young people alike. This will be far easier to explore if a positive health-promoting framework is already being employed within the organisation.

STEP 2:
Carry out a needs analysis:

Having explored in detail the present position within the organisation regarding the substance use work currently being undertaken, it is important to move on and carry out a comprehensive needs-analysis so that future substance use education provision can be planned and implemented on the basis of the real needs of the organisation and its target groups.

The needs-analysis should be such that it places substance use work within the context of a holistic health education structure as well as ensuring that both young people and their substance use are seen in terms of their physical and social community environment. The needs analysis should be given priority, and time should be set aside to research local issues in relation to substance use. This will ensure that the completed needs analysis will fill some of the gaps and provide answers to many of the outstanding issues raised by the discussions in step one of this process.

This should be a challenging piece of work, contributed to by the organisation as a whole, specifically the young people, and when completed, should provide a solid working document for the organisation in its overall strategy development as well as acting as a training and review document for the organisation.

This model provides a framework for the development of health promotion practice and policy for youth organisations and acknowledges the underlying necessity for good practice in this area at all times. It should be noted that this model is a cyclical model and each stage in the cycle is related to the next. No stage should be addressed in isolation e.g. the implementation of any programme is informed by effective planning and appropriate needs assessment. Furthermore, each stage is directly related to the policy and good practice that should underpin every aspect of this work within youth organisations.

STEP 3:
Draft the policy:

Drafting the policy should not be the work of any one individual within an organisation. Just as it is important for all those within the organisation to actively participate in clarifying the present

position of the organisation and in carrying out the needs-analysis, so too is it equally important for the entire organisation to contribute to policy formation.

A policy will only be effective if everyone has been involved in its development and there is agreement about its content and strategy. However, it is vital that someone within the organisation is vested with the responsibility for co-ordinating the process, from consultation stage through to writing the document and ongoing monitoring and evaluation of the policy. It is crucial that there is representation from the young people in this process so that any deficiencies in the policy can be identified and subsequently addressed.

(Support Pack for Dealing with the Drug Issue in Out of School Settings, 2003)

FRAMEWORK FOR A SUBSTANCE USE POLICY

What should be included in the policy document?

> A statement of the organisation's views on substance use;
> Clear definitions of substances and substance-related situations/incidents as understood by the organisation;
> The legal requirements;
> The aims and objectives of the policy and the policy statement;
> Staff responsible for implementing the policy and their levels of knowledge and understanding;
> The geographical boundaries of the policy (i.e. what are the physical building boundaries and if the policy covers both "on-site" and "off-site" activities organised by the club);
> Substance use education -the aims, objectives and approaches of the policy;
> Guidelines on managing substance use-related situations;
> Reporting, recording and referral procedures;
> Staff development, training and support issues;

> The organisation's substance use work in a community context;
> The involvement under defined circumstances of outside agencies where appropriate;
> Specific roles and responsibilities;
> Health and welfare procedures;
> The process by which the policy is to be implemented;
> Procedures for review, monitoring and evaluation;
> Appendices if appropriate.

Step 4:
Pilot the Policy:

Once the draft document has been completed, it is essential that all members within the organisation (workers and young people alike) have an opportunity to consider and comment on its usefulness and appropriateness. This stage of the process should not create any problems if there has been consultation throughout the process.

Those involved in putting together the document need to consider the feedback in a constructive way and ensure appropriate changes or adjustments are made where necessary.

The development of any document by an organisation is an important process. It will have taken quite a long time, perhaps months, to complete the document and the organisation will perhaps wish to make the community aware of its existence. An official launch may be deemed necessary in order to assist this process.

An official launch will provide this opportunity as well as an opportunity for the organisation to avail of local, and in some cases, regional or national media coverage for their work and to highlight the importance of how their policy will impact on the work. A launch also provides an opportunity for others to learn from the principles and practice of the organisation.

Step 5:
Disseminate the policy and provide training:

Once developed the organisation as a whole needs to become familiar with the policy and begin to use it to inform their work. It is important to accompany the dissemination of the document with appropriate training on the use of the document.

This training should be available to all staff, volunteers and management within the organisation, not only to those who will be dealing with substance use issues directly. The substance use situation impacts on the organisation as a whole; therefore, everyone should be adequately prepared to deal with it.

Step 6:
Monitor and Evaluate:

This policy should advocate the development of on-going substance use related work by the organisation. Given the nature of youth culture and the changes in drug types and substance use, this work may need to change to accommodate these changing needs. Organisations should, therefore, continuously monitor (look at the process of implementation), evaluate (look at the outcomes) and update their policy and substance use work strategy in general so that the policy can continue to be used in the most effective way possible.

SUMMARY

It is vital that organisations commit to developing substance use policy and guidelines. It should be considered fundamental to ensure that the policy development process is as inclusive as possible and therefore any group established should at a minimum have representation from the key stakeholders in the organisation. By ensuring thorough consultation has occurred, it is more likely that all members of the club or group will take ownership of its implementation, and therefore give the document a best chance to be effective.

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08

PREVENTION

PREVENTION

* Prevention

SUBSTANCE USE AND THE PREVENTION OF HARM

Drug prevention programmes remain topical in that many different approaches have been attempted in differing settings in Ireland, with differing results. Factors which are likely to interfere with the effectiveness have been identified by Dr. Mark Morgan who has identified five factors that contribute to rendering certain drug prevention programmes ineffective. Although some factors which are highlighted here are specific to school settings, these are nevertheless important to consider in an out of school setting:

1. Unrealistic Expectations:
This has to do with differing expectations about what a prevention programme can achieve in general and more specifically to what extent the school curricula can contribute to drug prevention.

2. Programme Implementation:
Many prevention programmes fail as a result of non-implementation or partial implementation.

3. Problems of Implementation:
This refers to the number of practical problems involved in implementation, including the failure to evaluate the process and outcomes as well as other chronological and administrative difficulties.

4. The future of Implementation:
Here, attention is drawn to the congested curriculum that exists in the formal education sector and the difficulties in providing space for prevention programmes.

5. Environmental and Cultural Factors:
This relates to a number of issues. Firstly, there is often a major gap between the content of programmes and the experience of the young people at whom they are targeted. Secondly, for many young people, experimentation with drugs is the norm while use of recreational drugs has a specific function. Finally, the effectiveness of interventions is sometimes lessened by a failure to take into account that young people may be at different stages of use.

(Morgan, 2001:46–56)

INTERVENTIONS AIMED AT PREVENTING SUBSTANCE USE

Three main types of prevention exist and they are;

> **Primary prevention –** aimed at preventing the onset of substance use.

> **Secondary prevention**- aimed at intervening if a problem is likely to occur (for example, in high risk groups) or if an issue exists but is not yet fully developed.

> **Tertiary prevention – Type A and B**

> **Type A** involves dealing with problems once they are fully manifested and the prevention of further harm in those who use and

> **Type B** involves the prevention of further problems recurring once they have been successfully treated (relapse prevention).

These terms, however are 'updated' by the EMCDDA (European Monitoring Centre for Drugs and Drug Abuse) in noting that the distinguishing variable between these types of prevention is not the level of use but the level of risk or vulnerability of the target group. Hence the use of three further terms when describing prevention strategies:

> **Universal prevention strategies** aim to address an entire population (national, local community, school, neighbourhood) with interventions aimed at preventing or delaying the use of substances.

> These programmes avoid labelling of groups or individuals by aiming prevention messages at everyone; however, they can be ineffectual because, in aiming to speak to everyone, they may instead be ignored by everyone.

> **Selective prevention strategies** target subsets of the total population that are deemed to be at risk for substance abuse by virtue of their membership to a particular population segment. An example might be young people involved in the criminal justice system, young people not engaged with education or those at risk of disengaging from education. Risk groups may be identified on the basis of social, demographic or environmental risk factors known to be associated with problematic substance use.

While these programmes are useful in focusing resources at those in apparent need, there is a risk of labelling and stigmatising members of groups for whom substance use is not an issue. It is also noteworthy that in certain communities, that which is deemed high-risk behaviour in the general population may be accepted as normal behaviour in the targeted community.

> **Indicated prevention** aims to identify individuals who are exhibiting early signs of problematic substance use and associated issues and to target them with special interventions"

Similar problems as outlined above exist for this type of prevention – except with more complex labelling and stigmatising occurring. Also effective targeting of these groups may be difficult.

As substance use is complex and usually characterised by a cluster of presenting needs, effective prevention programmes need to be directed towards addressing the needs of the target group. This employment of differing strategies aimed at preventing harm, or the progression of further harm occurring to individuals who use varying amounts of substances is illustrated in the following diagram. This diagram is also useful in understanding that the more of a substance a person uses and the frequency with which they engage in their use, the more likely it is that they will come to harm. While this diagram was developed as a means to help understand this principle in relation to alcohol use, it is applicable to all substance use.

EDUCATION AS PREVENTION

It is evident that education or the passing of information forms an element of all prevention efforts. However the means by which this is executed and the messages being delivered are fundamentally important. The examples overleaf of education based prevention have been presented here to demonstrate "at a glance" the different approaches which are used and highlights expected outcomes.
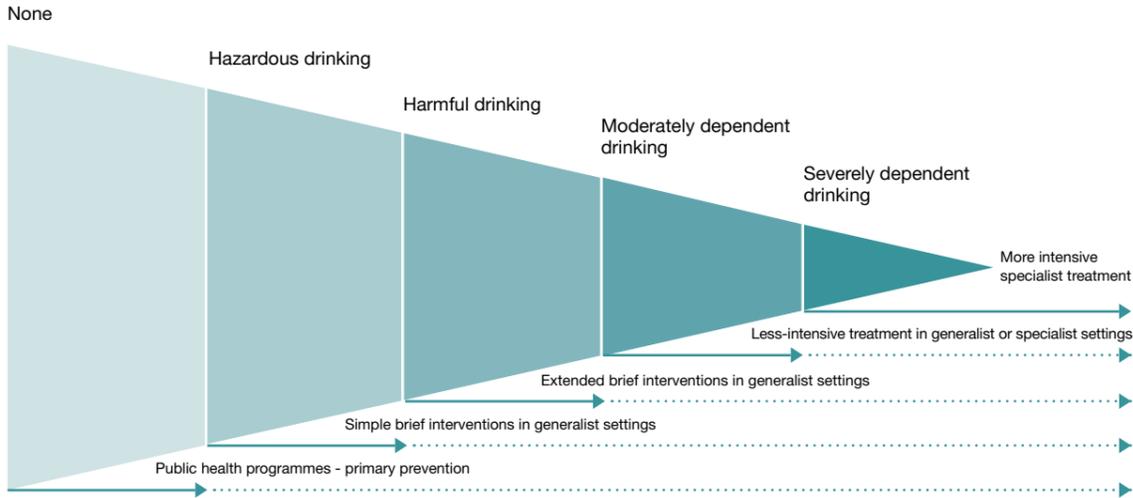

Figure 1 A spectrum of responses to alcohol problems {Source: Rastrick et al. (2006),[1] adapted from Institute of Medecine (1990).[2]}

	APPROACH	METHOD	USES/LIMITATIONS
A	Didactic, 'fear-based' approach	Encourages shock and horror responses from audience, convincing those who have already decided not to use a substance that that is a correct decision.\n\nCan also deter people from actions in the immediate (e.g. drink driving today)	Not effective in encouraging lasting change\n\nMay confuse, as message may often be given by a 'survivor'\n\nMay suggest that it is others who are at risk rather than self
B	Didactic, 'science-based' approach	Assumes that by giving information people will react in a rational way to that information	Can inappropriately increase knowledge\n\nNo impact on changing substance use
C	Affective approach	Attempts to clarify feelings about substances and clarification of both knowledge and attitude will change behaviour	Little evidence of impact on changed behaviour in relation to substance use
D	Behavioural approach	Increases life skills, self-esteem and social skills so that these will lead to reduced substance use.\n\nSummarised into the 'just say no' approach	Can have some impact on some substance use e.g. tobacco and alcohol\n\nHowever, generally found to be ineffective if used as a stand-alone approach
E	Situational approach	Attempts to increase skills for when someone is first offered substances\n\nAssumes situation and certain skills are important for health choices to be made	Useful for reducing potential harm but has little impact on experimentation with substances

	APPROACH	METHOD	USES/LIMITATIONS
F	Cultural approach	Focus is placed on the social situation of the substance use\n\nConsiders role of culture, race, class and income effect behaviour norms\n\nSimilar to political education model	Recognises the realities of substance use and can be very useful in areas where substance use is well recognised.\n\nCan help empower young people to be involved in change.\n\nEffectiveness on changing substance use requires further research
G	Harm reduction approach	Focuses on reducing and limiting harm of substance use on individuals\n\nInstead of aiming to stop substance use its aim is to reduce harm of use of different substances\n\nCan be used in conjunction with many of the above approaches	Effective in minimising substance use related harm\n\nOften a 'hidden' part of prevention programmes because it is politically difficult to promote.
H	Peer education approach	Employs peers to educate others within the peer group\n\nCan offer mentoring and skills building, offering information, life skills and resistance training approaches	Peer leaders must have credibility within the peer group – personally, experientially and message-based.\n\nCan impact on delaying onset of substance use but care must be taken with choice of peers and group mix for approach not to be undermined.

(Support Pack for Dealing with the Drug Issue in Out of School Settings, 2003)

Prevention efforts, as highlighted above, need to be specifically designed and targeted towards clearly defined groups and related to specific behaviours or risks; the job of planning and implementing such strategies may appear daunting. However drawing on supports and resources in your local area, both general and substance use specific will help in establishing a multi-agency approach which can assist in developing a holistic preventative strategy.

Key points which have been identified as promoting effectiveness have previously been identified and can serve as a guide to ensure the programme has the best chance of being effective. According to Baker and Caraher (2001), strategies which are effective are those that;

> Have a clear highly defined purpose, including clear aims and objectives which are measurable and realistic;
> Are subject to careful planning, research and implementation;
> Are relevant to the audience and based on adequate insights from formative research into the needs of the target group;
> Are perceived as familiar, attractive and credible by the target audience;
> Are consistent, sustained and repeated;
> Are combined with community, small group and face-to-face interventions;
> Are located within a context such as the family, community or the school;
> Do not target young people in isolation but provide support in the form of information and training for parents, teachers etc;
> Build on the target audience's existing motives, needs and values;
> Provide information of the social benefits of non-drug use and reinforce existing non-using behaviour;
> Emphasise the positive benefits of changing behaviour rather than the negative effects of current behaviour;
> Stress the short term effects and benefits to the audience;
> Reinforce existing anti-drugs attitudes and beliefs of non-regular users;
> If trying to promote a behaviour change, then this behaviour should be specific.

(Baker and Caraher, 2001)

SUMMARY

There are a number of different approaches in relation to Substance Use prevention. It is important that any approach adopted is evidence informed and based on the needs of the specific target in mind.

However drawing on supports and resources in your local area, both general and substance use specific will help in establishing a multi-agency approach which can assist in developing a holistic preventative strategy.

09

INTERVENTION

INTERVENTION

* Intervention

INTRODUCTION

The following chapter describes a range of intervention techniques and tools used as part of treatment in the substance use field. Effective treatment plans will reflect the complexity of individual's situations and associated needs as outlined previously in this manual.

While the contents of this chapter may help inform workers on the techniques involved in each intervention strategy, the following descriptions should not be interpreted as a form of training.

The use of any of the following interventions would form only part of an overall treatment approach. In recent times much research has taken place concerning the needs of family members or other people affected by substance use. This has led to the development of interventions specific to their needs.

This section outlines approaches to treating problematic substance use and includes those developed specifically to assist family members and concerned and affected others.

HARM REDUCTION

The harm reduction approach to treatment meets the young person where they are at in life. Harm reduction could be described as an approach to working with substance users that fundamentally accepts a reduction in use or associated harms as valid treatment goals. It is accepted that in order to eliminate any possible harms occurring due to substance use, abstinence would be the desired outcome. However, it should be noted that some people may present as either unwilling or unable to change their behaviour.

Harm reduction initiatives have been developed to work specifically with people who engage in problematic substance use.

Examples of harm reduction initiatives include;

> Needle exchange programmes
> Availability of condoms
> Methadone maintenance programmes

Within the wider public health sphere harm reduction interventions that affect everyone in society are present which affect everyone in society, such as;

> Drink driving limits
> Seat belt laws
> Smoking ban

A harm reduction approach has become a central theme of Irish drug policy. There has been some concern expressed about the lack of public debate and clarity around what constitutes harm reduction and this has been cited as an issue which has affected the further development of this approach.

THE WHEEL OF CHANGE

This model of how change occurs is also referred to as the Trans Theoretical Model of Change, and can be applied to a wide variety of settings and theoretical approaches beyond the substance use field.

In substance use work it offers an acceptable model by which to understand change and in particular offers understandings of;

> When people are more likely to change their behaviour, and therefore help to inform the approach or strategy most likely to assist.
> This model identifies strategies which can be employed and therefore it is not necessary that a person must deteriorate or "reach rock bottom" before change can occur.
> This model offers a more optimistic view of lapse and relapse in that it advocates that when relapse occurs, an individual can re-engage with their goals without automatically returning to the same level or type of using.

This model identifies change as occurring in stages, these stages of change are illustrated and explained below:
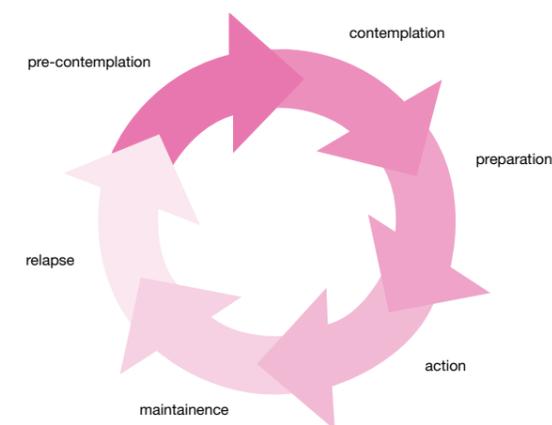
Transtheoretical Model of Change
Prochaska & DiClemente

> **Pre-contemplation** — No awareness of a need for change.
> **Contemplation** — Client is thinking about change.
> **Preparation** — Client is taking preliminary steps towards change.
> **Action** — Goals have been set and the client has engaged on a course to achieve them.
> **Maintenance** — A period of success has been achieved and behaviours are modified to cope with the changes.
> **Relapse** — Can occur at any of the stages.

(Prochaska and DiClemente,1983)

SOLUTION FOCUSED BRIEF THERAPY

Background
Solution Focused Brief Therapy (SFBT) is a time-limited, goal focused therapy that aims to resolve client problems by increasing their present coping abilities and devising future strategies in order to overcome potential difficulties.

> Workers can use SFBT to work with all age groups and with a wide variety of presenting problems.
> SFBT does not aim to address the root cause of problems, but rather enable people to increase their coping skills.
> Classic SFBT usually involves between three and five sessions but can be incorporated into other longer term therapeutic relationships.

Theory of SFBT
SFBT can help young people to do three things;

1. Describe a mental picture of their preferred future
2. Find aspects of this vision that have already occurred and
3. Define pathways to create further solutions in other areas of their lives.

SFBT operates under certain assumptions that are considerably different from traditional talking therapies. These assumptions are listed below, and in order to successfully practice SFBT, therapists will need to incorporate and model the assumptions in sessions with young people.

> It is not important to understand the cause of the problem
> Finding exceptions to the problem, meaning exploring times when the problem did not exist or was less intensive.
> Change is inevitable. Even small changes in the young person's perception of the problem or changes in their outlook can facilitate a sense of self efficacy and control.
> Realistic and achievable goals are central to SFBT.
> Seeing the "client as the expert". SFBT theory regards the young person as the primary expert within his/her life.

By exhibiting behaviours that demonstrate these principles in the session, the worker is allowing the young person to significantly influence the content of what is discussed and is sharing the control of session with the young person.

By exhibiting behaviours that demonstrate these principles in the session, the worker is allowing the young person to significantly influence the content of what is discussed and is sharing the control of session with the young person. The worker however, still remains in charge of the purpose of session; helping the young person to build solutions.

The completion of the interventions described below, are essential to the process of SFBT. The ability of the worker to perform these tasks while working from the ideology described above constitutes the practice of SFBT.

Scaling Questions
As the model regards problems as fluid and not fixed entities, this opens the possibility that they can be influenced by the young person, worker and by other people.

To highlight how this can happen, scaling questions are of central importance. A typical scaling question would look something like

"Imagine a scale of 1 to 10 where 1 is when (describe problem) affected you least, and 10 when it affected you most, where are you now?"

The young person is then asked to describe what small changes would have to take place to move them along the scale towards their goal.

The Miracle Question
The Miracle Question was devised by de Shazer and Berg following a conversation with the client who said that a "miracle would have to happen" to help him resolve his problems. While discussing this client later, de Shazer and Berg realised that there were significant therapeutic gains to be made with clients by focusing on their preferred future rather than their problem saturated past.

(Berg, 1991)

Suppose that you go home from here, and tonight when you go to bed, while you were asleep, a miracle happens, and the problem that brought you here is solved.

But because you were asleep you don't know that it happened.

When you wake up tomorrow morning how would you know?

What would be the first thing that would tell you that this miracle has happened?

To ask the Miracle Question successfully it usually involves choosing the timing carefully, speaking slowly and in a manner that invokes a thoughtful response from the young person.

Through the development of the Miracle Question and SFBT, a range of other interventions to help the individual to connect their current reality to their preferred future were developed. Two of these are briefly described below.

Exception Finding Questions
Having gotten a detailed description of what a "miracle" would look like for the young person, the worker begins to explore when was the last time "even a small part of this miracle happened" or "when you last felt this way". The purpose here is to connect the young person's prior positive

life experiences, coping skills or resources to his/her present situation and put them the task of achieving their 'miracle'.

Compliments
The use of compliments is essential to the practice of SFBT. Young people are complemented for attending the present session and any other positive efforts that they have made in the past for trying to resolve their problems. The young person is constantly reminded that with a little work here she will be able to find solutions to his/her problems and that he/she is in control of their own lives.

SFBT retains a core common principle, that people are met respectfully and helped to articulate and execute the manner in which they wish to live within their family and wider community.

MOTIVATIONAL INTERVIEWING (MI)

Over the past number of years Motivational Interviewing (MI) has enjoyed a growing reputation as an effective intervention when working with those in addiction. It is not restricted to working exclusively in the area of addiction treatment and is also widely practiced in areas such as general medical care, health promotion and social work. MI seeks to elicit behavioural change and strives to build client motivation so that change is more likely to occur.

In everyday life people are generally "in two minds" about change, and often engage in an internal process whereby the pros and cons of making change are weighed up. Individuals who are using substances may acknowledge the risks they are taking but on the other hand can also enjoy many aspects of their behaviour for a variety of reasons.

> M.I. is a person-centered approach built on foundations of collaboration, evocation and autonomy, addressing ambivalence, rolling with resistance and working with people. It "is particularly useful with people who are reluctant to change and ambivalent about changing". (Miller and Rollnick, 1991).

> M.I. may be successfully employed for those who seek or require assistance to deal with making a significant change in their life.

> It can help people investigate the pros and cons of making a change.

> M.I. works to promote confidence in individuals and build their self-belief.

FIVE CORE PRINCIPLES OF M.I.

> **Express Empathy.**
The client may be stuck. They should be made aware that the worker seeks to understand their perspective.
Their ambivalence towards change is expected and their reluctance to give up the behaviour is accepted. Acceptance does not constitute approval. Acceptance provides space for change to occur.

> **Develop Discrepancy.**
Gaps are identified between current behaviours and future goals. This helps over-ride ambivalence.
Developing Discrepancy assists the client to deal with their ambivalence in a structured manner. In response to a client's remark that they "only" drank 10 pints on Saturday night and had to be up early for an important event on Sunday, the therapist could say,

"It sounds like you had a lot to drink at the weekend. I wonder if your drinking affected your ability to perform at the event that was so important to you?".

Creating a discrepancy between current behaviour and future wishes/wants can be instrumental in assisting the client to make a decision towards positive change.

> **Roll with Resistance.**
Clients in treatment may be resistant to change, in the same way that, generally people may be resistant to change. The worker accepts this resistance as normal human behaviour. Turning questions back on the client often presents different perspectives. For example, the client might say "That will never work for me" and the counsellor might respond, "What do you think might work for you"? This changes the client's focus away from a negative perspective and gives them the power to decide their own direction whilst providing them with autonomy in their recovery. Resistance is normal and confronting resistance should be avoided as confrontation will most likely to lead to further resistance. In a worst case scenario confrontation may only lead to damaging the supportive relationship between the client and worker, sometimes to a point where the client withdraws completely from the service.

> **Support Self-Efficacy.**
Workers instil hope for change in their client. The client is asked to recall a specific time when they succeeded. With the workers guidance this example is used to instil confidence in their ability to make future change. As a non-judgemental, person centred therapy, all efforts are made to make the person aware of their own abilities and their worth. Supporting and succeeding with this process empowers the client to make immediate changes and long-term improvements in their life.

> **Avoid Argumentation.**
Confrontation with a client is pointless and counter-productive. It provides individuals with an opportunity to develop resistance. If the client says that they do not want to do something then the therapist must accept this situation. This re-enforces the client's autonomy and helps the work remain part of a collaborative process.

O.A.R.S.: 4 STRATEGIES OF MOTIVATIONAL INTERVIEWING IN THE EARLY STAGES OF TREATMENT

The following are considered to be the four most important strategies to employ in order to support the principles of MI as set out above.

> Use of **O**pen-Ended Question
> Use of **A**ffirmations
> **R**eflective Listening
> **S**ummarise

The therapeutic alliance between worker and young person is key to the success of any relationship and this alliance is often bolstered by worker empathy and a non-confrontational approach. Understanding the principles of MI is important but the key element is that the worker remains young person centred in their approach. Within the spirit of M.I. lies collaboration. The worker is not the expert as M.I. is a unified approach. The worker needs to be where the young person is at and work with them towards where they want to go.

ADOLESCENT COMMUNITY REINFORCEMENT APPROACH

(www.robertjmeyersphd.com)

Background
Adolescent Community Reinforcement Approach (ACRA) is a structured, behavioural therapy that addresses young people's substance use and associated problems. ACRA aims to make adolescents substance use free lifestyle more rewarding than using substances.

Theory of ACRA
ACRA acknowledges the powerful role of environmental influences in encouraging or discouraging substance use. Correspondingly, if environmental influences can be arranged in such a way that substance use lifestyle choices are more rewarding than substance using lifestyles this will become the more likely choice for the adolescent.

Every small step that the young person makes towards reducing or abstaining is highlighted positively by the therapist.

Because ACRA is derived in part from the principles of operant conditioning, positive reinforcement is used systematically throughout the entire approach. Every small step that the young person makes towards reducing or abstaining is highlighted positively by the therapist.

The worker's consistent attention to positive changes that the client makes forms the basis of ACRA. This positive reinforcement by the worker becomes, in some small way a type of "pay-off " for the adolescent.

Early in the process, the worker elicits from the young person the rewards substance use provide him or her and works towards having these rewards provided by activities that do not involve substance use.

Within each session and throughout the therapeutic process ACRA aims to;

> Promote abstinence from substances
> Promote positive social activities
> Promote positive peer relationships
> Promote improved relationships with family members

Within ACRA the worker also works with the parents/carers (where possible) of young people to achieve specific goals;

> To motivate the parents/carers to participate in the treatment of the adolescent
> To promote the adolescents abstinence from substances
> To help parents/carers to improve their parenting practice with the adolescent

In addition to working with the young person and their parents/carers ACRA also recognises the importance of the influence that a young person's wider community has upon his or her substance use. ACRA also works to;

> Improve the positive interactions between the young person and the living/recreation/study/work environment
> Teach the adolescent through the medium of role play, appropriate problem solving and communication skills.

In Practice
It is essential when using ACRA to recognise that the use of substances may currently be meeting some of the young person's needs and therefore, from the adolescent's point of view, may be a valid behaviour.

Workers using ACRA must also exhibit a positive and enthusiastic approach when working with young people. It is important to note that the worker should rarely, if ever, be confrontational with a young person. Evidence has shown that confrontational behaviour on behalf of the therapist leads to higher levels of resistance behaviours with clients.

While every relationship will be unique, workers using ACRA will almost always use a common therapeutic structure from which they work to ensure that their practice keeps fidelity with the ACRA model. Below is a brief description of constituent parts to that common structure.

HAPPINESS SCALE

The Happiness Scale is a ten item likert-style questionnaire that rates the young person's immediate happiness in a number of areas in including substance use, money management, emotional life and general happiness. The adolescent usually completes this with the aid of the worker in the first or second session and it provides an overview of what are the presenting issues and allows the young person to co-direct therapy.

GOALS OF COUNSELLING

The worker will usually introduce the Goals of Counselling form following the completion of the Happiness Scale as it allows the adolescent to set goals for the same ten items that he or she previously rated. Achieving the goals set by the young person will form the basis of the therapy and ultimately the reward that he or she is seeking.

FUNCTIONAL ANALYSIS OF SUBSTANCE USE

Using ACRA the worker will use the "Function Analysis of Substance Use" to help the young person to outline, examine and understand his or her 'triggers' to using substance use, the amounts used, the effects of same and the consequences that follow as a result of using. The worker may also introduce a variation of the form titled "Functional Analysis of a Pro-Social Behaviour". This form will be used to identify and examine the benefits of a non-substance using activity that the adolescent engages in. Such behaviours will be encouraged by the worker and will compete with use of substances.

OTHER INTERVENTIONS

ACRA also uses specific exercises, techniques and skills training to teach adolescents how to handle difficulties in their lives without resorting to substance use. Examples of these interventions include:

> Communication skills,
> Substance refusal skills,
> Relapse prevention training,
> Problem solving and relationship building skills training,
> Job seeking skills and
> Anger management techniques.

Role play

The central method in imparting these skills to the young person is the use of role play. The worker will adapt generic interventions to specific situations that apply to the young person sitting in front of them through the regular use of short role plays not lasting more than 2-3 minutes. ACRA is an evidence base treatment that is more cost-effective than other approaches currently in use with adolescents. Part of its success may be due to its 'joining' nature and positive engagement with young people. As the evidence for its efficacy grows, along with a wider dissemination of training opportunities for professionals against a backdrop of lower-than-comparator costs its presence in the substance use treatment field seems assured.

ACRA is an evidence base treatment that is more cost-effective than other approaches currently in use with adolescents.

INTERVENTIONS WITH FAMILY MEMBERS/CONCERNED OTHERS

Traditionally interventions in the substance use sphere have focused largely on the person who is engaged in the problematic substance use. Over the past number of years several interventions have been designed to alleviate the stresses and strains associated with another's use.

The interventions described below are accepted as being compatible to use as part of an overall package of care provided to people affected by someone else's substance use.

Both interventions also have in common their unwillingness to accept "Co-dependence Theory", which seeks to label family members and those close to problematic users as "sick" and complicit with the problematic use. Both interventions see affected people as just ordinary people seeking ways to deal with sometimes extra-ordinary situations.

THE STRENGTHENING FAMILIES PROGRAMME

(strengtheningfamiliesprogram.org)

The Strengthening Family Programme (SFP) is a national and internationally recognised parenting, teen and family strengthening programme for high risk and regular families. The main features of SFP are skills based sessions which are designed to strengthen resilience factors outlined previously in this manual. SFP utilises the influence parents have with their teens and seeks to develop skills within the family to enable this influence to be effective.

The main features of SFP are skills based sessions which are designed to strengthen resilience factors outlined previously in this manual.

SFP is effective in reducing and preventing substance use. SFP focuses on the development of family skills, roles and expectations all of which can be undermined if a family member is involved in substance use. Therefore SFP is also beneficial for families who have experience of substance use and those thought to be at risk of substance use.

These skills include;

> Effective communication
> Understanding feelings
> Coping with criticism
> Stress management
> Social skills
> Problem solving
> Resisting peer pressure
> Consequences of substance use
> Compliance with parental rules

Skills are discussed and demonstrated using role play and various other interactive activities.

Alongside developing the skills set of family members, the programme also encourages the creation of consistent family rituals.

These rituals include;

> **Weekly family meetings –** Can be formal or informal. All family members get to speak and discuss the events of the previous week and plan for the coming week.
> **Our time –** Teens and parents are encouraged identify a specific time in the week when they will spend one-one time with each other doing something the teen enjoys.

A typical weekly session is run on a timescale outlined below;

6:30 Family members arrive and partake in a meal
7:00 Parents attend parent group and teens attend teen group covering related topics
8:00 Break
8:10 Parents and teens attend the family group
9:00 Home

To ensure barriers to attending are reduced or eliminated these need to be identified and managed. This is one reason behind the provision of food, but barriers which also need to be considered are childcare and transport issues.

SFP needs a substantial team effort to run. In Ireland the approach taken to run the programme is multi-agency. Agencies commit workers to roles within the programme such as Site-Coordinator (Manager), Group Leader, Referrer or member of the planning group.

THE FIVE-STEP METHOD

This intervention is based on the *"Stress-Strain-Coping-Support Model"* (Orford et al, 2010) which offers an understanding of family member's experiences of living with someone who is engaged in problematic substance use. This model refutes the traditional way of viewing problematic substance use and the family which have attributed dysfunction or deficiency to families or family members. Although primarily a family intervention, this approach can be utilised in helping other people who are part of the substance user's life. Also known as "concerned and affected others" these groups may include work groups, leisure groups or other friendships.

Stress and strain;
It is accepted that when someone in the family develops a substance use issue it is stressful for the whole family including the person who using substances. As problematic substance use is often characterised by a cluster of issues, the stressors for family members too can be multiple and complex. The stress caused by these issues can have a negative impact on intimate relationships.

Strain is described as the effect of the stress on family member's health. It is acknowledged that Disturbances of behaviour and apparent changes in personality or extreme distress, on the part of a close relative, are known to be amongst the most disturbing aspects of chronic mental and physical illnesses and disabilities for family members (Orford et al, 1987). These disturbances and changes are features of the experience of family members living with substance misuse. It is not surprising therefore that the family members who experience these strains have an increased rate of physical, mental and general ill-health.

Coping
Living with the above stresses and strains leaves family members with the task of finding ways to respond. This is often made more difficult due to sometimes conflicting emotions and uncertainties. Although people may respond in many ways and the strategies employed may be well thought out, or indeed dependent on many

variables which are present at the time. Similarly some coping responses may be more effective than others at dependent on the situation. Three main coping strategies have been identified through research and a central feature of this model involves ensuring that family members understand that each strategy has its merits and each is a valid response and have the capacity to mediate the strains experienced.

> *Putting up with it -* The family member does not engage directly with the issues created and just carries on as normal.
> *Standing up to it -* The family member actively engages with the issues in some way.
> *Withdrawing -* The family member withdraws from the substance user and the issues.

Support
Having appropriate support is perhaps the best way for the family member to deal effectively with the stresses and strains the experience. Support is explored from a social, personal, practical and material point of view with the aim to identify areas where the family member identifies little support and develop strategies to bolster that area.

The 5 steps.

1. Listen, reassure and explore the concerns of the family member.
2. Provide relevant information on substance use and other areas.
3. Explore coping responses and the use of different strategies.
4. Explore social support.
5. Explore further options for help and support.

COMMUNITY REINFORCEMENT AND FAMILY THERAPY (C.R.A.F.T)

(www.robertjmeyersphd.com)

It is commonplace for non-using family members to raise concerns with treatment centres and professionals about their partners or other family member's use of substances. The principal cause

of frustration and concern can be the lack of motivation on the part of the using individual to acknowledge or do anything about their use. This can very often render the Concerned Significant Other (CSO) feeling helpless in their quest to get help for their loved one and can lead them to on-going feelings of despair, depression, anxiety and anger. Within CRAFT a CSO may be a parent, carer, friend, partner or in fact any concerned person who is significant in the life of the individual who is using a substance. This model also refutes the traditional way of viewing substance misuse within a family which have attributed dysfunction or deficiency to families or family members.

CRAFT works with CSO's to teach them how to deal with their family member, otherwise known as an Identified Patient (IP), on a day to day basis. They are taught how to modify the typical way they react to IP's and new behavioural procedures are developed and learned. The approach allows for positive behaviour to be reinforced and bad behaviour to be discouraged. The process attempts to have the IP reduce their intake of substances with the ultimate objective of getting them to agree to enter treatment.

CRAFT also addresses the needs of the CSO and tries to have them recognise and take care of their own personal needs and increase their overall happiness. The loved ones of those who use a substance can experience many stressors as a result of the behaviours of their addicted family member.

The CSO's usually have an enormous amount of information that they can use when working with their loved one who uses a substance. They will potentially know what the IP was like before they began using. They will perhaps, have seen the deterioration in the IP's wellbeing over time. They will also have knowledge of the level of use and will have an idea of the substances used. In addition, they will be privy to the myriad of behaviours that manifest during sobriety, during a using period and in the aftermath of use. CRAFT teaches the family member how to use this information with the goal of moving the IP towards treatment.

CRAFT empowers the CSO with the skills to remain active in encouraging the IP towards treatment whilst avoiding confrontation. CSO's are instructed in how to:

1. Decide if they themselves are suitable for the CRAFT programme. Although the process is non-confrontational in that it is non-argumentative, there is an increased risk of negative reaction from the IP as their norms are challenged by the CSO.
2. Implement a CRAFT Functional Analysis that identifies triggers for the IP abusing substances. They would also be encouraged to consider how they may be unintentionally supporting the addictive behaviour.
3. Communicate effectively with the IP.
4. Effectively implement positive reinforcement of the IP's non-using and positive social behaviour.
5. Let the IP suffer the impact of negative consequences that occur due to their negative behaviour e.g. leave them to clear up their own mess and do not help them in these matters (where appropriate).
6. Learn how to address areas of their own lives that cause them distress.
7. CRAFT training identifies methods and appropriate times to suggest treatment to the IP.
8. Prepare for the therapeutic process and understand that success is not guaranteed. Relapse is a normal part of recovery and they need to remain patient throughout.

Research in to CRAFT has shown a high rate of success where success is measured on the number of IP's entering treatment. Results have claimed that seven out of ten IP's whose CSO received CRAFT training have entered treatment but there are no figures available to measure the success of those treatments. Evidence suggests that CSO's enjoyed a favourable outcome from the training where improvements in physical and emotional wellbeing made during treatment were retained in to the future. These improvements were not dependant on whether their IP entered treatment.

10

YOUNG PEOPLE, MENTAL HEALTH AND DUAL DIAGNOSIS

* Young people, mental health and dual diagnosis

OVERVIEW SUBSTANCE USE, MENTAL HEALTH AND DUAL DIAGNOSIS

The World Health Organization characterises mental health as 'more than the absence of mental disorders' (World Health Organization 2010). Mental health is a more holistic concept incorporating - social, physical, spiritual and emotional aspects of our lives. It influences the manner in which we cope with;

> Our everyday environments
> How the decisions we make in our lives impact on how we manage our surroundings and make choices, and as such should be viewed as a crucial factor in managing overall health.

Indeed it has been widely claimed by the World Health Organization that there is no health without mental health. It is accepted that positive health is affected by many determinants, some within our control and some, perhaps, which young people have little control over.

The following image presents a widely accepted view of these determinants.

(Dahlgreen and Whitehead, 1991)

Findings from a recent study of Irish teenagers aged between 12 and 18 years of age identified that positive mental health can include;

> A positive attitude to self
> A positive attitude to life Being able to deal with life
> Talking to others
> Positive relationships to others and
> A positive state of being

(Office of the Minister for Children and Youth Affairs, 2009).

WHAT IS DUAL DIAGNOSIS AND HOW DOES IT DEVELOP?

Dual diagnosis refers to the simultaneous existence of a substance use issue and a mental health issue. Other terminology used includes Co-morbidity. Four possible relationships among co-occurring disorders can explain how a dual diagnosis disorder may develop and in turn be diagnosed:

1. One issue may be a direct causal factor of the other issue
2. One issue may be an indirect causal factor of the other issue, e.g. Self medication
3. They may result from differing causal factors but interact with each other
4. There may be an independent factor e.g. Childhood emotional trauma, common to both the substance use issue and mental health issue.

(Hegner, 1998)

Dual diagnosis refers to the simultaneous existence of a substance use issue and a mental health issue.

CANNABIS USE AND YOUNG PEOPLE'S MENTAL HEALTH

Young people using cannabis and the development of mental health issues has been subject to much research and debate in recent years. Evidence to date suggests that there may be links between cannabis use and poor mental health outcomes in young people (Royal College of Psychiatrists, 2009). This may be explained partly by the fact that the human brain continues to develop into adulthood, therefore, the continued use of any substance may be likely to interrupt this development. Also worthy of note are the changes which have occurred in the cannabis products which are currently available in Ireland. While there are many types of substances (Cannabinoids) in cannabis, the two most important for consideration here are;

THC (Tetrahydrocannabinol) - Is the cannabinoid which produces the desired high. CBD (Cannabidiol) - Is a substance thought to counteract the effects of THC.

In recent years cannabis production techniques have concentrated on developing strains of the plant which have high levels of THC. This has happened at the expense of CBD with cannabis (such as "skunk") now containing very high levels of THC with reduced levels of CBD. This imbalance is thought to increase the risk of experiencing poor mental health in users. Similarly with smoking blends which were sold in "Head Shops" and still available on the illegal market or online. These mixtures usually contain combustible organic matter infused with synthetic cannabinoids which mimic the effects of THC. These synthetic cannabinoids can in some cases be much more potent than THC and do not contain any CBD, again increasing the risk of causing harm to the mental health of users.

TREATING DUAL DIAGNOSIS

It is accepted that in order to effectively treat dual diagnosis the young person and their various needs need to be treated holistically.

Treatment for people with a dual diagnosis can be viewed as follows;

Serial Treatment – Where the treatment services operate independently with little link up.

Parallel Treatment – Where treatment services are provided by different teams working together.

Integrated Treatment – Where treatment services are delivered by the one team with specialist knowledge in both substance use and mental health.

This presents challenges in an Irish context as mental health services and substance misuse services operate independently. Fractured and uncoordinated service delivery presents potential gaps in services which in turn presents young people with difficulties in achieving their treatment goals. Within this context a youth work service may find itself in a position where in supporting the young person, it becomes involved in helping to manage these interactions with and between services.

DISCRIMINATION AND PREJUDICE

Often individuals with mental health issues face varying levels of discrimination. This stigma can often play a role in creating a range of social problems, these include: unemployment, homelessness or poverty, these factors in turn can exacerbate the mental health issue. Stigma is thought to be a fundamental barrier to understanding mental health issues along with the critical role of good mental health (Seechange, 2011).

Three fundamental concerns arise when considering social stigma in the context of those with a mental health issue.

These are:

1. Lack of knowledge (ignorance)
2. Negative attitudes (prejudice)
3. Hostile behaviour (discrimination).

DUAL DIAGNOSIS AND YOUTH WORK

The skills and ethos of youth work are assets to the youth worker which are as applicable and beneficial in supporting a young person with a co-existing substance use and mental health issue as they are when working with young people who just uses substances. It would be difficult to provide a specific toolkit for working with dual diagnosis in this manual however further information on the core skills and competencies recommended for working effectively with individuals with combined mental health and substance use problems can be found in the dual diagnosis competency framework document "Closing the Gap" (Hughes, 2006) which was developed to assist workers from a range of services to assist in the delivery of appropriate care.

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APPENDICES

Appendix 1

SUBSTANCES FACT CHART

DRUG	SCIENTIFIC /TRADE OR SLANG NAME	METHODS OF USE	EFFECTS
Heroin A controlled substance, it is an offence to import, possess, distribute, produce or supply it.	A strong painkiller Smack, Skag, H, Brown, Gear, Tack, Yack, Junk	Smoked or injected	Effects last for 2-3 hours. Withdrawal begins after 8 hours. User feels warm, drowsy and euphoric. Substance causes physical and psychological dependency; other problems include constipation and overdose leading to coma and death. Injecting substance use carries dangers of infection including HIV and Hepatitis.
LSD Under schedule 1 of the Misuse of Drugs Act it is an offence to possess, produce and supply these drugs.	Lysergic Acid Diethylamide Acid, Trips, Microdots, Strawberries	Drug ingested orally	Effects begin about 30 mins after taking the drug and peak after 2-6 hours. Heightened sensory experience changes in sight and sound, hallucinations; quite possible dangers include mental illness including paranoia and depression. Immediate problems including panic attacks, dizziness, disorientation and "bad trips". Flashbacks or re-living experiences can occur at any time.
Magic mushrooms are controlled by the Misuse of Drugs Act, it is therefore illegal to possess, produce or supply them.	Psilocybe semilanceta Mushies, Liberty Caps	Swallowed raw, cooked, dried or brewed into beverage	Effects are felt soon after consumption and peak about 3 hours later. Altered sensory perceptions with possible hallucinations can produce feelings of hilarity, euphoria and relaxation. Nausea and sickness and possible poisoning can occur if wrong type of mushroom taken.
Alcohol 1988 Intoxication Liquor Act. It is illegal to sell alcohol to under 18's both on and off a licensed premises. It is also an offence to give alcohol to a child under 5 years of age.	Ethanol, Ethyl Alcohol Booze, alcohol brand names	A liquid which is swallowed	Intensity of the effects depend on the strength of the drink and the rate and amount of consumption. Feelings of relaxation, increased confidence leading to loss of inhibitions and self-control; behaviour becomes clumsy, tiredness and blackouts can occur leading to coma and death in extreme circumstances. Alcohol use can lead to dependency and damage to brain, liver and stomach.

SUBSTANCES FACT CHART

DRUG	SCIENTIFIC /TRADE OR SLANG NAME	METHODS OF USE	EFFECTS
Alkyl Nitrites Legal to buy in sex shops for over 18's	Poppers, brand names e.g. Rush, Liquid Gold	Vapours inhaled through nose	An immediate and short lived effects including "rush" of blood, reduction of inhibitions and relaxation of muscles
Anabolic steroids Prescription only medicines	Brands such as Dianabol, Decadurabolin, Nadarolone	Swallowed as pills or injected	Used to improve physique, muscle bulk and athletic performance. Other effects include increased aggression and sex drive, menstrual abnormalities and deepening of voice in women.
Caffeine Legal	Drug is present in products such as coffee, chocolate, soft drinks	Swallowed or eaten	A stimulant that increases alertness, delays sleep, can cause anxiety and nervousness.
Tobacco Illegal to sell tobacco to under 18's	Cigarettes, Cigars, Snuff, Smokes, Fags, Pipes	Generally smoked, snuff is snorted	An addictive stimulant which causes alertness, also used as relaxant. Use causes cancer, heart disease and ulcers, can affect unborn foetus in pregnant women.
OTC Medicines (Over the counter) Legal	Products such as Codeine, Ephedrine and Antihistamines	Swallows as pills, liquid or sprayed into nose	Various effects including euphoria and stimulation.
Amphetamine The Misuse of Drugs Act prohibits their unauthorised production, supply or possession. It is also an offence to allow one's premises be the venue for same	Stimulant Speed, Whizz, Uppers, Billy, Dexedrine, Ritalin and Sulphate	Powder swallowed may be smoked, sniffed or injected.	Takes effect after approximately 30 minutes. Increases stimulation, confidence and energy with alertness; other effects include nervousness, panic and damage to organs.

SUBSTANCES FACT CHART

DRUG	SCIENTIFIC /TRADE OR SLANG NAME	METHODS OF USE	EFFECTS
Barbiturates Prescription only medicines	Sleepers, Downers, brands such as Amytal, Tunial and Nembutal	Generally swallowed although some are injected.	Slows down the brains activity causing relaxation and sleepiness. Judgement is impaired. High overdose potential leading to coma and death.
Cannabis All cannabis products are controlled by the Misuse of Drugs Act. Cannabis is included in Schedule 1. It is therefore illegal to grow, produce, supply or possess. It is also an offence to allow ones premises to be a venue for cultivating/ supplying or smoking cannabis	Tetra Hydro cannibol Smoke, Dope, Ganja, Marijuana, Blow, Pot, draw, Grass, Weed, three forms: Oil, Herbal and Resin, Hash, Hemp	Smoked as cigarette or in pipe. Can also be added to food.	Effects can last several hours. Relaxes and alters perceptions; high doses lead to hallucinations. Short-term memory loss can occur while smoking can cause cancer and reduction in male virility. An amotivational drug; psychological dependence can occur.
Cocaine It is illegal to sell, possess or supply. It is also an offence to allow one's premises to be a venue for cultivation, supply or consumption	Coke, Snow, Charlie, Crack, Free Base.	Usually snorted up the nose, also injected. Crack is smoked.	Effects felt rapidly and peak after about twenty minutes. A powerful and short acting drug that increases alertness, provides feelings of great confidence and strength. Problems include mental illness, both short and long term, as well as potential damage to organs and nasal passages. Crack has similar though more potent effects which affect the user for a very short time, approx. 15 min.

SUBSTANCES FACT CHART

DRUG	SCIENTIFIC /TRADE OR SLANG NAME	METHODS OF USE	EFFECTS
Ecstasy Under the Misuse of Drugs Act, it is illegal to sell, possess or supply ecstasy. It is also an offence to allow ones premises to be a venue for cultivation, supply or consumption	Stimulant Methylene dioxymethyla mphetamine (MDMA) Street Names inc. E, XTC, Doves, Disco Biscuits, Shamrock, Adam, Edward, Denis the Menace. Yokes	Generally swallowed as tablets	Takes affect 20-60 min, usually for about 2 hours. Provides stimulation and empathy, alters sensory perception in sight, sound and touch. Problems include nausea, sweating, a raise in body temperature, which may lead to heat stroke and coma. Drug may cause long term damage to organs. Other physical effects include tingling sensation, jaw stiffness, pupil dilation, grinding of teeth, dry mouth, and blurred vision. Has the potential to become psychologically addictive.
Benzodiazepines Prescription only medicine	Various prescribed drugs inc. Valium, Mogodon and Librium, Jellies, Lorazepam	Swallowed as tablets, may be injected from tablets or capsules	Regularly implicated in poly drug misuse. Calms and sedates users, reduces anxiety and promotes sleep. Causes lethargy and dependency. Extremely dangerous when mixed with alcohol.
Volatile Substances It is an offence to sell, offer or make available volatile substance to persons under 18 which they know or have cause to believe is likely to be inhaled	Household products inc. glues, aerosols, lighter fuels, tippex.	Gases and vapours inhaled or sprayed in and through mouth or nose	An immediate intensely drunk feeling. Light headedness and hallucinations. Problems include nausea and vomiting, asphyxiation and accidental injury and death.

SUBSTANCES FACT CHART

DRUG	SCIENTIFIC /TRADE OR SLANG NAME	METHODS OF USE	EFFECTS
Rohypnol Prescription only medicines	Roche, Ropies, 'date- rape drug'	Swallowed or dissolved in liquid	Takes effect within 20-30 minutes and lasts up to 8 hours. It acts as a sedative and is 10 times stronger than valium; it induces amnesia and slows down psychomotor responses. Withdrawal symptoms include headaches, muscle pain.
Methadone Prescription only medicine	Meth, Physeptone, Phy	Orally	Methadone is an opioid, a painkiller and a depressant. It is used as a heroin substitute and is a slow release drug. Methadone is equally as addictive as heroin and can be dangerous if mixed with barbiturates or alcohol.
Ketamine Subject to certain controls under the Misuse of Drugs Act	K, Special K, Ketalar	Swallowed as a tablet or powder	Swallowed as a tablet or powder It can take up to 20 minutes for ketamine to take effect. Such effects often include a cocaine-like 'rush', loss of muscular co-ordination and L.S.D. hallucinations. Can cause psychological dependence.
G.H.B Gammahy droxybutyr ate Subject to certain controls under the Misuse of Drugs Act	G.H.B (or G.B.H)	Swallowed as a liquid, less commonly as powder or capsule	A sedative which takes effect between 10 minutes and one hour. Low doses similar to the effects of alcohol; higher doses are likened to ecstasy. Like many sedatives there is potential for physical and psychological dependence.

NOTE: *The effects upon the individual of any drug may vary, depending on factors such as the expectations of the user, mood, amount used, the setting, tolerance, and whether it is mixed with other substances, which can be fatal. Some of the substances above are synthetic substances that are produced in unregulated laboratories. As such they are rarely pure and are often altered with a range of toxic and other dangerous agents.*

Appendix 2

DECISION MAKING FORM FOR DEALING WITH SUBSTANCE USE RELATED INCIDENTS;

Support needs of the young person; Has an assessment of their needs taken place? Do you need to inform parents? Is there advantage for the young person in having them involved? What are the limitations of the support you can offer? What other services could be involved to meet needs that your project cannot?	
Support needs of the worker; Is your line manager informed? What supervision or other internal support structures are available to you? What informal support structures are available to you? Do you know what relevant services are present in the community and how to refer the young person?	
Organisation expectations and duties; Does your project/club have a policy or guidelines to assist your decision making? Have you made a written report of the incident for your organisation?	
Legal implications; What are your responsibilities if any under the Misuse of Drugs Act? Do you need to involve social workers or Gardaí? What are your responsibilities under relevant childcare legislation? Are there responsibilities under any other legislative Act?	
How have you decided to respond?	

Appendix 3

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