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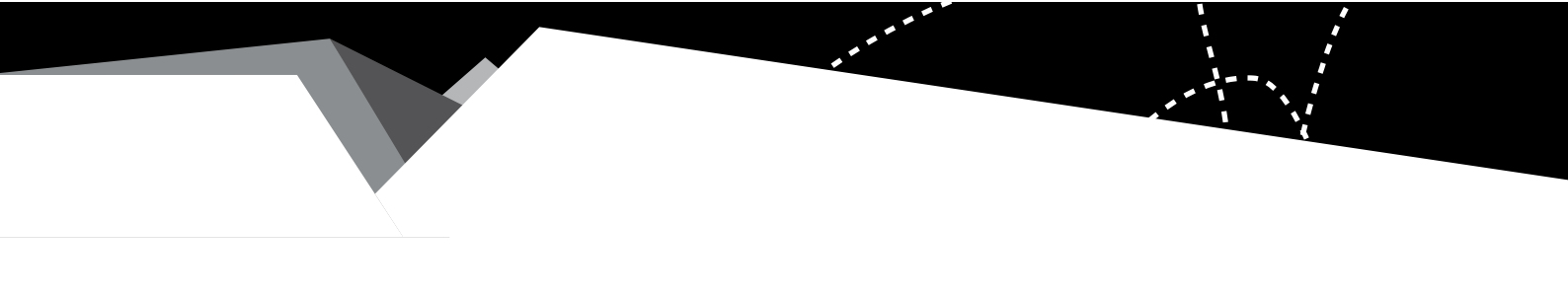
A resource for strengthening

therapeutic practice frameworks in youth alcohol and other drug services

Andrew Bruun & Penny Mitchell



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Andrew Bruun & Penny Mitchell

YSAS Pty Ltd
Melbourne, Victoria

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YSAS practice framework leadership group:

Lynn Exton	Constance Karametos
Chris Morley	Arry Valastro
Dom Ennis	Katrina Bould

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Johanna Wyn	Sandra Radovini
Lenice Murray	Steve Halperin
John Toumbourou	Gary Croton
Liz Hodgkinson	Peter Wearne

Focus group members from the Victorian youth AOD service system & Dovetail Team

Faye Edebohls	Chris Morley
Ipsita Wright	Horace Wansborough
Brad Pearce	Steve Devery
Rob Testro	Kym Richards
Leigh Beresford	Cameron Francis

Editor: Paula Ruzek: Professional Word Services

Research assistance and editorial work: Rachael Green

Design: Green Scribble

Coordination: Robyn Freestone

For further information about this work please contact:

Dr Penny Mitchell, email pmitchell@ysas.org.au or
Mr Andrew Bruun, email abruun@ysas.org.au

www.ysas.org.au

Contents

A. Executive Summary

A resource for strengthening therapeutic practice frameworks in youth AOD services

1. Introduction

This resource has been compiled for the purpose of enabling youth alcohol and other drug (AOD) services to develop and/or strengthen their therapeutic practice frameworks.

The majority of health and social care services, including Victoria's youth AOD services, are built around a 'therapeutic practice framework'. Whether or not it is explicit and documented, this framework provides the 'who', 'what', 'where', 'when', 'why' and 'how' of each service's existence and practice.

A service's therapeutic practice framework is crucial for its successful operation. It informs how the service works with its clients. It guides decision making and enables measurement of outcomes. It gives practitioners a shared point of reference to discuss practice issues and consider how to improve their service.

To maximally fulfil this role in a service, a practice framework must be:

- *Comprehensive* – it must cover all the necessary components
- *Coherent* – all the components must fit and connect in a logical manner
- *Developed* – the relevant empirical evidence, theory and practice wisdom must be integrated into its knowledge base
- *Well documented* – well written in just a few documents that are easily accessible to all members of the service.

Youth specific AOD service provision is a relatively new and emerging field. As such, the therapeutic practice frameworks of many youth AOD services are under-documented and, in some cases, under-developed. As a consequence they may be insufficiently comprehensive and lack coherence. Where documentation exists, it tends to be particularly weak in defining the nature and place of therapeutic interventions (treatment) in enabling clients to meet their needs and achieve their goals.

This resource defines the key components of a comprehensive therapeutic practice framework. Some, such as mission statement, and values/principles/beliefs, are highly unique to the history and focus of each service and are relatively well documented, so these are not specifically examined.

Instead, we have chosen to provide information and analysis in component areas where youth AOD service documentation appears less well developed. The component areas addressed are:

- Theories of problem development and amelioration
- Domains of responsibility (resources and assets)
- Domains of need for intervention
- Evidence-based therapeutic models and elements
- Characteristics of effective services and programs
- Frameworks to guide assessment and care planning.

The information and analysis provided within this resource has been developed through a comprehensive research process that involved:

- Extensive literature review
- Consultation with leading youth AOD practitioners in Victoria
- Analysis and synthesis of research evidence, theory and practice wisdom
- Primary research conducted with staff and clients of the Youth Support and Advocacy Service (YSAS).

2. Background: Young people and development

Section 2 provides an analysis of the key theoretical constructs that underpin effective youth AOD practice. This includes an overview of adolescent development in relation to youth AOD work. It examines:

- Developmental theories including historical perspectives, staged or 'building block' theories, and ecological and experiential theories
- Vulnerability and resilience research (with a strong focus on) coping and adaptation that includes the influence of culture and risk and protective factors that correlate with the development of AOD problems, or otherwise
- Stage of development considerations in the way young people use alcohol and other drugs, the function of substance use, and the impact of substance use on development.

Adolescence is a dynamic period of development and rapid change through several domains: physical,

psychological, cognitive, emotional and social. Young people must successfully undertake a range of 'developmental tasks' to make the transition to adulthood. These include:

- Achieving independence from parents and other adults
- Developing a realistic, stable, positive self-identity
- Forming a sexual identity
- Negotiating peer and intimate relationships
- Development of a realistic body image
- Formulation of their own moral/value system
- Acquisition of skills for future economic independence.

To achieve their developmental tasks, young people must take risks and learn through experience. At the same time they require protection and care to ensure that these experiences are not overwhelming and detrimental to their health, safety and future prospects. The experiences of many youth AOD clients are not regulated sufficiently, which renders them vulnerable to developing a range of health compromising issues and behaviours, including problematic substance use.

The characteristics and experiences of young people engaged with youth AOD services in Victoria and how they differ from young people in the general Victorian population are also examined.

3. Characteristics of effective services and programs

Section 3 is based on an examination of 'practice wisdom' or knowledge that has emerged and evolved primarily from practical experience rather than from science-based research.

Sources of practice wisdom and knowledge for youth AOD services include:

- Direct personal experience or the personal experience of others that is disseminated among practitioner networks
- 'Situated learning' that takes place within a service or a community of services
- Clinical practice literature or writing based on reflections, opinions and general knowledge
- The work of qualitative researchers, who study the nature of practice and experience of practitioners in youth AOD and related services
- Expert consensus synthesis work that uses systematic strategies for gathering and organising the opinions of experts around practice approaches
- Textbooks for the disciplines in the youth AOD workforce.

From our examination and analysis of sources within these areas, we describe 10 characteristics of effective services and programs that are readily discernible for the youth AOD field. They are equally apparent in the literature describing effective prevention and early intervention programs as they are in the treatment literature. These characteristics almost all refer to questions of 'how' – the ways in which services should be delivered. By contrast, in clinical research literature the core concepts focus on 'what' is delivered – the composition of the therapeutic content of an intervention.

This list of characteristics is not exhaustive or definitive. Not every characteristic will be relevant to every youth AOD program or service, and some will be best applied at system or network level.

The characteristics of effective services and programs identified and discussed in detail are:

1. Client centred/socio-culturally relevant
2. Relationship based/focus on relationships
3. Developmentally appropriate. This is broken down into a further eight areas
4. Comprehensive, holistic, ecological, multisystemic and integrative
5. Family involvement
6. Sufficient duration and intensity
7. Engagement and retention strategies
8. Behavioural, experiential and skill focused
9. Building on strengths
10. Use of theory and evidence to guide program design and refinement.

4. Guide to effective psychosocial therapeutic interventions

Section 4 describes seven therapeutic practice approaches or models that are highly appropriate for use in Victorian youth AOD services. Their selection is based on: evidence of effectiveness; practice wisdom and consistency with the characteristics of effective services and programs; client characteristics; and characteristics of the Victorian youth AOD service system.

This resource proposes that a variety of different therapeutic models could be applicable within the therapeutic practice framework of a youth AOD service or network. For Victoria, we propose that all the practice models discussed should be adopted and supported.

The seven therapeutic practice approaches or models are:

1. Motivational Interviewing
2. Community Reinforcement Approach (particularly the adolescent version)
3. Cognitive Behaviour Therapy
4. Multidimensional Family Therapy
5. Dialectical Behaviour Therapy
6. Narrative Therapy
7. Solution Focused Therapy.

Discussion of each model includes:

- Some theoretical and philosophical background
- An outline of the research evidence for effectiveness of the model and the relevance to young people with AOD problems and other complex needs
- How the model is consistent with the characteristics of effective services and programs
- Its limitations
- How well it can be applied to outreach and residential services, the two key service modes used in the Victorian youth AOD sector.

The aim in presenting this material is to encourage practitioners to consider the relevance and usefulness of these models within therapeutic practice frameworks that might be developed in their own organisation or at the state policy level.

5. Behaviour change

Youth AOD services seek to create the conditions that make bahaviour change possible, particularly in relation to substance use. To achieve this, two important issues must be addressed simultaneously:

1. Harmful substance use as an individual health-compromising behaviour; and
2. The developmental vulnerability of young people, which is largely determined by social/ecological factors.

An overarching therapeutic practice framework for youth AOD services therefore requires:

- An individual health behaviour change framework to guide youth-specific AOD assessment and intervention planning (covered in Section 5).
- A developmentally attuned, social-ecological framework that addresses vulnerability and the determinants of AOD problems (covered in Section 6).

Section 5 identifies the Transtheoretical Model of Change as the individual health behaviour change framework most relevant for youth AOD work in Australia. This model's central organising construct, the 'Stages of Change' is well understood by youth AOD practitioners and widely used to assess client readiness and to guide intervention planning. Even so, the Transtheoretical Model has several limitations which are also discussed in this section.

Each 'Stage of Change' is described in relation to the needs and characteristics of youth AOD clients. There is also a discussion of which therapeutic practice approach described in Section 4 (Motivational Interviewing, Cognitive Behaviour Therapy, etc.), is most suited to each stage.

6. Framework for Resilience Based Intervention

Section 6 provides a framework for Resilience Based Intervention. This framework focuses on how youth AOD services can facilitate both short and long term behaviour change using the concept of 'resources and assets'. These resources and assets can be used to lessen the immediate risk of harm and begin protective processes that guide positively a young person's developmental pathway.

'Resources and assets' are broken into three categories:

- Social ecology (material, human, socio-cultural, health and community services), which contribute to a young person's capacity for resilience
- Knowledge, skills and attributes (living skills, self-management skills, interpersonal skills, personal attributes)
- Systems of belief, covering identity and motivation (self-concept and world view; and 'meaning making' – sense of security, sense of purpose, sense of belonging and connectedness, and hope and expectancy).

The framework uses evidence from resilience research and developmental health research, emphasising social and emotional well-being. The aim is to enable young people to increase control over their own health and well-being – which depends on them having the internal and external resources and assets required to meet their needs, fulfil their aspirations and respond to environmental influences.

However, young people with AOD problems, particularly in combination with other complex problems, frequently lack experience of and access to many of the resources and assets required to meet their needs. The framework defines and discusses 'needs' over five domains:

- Protection from harm and the capacity to respond to crisis
- Stability and the capacity to meet basic needs
- Participation in constructive activity
- Developmentally conducive connections
- Greater control over health-compromising issues and behaviours (e.g. harmful substance use).

Section 6 explores the relevance of each domain to the youth AOD target group in Victoria. It then identifies the resources and assets that can be applied within each domain to enable young people to attain their goals and to gain greater control of their own health and well-being (including change in their substance-using behaviour).

7. Practice framework implementation

Section 7 introduces and discusses several extra structures, processes and design features of service systems that need to be considered when thinking about how a therapeutic practice framework will be implemented.

These extra structures, processes and features are:

- Service modalities. These are the structural platforms used to deliver services and programs. The main ones used in Victoria are: outreach; clinic-based, day programs; acute residential services; long-term residential rehabilitation; and specialist programs.
- Therapeutic vehicles. These are the interpersonal, environmental and technological platforms for the delivery of therapeutic interventions. Victorian youth AOD services tend to rely on two main vehicles: therapeutic relationships (between worker or a team of workers and the young person) and therapeutic environments (e.g. residential).
- Therapeutic intentionality. This means the practitioner having clear and explicit objectives in what they are trying to achieve in their therapeutic work with a client at any particular point in time. Five intentions that repeatedly arise in the literature are briefly discussed and placed within the wider therapeutic practice framework.
- Use of a modular practice elements approach. This is an innovative approach to describing and packaging the content and techniques of psychotherapeutic interventions. Many of the therapeutic models discussed in Section 4 share common 'practice elements' – discrete techniques or strategies that are used as part of a larger intervention plan. Services may not be able to implement all of a therapeutic model, but practice elements from it may be suited to their clients' treatment plans. There is a discussion of the benefits of 'modular' design when choosing therapeutic content of a treatment.
- Processes to support clinical decision-making. The role of six main processes – assessment, case formulation, care planning, recording case notes, regular supervision and case review – in supporting the implementation of a therapeutic practice framework is described. There is also analysis of how they may need to be improved within youth AOD services.

1. Introduction

1.1 Purpose of this resource

This resource is designed for use by youth alcohol and other drug (AOD) services to assist in the development and strengthening of therapeutic practice frameworks. Development of such frameworks might involve clarification, refinement and strengthening of existing practice frameworks, or formulation and documentation of new practice frameworks. These frameworks can be specific to individual services, service networks or whole service systems [1]. Although this resource has been developed in Victoria, most of the information and analysis will be relevant to youth AOD services more broadly.

This resource focuses on several dimensions of practice frameworks that are underdeveloped in existing documentation at the service and policy level. It also contains analysis of conceptual linkages between dimensions that have not been adequately elaborated.

1.2 Purpose of therapeutic practice frameworks

A therapeutic practice framework is a coherent set of ideas about the targeting, approaches, content, techniques and modalities of therapeutic practice that is endorsed and shared by practitioners within a particular service or service system. It can be communicated in terms that are understood by stakeholders in an organisation's authorising environment.

A comprehensive therapeutic practice framework should include a set of components or dimensions similar to the following (see also Figure 1.2):

1. A statement of mission or purpose
2. Specification of the target population
3. Statements of values, principles and other key beliefs underpinning the practice approach or the design of the service or service system
4. Theories of problem development and amelioration
5. Specification of domains of responsibility for the service or service system
6. Specification of the domains of need to be addressed
7. Articulation of the key therapeutic intentions
8. Description of, and justification for, therapeutic interventions
9. Characteristics or principles of service delivery at the program or organisational level
10. Modalities and vehicles of service delivery
11. Conceptual frameworks that guide assessment and care planning at the individual client level
12. Performance indicators
13. Client outcome domains.

A *comprehensive* and *coherent* therapeutic practice framework brings all relevant information together in a way that ensures logical articulation between the various components, and in a way that provides guidance for decision-making at various levels in service systems.

Clear documentation of a therapeutic practice framework can provide many advantages to an organisation that is committed to quality improvement. It enables readers to more readily grasp the breadth, depth and complexity of practice within their service or service system and to participate more fully in the collective tasks of critiquing and strengthening practice. It provides an organisation with a shared point of reference or a map to orient and inform discussion of practice issues. This provides a foundation for an organisation to:

- Be more intentional and reflective in its practice;
- Identify areas of strength and weakness in practice as compared with ideals communicated in theory, policy and the evidence base;
- Design or select practice and workforce development materials and strategies that have a good fit with existing approaches;
- Better communicate with stakeholders to improve interagency coordination and collaboration; and
- Clarify the rationale for investment in particular innovation and service development projects.

[1] This document is not intended to be used as a therapeutic practice framework in itself. It does not contain all of the necessary elements and specifications of such.

Figure 1.2: A structure and logic for therapeutic practice frameworks

CONTEXTUAL PARAMETERS	NEEDS & INTENTIONS	THERAPEUTIC INTERVENTIONS	IMPLEMENTATION	OUTCOMES
1. Mission statement	**4. Theories of problem development & amelioration** e.g. - Developmental theory - Resilience & vulnerability	**8. Evidence-based therapeutic practice elements (i.e. therapeutic content & techniques for which there is evidence of effectiveness within the specified domains of need for intervention)** e.g. practice elements drawn from: - Motivational interviewing - Cognitive behaviour therapy - Community reinforcement approach - Family therapy - Dialectical behaviour therapy - Narrative therapy	**9. Characteristics of effective services & programs** e.g. - Client-centred - Relationship-based - Developmentally appropriate - Engagement strategies - Multisystematic - Sufficient duration	**12. Performance indicators** e.g. - Proportion of compulsory referrals who return voluntarily
2. Target population e.g. - AOD only - AOD + mental health - AOD + justice system - Multiple needs	**5. Domains of responsibility** e.g. - Resources & assets - Prevention, early intervention, treatment, aftercare		**10. Modalities & vehicles of service delivery** e.g. - Outreach - Clinic-based - Day programs - Acute residential - Residential rehabilitation	**13. Client outcome domains** e.g. - Meeting individual goals - Health & wellbeing - Quality of life - Reduced AOD use - Reduced crime
3. Organisational values & principles e.g. - Human rights - Social justice - Empowerment - Transparency - Harm reduction - Learning & evolving	**6. Domains of need for intervention** e.g. - Protection from harm - Stability - Participation - Developmentally conducive connections		**11. Frameworks to guide assessment & care planning** e.g. - Stages of Change Model - Resources & assets	
	7. Therapeutic intentions e.g. - Engagement - Enhancing motivation - Modifying cognitions - Building skills - Modifying contingencies - Stengthening relationships			

1.3 Why we need stronger therapeutic practice frameworks

A major assumption embedded in this resource is that to develop a stronger therapeutic framework, it is first necessary to document a more comprehensive and coherent framework. A framework may be weak because:

- it is insufficiently comprehensive (documentation does not cover all necessary components or dimensions);
- it insufficiently coherent (the components are poorly connected to one another); or
- certain components are underdeveloped or not well grounded on empirical evidence, theory or widely shared practice wisdom.

The therapeutic practice frameworks of services that comprise the Victorian youth AOD system are poorly documented and therefore insufficiently comprehensive or coherent. Practitioners tend to share certain understandings about general therapeutic intentions and the types of interventions that should be used, but there may be little written information describing these understandings.

Any written information may be fragmented across a variety of documents such as service contracts, job descriptions, various policy and procedure manuals, training materials, strategic plans and program evaluation reports. These sources of information are often poorly connected, updated at irregular and variable intervals, and few practitioners may be across all of the up-to-date information.

1.4 How this resource was developed

This resource was developed through a process of research involving extensive literature review, consultation with leading youth AOD practitioners in Victoria, and analysis and synthesis of research evidence, theory and practice wisdom. It was also informed by primary research conducted by the authors with staff and clients of YSAS, the largest provider of youth AOD services in Victoria. Therefore, this resource builds upon the strengths of youth AOD services rather than proposing any radical reorientation.

1.5 Contents of this resource

This resource provides content relevant to most but not all of the 13 components of practice frameworks outlined in Figure 1.2. The aim has been to provide information and analysis that address major gaps and weaknesses in documentation of practice approaches. Within each of the included dimensions, a wide range of content is surveyed. Not all of the content will be relevant to every youth AOD service. The intention is that people developing practice frameworks can select content most relevant to practice within their unique context. Analysis aims to assist decision processes around selection of content.

1.5.1 What is covered and why

This resource provides an extensive review of research-based evidence and practice-based knowledge for components 4, 5, 6, 8, 9 and 11 of therapeutic practice frameworks:

- Theories of problem development and amelioration;
- Domains of responsibility (resources and assets);
- Domains of need for intervention;
- Evidence-based therapeutic models and elements;
- Characteristics of effective services and programs; and
- Frameworks to guide assessment and care planning.

In addition to lack of comprehensiveness, practice frameworks have tended to be weak in defining the nature and place of therapeutic interventions. This resource seeks to redress the various weaknesses identified by providing:

- detailed analysis of a range of empirically and theoretically supported therapeutic psychosocial interventions relevant to youth AOD services (component 8);
- detailed analysis of the practice wisdom-based knowledge that has shaped the development of youth AOD services in Victoria and which is becoming increasingly formalised in the academic literature (component 9); and
- integrative analysis illustrating how practice-based knowledge and knowledge of the Victorian youth AOD system can be used to explore technical issues and promote effective decision-making around implementation of psychotherapeutic interventions (components 8, 9 and 10).

Component 10 (modalities and vehicles) is relatively well covered in existing service documentation. However, what is missing is detailed analysis of how therapeutic interventions can be applied within two of the major modalities used in Victoria – outreach and residential (components 8 and 10). This resource provides that detailed analysis.

Another major weakness concerns how information from client assessment is used to specify domains of need for intervention at the individual level, and then is subsequently used to inform the selection of therapeutic interventions.

This resource approaches these challenges in the following ways.

- It takes into account prevention, early intervention and post-treatment reconnections when considering domains of responsibility (component 5). An extensive range of 'resources and assets' that all young people require for optimal development is presented. Literature describing these resources and assets and conceptual frameworks for organising them is reviewed. This material is synthesised into a framework comprising resources and assets that are:
  - > Internal to the individual (i.e. skills and attributes and beliefs); and
  - > External to the individual (i.e. present in the social ecology of the person).
- It takes into account the requirement to improve responses for young people with complex needs in its consideration of the domains of need (component 6). These domains are defined in terms of sets of closely related risk factors as well as sets of 'resources and assets' that are commonly missing or inaccessible in the developmental pathways of young people who present with multiple and complex needs. Five key domains of need are described:
  - > Protection from harm and the capacity to respond to crisis
  - > Stability and the capacity to meet basic needs
  - > Participation and constructive activity
  - > Developmentally conducive connections
  - > Greater control over health-compromising issues and behaviours.

Research and practice wisdom literature is reviewed that describes these domains of need and examines evidence of their importance.

- It describes and elaborates on the conceptual frameworks relevant to assessment and care planning (component 11) used within the Victorian AOD system (e.g. the Transtheoretical or Stages of Change Model).
- It analyses how resources and assets and domains of need can articulate with each other to indicate the use of particular therapeutic interventions (component 11).

1.5.2 What is not covered and why

Mission statements (component 1) and statements of organisational values and principles (component 3) depend upon the unique history and focus of each organisation. It was considered unnecessary to address these in detail. However, the implications of values and principles that are widely shared in the Victorian youth AOD system are discussed regularly in other sections.

There is no specific section devoted to modalities (component 10) or vehicles for service delivery, but they are discussed in section 7. Outreach and residential modalities are discussed while exploring the application of therapeutic interventions in youth AOD services in Victoria.

Performance indicators or outcome domains (components 12 and 13), while essential elements of any therapeutic practice framework, depend on an organisation's mission and values, theories of problem development and amelioration, identified client needs and particular therapeutic intentions. For this reason, these components are not covered in this resource.

2. Background information

2.1 Young people and development

2.1.1 Introduction

Maturation is a biologically universal phenomenon, as is the notion of a developmental transition. How this transition is structured and understood varies according to culture (Sigelman & Rider, 2006). Adolescence, as understood in the Western sense, begins with the changes brought on by puberty and culminates in the acquisition of adult roles and responsibilities. This includes the formation of a personal and social identity and the discovery of moral purpose. The consensus view from the fields of neuroscience, developmental psychology and sociology is that the 'adolescent transition' begins as early as 10 years old and continues into the mid-twenties.

Adolescence is not a uniform process but a dynamic period of development characterised by rapid change. The following domains have been identified as central to these changes by the NSW Centre for the Advancement of Adolescent Health and the Transcultural Mental Health Centre (2008):

- **Physical** – onset of puberty (physical growth, development of secondary sexual characteristics and reproductive capability)
- **Psychological** – development of autonomy, independent identity and a value system
- **Cognitive** – moving from concrete to abstract thought
- **Emotional** – moodiness; shifting from self-centredness to empathy in relationships
- **Social** – peer group influences, formation of intimate relationships, decisions about future vocation.

No single theory or model of development provides a truly universal construct for understanding the changes that young people will undergo in the transition to adulthood. The elucidation of forces shaping young people's development and the patterns that it typically follows has given rise to a generalised model of "normative" adolescent development. Melbourne-based anthropologist David Moore (2002) recommends being suspicious of "…universalising, ideological statements about the archetypal 'adolescent', animated by internal drives, that require careful handling and engaged in the search for a fixed personal identity" (p49).

Conceptualising development as normative has been critiqued for the inadequate consideration given to changes occurring within the broader social and economic environment. Kilmartin (2000) points out that the idea of normative development remains based on traditional pathways such as moving from school to work, leaving home, establishing a relationship, getting married, purchasing a home and having children.

The power inherent in the social divisions of society is also underplayed. Wyn and White (1997) found that "…Social change has both costs and benefits that are not evenly distributed or confined to particular groups of young people" (p15). Further criticisms centre on a failure to take into account cultural and religious differences among young people (Sigelman & Rider, 2006) and a tendency to masculinise adolescence (Gilligan, 1982).

While acknowledging the validity of this critique, it is generally accepted that young people must undertake a range of developmental tasks to successfully negotiate the adolescent transition. The NSW Centre for the Advancement of Adolescent Health and Transcultural Mental Health Centre (2008) provide the following list of tasks:

- Achieving independence from parents and other adults
- Developing a realistic, stable, positive self-identity
- Forming a sexual identity
- Negotiating peer and intimate relationships
- Development of a realistic body image
- Formulation of their own moral/value system
- Acquisition of skills for future economic independence.

To achieve developmental tasks, young people must take risks and learn through experience. The risks young people take and the way they behave on their developmental journey can only be understood in light of the gains they hope to make. Young people need the space, support and experience to develop the necessary capabilities to eventually take responsibility for their own safety, health and well-being. Adolescent perspectives and motivations are likely to differ from adults. Table 2.1 offers simple examples of alternative explanations that either adults (care givers) or young people may have to explain typical adolescent behaviour.

Table 2.1: Differing perspectives on adolescent behaviour

ADULT PERSPECTIVE	ADOLESCENT PERSPECTIVE
stupid / foolish	exciting / fun
easily influenced	sense of belonging
acting without regard for consequence	testing limits / not caring / gaining status
dangerous	thrilling / exciting
withdrawn	needing privacy

Source: Bruun and Palmer (1998).

At times, young people expect or yearn for the structure, support and nurturing that was available to them as a child, even though they will almost always be reluctant to admit it.

Young people require support, guidance, modelling and teaching from others in the course of their development. They also require appropriate discipline and monitoring from caring adults. This role is typically performed by parents or legal guardians, who must constantly consider the capacities of the young person and set relevant limits to regulate their exposure to risk. Limits are most often set around behaviours that are believed to compromise the safety, health and future prospects of the young person.

Young people often complain about the limits that are set for them as they naturally desire more responsibility for decision-making than their parents or guardians are prepared to give. Even so, the setting of limits linked with fair consequences provides structure and a sense of containment as well as a clear set of rules that young people can test out and define themselves against.

2.1.2 Developmental sub-stages

Youth AOD services are faced with the challenge of designing interventions for a target group spanning 12 to 21 years of age, featuring marked differences between clients in terms of maturity, needs and social expectations. Yates and Masten (2004) point out that expectations and indicators of good outcomes change with age. They argue that intervention strategies need to be built around appropriate expectations and changing developmental needs.

This view is supported by evidence that effective interventions for young people are customised according to developmental stage (Nation, Crusto, Wandersman, Kumpfer, Seybolt & Morrisey-Kane 2003; Small, Cooney & O'Connor, 2009). Targeting interventions in this way maximises the prospects for effective engagement while mitigating the risks associated with mixing adolescents in early and later stages.

The task of identifying discrete developmental periods or sub-stages is not straightforward as adolescence in contemporary society tends to be non-linear and stretched over a longer period than in previous times (Hilman & Marks, 2002; Kilmartin, 2000). A pragmatic response is required. As such, described below are the key characteristics of young people according to the three sub-stages (early, middle and late) that have generally been used in developmental psychology (Steinberg & Morris, 2001; Bashir & Schwarz, 1989). It is acknowledged that these stages cannot capture the unique and continuous nature of each young person's developmental journey.

Early adolescence (10 to 13/14)

Young people who are 12 and 13 years old are clearly in the early adolescent phase. The needs and functioning of some 14 and even 15 year olds may also mean they fit within this stage, highlighting the limitation of using age as a marker. The key characteristics of young people in this stage that are relevant to delivery of youth AOD services are:

- The commencement of individuation – a shift in orientation from parents to peers
- Relatively amenable to direction
- Need and respond well to structure
- Tendency for concrete or more black-and-white thinking
- Strongly focused on the present and can be impulsive
- Experiential learners
- Primary to secondary school transition
- Legal status as minor.

Mid-adolescence (14 to 17)

The middle adolescent stage generally pertains to young people within the 14 to 17 years old age range. This stage is associated with heightened cognitive and emotional development. The characteristics relevant to delivery of youth AOD services are:

- Critical period for identity and value system development
- Desire to appear in control
- Strong need for privacy
- Continued need for structure and regulation of experience
- Need for status and acceptance
- Increased experimentation and risk taking
- Can overestimate coping abilities
- Increasing capacity for consequential thinking
- Still minors, school attendance compulsory until 15.

Late adolescence (17/18 to 21)

Young people aged 18 to 21 years are generally considered to be in the late adolescent stage. In this stage, young people are typically beginning to consolidate their identities and further develop their capacity for problem solving, consequential thinking and self-management. This process is likely to continue well into their twenties. It is critical to remember that all young people in this stage retain a propensity for impulsivity and exhibit characteristics commonly associated with early developmental sub-stages. Relevant characteristics are:

- Beginning to consolidate identity
- Further capacity for problem solving and consequential thinking
- More future oriented
- Increased mobility
- Continued risk taking
- Greater societal expectations to 'act' as an adult
- Transition to adult legal system
- Considering vocational choices
- Increased ability to access more adult-style service provision.

2.1.3 The contribution of neuroscience

There is an emerging and significant body of research that explores the neurobiological and neuropsychological underpinnings of young people's developmental experience. This research confirms that the distinction between teenagers and adults is more than one of age.

Brain development proceeds from back to front; sensory inputs first, then coordination functions, then lastly executive functions that include decision-making ability and impulse control. Two processes take place at a rapid rate: (i) pruning, the process by which unnecessary nerve synapses (grey matter) in the frontal lobe are eliminated; and (ii) myelination, in which white matter envelops connections to stabilise them. This conversion of grey to white matter is critical to the brain's operation becoming more efficient and the development of neural networks that regulate behaviour (Spano, 2002).

The brain region most closely associated with the executive functions and the regulation of behaviour is the prefrontal cortex. It is restructured in the teenage years but is possibly not fully developed until the early to mid-twenties (Shonkoff & Phillips, 2000; Giedd, Blumenthal, & Jeffries, 1999). These revelations have led to concern being expressed over whether young people lack the judgment to make decisions about their substance use (Reyna & Farley, 2006). Given that many youth AOD clients continue to use substances, the formulation and application of harm reduction interventions must include consideration of a young person's capacity to exercise executive functions. It also reinforces the need for practitioners to properly calibrate their expectations with the emerging capacity of young people for effective decision making and self-regulation (see Section 3.4).

Judith Bessant (2008) warns against using the recent neuro-scientific discoveries as a rationale for overprotecting young people. She points out that:

> "Some young people are sometimes at risk, not because brains are different but because they have not had experience or opportunity to develop skills and judgment that engagement in those activities and experiences supply" (p358).

2.1.4 Overview of developmental theories in relation to youth AOD work

The following is a brief account of the theories pertaining to adolescent development that are influential in how AOD services are designed and delivered for young people.

The ongoing influence of historical perspectives

More than a century ago, American psychologist Grandville Stanley Hall (1904) produced a seminal treatise on adolescence that dramatised the transition between child and adulthood as a period of "storm and stress". Hall viewed adolescence as a time of high emotional and psychological conflict triggered by hormonal changes in puberty. Hall identified the attainment of "higher human capacities" such as the ability to reason as the core developmental task of adolescence. The major characteristics of adolescence for Hall included conflict with parents, mood disruptions and risky behaviour. At the same time, Freud also portrayed adolescence as a period of intense turmoil (Moore, 2002).

Hall's treatise may mark the beginning of the modern study into adolescent development, but the notion that adolescence is a period of "storm and stress" goes back to the origins of Western civilisation. Moore (2002) points out that ancient Romans (and their predecessors the Greeks) considered the transition from childhood to adulthood a volatile emotional period and young people were thought to require guidance to forestall their squandering of new-found social freedom. Prior to maturation, instinct and desire were thought to drive human action. Moore adds that for the Romans, growing up required the acquisition of logic and reason. The parallels with Hall's theory are striking.

Daniel, Wassell, and Gilligan (1999) point out that the "storm and stress" view of adolescent development is now largely unsupported. Given the long history of these ideas, however, it is perhaps understandable that such themes persist in the discourse on adolescence to this day. Steinberg and Morris (2001) posit that this has created a "…misleading perception that healthy development is more about the avoidance of problems than the growth of competencies" (p85).

Staged or 'building block' theories

Several 'staged' or 'building block' theories of human development were generated in the mid-twentieth century. Included in this group of theories are Havighurst's 'developmental task theory', Erikson's theory of 'psychosocial' development, Piaget's cognitive development theory (in Gruber & Voneche, 1977), and Kohlberg's (1981) theory of 'moral reasoning'. The conceptual basis of these theories is that development is a stepwise progression through stages, with movement to each new stage dependent on successfully completing tasks in the previous stage.

Contemporary research in the social sciences, psychology and neuroscience has demonstrated that development is continuous rather than staged, and that it varies according to socio-cultural and environmental influences. While the relevance of these once-dominant theories has diminished, they have nevertheless contributed much to current theory.

In developmental task theory, Havighurst (1972) identified six age-specific life stages covering birth to old age, each with a discrete set of developmental tasks. For Havighurst, developmental tasks derived from physical maturation, personal values and the pressures of society. The tasks identified by Havighurst for the adolescent period (13 to 18 years old) included acceptance of one's physique; adopting a set of values and an ethical system as a guide to behaviour; developing healthy attitudes towards the self as well as social groups and institutions; developing new and more mature relations with age mates of both sexes; settling on an appropriate social role and selecting an occupation; and achieving emotional independence from parents and other adults.

The notion that mastery of developmental tasks leads to healthy adjustment still has much salience today. However, Havighurst's conception of typical age-graded stages no longer fits with contemporary evidence, which demonstrates considerable variation in the developmental trajectories of individuals across the life course.

Like Havighurst, Erikson's model of Psycho-Social Development (Erikson, 1968) contained several stages with discrete tasks. Erikson believes that the critical task of adolescent development (teens to age 20) is to differentiate from family of origin/society. This process of individuation involved resolving the 'identity crisis', the main question being 'Who am I?' Erikson's ideas have been extremely influential and, as such, adolescence is commonly understood as a time of self-exploration. Research has confirmed that as adolescents develop, they evolve more abstract characterisations of themselves and self concepts become more differentiated and better organised (Steinberg & Morris, 2001).

However, research has not supported Erikson's timetable for development. The tasks within some of his stages have been criticised for being based more on speculation than evidence. Further, it is now argued that only a small minority of young people experience the kind of identity crisis described by Erikson.

Cognitive Development Theory, originated by Swiss psychologist and natural scientist Jean Piaget (1977),

a contemporary of Erikson, identified four developmental stages. His work was particularly influential throughout the second half of the twentieth century. Piaget used rigorous observational research methods to fully develop his theory, but empirical studies of cognitive development, now based more on information processing and computational models, have brought many of his basic propositions into doubt (Steinberg & Morris, 2001).

Even so, still relevant is Piaget's observation that as children transition to adolescence their cognitions develop from "concrete operational thought" (logical but black-and-white or concrete thinking) to formal operational thought (increased ability to think abstractly, beyond the here-and-now, and to better understand the perspectives of others).

American psychologist Lawrence Kohlberg concentrated on the development of logic and morality. His model is based on moral reasoning. Six constructive stages are proposed, each more effective at responding to moral dilemmas than its predecessor (Kohlberg, 1981). The six stages are identified in Figure 2.2.

Table 2.2: Kohlberg's stages in moral development

LEVEL	STAGE
Level 1: Pre-Conventional	1. Obedience & punishment orientation (How can I avoid punishment?)
	2. Self-interest orientation (What's in it for me?)
Level 2: Conventional	3. Interpersonal accord & conformity (social norms – the good boy/good girl attitude)
	4. Authority & social-order maintaining orientation (law & order morality)
Level 3: Post-Conventional	5. Social contract orientation
	6. Universal ethical principles (principled conscience)

Jonathan Haidt (2007) has made an incisive critique of Kohlberg's theory, demonstrating that moral action is based more on intuition and unconscious processes than reasoning. Gilligan (1982) also points out that the theory is not culturally neutral and is based on research with male participants. She explains that where Kohlberg's focus is on justice, other models might equally focus on the ethics of caring.

Ecological and experiential theories

Developmental Systems Theory (DST) makes individual-context relations the basic unit of analysis and the focus of intervention (Silberstein & Lerner, 2007). Emphasis is on understanding how each young person's unique experiences within their social ecology shape their development.

DST emphasises the diversity of human development and strong evidence is posited for 'plasticity' in human developmental processes. This means that regardless of past experience, there is always potential for change and reason for optimism – a view that is commensurate with both progressive neuroscience and contemporary social science perspectives.

DST demonstrates how the promotion of positive human development can be achieved by aligning the strengths and potentials of individuals and contexts. Biological and psychological processes and developmental milestones, so often viewed as predetermined and fixed, are demonstrated to be dynamic and subject to socio-cultural and historical influences. DST provides a sound scientific framework for understanding how multiple factors work together to shape human development. In this way, DST provides for the complexity of young people's developmental experience to be captured and understood.

DST evolved from Ecological Systems Theory (EST), which was developed by Urie Bronfenbrenner (1979). EST is also known as 'development in context' or 'human ecology' theory. EST holds that everything in a child or young person's environment affects how he or she grows and develops. Development is viewed as a continuous process and the idea of discrete stages or building blocks is not supported. Bronfenbrenner specifies four types of integrated environmental systems, each with their own roles, norms and rules that can powerfully shape development. These are the:

- **Microsystem** – immediate environments (e.g. family, school, peer group, neighbourhood, etc)
- **Mesosystem** – connections between immediate environments (e.g. a young person's connection with home and school or the family's status in the community)
- **Exosystem** – external environmental settings that only indirectly affect development (e.g. parent's workplace)
- **Macrosystem** – the larger socio-cultural context.

Each young person's interactions with people and within systems are ecologically shaped, but equally, how he or she acts or reacts affects the response of people and systems. This brings each young person's special genetic and biologically influenced personality traits (temperament) into the developmental equation.

Another seminal (but little known) theory that considered development as context dependent is Cultural History Theory, developed by Lev Vygotsky (1978). Vygotsky was a pioneering development scientist working in the former Soviet Union, whose recognition has not matched his influence on later developmental theorists. His work predates and foreshadows Social Learning Theory.

Cultural History Theory holds that development is a continuous process whereby children and young people learn through hands-on experience. Development is believed to be best facilitated by adults, who through being connected with the child or young person are available to provide timely and sensitive intervention when they are on the edge of learning a new task. This is known as the 'zone of proximal development'.

Vygotsky introduced the concept of 'scaffolding' to represent how the knowledge children already have can be built upon by supportive and available adults. Scaffolding has become a widely used construct in resilience research and in the provision of youth services more generally (see Section 2.2.5).

Albert Bandura's seminal work, Social Learning Theory (1977), also demonstrates the importance of social experience and observational learning for young people. Social Learning Theory emphasises that opportunities for modelling, imitation and identification through interaction with significant others within one's environment is critical for human learning and development.

Social Learning Theory also makes paramount the role of reward and punishment. Bandura introduced the concept of self-efficacy – a person's own judgment of how well he or she can execute courses of action required to deal with prospective situations (see Section 5.2.4) – which is central to the study of resilience and health behaviour change (see Section 5).

Attachment Theory is another with profound implications for how development is understood and nurtured. It was formulated by British psychiatrist and psychologist John Bowlby and further developed by American developmental psychologist Mary Ainsworth (see Bretherton, 1992).

Bowlby's original theory held that human infants need a secure relationship with adult caregivers, without which normal social and emotional development will not occur. Ainsworth added the concept of the 'secure base' that is instilled through the nurturing provided by a loving parent, particularly a mother. She also identified several 'attachment patterns' that guide the individual's feelings, thoughts and expectations in later relationships (Vaugh et al., 2008).

Early conceptualisations of Attachment Theory were viewed as too deterministic, with development now demonstrated to be subject to more varied social processes. A further criticism is levelled by Kagan (1994), who rejects the notion that the bond between caregiver and infant is crucially influential in later emotional and even intellectual growth. Kagan demonstrates that temperament is a strong predictor of behavioural and emotional reactions that appear early and are influenced in part by genetic constitution. Subsequent research demonstrated that it is the caregiver's behaviours that form the child's attachment style, although how this style is expressed may differ with temperament (see Bretherton, 1992).

Further empirical studies have supported the role of early and ongoing attachment in shaping development. Robinson and Miller (2010) explain that the attachment system, including the secure base provided by an emotionally supportive, warm and communicative relationship with parents and/or caregivers, has an integral role to play in helping children and young people develop autonomy and identity.

2.2 Vulnerability and resilience

2.2.1 Introduction

Vulnerability and resilience are both key concepts that are highly relevant in the provision of youth alcohol and other drug (AOD) services.

Vulnerability corresponds with the differing potential of young people for either healthy development or adverse social, behavioural and health outcomes. Consistent with this notion, the Victorian Government has developed a Vulnerable Youth Framework (DHS, 2010) to guide policy development and service provision in the youth sector.

Resilience research has made a significant contribution to how young people experiencing vulnerability can be guided and supported to achieve better health and developmental outcomes. Further, the study of resilience has had a transformative effect on how issues that affect development (such as substance use problems) are understood and addressed.

This has involved "…shifting goals, methods, and models away from deficit-oriented and medical disease models to approaches that focus on strengths, health, and well-being" (Masten & O'Dougherty Wright, 2009; p214-215). Further, it has been demonstrated

that a young person's capacity to be resilient in the face of adversity is determined not only by their own motivation and capabilities, but also by the capacity of their family, community and culture to provide crucial resources and opportunities in meaningful ways (Ungar, 2006).

The following material on vulnerability and resilience underpins the framework for resilience-based intervention described in Section 6.

2.2.2 Resilience

At its most basic, resilience describes a person's capacity to face, overcome and even be strengthened by life's adversities. Harvey and Delfabbro (2004) demonstrate that 'bad' experiences that constitute adversity are not randomly distributed in the population and point to "…huge individual differences in people's exposure to environmental risks" (p3). They acknowledge that while disadvantage increases the likelihood of "…subsequent difficulties in psychological functioning and life success", it is also clear that many young people do not inevitably succumb to their circumstances or become overwhelmed by the adversity with which they are faced (ibid).

Through the 1970s, the significance of this phenomenon began to be recognised in the fields of medicine, psychology and education. Researchers set out to identify the correlates and markers of healthy adaptation among young people expected to struggle because of genetic or environmental risk.

This early research tended to focus on the qualities of the individual. Those who did well despite multiple risks were described as invulnerable (Anthony, 1974) or invincible (Werner & Smith, 1982). These terms proved to be misleading, implying that a child or young person's capacity to evade or cope with risk was absolute and unchanging. As research evolved, it became clear that positive adaptation, despite exposure to adversity, involves a developmental progression, such that new vulnerabilities and/or strengths often emerge with changing life circumstances.

Subsequent research has yielded a substantial body of evidence (described below) confirming that there are no invulnerable children or young people. Rather than being an intrinsic trait, resilience has been shown to be a dynamic process occurring under specific circumstances (Masten, 2001).

Consequently, resilience is now understood as "…both an outcome of interactions between individuals and their environments, and the processes which contribute to these outcomes" (Ungar, 2007, p228). Resilience is therefore closely aligned with ecological and experiential developmental theories such as Ecological Systems Theory, Developmental Systems Theory and Social Learning Theory (see Section 2.1.4).

This is confirmed by Johnston and Howard (2007), who emphasise the importance of context and point out that given favourable conditions, resilient behaviour can be learnt, and destructive coping responses such as harmful patterns of substance use, unlearnt. This note of optimism is tempered by the unfortunate fact that in some circumstances "…levels of risk and adversity are so overwhelming that recovery is extraordinarily rare or impossible" (Masten, Obradovi, & Burt, 2006, p21).

Resilience is never an "across the board phenomenon" (Luthar, 2006, p741). It can be demonstrated by young people in one or many aspects of their life (ibid) and be associated with particular kinds of stressors and not others (Masten et al., 2006). While acknowledging that there are multiple pathways to resilience, researchers have endeavoured to identify particular patterns. We have drawn on the work of Masten and O'Dougherty Wright (2009) to provide a brief overview of these most widely recognised patterns.

- *'Resistance'* refers to patterns of reasonably steady and positive adaptive behaviour in the presence of significant threats. An example would be children who show a steady course of good function in all age-salient developmental tasks despite growing up in a poor family in a disadvantaged neighbourhood.
- *'Recovery'* refers to individuals who struggle when confronted with conditions so challenging that maintaining good adaptation is not expected, but positive adaptive functioning returns when circumstances improve. Masten and O'Dougherty Wright (2009) provide the example of a child subjected to abuse or neglect not being expected to function well in age-salient developmental tasks until care-giving conditions improve. The same can apply in the case of natural disaster or sudden catastrophe. Recovery may be long delayed if severe adversity continues or is repeated over a long period of time.
- *'Normalisation'* refers to patterns where a child begins life in an adverse environment, but as conditions improve so does their functioning. Masten and O'Dougherty Wright draw on the research of Beckett et al. (2006) as well as Rutter and the English and Romanian Adoptees Study Team (1998) to demonstrate that children who have been severely neglected, when put in a conducive environment, can show accelerated development and changes that eventually put him or her back on a normal developmental trajectory.

- *'Transformation'* patterns refer to cases where individuals had been involved in problematic and even anti-social behaviour, but subsequently made changes and improved their adaptive functioning. Masten and O'Dougherty Wright highlight the 'Kauai Study' (Werner & Smith 1982), as well as 'Project Competence' (Masten et al., 2006) and several other longitudinal studies of resilience where 'late bloomers' have been identified and studied. These young people do poorly in adolescence and turn their lives around in the transition to adulthood, when there appears to be a window of opportunity for positive change. This pattern can also be reversed under particular circumstances (Rutter, 2007).

2.2.3 Resilience and development

Masten (2009) demonstrates that resilience arises naturally from the interaction of the same basic adaptive systems that foster and protect human development.

From the outset, modern resilience research has incorporated developmental perspectives, which are crucial for making an accurate evaluation of risk, adversity, or trauma experiences that may threaten individual adaptation. British psychologist Michael Rutter (1987) consolidated the link between resilience and human development by defining resilience as "…behaviourally manifested success at negotiating salient developmental tasks, in spite of major stressors and possible underlying emotional distress" (p317). Consequently, age-salient developmental tasks were used to define and measure positive adaptation in numerous studies of resilience, including the Kauai Longitudinal Study (Werner & Smith, 1982, 1992) and Project Competence (Masten & Powell, 2003).

The "Positive Youth Development" movement (Silberstein & Lerner, 2007) employs Developmental Systems Theory (DST) as the theoretical underpinning for its developmental assets concept. Intensive and sustained investigation has identified internal and external assets whose availability to children and young people is associated with healthy development (Lerner & Benson, 2003). Ungar (2006) makes the point that the concept of developmental assets has moved resilience research beyond explaining the small percentage of young people that do not manifest expected negative outcomes through the experience of adversity, to understanding how positive developmental processes and pathways can be supported.

2.2.4 The influence of culture

Almost all resilience research, until recently, was based on culturally specific views about how 'normal' functioning is defined and the outcomes or behaviours deemed to be indicative of success or failure. For this reason, early definitions reflected mainstream Western cultural and social norms and were heavily weighted towards the sorts of outcomes emphasised in an individualistic culture (Harvey & Delfabbro, 2004, p6).

Resilience researchers and theorists have started exploring the influence of culture in defining the criteria for judging good adaptation and reinforcing resilience. The term 'cultural resilience' is frequently used to denote the role that culture may play as a resource for individuals, but it also applies to whole communities or entire cultural systems. Fleming and Ledogar (2008) define community or cultural resilience as "…the capacity of a distinct community or cultural system to absorb disturbance and reorganize while undergoing change so as to retain key elements of structure and identity that preserve its distinctness" (p10).

2.2.5 Risk and protective factors

All resilience research shares the basic assumption that there are potentially many factors that can contribute to how people deal with adversity and life stressors. Early resilience research revealed "…a surprising degree of consistency in qualities of people, relationships, and resources that predicted resilience" (Masten & O'Dougherty Wright, 2009, p214). The factors so identified have shown robust staying power in later research efforts.

Risk factors are defined as those that predispose a young person to a range of poor social and behavioural outcomes, such as harmful substance use (Williams, Toumbourou, Williamson, Hemphill, & Patton, 2009; Catalano & Hawkins, 1996; Lerner & Benson, 2003; Bond, Thomas, Toumbourou, Patton & Catalano, 2000). Conversely, protective factors reduce the likelihood of adversity leading to poor social and behavioural outcomes and moderate the influence of other risk factors.

Williams and colleagues (2009) explain that risk or protective factors can be intrapersonal and operate at an individual level, or they can be found within an individual's social environment or result from the interaction of the individual and the social environment. Spooner, Hall and Lynskey (2001) add that different risk factors are important at different times in one's development. A variable that is a risk factor at one time can become a protective factor at a different point in the developmental pathway.

These factors have been determined through many large-scale quantitative studies conducted to find out the statistical probabilities for either maladjustment or positive adaptation (see Luthar, 2006; Masten, 2001). They have been complemented by qualitative longitudinal studies that enable "…researchers to see the working parts of people's lives; they give us rich pictures which flesh out the general patterns revealed by larger quantitative studies" (Johnston & Howard, 2007; p13).

Masten and O'Dougherty Wright (2009) warn that in the field of human behaviour and development, risk and protective factors are indicative and should not be used in efforts to predict future outcomes with certainty. Further, they note that:

> "… it is often difficult to show that a chronic risk factor (e.g. family violence) occurred before any sign of problems in a child, since the risks and outcomes are ongoing in development and often do not have a readily identifiable beginning or end" (p220).

This uncertainty about objective reality suggests the potential value of investigating the subjective understandings and meanings that young people and those in their intimate social networks might ascribe to their experiences. Boyden and Mann (2005) and Ungar et al. (2007) have advocated for the use of people's own culturally determined indicators of resilience in contemporary studies. This would include more subjective measures such as enabling young people to assess their own resilience and flexible notions of what constitutes success based on culturally and contextually appropriate measures.

2.2.6 Risk chains and protective processes

To understand the specific processes that might lead to resilience, researchers have moved beyond the identification of factors and variables. They have turned their attention to the mechanisms or processes by which risk and protective factors interact to shape the life trajectory of each child or young person. Rutter (1989) identified the existence of long-term negative chain effects that intensify and entrench the ill-effects of early stress and adversity.

Subsequent research has identified fundamental protective processes and systems for human adaptation that, when operating normally, foster and protect young people's development (Masten, 2009; p30). Young people's exposure to risk factors, and consequent degree of vulnerability, is heightened when the influence of these key systems has been degraded and the resources and opportunities that go with them diminished (Johnson & Howard, 2007).

The likelihood of serious social problems continuing from adolescence into adulthood seems linked to the extent to which resources are available to the individual and the sheer range of problems they have to contend with (Gilligan, 2008). Also, the choices and actions of individuals are crucial in selecting and shaping their experiences. In line with this observation, Masten (2001) found that "…resilient youth appear to place themselves in healthier contexts, generating opportunities for success or raising the odds of connecting with pro-social mentors" (p234).

Johnson and Howard (2007) identify that "…positive and negative chain effects can often have their starting points in random, even accidental events" (p4). Opportunities and choices made at crucial junctures play an important role in the life course of resilient individuals. Thomson, Bell, Holland, Henderson, McGrellis et al. (2002) demonstrate that "…critical or fateful moments" can become turning points for a young person (p350). An effective, competent response that promotes desirable outcomes and is recognised by others is likely to be repeated. If this happens often enough, certain ways of behaving become part of the individual's behavioural repertoire. This phenomenon is known as a "developmental cascade" or as a "progressive snowball effect" (Masten & O'Dougherty Wright, 2009, p217).

Masten (2009) explains that well-timed interventions geared to respond at critical moments have the potential to disrupt negative cascading effects or initiate healthy developmental processes and positive adaptation. Given favourable conditions, even small changes in an individual's profile and functioning can create a ripple effect, possibly generating momentum for further change and development across a range of life domains (Gilligan, 2008; Masten, 2001). For example, educational success and/or sporting prowess often translate into forming close friendships with pro-social peers. In other words, competence begets competence.

Homel, Freiberg, Lamb, Leech, Batchelor, Carr et al. (2006) advocate a developmental pathways approach because it captures the relative influence of risk and protective factors and is understood in the context of each young person's biography, past and present. This approach requires investigation into the "…interconnected systems in which human development unfolds, such as families, schools, and neighborhoods" (Masten & Obradovi, 2006, p24) to determine how each young person's opportunities for pro-social development are either nurtured or obstructed.

The Social Development Model (SDM) (Catalano & Hawkins, 1996) provides a useful theoretical framework for explaining a young person's commitment to pro-social development. The Australian Research Alliance for Children and Youth (Williams et al., 2009) draws from the extensive body of research into the application of SDM to outline the dynamics by which young people adopt pro-social attitudes and behaviours:

- A child or young person perceives opportunities for pro-social interactions
- Through engaging in pro-social activity and experiencing pro-social interactions, a child or young person comes to understands that he or she is positively rewarded for his or her participation
- The child or young person develops the emotional, cognitive, and behavioural skills that allow him or her to continue earning, perceiving and experiencing positive reinforcement.

In this way, new, more productive ways of dealing with life can be substituted for behaviours that served as coping mechanisms but led to further social dislocation and poor development outcomes (Williams et al., 2009).

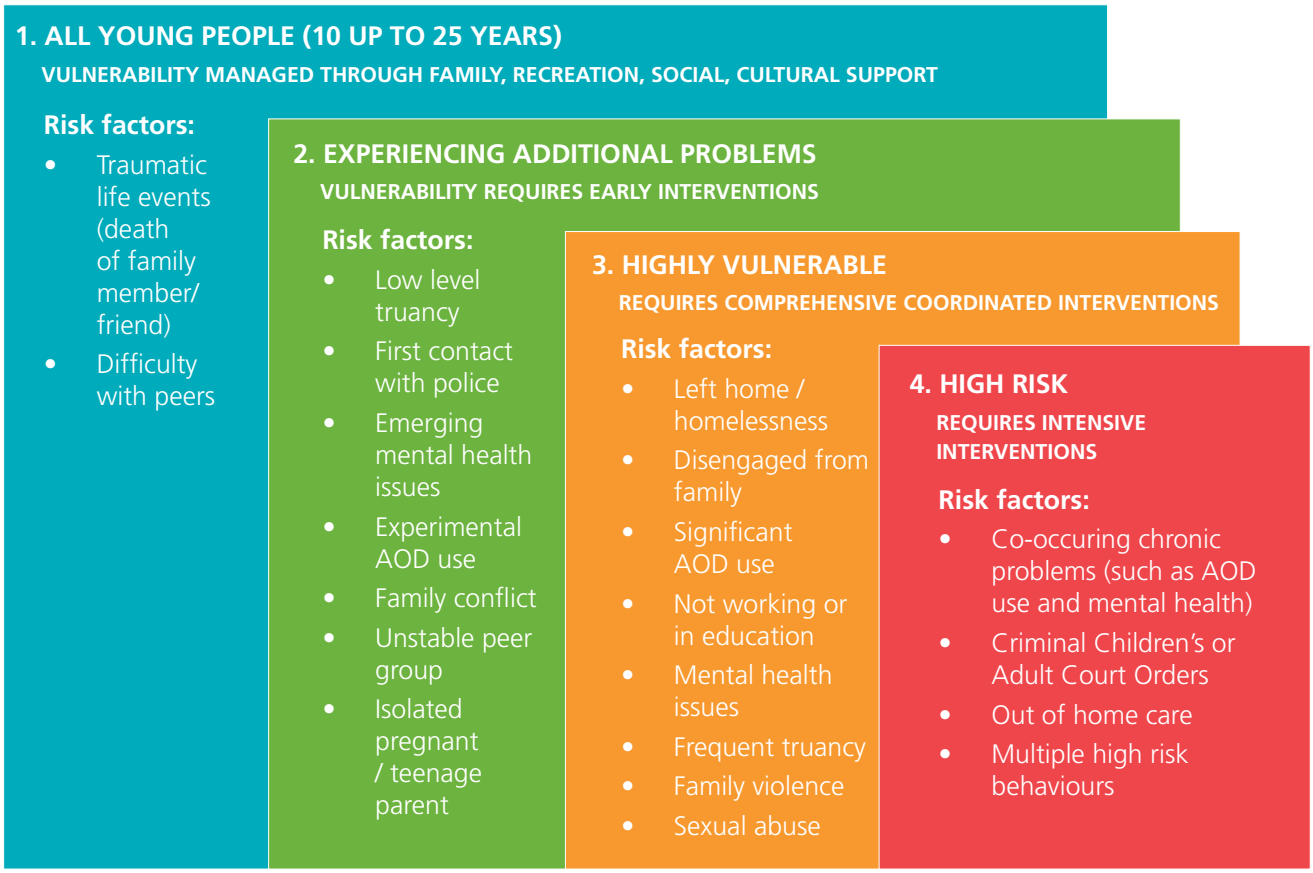
2.2.7 Vulnerability

All young people are vulnerable to disruptions and challenges that make developmental tasks difficult to achieve. In Victoria, the State Government's Vulnerable Youth Framework (VYF) (2008) makes it clear that for the bulk of Victorian young people such vulnerability "…is managed through family, recreational, social and cultural support" (p12). Most young people negotiate adolescence successfully with relatively few problems. However:

> "Vulnerability becomes problematic when negative behaviours or experiences multiply and there are few or no supports in place to assist young people [who ….] confront issues that they do not have the skills, knowledge or support to get through" (p12).

The VYF identifies four layers or levels of vulnerability (see Figure 2.1). While the categories are theoretically arbitrary and no consideration is given to the moderating influence of protective factors, the framework could be a useful conceptual tool for youth AOD practitioners.

Figure 2.1: Layers of vulnerability



The emergence of problems in adaptive function is strongly associated with the accumulation of risks and adverse experiences, particularly in a concentrated time frame (Masten & Obradovi, 2006). Adversity seems to be most debilitating when it comes in multiple forms (Gilligan, 2008). Further, the timing of adversity has also been found to have an impact, particularly when occurring at critical periods of development (Masten & O'Dougherty Wright, 2009). Gilligan (2008) adds that:

> "…young people may be able to cope with one or two fairly serious adversities in their lives, but as the number of adversities rises to three, four or beyond, they may begin to buckle under the strain" (p38).

He draws from the work of Rutter (1990) to show that reducing the number of problem areas in the life of a child or young person (even by one) may have a disproportionate and decisive positive impact in terms of reducing the risk of later problems.

Masten and O'Dougherty Wright (2009) report that models focusing on the related concepts of 'differential susceptibility' and 'sensitivity to context' have been advanced to explore the possibility that some children are more susceptible or sensitive to the influence of context, whether the context is adverse or beneficial.

Such children may also be differentially responsive to contextual protective factors. Further, they refer to "…great interest in models that examine the moderating influence of genes and personality on differential reactivity in the context of adversity" (Kim-Cohen & Gold, 2009). Contemporary research, particularly on the plasticity of adaptive functioning, is overturning some long-held assumptions about the enduring nature of individual traits, suggesting instead that many are 'reprogrammable' (Masten & Obradovi, 2006, p24).

A young person's level of vulnerability is not only determined by the number of risk factors, but also the degree to which they are moderated by the influence of protective factors. Newman (2004) identifies that vulnerability renders a young person more susceptible to threat and affects their ability to cope and adapt. Fleming and Ledogar (2008) stress that when a young person is adequately supported and resourced, exposure to threats or challenges can be an opportunity for learning and personal growth (see next section, Coping and adaptation). This has been described in early research into vulnerability and resilience as an inoculation or steeling effect (Garmezy, Masten & Tellegen, 1984; Rutter, 1985). So developmental problems could arise when children and young people are exposed to either not enough risk, or so much that it is impossible to overcome.

Masten (2009) draws on substantial evidence to identify basic adaptive systems that interact to foster and protect human development (see Section 6.2.1). Like people, these systems are not invulnerable and require nurturing. She writes:

> "The greatest threats to young people occur when these key systems and the capacity they represent are damaged or destroyed and never restored. Nurturing, supporting, and restoring these fundamental adaptive systems for human development are top priorities for promoting competence or resilience in young people and preparing them to weather the storms of life" (p32).

Masten (2001) points out that it is most often the children and young people who contend with the greatest adversities that do not have the protections offered by adequate resources and social 'scaffolding' capable of regulating their exposure to risk. Collective efficacy has a crucial role in protecting and fostering personal efficacy and it is possible that undue emphasis on the individual reflects a cultural bias (Bandura, 2000, cited in Alkire, 2007; Christopher & Hickinbottom, 2008). Friedli (2009) argues that "…social recognition and collective activity are frequent casualties of current economic and cultural trends" (p38).

2.2.8 Coping and adaptation

The capacity to adapt to changing circumstances is a feature of healthy development and optimal functioning. How a young person responds is determined by their coping and behavioural repertoire, which is shaped by the history of their lived experience, the social and material resources at their disposal and the magnitude of the stressors in their lives.

Ungar and Kipke (1998) broadly categorise young people's coping responses as 'problem-focused' or 'emotion-focused'. Problem-focused responses seek to address the cause, manifestation or practical effects of the problem directly, while emotion-focused responses aim to reduce emotional distress surrounding the problem. Their research with young people who were homeless revealed how each young person, when confronted by a stressor, went through a process of appraising its magnitude in relation to his or her perceived ability to handle it. If their coping abilities and resources met or exceeded the demands of the stressor, then problem-focused coping strategies aimed at removing or reducing the impact of the stressor can be used.

Alternatively, when young people gauged that there was no way to effectively deal with the stressor, they were more likely to adopt emotion-focused coping strategies. Substance use, for example, could be used in this way by a young person. Davis (1999) concurs, pointing out that coping is often reactive or defensive in nature and can involve merely avoiding a stressful situation or a negative event. A young person who demonstrates resilience is therefore able to employ their coping ability over time, in the interests of moving beyond the defensive and protective into adjustment and positive adaptation.

Consistent with this, Richardson (2002) describes resilience as an active process involving growth and development through disruption and adversity rather than just recovering or bouncing back. He conceptualises life as a progression of repeated responses to either planned or reactive disruptions. He believes that each person's development throughout their life course is shaped by the manner in which their experience of disruption and adversity is integrated.

According to Richardson, "[R]esilient reintegration refers to the reintegrative or coping process that results in growth, knowledge, self-understanding, and increased strength of resilient qualities" (2002, p310). Conversely, "…dysfunctional reintegration occurs when people resort to substances, destructive behaviors, or other means to deal with the life prompts" (ibid).

Like Ungar and Kipke (1998), Richardson (2002) has identified a dichotomy in how people respond to disruption and adversity, albeit with subtle differences in focus. Ungar and Kipke concentrate on the process of choosing a viable coping response whereas Richardson's focus is on the meaning derived from how one coped and the outcomes of the response. The choice of coping response and how experience is integrated to shape one's self concept relies on both conscious and sub-conscious processes.

Richardson contends that most people who reintegrate 'dysfunctionally' have "…blind spots in their introspective skills and require therapy to fill the holes" (2002, p310). He also points out that resilient reintegration may be postponed or delayed, bringing his theory into line with the aforementioned patterns of resilience.

A child, for example, who has suffered abuse and neglect, may not have the personal capacity or the level of support required to make a resilient reintegration, but later in life may be better positioned to do so. Further, the process of reintegrating from disruptions in life requires some form of motivational energy. This provides a cogent rationale for 'youth AOD practice' to be geared towards creating conditions that give young people reasons to consider and work towards a better future.

Richardson recognises that constructive intervention via 'therapy' and/or 'education' serves as a positive disruption to the adaptation patterns that develop through repeated 'dysfunctional' reintegration. A client's capacity to initiate problem-focused coping strategies or make resilient reintegrations through disruption might be influenced by their beliefs about how much choice and self-determination they have; their sense of personal agency. This indicates the extent to which a client's 'locus of control' is either internal or external.

Naidoo and Wills (2000) explain that a strong internal locus of control is associated with a belief in one's own power to make decisions that will affect the course of life. This can be the source of motivation to invest in self care and make changes to improve health. By contrast, people with a strong external locus of control believe they are relatively powerless to make changes that will affect their life. They are more likely to be fatalistic and pessimistic about the future, and more likely to continually resort to emotion-focused coping strategies.

2.3 Young people and AOD use

2.3.1 Introduction

Young alcohol and other drug (AOD) users are a heterogeneous population with diverse interests and needs. The usage patterns of different groups can convey nuanced expressions of identity around ethnicity and particular forms of masculinity, femininity or sexual preference. Behaviours that are typical for young people undertaking an adolescent transition are often mistaken as drug related. For example:

- Being rude
- Testing limits
- Demanding more privacy
- Having mood swings
- Having a sudden change in appetite or energy level
- Changing peer group
- Becoming a part of different sub-cultures (Mentha, 1999; p31).

Most young people will experiment with alcohol and potentially other drugs at some stage (Bruun, 2008). Steinberg and Morris (2001) distinguish between occasional experimentation and enduring patterns of dangerous or troublesome behaviour. "Many prevalence studies indicate that rates of occasional, usually harmless, experimentation far exceed rates of enduring problems" (ibid p90). Even though experimentation can

be reckless at times, and binge-style patterns of AOD use can create great risk for adolescents, the majority will go on to develop an ongoing pattern of use that is relatively harmless.

2.3.2 Developmental considerations

Each young person's stage of development and level of maturity have a bearing on the way they use alcohol and other drugs. It is useful to consider the extent to which the AOD use of young people is influenced by the characteristics of different adolescent sub-stages (even with the limitations described earlier in this section). Bruun and Palmer (1998) offer the following as a guide for the general youth population.

- *Early adolescence* (10 to 13/14): At this stage young people's AOD use is often experimental and determined by the substances available in immediate proximity and easily available (e.g. inhalants, alcohol, etc). All substance use (except inhalants) is illegal for young people in this age range. Using is most likely to begin as a shared experience with peers, usually of the same gender. AOD use can be a passport to membership of a group, providing status and an opportunity to be seen as mature.
- *Mid-adolescence* (14 to 17/18): Due to increased ability to procure drugs through a broader social network, greater autonomy and mobility, young people at this stage are most commonly using for a particular effect. This means that poly drug use is more common. Increased confidence can also mean more risk taking and further experimentation. Socially, AOD use can be a means to status with some peer networks and/or connecting with potential sexual partners. For young women in this stage, the connections will often be with older adolescents. All AOD use (except inhalants) continues to be illegal.
- *Late adolescence* (18 to 21): Young people may continue to use substances in a similar manner to the mid-adolescent group but in general, by this stage, will have settled on one or more drugs of choice and a pattern of use. Naturally, this is subject to change. Drug choice will often be the result of relationships developed in new social circumstances such as work or study.

Young people who use substances tend to be strongly invested in the notion that for them, using is an active choice over which they are able to maintain control (Guttierrez & Palacios, 2004). This is unsurprising given that in contemporary society young people are increasingly required to be active managers of their lives and responsible for producing their own sense of identity (Giddens, 1991; Melucci, 1996; Furlong & Cartmel, 1997; Kelly, 2006).

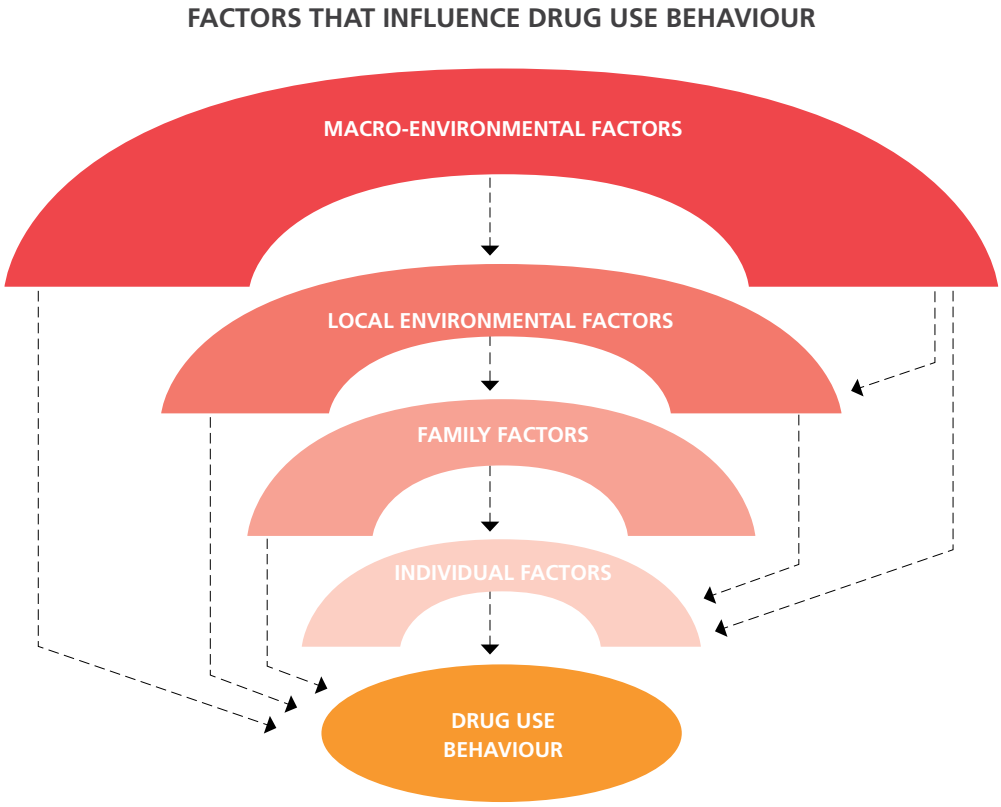
As such, they commonly differentiate themselves from dependent drug users and resist any possibility that their AOD use is problematic (Muck, Zempolich, Titus, Fishman, Godley et al., 2001; Chassin, 2008). This has proven to be the case even when AOD use is closely connected with highly problematic life experiences (Rosenthal, Mallett, Milburn & Rotheram-Borus, 2008). This could go a long way to explaining why young people are generally far less likely than adults to access treatment services. As Room (2005) explains, this can be "…humiliating evidence of failure in self-management" (p151).

Duff (2003) recognises that contemporary youth culture in Western societies has produced the well-adjusted, responsible adolescent "…who uses drugs recreationally, very deliberately and very strategically" (p435). Such young people manage to stay integrated with a cultural mainstream (through education, employment, etc) and seldom come to the attention of AOD services.

For other young people the demarcation between recreational and problematic use is less clear, being determined by a range of intrapersonal and socio-ecological factors that are often beyond their control (Measham & Shiner, 2009). The 'influences model' (Spooner et al., 2001) describes how such factors operate at multiple levels to shape the AOD-using behaviour of individuals (see Figure 2.2). Each level is associated with several factors.

- *Macro-environmental* factors include legislation, law enforcement, availability, and social 'messages' about use, e.g. via the media.
- *Local environmental* factors include traumatic experiences (e.g. child abuse, war, refugee camp), socio-economic status, support (e.g. peers, community), peer influences and labelling.
- *Family* factors include ineffective parental family management techniques, negative communication patterns, and poor family relationships and parental role-modelling.
- *Individual* factors include genetic predisposition, behaviour under control, personality (lack of social bonding, alienation, high tolerance of deviance, resistance to authority), knowledge about drugs, coping skills, commitment to education/academic problems, and early age of first use.

Figure 2.2: Influences model



Structural Determinants of Youth Drug Use, ANCD research paper 2, Australian National Council on Drugs, 2001

Spooner and colleagues (2001) drew on extensive research to identify the common factors at each level that either increase the risk, or prevent children and young people from developing harmful patterns of AOD use. Loxley, Toumbourou and Stockwell (2004) reported that there are social, environmental and individual risk factors that act together to predict involvement in early and heavy drug use. These factors have generally been developed to inform population-focused drug prevention and health promotion initiatives targeting young people.

2.3.3 The function of substance use

The substance-using behaviour of all young people develops over time and is subject to a complex interplay of bio-psycho-social processes. The substance use of each young person has a function even when associated with unwanted complications. Paglia and Room (1998) identify that, for adolescents in the process of developing their own identity, AOD use might have several functions including: providing pleasure; alleviating boredom; satisfying curiosity; facilitating social bonding; attaining peer status; or as an escape or coping mechanism. Equally, substance use could be a form of rebellion or sensation seeking that has a symbolic function such as "…expressing solidarity in a group and marking off social boundaries" (p6).

Young people who come to rely on substance use as a coping mechanism or form of escape are those most likely to come to the attention of services. Young people tend to use substances as a coping strategy in response to life stressors or underlying problems that they believe are insurmountable or irresolvable (see Section 2.2.8).

In this way, substance use problems are often manifestations of unresolved, underlying issues that have a cumulative effect in the life of each young person. In turn, substance-using behaviour can add complexity to those underlying issues. Some young people use substances in an effort to reduce the resultant emotional distress; commonly referred to as self medication. The efficacy of substance use as a coping strategy is confined to the present, because it tends to undermine the efforts of young people to deal with underlying problems or stressors over the longer term.

Particular substances might also be used to better negotiate complex social processes and difficult environmental conditions. Clark, Scott and Cook (2003) refer to "reality swappers" (p2); particular young people who use substances as a means of accessing alternative experiences in response to, or anticipation of, unpalatable or uncomfortable events and circumstances.

This way of understanding substance use recognises that young people are active in making choices in managing their own lives and de-emphasises the role of pathology and deviance. Even in cases when substance use is intentionally self-destructive, it is possible to recognise the agency of a young person and crucial to understand their reasons for taking such action.

Van Brocken (1998) makes the case that the behaviours of 'troubled' young people (including substance use) are best understood as attempts to cope with abnormal life circumstances or "…fix discouraging life situations" (p174). Munford and Sanders (2008) concur, recognising that for "excluded" young people, "… successful attempts at change need to build upon the social bonds and integrative characteristics that coexist with the harmful and troubling behaviours" (p3).

There is strong evidence that substance use problems correlate closely with the experience of disadvantage and are almost always exacerbated by the loss of major structures in young people's lives (Room, 2005). The United Nations (UN, 2004) reported that the substance use of this group tends to be about relieving the pressures of life, deriving from difficult circumstances. Munford & Sanders, (2008) corroborate these findings and demonstrate that problematic substance use for young people is linked with chronic stress, alienation and a marginalised social network. For this reason, Friedli (2009) suggests that "levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological wellbeing".

The Victorian Youth Alcohol and Drug Outreach Guidelines (Pretroulias, Bruun, Papadontas & Roy, 2006) identify several personal issues that may turn a young person towards substance use for solutions. These include, but are not limited to: "…significant loss and complicated grief reactions; isolation and loneliness; adoption and family breakdown; depression and anxiety; problems with anger; past or ongoing sexual assault and physical violence; and the effects of trauma such as post traumatic stress disorder" (p67). These issues also contribute to the uptake and continuation of behaviours such as offending, truancy and self-injury and are factors that contribute to suicide risk for some clients. To this list of issues can be added poor physical health and less prevalent mental health concerns such as psychosis and bipolar disorder.

2.3.4 The impact of substance use on young people's development

An early start to substance use during adolescence and continued intensive use is believed to interfere with transitional milestones being reached and developmental tasks being completed. Spooner and colleagues (2001) point out that the earlier a young person becomes involved in chronic, problematic substance use the greater the developmental impact on cognitive functioning, emotional adjustment, social functioning and the formation of self-concept.

Even so, contemporary evidence-based theories, such as Developmental Systems Theory (see Section 2.1.4), recognise plasticity in the bio-psycho-social processes that underpin human development and emphasise the significance of experience in determining outcomes for young people.

Substance use, particularly when it is ongoing and used as a coping strategy, will directly influence the experiences of young people and therefore shape the way their development unfolds. This means that even in cases where developmental processes have been disrupted by substance use, these young people continue to develop, albeit in an atypical manner.

For example, the development of a young woman who at 16 has been involved in procuring and trafficking substances, is not at school, and has had to fend for herself, may be accelerated in some areas and delayed in others. She may have developed the capacity for consequential thinking and have achieved a degree of independence and resourcefulness in advance of other young people of a similar age. On the other hand, she may have limited opportunities to develop values, attitudes and social skills that are in step with other young people experiencing a more typical developmental progression. This can mean that progress towards key developmental milestones, such as developing a vocational identity, is curtailed and in some cases they may not be reached. This can lead to further marginalisation, thus entrenching problematic substance-using behaviour and limiting options for change. In this way the developmental trajectories and lifestyles of many young people with serious substance use-related problems can become less and less synchronised with most other adolescents.

However, on a positive note, there is evidence to show that developmental milestones and tasks do not have to be achieved at predetermined times. Given conducive conditions and experiences, young people who have had substance use problems can change their developmental pathway and become healthy adults.

2.4 Youth AOD clients

2.4.1 Overview

Seeking assistance for a problem with alcohol or illicit drug use is not common among the general population of young people. Only 5% of the 5000 young people (aged 16–24 years) surveyed in the *Victorian Youth Alcohol and Drugs Survey*/VYADS (Social Research Centre, 2010) had ever accessed an AOD service.

Those that do become youth AOD clients are a heterogeneous population of young people with diverse needs. They differ in relation to maturity and developmental stage, gender, ethnicity and cultural identity, spiritual and religious beliefs, socio-economic status and access to income, legal status, sexual identity, and identification with particular youth sub-cultures. Effective youth AOD services have the capacity to respond to the unique circumstances and preferences of each young person and their family (see Section 3.2).

The need to provide specifically targeted AOD services for young people in Victoria was identified by the Premiers Drug Advisory Council (PDAC) in 1996 on finding that "…there are large gaps in the network of services available to support young people, particularly those with serious drug abuse and related problems" (p95).

Based on the PDAC recommendations, the State Government devised a new framework for the delivery of AOD treatment services that included a specialised response to the needs of "…young people between 12 and 21 years of age, whose use of licit and illicit drugs causes significant physical, psychological and social harm" (ibid). This continues to be the target group for youth AOD services in Victoria.

PDAC anticipated that youth AOD clients were also likely to experience multiple and concurrent problems, such as homelessness and a broad range of health concerns. These findings foreshadowed the observation made by the United Nations' (2004) that there is an especially vulnerable population of young people who "…use substances in risky ways and require support in a number of areas of their lives" (p150). This observation is reflected in the *Vulnerable Youth Framework* (2008, see Section 2.2.5).

Youth AOD clients typically meet the criteria to be considered 'highly vulnerable' and 'high risk'. This requires a service response that takes account of the unique needs and characteristics of this population (see below 2.4.2 and 2.4.3).

2.4.2 Characteristics

In this section we seek to establish that the life circumstances of youth AOD clients and their substance use patterns are significantly different to those of young people from a general population.

Our discussion is focused on Victoria. We draw from two main studies involving young clients: the *Youth Illicit Drugs Reporting System*/YDRS (MacLean, Bruun, Mallett & Green, 2009); and the *Australian Treatment Outcomes Study* (Thompson, Talko, Ritter & Pahoki, 2007). The key characteristics of these studies are outlined in Table 2.3.

We consider data gained from these studies in relation to broader population data drawn from:

- The Victorian component of the Australian Census (AIHW, 2005; 2007; 2011a; 2011b)
- Other Victorian youth-focused studies, including *The State of Victoria's Young People*, 2007 (Department of Education and Early Childhood Development/DEECD, and the Department of Planning and Community Development/DPCD), which analyses youth and Victoria-specific secondary data, and the *Victorian Youth Alcohol Drugs Survey*/VYADS (Social Research Centre, 2010).

Some details of these sources are included in the table 2.3.

Due to the size of the survey sample in the two client studies (and other methodological factors), comparisons with broader population studies are indicative only.

Gender and cultural background

Males are over-represented in the AOD service system, as are Aboriginal and Torres Strait Islander (ATSI) young people. Studies show that young people from culturally and linguistically diverse backgrounds are also strongly represented (MacLean et al., 2009; YSAS, 2011).

Table 2.3: Summary of Victorian-specific study characteristics

STUDY/REPORT NAME	YEAR DATA COLLECTED	METHOD	SAMPLE SIZE (N)	AGE OF PARTICIPANTS (YEARS)	PARTICIPANT LOCATION
Youth AOD client studies					
Australian Treatment Outcomes Study (ATOS): Thompson, Talko, Ritter & Pahoki, 2007	2005	Longitudinal cohort study (baseline, three and 12 months surveys)	38	Under 21 years	Victoria
Youth Illicit Drug Reporting System (YDRS): MacLean, Bruun, Mallett & Green, 2009	2006-07	Survey	163	13-24	Victoria
General population studies					
The State of Victoria's Young People: Department of Education & Early Childhood Development, & Department of Planning & Community Development (DEECD and DPCD, 2007)	Primarily 2006	Secondary data analysis	Various	12-24	Victoria
Victorian Youth Alcohol & Drug Survey (VYADS): Social Research Centre, 2010	2009	Survey	5001	16-24	Victoria

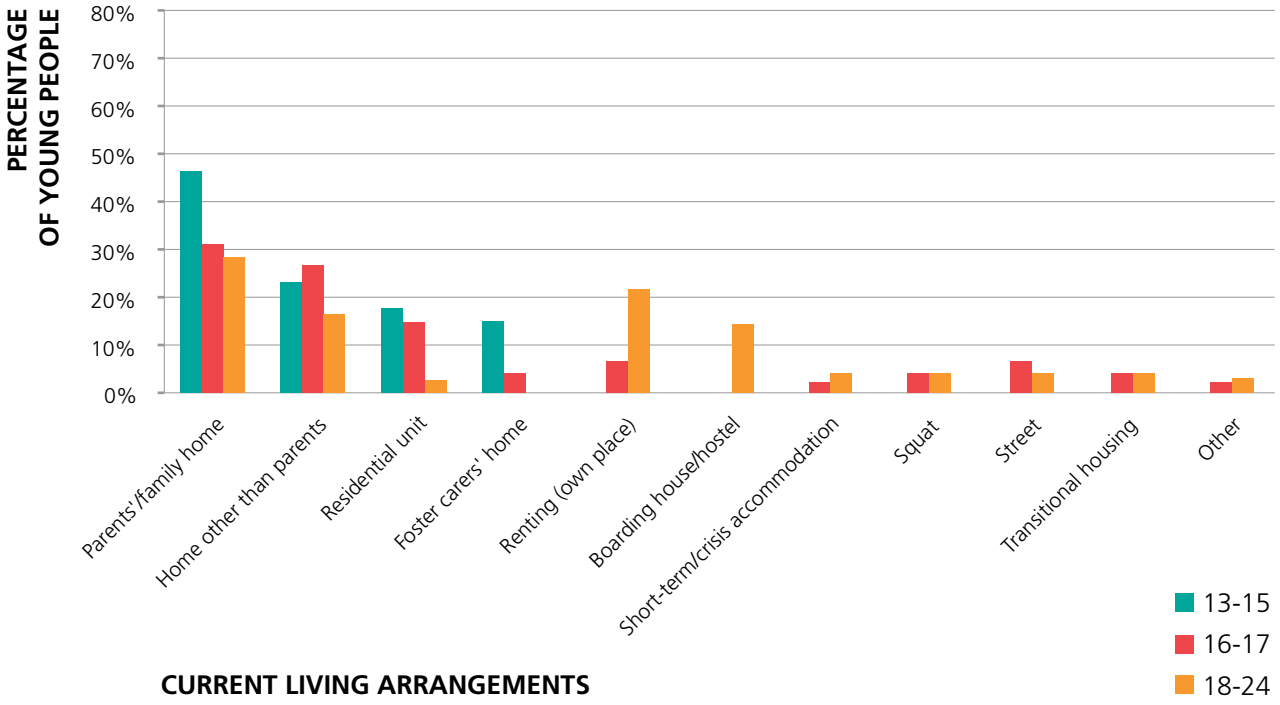
Living arrangements

Young people are particularly vulnerable to experiencing homelessness (Chamberlain & MacKenzie, 2009). Youth AOD clients are far less likely to live in the parental home than young Victorians from the general population. In 2007, an estimated 69% of 12–24 year olds in Victoria were living in a parental home (DEECD & DPCD, 2008).

By comparison, just under one-third (33%) of YDRS survey participants (n=53) lived with one or both parents (DEECD & DPCD, 2008; MacLean et al., 2009). This group left home for the first time at age 13 years (MacLean et al., 2009), while young people from a general population are shown to leave home at approximately age 20 (ABS, 2009). Many YDRS participants also reported having housing arrangements that were temporary (MacLean et al., 2009). This is represented in Figure 2.3.

Figure 2.3: Current living arrangements for YDRS survey participants

Source: MacLean et al., 2009



Education

Among YDRS survey participants (MacLean et al., 2009) there was a strong pattern of early school leaving, as shown in Figure 2.4. Several studies show low levels of engagement in school, training and employment among service-engaged young people (Thompson et al., 2007; MacLean et al., 2009) compared with a general population (DEECD & DPCD 2008).

Among YDRS survey participants, 84% had been suspended from school or an educational program at some point and 65% of 18-24 year olds had been expelled or asked to leave a school.

YDRS survey participants reported that they "dislike" school to a greater extent than among the general population of young Victorians. In a survey conducted in Victorian government schools, 21.7% of males and 15.5% of females in years 7-9 stated that they hated school "almost always" or "often" (Williams 2007, cited in DEECD & DPCD, 2008, p107). In response to a comparable question, 49% of 13–15 year old participants (n=17) reported that they "never" or "rarely" enjoyed being at school. Figure 4 also indicates that YDRS survey participants were often intoxicated at school.

Figure 2.4: Currently Attending School University or training

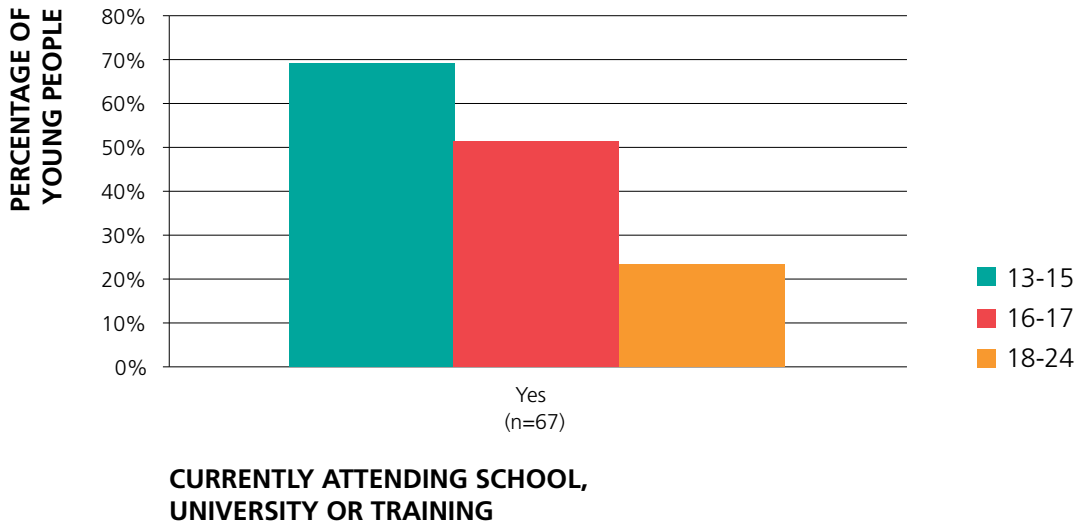
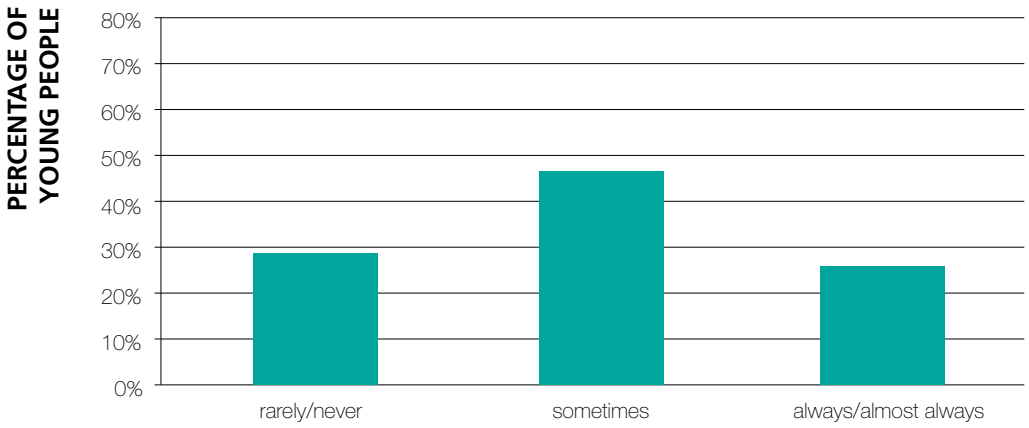


Figure 2.5: Intoxicated whilst at school



Employment

Available data shows that access to income is an area of considerable difficulty among young people engaged in AOD services. More than half of all 163 YDRS survey participants (57%, n=93) were not participating in work, education or training. Only 3% were employed full-time and 7% were employed part-time or on a casual basis.

MacLean et al. (2009) and Thompson, Talko et al. (2007) demonstrate a strong reliance among this group on welfare. Of 13–15 year old YDRS participants (who are below the age of eligibility to receive income support), 69% (n=24) reported receiving an income as a result of stealing or theft during the previous six months.

Sexual activity

Smith, Agius, Mitchell, Barrett and Pitts (2009) have undertaken one of the largest Australian studies of youth sexual activity, surveying more than 3000 students. By comparison to this general group, it appears that YDRS study participants (involved in AOD services) are more sexually active at younger ages.

Among the general population of year 10 and 12 Australian students, one-quarter reported that the last time they had sex they were either drunk or high (Smith & Agius et al., 2009, p38) compared with one-half and two-thirds of 13–15 year old and 18–24 year old YDRS participants, respectively (MacLean et al., 2009).

Sexual attraction to people of the same sex was reportedly higher among MacLean et al.'s sample of service-engaged young people (2009) than Smith et al.'s from a school population (2009). Among YDRS survey participants, 15% (n=20) reported that they were sexually attracted to people of the same sex or to people of both sexes, whereas 7% of Smith et al.'s study responded positively to a similar question.

Physical health

The AIHW (2007) concludes that socio-economic status strongly correlates with young people's levels of health and well-being. Socio-economic deprivation is associated with poorer health outcomes, higher hospital separations, protective or juvenile justice involvement, lower educational achievement and higher death rates.

Studies indicate that young Australians generally experience relatively good physical health (AIHW, 2011b). While this is generally also true among most young people engaged in services, it appears that declining levels of good health can be identified among service-connected young people aged over 18 years (MacLean et al., 2009).

While 70% of Victorian year 7 students reported that they had been vaccinated for hepatitis B in 2007 (DEECD & DPCD, 2008), a slightly lower number of YDRS survey participants (58%) reported the same (MacLean et al., 2009). However, 61% of YDRS survey participants had been tested for HIV (MacLean et al., 2009) compared with 3% of Smith, Agius et al.'s sample (2009).

Emotional and mental health

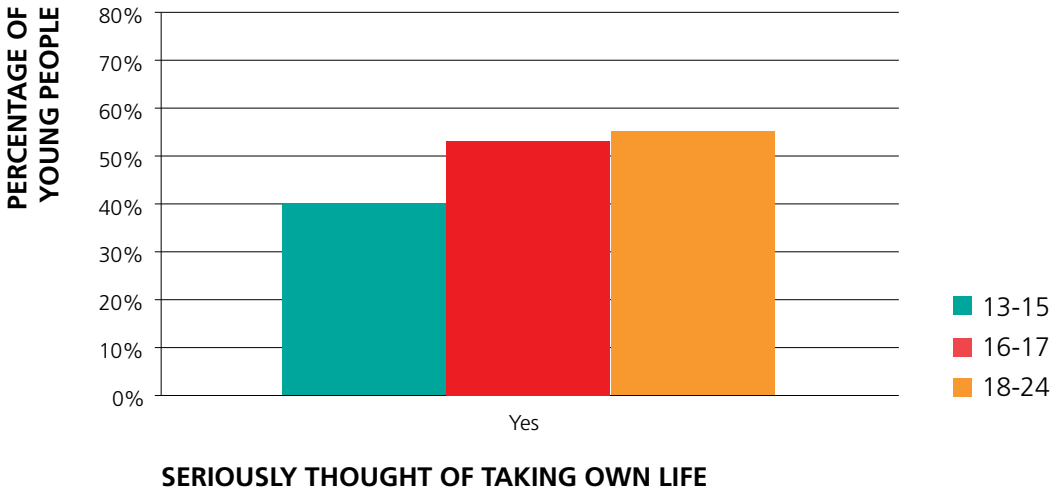
The leading cause of disease and injury for young people in Australia in 2007 was mental health disorders. In 2007, just over 25% of young people in the general population aged 18–24 years were diagnosed with anxiety, affective or substance use disorders (AIHW, 2007).

YDRS survey participants reported relatively high rates of mental health diagnosis and distress. More than one-third of participants (38%, n=61) had been diagnosed with a mental illness. This rate was 44% for 18–24 year old participants (MacLean et al., 2009). Among the Australian Treatment Outcomes Study/ATOS (Thompson et al., 2007), which surveyed AOD clients under 21 years at a baseline, three-month and 12-month interviews, 24% of participants were diagnosed as having experienced a major depressive episode in the month prior to their baseline interview.

Figure 2.6 shows YDRS participants who had seriously thought of taking their own life. Additionally, 29% of all YDRS participants (n=59) reported that they had attempted suicide during the six months prior to interview. Similar statistics are reported in Thompson et al.'s study (2007), with 45% reporting at least one previous suicide attempt at some time in their life and 13 young people having attempted suicide in the 12 months prior to baseline interview (p6).

Among the YDRS sample, around one-third of participants (32%, n=52) had deliberately hurt, cut or burned themselves during the six months prior to interview (MacLean et al., 2009).

Figure 2.6: YDRS survey participants who had seriously thought of taking their own lives



Source: YDRS survey

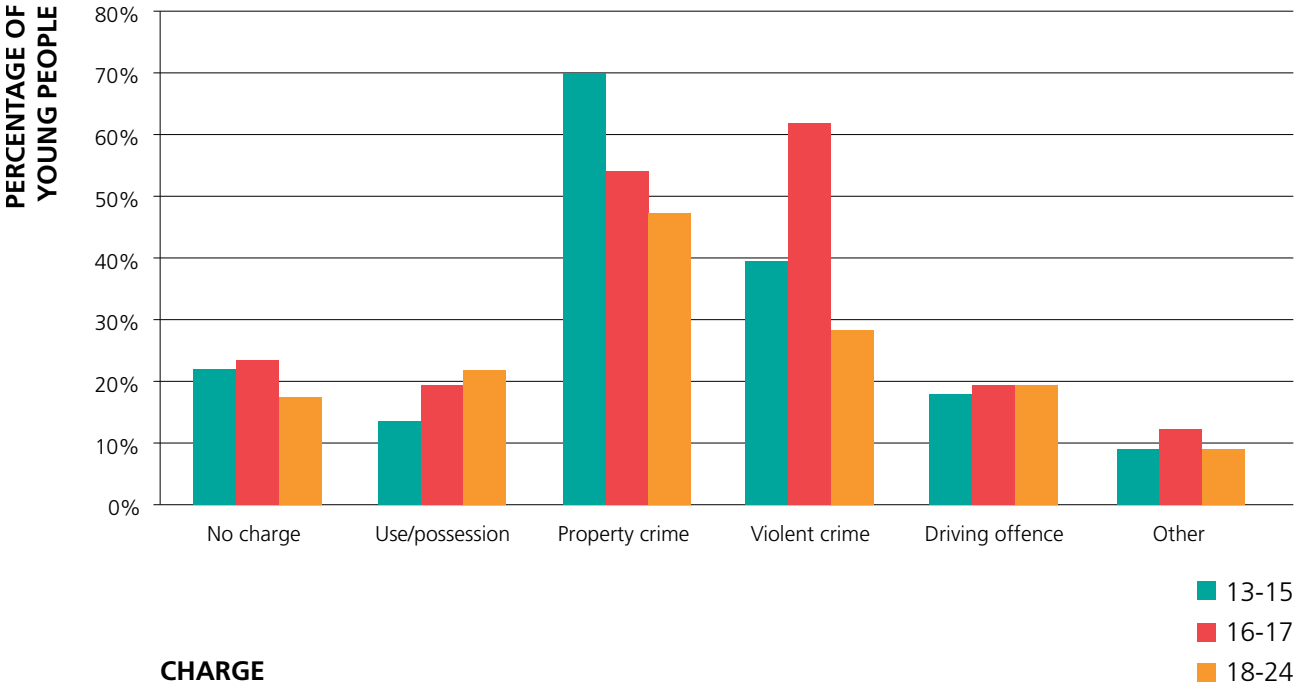
Youth and criminal justice

In 2005–06, 2.6 per 1000 young people aged 10–17 in Victoria were subject to youth justice supervision orders, meaning they were involved with the youth justice system because they had committed an offence (DEECD and DPCD, 2008). By comparison, 60% of YDRS participants (n=72) had been charged with a crime during the past six months (MacLean et al., 2009).

In Victoria, 0.5 per 1000 of the Victorian youth population aged 12–17 were sentenced to a period of incarceration in a youth justice or youth residential centre (DEECD & DPCD, 2008). By comparison, 35% (n=12) of 13–15 year old and 49% (n=38) of 18–24 year old YDRS participants had ever been incarcerated.

Figure 2.7 shows the range of offences YDRS survey participants had been charged with during the six months prior to the survey. Younger participants aged 13–15 were more frequently involved in property offences than older participants, who were more likely to be involved in violent crime.

Figure 2.7: Offences YDRS survey participants had been charged with during the six months prior to the survey



Source: MacLean et al., 2009

Child protection

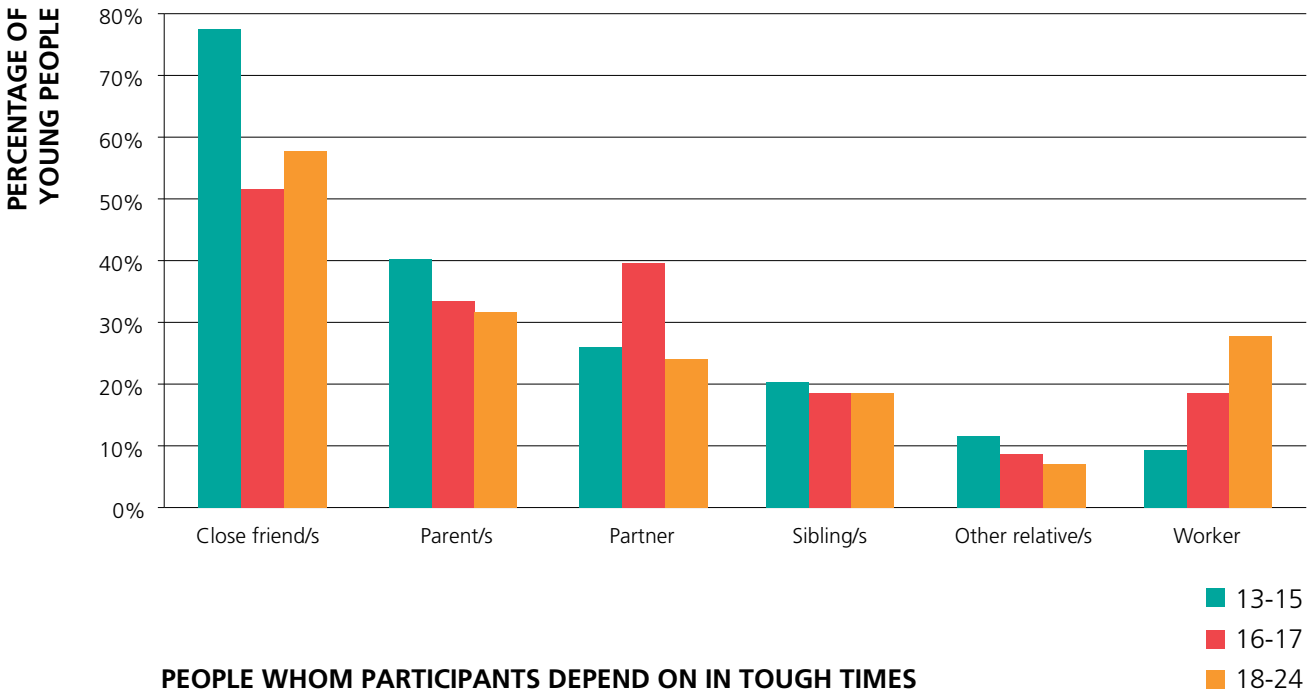
In 2005–06, 1.5% of the total population of young Victorians aged 10–17 were subject to care and protection orders. At the end of June 2006, of young people aged 10-17, 2502 were living in out-of-home care. This comprised 3.47 per 1000 Victorian young people. Rates of involvement with child protection are significantly higher among young people in the AOD system. For example, 30% (n=20) of YDRS survey participants aged 13–17 years lived in either a foster carer's home or a residential unit (MacLean et al., 2009).

Relationships

Data from The State of Victoria's Young People (DEECD & DPCD, 2008) indicate that family is very important and a critical source of support for young people. Ninety-two per cent (92%) of this sample identified friends as 'very important' or 'extremely important' to them.

Friendships appear similarly important for a service engaged group, but families somewhat less so. Figure 2.8 provides an indication of who YDRS survey participants believed they could "depend on in tough times". It shows that a greater proportion of 13–15 year olds identified friends as dependable during tough times than did older YDRS cohorts.

Figure 2.8: People on whom YDRS survey participants could depend in tough times



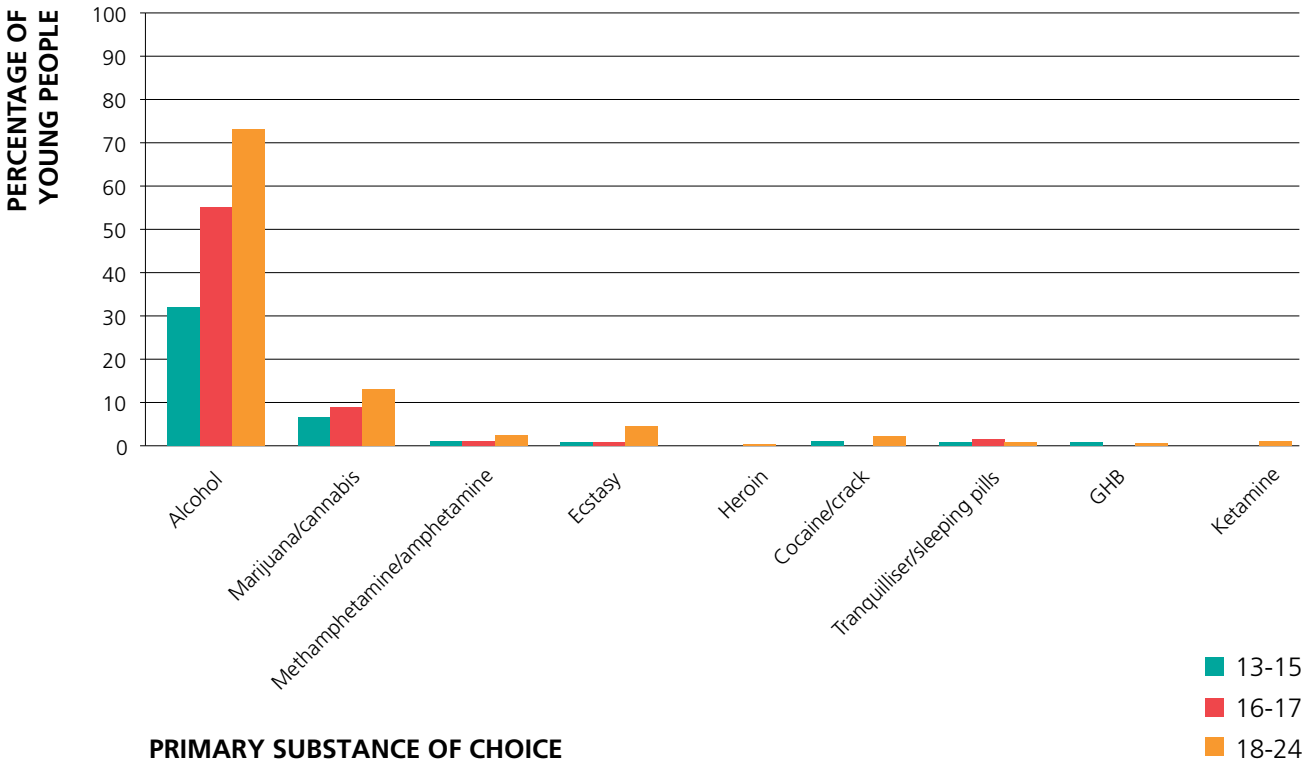
Source: MacLean et al., 2009

MacLean et al. (2009) also reported that most participants said they have connections with at least one person, but among this sample 14% felt they had no one on whom to depend during tough times.

2.4.3 Substance use patterns

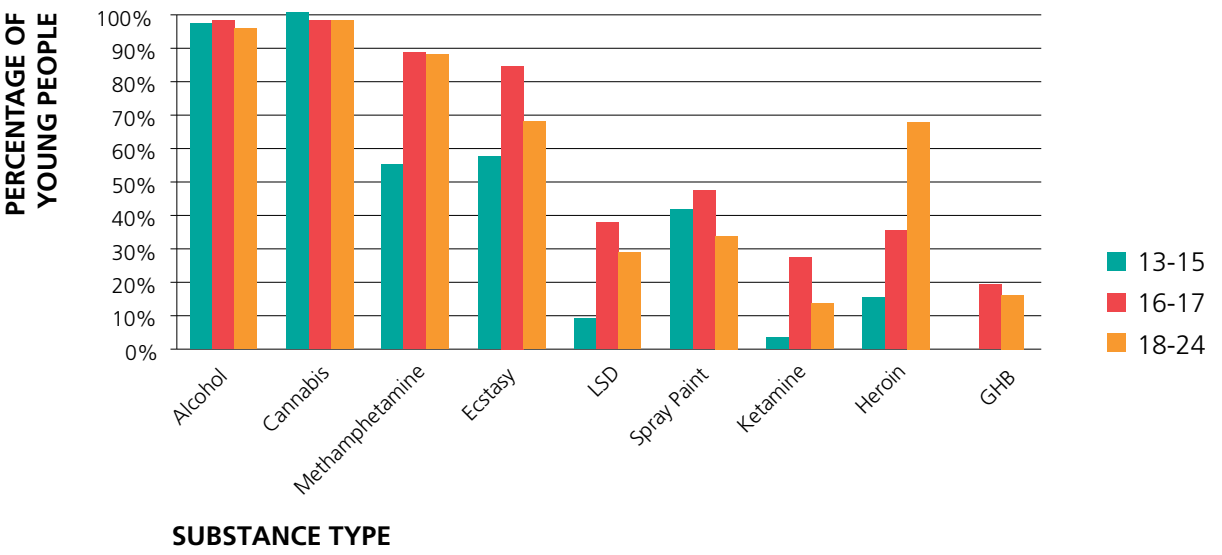
The substance use of youth AOD clients is expected to be more prevalent, heavier and more risky than patterns among a general population of young people. Figure 2.9 shows substances used in the last six months by the YDRS population. Figure 2.10 represents lifetime use among participants of the YDRS study. By comparison, Figure 2.11 respresents lifetime use of substances by young people from the general population.

Figure 2.9: Prevalence of lifetime substance use among Victorian young people aged 13 to 24 years, 2004



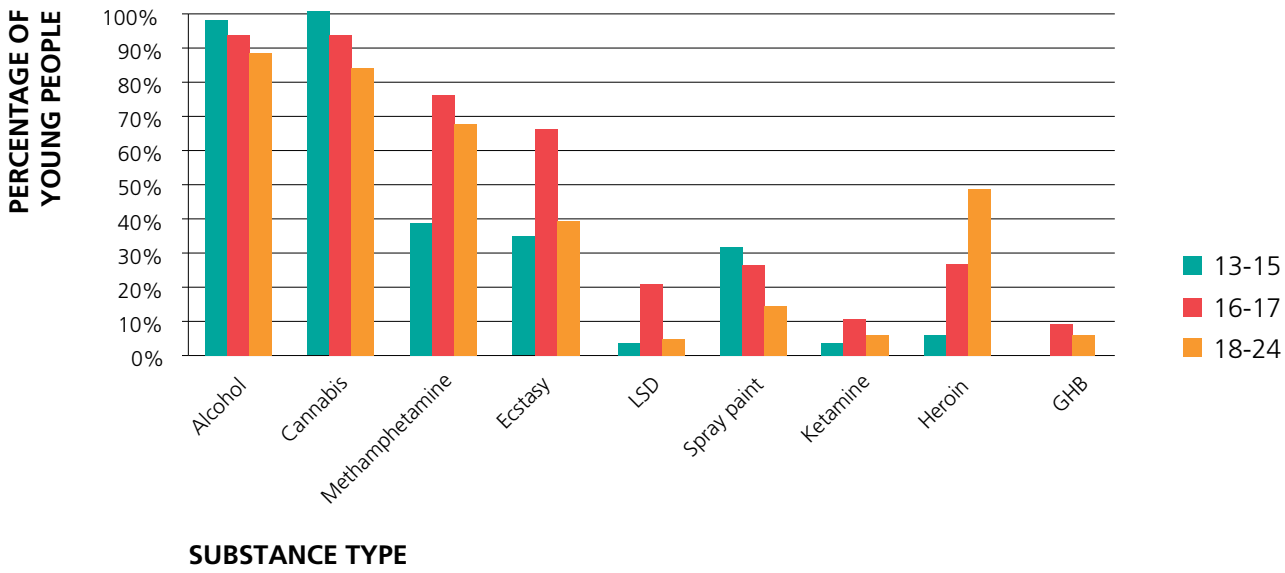
Source: AIHW 2005, analysis by Turning Point Alcohol and Drug Centre

Figure 2.10: Lifetime substance use for YDRS survey participants



Source: MacLean et al., 2009

Figure 2.11: Previous six months of substance use for YDRS survey participants



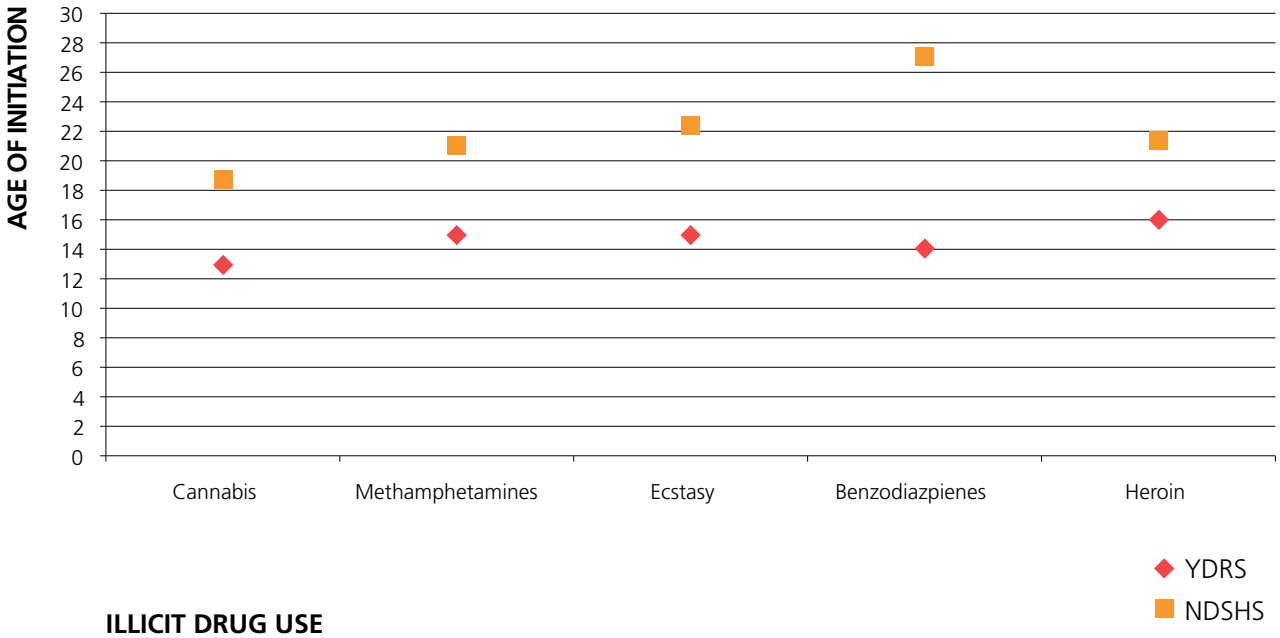
Source: AIHW 2005, analysis by Turning Point Alcohol and Drug Centre

Aside from the high prevalence of drug use, there are several aspects of substance use patterns that are most striking among a marginalised group. We list some broad characteristics, which are supported by examples drawn from recent statistics (statistics used here are broadly indicative only, as client studies do not generate large enough samples to be representative and there are methodological differences between studies).

Mayock (2002) identifies two significant transition points in young people's drug using careers. The first is commencing drug use (usually cannabis) and the second is transitioning from cannabis to other drug use. YDRS survey participants reported initiating both cannabis and other drug use many years earlier than drug users in the general Australian population surveyed by NDSHS in 2010.

Figure 2.12: Age of Initiation into Illicit Drug Use YDRS vs NDSHS^*

*Youth Drug Reporting System; ^National Drug Strategy Household Survey



ILLICIT DRUG USE

- Early age of initiation into illicit drug use (see Figure 2.12).
  - > The mean age for commencing cannabis use for 2010 NDSHS respondents reporting lifetime cannabis use was 18.5 years (Australian Institute of Health and Welfare, 2011a). The mean age for the YDRS survey sample was over years earlier, at 13 years (n=160).
  - > Two percent of 13–15 year old *National Drug Strategy Household Survey*/NDSHS participants (AIHW, 2011a) had ever used ecstasy compared with 57% of the YDRS survey sample; and 2% of NDSHS participants had ever used inhalants compared with 57% of 13–15 year olds in the YDRS survey sample.
  - > The mean age of initiating methamphetamine reported by the general Australian methamphetamine-using population, sampled by NDSHS in 2010, was 20.9 years, and 22.2 years for ecstasy use. This is compared with a mean of 15 years for YDRS survey participants for both drug types.
  - > YDRS survey participants' mean age of initiating use of illegally obtained benzodiazepines was 15 years (n=62). This compares with 27 years for initiating use of tranquillisers or sleeping pills for non-medical purposes among NDSHS respondents aged over 14 years in 2010 (AIHW, 2011a, p12).
  - > Initiation of heroin use occurred at an average age of 21.4 years among the general population of Australians who had ever used heroin, compared with an average age of under 16 years among YDRS survey participants who had ever used heroin (n=75).
- Regular and heavy use of a greater range of illicit drugs.
  - > In Melbourne, *Project i* collected data on substance use among homeless young people. Like YDRS survey participants (described below) *Project i* participants reported alarmingly high levels of substance use, including frequent polydrug use, with those who had been homeless longer using more intensively than the newly homeless (Rosenthal et al., 2008).
  - > All YDRS survey participants aged 13–15 years had used cannabis in the six months prior to interview and reported that they had used cannabis slightly more frequently than every second day.
- Engagement in high-risk forms of drug use.
  - > Heroin had ever been used by 46% of YDRS participants aged 13–24 years and is very uncommon in the general population. Lifetime heroin use was reported by 0.4% of Victorians aged 16–24 years participating in the VYADS (2010, p40), and similarly low numbers of the Australian sample in the NDSHS (0.1% of 14–17 year olds, 0.3% of 18–19 year olds, and 0.4% of 20–29 year olds; AIHW, 2011, p21).
  - > YDRS survey participants who did inject drugs reported unsafe injection practices. Of 53 YDRS survey participants who had injected during the past month, just over one-quarter (n=14) had used a needle that someone else had already used. The proportion reporting sharing spoons was slightly higher.
- Younger cohorts show different patterns in substance use.
  - > Recent use of heroin, ketamine, LSD and GHB by YDRS 13–15 year olds is relatively low compared with that of YDRS survey participants aged 18–24 years
  - > Cannabis was cited as the main drug of choice for 60% of 13–15 year olds (n=21) but only 42% of 18–24 year olds (n=33).
  - > Heroin was cited as the main drug of choice for 21% of 18–24 year olds (n=79) but not by any 13–15 year old participating in the YDRS survey.
  - > Recent inhalation of spray paint was higher among 13–15 year olds compared with the older YDRS survey participants.
  - > Older YDRS survey participants appeared more concerned about substance use than younger participants. Just over half of 13–15 year olds (54%; n=19) "never" or "almost never" worried about their main drug use, compared with 29% (n=14) of 16–17 year olds.
  - > Overdoses increased as participants aged, perhaps reflecting changes in substances used. Only one YDRS survey participant aged 13–15 had overdosed during the previous six months, with alcohol cited as the main substance involved, compared with 13% (n=10) of 18–24 year olds.

Finally, more than 85% of the 163 YDRS participants had been able to access services when required. Seventy-two% (n=117) of the overall sample also identified that they had been able to stop or reduce drug use on their own or without help.

References

ABS (2009). *Home and Away: The living arrangements of young people.* Cat. no. 4102.0 – Australian Social Trends Canberra, Australian Bureau of Statistics.

AIHW (2005). *2004 National Drug Strategy Household Survey: Detailed findings.* Canberra, Australian Institute of Health and Welfare.

AIHW (2007). *Statistics on drug use in Australia 2006. Drug Statistics Series 13*. Canberra, Australian Institute of Health and Welfare.

AIHW (2011a). *2010 National Drug Strategy Household Survey report.* Canberra, Australian Institute of Health and Welfare.

AIHW (2011b). *Young Australians: Their health and wellbeing.* Cat. no. PHE 140. Canberra, Australian Institute of Health and Wellbeing.

Alkire, S. (2007). Concepts and Measures of Agency. Oxford, Oxford University Press, Oxford Poverty and Human Development Initiative.

Bandura, A. (1977). Social Learning Theory. General Learning Press. New York.

Bashir, M., Schwarz, M. (1989). Adolescent Psychiatry. Taken from Beaumont, P.J.U., Hampshire, R.B., Text Book of Psychiatry. Blackwell Publishing Asia Pty Ltd.

Bessant, J. (2008) Hard wired for risk: neurological science, 'the adolescent brain' and developmental theory. Journal of Youth Studies, 11, 347-360.

Bond, L., Thomas, L., Toumbourou, J.W., Patton, G., and Catalano, R. (2000). *Improving the Lives of Young Victorians in Our Community: A survey of risk and protective factors.* Melbourne: Centre for Adolescent Health.

Boydon, J., Mann, G. (2005). Children's risk, resilience, and coping in extreme situations. In Ungar, M. (Ed.), *Handbook of working with children and youth: Pathways to resilience across cultures and contexts* (pp3-26). Thousand Oaks, CA, Sage.

Bretherton, I. (1992). The Origins of Attachment Theory: John Bowlby and Mary Ainsworth. *Developmental Psychology* 28, p759.

Bronfenbrenner, U. (1979). The Ecology of Human Development. Harvard University Press, Cambridge, Massachusetts.

Bruun, A. (2008). Effective Practice for Young People Experiencing Alcohol and Other Drug-Related Harm. In Moore, D. and Dietze, P. (Eds.), *Drugs and Public Health: Australian Perspectives on Policy and Practice.* Melbourne: Oxford University Press.

Bruun, A., Palmer, T (1998). *Orientation to the Alcohol and Other Drugs Sector, YSAS Accredited Training Manual*. Youth Substance Abuse Service, Melbourne, Australia.

Catalano, R.F., Hawkins, J.D. (1996). The social development model: A theory of antisocial behaviour. In Hawkins, J.D. (Ed.), *Delinquency and crime: Current theories* (pp149–197), Cambridge University Press, New York.

Chamberlain, C. & MacKenzie, D. (2009). *Counting the homeless 2006: Victoria.* Cat. no. HOU 203. Canberra, AIHW.

Chassin, L. (2008). Juvenile justice and substance use. *The Future of Children 18*(2): 165-183.

Christopher, J.C. & Hickinbottom, S. (2008) Positive psychology, ethnocentrism, and the disguised ideology of individualism. *Theory and Psychology 18*(5), pp.563-589

Clark, G. Scott, N & Cook, S. (2003). *Formative Research with Young Australians to assist in the development of the National Illicit Drugs Campaign:* Prepared for Commonwealth Department of Health and Aging, Canberra.

Daniel, B. & Wassell, S. (2002). Assessing and Promoting Resilience in Vulnerable Children: The Early Years, The School Years, Adolescence London, Jessica Kingsley publishers.

Daniel, B., Wassell, S. & Gilligan, R. (1999). Child development for child care and protection workers. London, Jessica Kingsley publishers.

Davis, N (1999) *Resilience: Status of the Research and Research-Based Programs* (draft, 28 May 1999). Rockville, MD: Substance Abuse and Mental Health Services Administration, Centre for Mental health Services, Division of Program Development, Special Populations and Projects, Special Programs Development Branch.

DEECD & DPCD (2008). *The state of Victoria's young people: A report on how Victorian young people aged 12-24 are faring,* Department of Education and Early Childhood Development and Department of Planning and Community Development, Melbourne.

DHS, DPCD, DEECD & Victoria Police (2010). *Positive Pathways for Victoria's vulnerable young people.* Department of Human Services, Department of Planning and Community Development, Department of Education and Early Childhood Development, Victoria Police, Melbourne.

Duff, C. (2003). Drugs and Youth Cultures: Is Australia experiencing the 'normalization of adolescent drug use? *Journal of Youth Studies, 6*(4), 433-446.

Fleming, J. & Ledogar, R.J. (2008). Resilience, an Evolving Concept: A Review of Literature Relevant to Aboriginal Research. Pimatisiwin: *A Journal of Aboriginal and Indigenous Community Health 6*(2).

Friedli, L. (2009). *Mental health, resilience and inequalities.* World Health Organization, Geneva.

Furlong, A. & Cartmel, F. (1997) Young People and Social Change: Individualisation and Risk in Late Modernity, Buckingham, Open University Press.

Garmezy, N., Masten, A.S., Tellegen, A. (1984). The study of stress and competence in children: A building block for developmental psychopathology. *Child Development 55*:97–111.

Giddens, A. (1991) Modernity and Self-Identity: Self and Society in the Late Modern Age, Cambridge, Polity Press.

Giedd, J.N., Blumenthal, J., Jeffries, N.O., (1999), Brain development during childhood and adolescence: a longitudinal MRI study. *Nature Neuroscience, 2*(10):861-3

Gilligan, C. (1982). In A Different Voice. Cambridge: Harvard University Press.

Gilligan, R. (2008). Promoting resilience in young people in long-term care- the relevance of roles and relationships in the domains of recreation and work. *Journal of Social Work Practice, 22*(1), 37-50

Gruber, H.E.; Voneche, J.J. (Eds). The essential Piaget: An interpretive reference and guide. New York: Basic Books.

Guttierrez, B. L. N. & Palacios, F. F. (2004) A search for a different world. Social representation that determines decision-making by Mexican adolescent users of illegal drugs. *Salud Mental,* 27, 26–34.

Haidt, J. & Graham,. J. (2007). When Morality Opposes Justice: Conservatives Have Moral Intuitions That Liberals May Not Recognize. *Social Justice Research, 20*(1): 98-116.

Hall, G.S. (1904). Adolescence. New York: Appleton.

Harvey, J. & Delfabbro P. H. (2004) Psychological resilience in disadvantaged youth: A critical overview. *Australian Psychologist, 39*(1): 3 – 13

Havighurst, R. J. (1972). Developmental task sand education (3rd ed.). New York: McKay.

Hilman, K., & Marks, G (2002). *Becoming an adult: Leaving home, relationships and home ownership among Australian youth,* Research report number 28, Longitudinal surveys of Australian youth. Australian council of Educational Research.

Homel, R., Freiberg, K., Lamb, C., Leech, M., Batchelor, S., Carr, A. et al. (2006). Pathways to Prevention Project: Doing developmental prevention in a disadvantaged community, *Trends and Issues 323*, 1-6.

Johnson, B. & Howard, S. (2007) Causal chain effects and turning points in young people's lives: a resilience perspective. *Journal of Student Wellbeing, 1*(2), 1-15.

Kagan, J. (1994) Galen's Prophecy: Temperament in Human Nature. Westview Press.

Kelly, P. (2006) The entrepreneurial self and 'youth at risk': exploring the horizons of identity in the twenty-first century. *Journal of Youth Studies, 9,* 17–32.

Kilmartin, C. (2000). Young adult moves: Leaving home, returning home, relationships. *Family Matters, 55*(Autumn), 34-30

Kim-Cohen, J., & Gold, A. L. (2009). Measured gene–environment interactions and mechanisms promoting resilient development. *Current Directions in Psychological Science, 18,* 138–142.

Kohlberg, L. (1981). Essays on Moral Development, Vol. I: The Philosophy of Moral Development. San Francisco, CA: Harper & Row.

Ledogar, R.J. & Fleming, J. (2008) Social capital and resilience: a review of concepts and selected literature relevant to Aboriginal youth resilience research. Pimatisiwin: *A Journal of Aboriginal and Indigenous Community Health,* 2008, 6(2):25–46.

Lerner, R. M., & Benson, P. L. (Eds.). (2003). Developmental assets and asset-building communities: Implications for research, policy, and practice. New York: Kluwer Academic/ Plenum Press.

Loxley, W., Toumbourou, J., & Stockwell, T. (2004). The Prevention of Substance Use, Risk and Harm in Australia. A Review of the Evidence. Summary: Australian Government Department of Health and Ageing, Canberra.

Luthar. S.S. (2006). Resilience in development: A synthesis of research across five decades. In D. Cicchetti and D.J. Cohen (Eds.), *Developmental Psychopathology: Risk, Disorder, and Adaptation* (pp740-795). New York: Wiley.

MacLean, S., Bruun, A., Mallett, S., & Green, R. (2009). *Social contexts of substance use for vulnerable 13-15 year olds in Melbourne: Youth Drug Reporting System.* Melbourne: Turningpoint Alcohol and Drug Centre, Youth Substance Abuse Service (YSAS), Keys Centre for Women's Health.

Masten, A. (2009) Ordinary magic: Lessons from research on resilience in human development

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist,* 56, 227-238.

Masten, A. S., & O'Dougherty Wright, M. (2009). Resilience over the lifespan: Developmental perspectives on resistance, recovery, and transformation. In J. W. Reich, A. J. Zautra & J. S. Hall (Eds.), *Handbook of adult resilience* (pp213-237). New York: Guilford Press.

Masten, A. S., & Obradovi, J. (2006). Competence and resilience in development. *Annals of the New York Academy of Sciences*, 1094, 13–27.

Masten, A. S., & Powell, J. L. (2003). A resilience framework for research, policy, and practice. In S. S. Luthar (Ed.), *Resilience and vulnerabilities: Adaptation in the context of childhood adversities* (pp1–25). New York: Cambridge University Press.

Masten, A. S., Obradovi, J. & Burt, K. B. (2006). Resilience in emerging adulthood: Developmental perspectives on continuity and transformation. In J. J. Arnett & J. L. Tanner (Eds.), *Emerging adults in America: Coming of age in the 21st century* (pp173–190). Washington, DC: American Psychological Association Press.

Measham, F. & Shiner, M. (2009), The legacy of Normalisation: The role of classical and contemporary criminological theory in understanding young people's drug use, *International Journal of Drug Policy,* Special edition: ISDDP 2nd international conference, 20(6) 502-508.

Melucci, A. (1996) The Playing Self: Person and Meaning in a Planetary Society, Cambridge, Cambridge University Press.

Moore, D. (2002). Opening up the Cul-De-Sac of Youth Drug Studies: A contribution to the construction of some alternative truths. *Contemporary Drug Problems,* 29(1), 13-63.

Muck, R., Zempolich, K., A. , Titus, J., C. , Fishman, M., & et al. (2001). An overview of the effectiveness of adolescent substance abuse treatment models. *Youth and Society, 33*(2), 143.

Munford, R., & Sanders, J. (2008). Drawing out strengths and building capacity in social work with troubled young women. *Child & Family Social Work, 13*(1), 2-11.

Naidoo, J., & Wills, J. (2000). Health Promotion: Foundations for Practice (Second ed.). London: Bailliere Tindall.

Nation, M., Crusto, C., Wandersman, A., Kumpfer, K. L., Seybolt, D., & Morrissey-Kane, E.. (2003). What works in prevention: Principles of effective prevention programs. *American Psychologist, 58*, 449–456.

Newman, T. (2004) What Works in Building Resilience. Ilford: Barnardo

NSW Centre for the Advancement of Adolescent Health & Transcultural Mental Health, (2008) *Adolescent Health, Enhancing the skills of the General Practitioners in caring for young people from culturally diverse backgrounds,* GP Resource Kit 2nd Edition

Paglia, A., & Room, R. (1998). *Preventing substance-use problems among youth: A literature review and recommendations:* ARF Research Document Series no. 142. Toronto: Addiction Research Foundation.

Petroulis, D. Bruun, A. Papadontas, M. & Roy, I. (2006) *Clinical Treatment Guidelines for Alcohol and Drug Clinicians.* No 13: Youth Alcohol and Drug Outreach. Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.

Premier's Drug Advisory Council. (1996). Drugs and Our Community. Melbourne.

Reyna, V. F. & Farley, F. (2006) Risk and rationality in adolescent decision making - implications for theory, practice, and public policy. *Psychological Science, 7*, 1–44.

Richardson, G.E. (2002). The metatheory of resilience and resiliency. *Journal of Clinical Psychology 58*(3):307–321.

Robinson, E & Miller, R. (2010). *Adolescents and their families: Best interests case practice model specialist practice resource.* Victorian Government Department of Human Services.

Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review, 24*, 143-155

Rosenthal, D., Mallett, S., Milburn, N., & Rotheram-Borus, M. J. (2008). Drug Use Among Homeless Young People in Los Angeles and Melbourne. *Journal of Adolescent Health, 43*(3), 296-305.

Rutter, M. (1985). Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry, 147,* 598–611.

Rutter, M. (1987). Psychosocial resilience and protective mechanisms. American Journal of Orthopsychiatry, 57, 316–31.

Rutter, M. (1989). Pathways from childhood to adult life. Journal of Child Psychology & Psychiatry, 30, 23-51.

Rutter, M. (1990). Psychosocial resilience and protective mechanisms. In J. Rolf, A.S. Masten, D. Cicchetti, K.H. Nüchterlein & S. Weintraub (Eds.), *Risk and Protective Factors in the Development of Psychopathology* (pp181–214). New York: Cambridge University Press.

Rutter, M. & the English and Romanian Adoptees (ERA) Study Team (1998). Developmental catch-up, and deficit, following adoption after severe early privation. *Journal of Child Psychology and Psychiatry, 39,* 465-476.

Rutter, M. (2007). Gene-environment interplay and developmental psychopathology. In A. Masten (Ed). Multilevel dynamics in developmental psychopathology: Pathways to the future. Minnesota Symposium 2004, Vol. 34. Mahwah, NJ: Lawrence Erlbaum. pp. 1-26.

Shonkoff, J., & Phillips, D. (Eds.). (2000). From Neurons to Neighbourhood: The science of early childhood development. Washington: National Academy Press.

Sigelman, C. K. & Rider, E A. (2009) Life-span human development, international 6th edition, Wadsworth.

Silberstein R. & Lerner R. (2007) Approaches to positive youth development. Thousand Oaks, CA, Sage.

Small, S. A., Cooney, S. M., & O'Connor, C. (2009). Evidence-informed program improvement: using principles of effectiveness to enhance the quality and impact of family-based prevention programs. *Family Relations, 58*(1), 1-13.

Spano, S. (2002) *Adolescent Brain development:* ACT for Youth Upstate Centre of Excellence, USA.

Spooner, C., Hall, W. & Lynskey, M. (2001). *Structural determinants of youth drug use,* Canberra, Australian National Council on Drugs.

Steinberg, l. & Morris, M.A. (2001). Annual Review of Psychology, *Annual Reviews, 52,* 83-110.

Thompson, N., Talko, T., Ritter, A., & Pahoki, S. (2007). *Australian Treatment Outcome Study (ATOS): Youth Alcohol and Drug Outreach 12 Month Report:* Victoria Melbourne: TurningPoint Alcohol and Drug Centre.

Thomson, R., Bell, R., Holland, J., Henderson, S., McGrellis, S., & Sharpe, S. (2002). Critical Moments: Choice, Chance and Opportunity in Young People's Narratives of Transition. *Sociology, 36,* 335-354.

Ungar, M. (2006). Resilience Among Children in Child Welfare, Corrections, Mental Health and Educational Settings: Recommendations for Service. *Child and Youth Care Forum, 34*(6), 445-464.

Ungar, M., Brown, M., Liebenberg, L., Othman, R., Kwong, W.M., Armstrong, M. & Gilgun, J. (2007). Unique pathways to resilience across cultures. *Adolescence, 42(*166), 287-310.

Unger, J.B. & Kipke, M.D. (1998). Stress, coping, and social support among homeless youth. *Journal of Adolescent Research 13*, 134-157.

U.N. (2004). *World Youth Report 2003: The global situation of young people,* Department of Economic and Social Affairs of the United Nations Secretariat, United Nations, United Nations Publications.

Van Brocken, S. (1998) Meeting the Needs of Our Youth. *Reclaiming Children and Youth, 7,* 172-175.

Vaughn, B.E., Bost, K.K., Van Ijzendoorn, M.H. (2008). Attachment and Temperament. in Cassidy J, Shaver PR. *Handbook of Attachment: Theory, Research and Clinical Applications.* New York and London: Guilford Press.192–216.

Werner, E.E. and Smith, R.S. (1982). Vulnerable but Invincible: A Longitudinal Study of Resilient Children and Youth. New York: McGraw-Hill.

Werner, E.E., & Smith, R.S. (1992). Overcoming the odds: High risk children from birth to adulthood. Ithaca, New York, Cambridge University Press.

Williams, J., Toumbourou, J., Williamson, E., Hemphill, S., & Patton, G. (2009) *Violent and antisocial behaviours among young adolescents in Australian communities: an analysis of risk and protective factors.* Australian Research Alliance for Children and Youth, Canberra.

Wyn, J., & White, R. (1997). Rethinking youth. St Leonards, New South Wales: Allen & Unwin.

Yates, T. M., & Masten, A. S. (2004). Fostering the future: Resilience theory and the practice of positive psychology. In P. A. Linley & S. Joseph (Eds.), *Positive psychology in practice* (pp521-539). Hoboken, NJ: Wiley.

YSAS (2011). *YSAS Annual Report 2010-2011.* Melbourne, Youth Support and Advocacy Service.

3. Characteristics of effective services and programs

3.1 Introduction

Historically, the literature on clinical interventions including evidence-based practice (EBP) has focused strongly on the content and techniques of clinical treatments or interventions. The model of EBP that has received most attention in research centres is the notion of discrete clinical interventions that are supported by empirical evidence (Garner, 2009; McHugh, Murray, & Barlow, 2009; Stirman, Crits-Christoph, & DeRubeis, 2004; Weisz, Jensen-Doss, & Hawley, 2006). The term 'empirically supported treatments' (ESTs) will be used to refer to this model and to distinguish it from alternative approaches that are broader in scope.

Practitioner critics of the EST approach to EBP have argued that this agenda is too narrow and that it places too little value on the expertise of clinicians or the experience and preferences of clients (Larner, 2004; Walker, 2003). Such critics have argued in favour of an approach that combines science and practice wisdom (Larner, 2004). Perhaps in response to these criticisms, the literature on EBP has recently begun to expand to consider characteristics of practice, programs and services that are broader than the content and techniques of clinical treatments. This trend is consistent with the Institute of Medicine's definition of EBP, which centres on the integration of best research evidence with practitioner expertise and client values (Aarons & Palinkas, 2007; Henderson, Taxman, & Young, 2008).

If we are to endorse an integrative approach to EBP, the question arises as to the types of practice that are widely endorsed by practitioners and which are understood as respecting client values. This brings us to consideration of the practice wisdom literature.

Practice wisdom is practice-based knowledge that has emerged and evolved primarily from practical experience rather than from empirical research. This knowledge may be acquired directly by a practitioner through their personal experience, or it may be based on the personal experience of others and acquired through dissemination among practitioner networks. A well-elaborated example is the kind of knowledge that is generated and acquired through the 'situated learning' that takes place in 'communities of practice' (Lave & Wenger, 1991; Wenger, 1998).

Much practice wisdom or practice-based knowledge remains tacit and undocumented. This knowledge may drive many decisions and actions without being articulated, but much has been explained and documented. Key documentary sources for the youth AOD field include:

- The clinical practice literature or writing based on the reflections, opinions and general knowledge, including varied reading of the writer. This includes many articles published in discipline-based journals and magazines;
- The work of largely qualitative researchers who study the nature of practice and experiences of practitioners in youth AOD and related services; and
- Textbooks for disciplines that comprise the bulk of the workforce in the youth AOD field (social work, youth work, community nursing).

The characteristics of effective services and programs that we have outlined below are broad approaches to practice that can be readily discerned from these types of sources. The nature of these characteristics is distinctly different from clinical interventions. They are concerned with different levels of analysis. A simple analogy for these levels of analysis is the difference between 'what' and 'how' or the difference between 'contents' and 'infrastructure'.

The core concepts used in the practice wisdom literature to describe characteristics of effective services and programs almost all refer to how, or the ways in which, services should be delivered. In contrast, the core concepts used in the clinical research literature are strongly focused on what is delivered; treatments comprised of therapeutic content that is behavioural or cognitive, for example. Characteristics of effective programs enable or facilitate delivery of effective treatment content and techniques.

The practice wisdom literature has historically been quite separate from the mostly quantitative clinical research literature of EBP. While there is considerable theoretical and empirical support for these characteristics, they have been poorly researched relative to clinical interventions, partly because they are conceptually complex, not easily defined and therefore difficult to quantify and investigate in empirical research compared with treatment models in manuals (Larner, 2004; Walker, 2003). Despite these difficulties, these characteristics have persisted in the practice wisdom literature and are beginning to make inroads to the broader EBP literature (Austin, Macgowan, & Wagner, 2005; Brannigan, Schackman, Falco, & Millman, 2004; Henderson et al., 2008; Henderson et al., 2007; Mark et al., 2006).

Recently, several groups of youth AOD treatment researchers have sought to bring insights from the practice wisdom literature into the discourse of evidence-based practice using systematic strategies for gathering and organising the opinion of experts around these types of practice approaches (Brannigan et al., 2004; Henderson et al., 2008; Henderson et al., 2007).

Similar work has been done in the area of prevention and early intervention using traditional literature review (Nation et al., 2003; Small, Cooney, & O'Connor, 2009). Work compiling evidence across multiple sources tends to focus on approaches that reduce risk factors and build protective factors recognised as determinants of various behavioural health problems commonly experienced by adolescents. Thus our review of the prevention and early intervention literature extends beyond a narrow focus on AOD problems to include common 'upstream' determinants.

The list of characteristics of effective service provision described below uses the findings of the expert consensus synthesis as a starting point. The work has focused on compiling lists of consensus-based characteristics. With respect to treatment programs, this work has not extended to detailed description of the characteristics, and the context is strongly North American.

Several critical features of the broader AOD and health and social care systems in Australia are different from those in the United States. Our review builds on existing work by fleshing out the descriptions of the characteristics using the diverse literatures outlined above. Names and definitions of some of the characteristics have also been modified in an effort to use language and recognise values consistent with the Australian context.

The list of characteristics of effective services and programs provided here is not exhaustive or definitive. Consultation with practitioners and consumer advocacy groups in Victoria is necessary to determine the full scope of the literature that should be drawn upon and the range of characteristics that should be included.

It is important to note that each item on this list of characteristics is not necessarily relevant for every program that offers treatment, prevention or early intervention for youth AOD problems. Some characteristics are best applied at the level of service systems or networks of coordinated programs.

3.2 Client-centred / socio-culturally relevant

Many writers on the topic of treatment and support for young people with AOD problems strongly endorse the principle of client-centred care (Bell, 2006; Bruun, 2008; Clark, 2001a, 2001b; Miller & Duncan, 2000; Moos, 2007; Pichot, 2001; Schuetz & Berry, 2009; Ungar, 2005a). Other terms that are widely used in the literature include **'individualised'** or **'needs-led'** care. At its most basic, client-centred care involves a focus on meeting the individual needs of each youth, or assessment and treatment matching. It is one of the key elements of effective adolescent drug treatment practices identified by expert consensus processes as reported in the various publications from this work (Austin et al., 2005; Brannigan et al., 2004; Henderson et al., 2007; Mark et al., 2006).

Assessment and treatment matching involves selecting and then tailoring interventions to the individual needs of the client. Comprehensive assessment, individualised treatment plans, and regular case review are widely regarded as key technical requirements for individualised treatment (Marsh, Dale, & Willis, 2007).

Pichot (2001) points out that while many AOD treatment agencies claim that their services are individualised according to client need, the content of the program has usually been determined before the client seeks admission. In contrast, genuine client-centred care involves ensuring that interventions (i.e. the content) are selected, adapted, and delivered in ways that are consistent with the individual needs of the client (Bell, 2006; Bruun, 2008; Clark, 2001a, 2001b; Miller & Duncan, 2000; Pichot, 2001; Schuetz & Berry, 2009; Ungar, 2005a). Barry et al. (2002) recommend an orientation that "responds to what our patients require from us rather than our deciding what they need in advance" and "incorporat[ing] the services of the program into their lives rather than having them adjust to us" (p147).

Numerous writers, particularly those from a youth work or social work perspective, argue that to genuinely understand what clients need, more emphasis must be placed upon eliciting and validating clients' subjective experience and securing their active participation in formulating their treatment or care plan. At the very least, most advocates of client-centred care recommend that the client be consulted in the design of the treatment plan. Others advocate an approach that seeks to maximise client input to the extent of driving the treatment process.

Moos argues that grounding the intervention in the client's perspective, affirming the client's strengths, and finding out the client's ideas about change all support the client's responsibility and self-efficacy for change (Moos, 2007). This is viewed as essential to the effectiveness of efforts to motivate and engage clients in treatment for AOD problems.

Similarly, other writers argue that practitioners need to understand the subjective experience of young people, especially their understandings of 'problem behaviours', before attempting to create change or intervening to reduce any harm associated with them (Munford & Sanders, 2008; Ungar, 2006). This understanding is viewed as necessary for drawing the client into an active and collaborative process of solution-finding (Munford & Sanders, 2008; Pichot, 2001; Ungar, 2006).

Identifying, working with, and building upon strengths, rather than focusing solely on problems, is particularly emphasised in the social work practice literature (Aronowitz, 2005; Karabanow & Clement, 2004; Kidd, 2003; Munford & Sanders, 2008; Pichot, 2001; Ungar, 2006). This is closely related to, even dependent upon, a client-centred or person-focused approach, because personal strengths and social assets are highly individualised and dependent upon the unique characteristics, circumstances, experiences and self-perceptions of the young person.

While understanding and responding to the unique needs and preferences is a definitive feature of client-centred care, some pre-planning is necessary if services are to have the capacity to respond rapidly to the needs identified.

Concepts equivalent to that of client-centred care are also readily found in the prevention literature. Practitioners and researchers concerned with ensuring that prevention programs are embraced and sustained by communities long enough to have a positive impact on rates of problem behaviours and risk factors have noted that programs must be **socio-culturally relevant**.

This means ensuring that interventions are:

- Targeting problems of most relevance and concern to particular communities;
- Culturally appropriate;
- Politically feasible; and
- Sensitive to community readiness to implement programs (Bond & Hauf, 2007; Nation et al., 2003; Woodland, 2008).

Adapting prevention programs to ensure they are culturally appropriate generally involves making surface level changes, such as ethnic matching of program facilitators to communities, use of language, and tapping into cultural traditions in the choice of exercises and modalities (Kumpfer, Whiteside, Greene, & Allen, 2010). Achieving socio-cultural relevance is generally viewed as requiring input from potential program participants and community stakeholders.

3.3 Relationship-based / focus on relationships

The practice-based literature emphasises the importance of the relationship between the young person and the provider as vital to any chance of positive outcomes of therapeutic interventions.

Surveys of child and adolescent behavioural health care practitioners suggest that for many, the quality of the therapeutic alliance is more important than the specific therapy techniques that are the focus of evidence-based practice research (Garland, Hurlburt, & Hawley, 2006). A focus on relationship building over therapeutic strategies has been viewed as essential to getting and keeping young people engaged in the therapeutic process (Brannigan et al., 2004; McLeod & Weisz, 2005). Well-designed prospective research has also demonstrated that therapeutic alliance, measured objectively, predicts outcomes of therapy for children and adolescents (McLeod & Weisz, 2005). Qualitative research involving adolescents with multiple and complex needs has found that young people place very strong value on having quality relationships with workers (Russell & Evans, 2009).

In work with particularly vulnerable young people – such as homeless, offending and drug-using populations – the importance of a well-built relationship to engage young people has long been recognised as particularly critical. This vulnerable group is notoriously difficult to engage in AOD and other behavioural health services (Barry, Ensign, & Lippek, 2002; Brannigan et al., 2004; Henderson et al., 2007).

Relationships based on respect and trust and oriented towards empowerment are advocated as catalysts for building a sense of free choice, autonomy, competence and hope for youth whose previous experiences have undermined this (Aronowitz, 2005; Crago, Wigg, & Stacey, 2004; Ungar, 2005a). To do this, it has been identified that practitioners need to gain active participation by the young person in a collaborative process that develops a shared understanding and joint decision making (Bruun, 2008; Munford & Sanders, 2008).

The working relationship between practitioner and young person is often understood as broader than the classical counselling or therapeutic alliance and extends to include informal time and the creation of safe spaces. In their review of essential components of programs for homeless youth, Karabanow and Clement (2004) observe that successful programs achieve a 'safe space' by developing trusting, respectful, and safe relationships with street youth, among other things.

In talking about the value of mentoring programs they note that mentoring provides the opportunity to build positive relationships, and that to be effective the relationship should last several years. In their recent study of youth work in Australia, Rodd and Stewart (2009) liken the relationship between a young person and a youth worker, particularly the informal time spent together, to the 'glue' that holds all of the work together, as well as being therapeutic in its own right. Respondents described the relationship as a prerequisite to making other things happen, the foundation to the achievement of other youth work goals.

In relation to prevention and early intervention, attachment, nurturance and support from within the family are well-recognised protective factors contributing to resilience (Luthar, 2006). For young people who may lack a positive family environment, the existence of at least one unconditionally supportive parent, parent substitute, committed mentor or other person from outside the family has been consistently highlighted as one of the factors that make children in difficult circumstances more resilient and promote their ability to reach their goals (Aronowitz, 2005; Nation et al., 2003; Statham, 2004).

In terms of intervention effectiveness, providing opportunities for youth to develop strong positive relationships is consistently associated with positive outcomes (Nation et al., 2003). Positive relationships with a program facilitator, family members, peers and concerned others provide motivation to resist risky behaviours (Arnold & Rotherham-Borus, 2009).

Reviews of the literature on factors that protect against alcohol and illicit drug-related harm, as well as interventions likely to be effective in preventing this harm, consistently identify family factors including family support (Leung, Kennedy, Kelly, Toumbourou, & Hutchinson, 2010; Loxley, Toumbourou, & Stockwell, 2004; Mitchell et al., 2001) and interventions aimed at improving the quality of social connectedness (Leung et al., 2010; Loxley et al., 2004). Reviews of family-based prevention programs have observed that effective programs foster safe, trusting relationships between participants and staff (Nation et al., 2003; Small et al., 2009).

3.4 Developmentally appropriate

Adolescents with AOD and other psychosocial difficulties are best served by services that are developmentally appropriate (Barry et al., 2002; Brannigan et al., 2004; Henderson et al., 2008; Henderson et al., 2007).

Developmentally appropriate services and programs are designed to meet the unique developmental needs of children or adolescents. Merely being 'adolescent specific' does not guarantee developmentally appropriate services. A sophisticated approach demands the deliberate use of strategies that are adaptively tailored to the requirements of young people at particular developmental stages.

There is surprisingly little published literature that provides detailed, focused description or analysis of the features of programs and services that are widely understood as developmentally appropriate. The following analysis describes several broad guiding principles that need to be applied across all areas of work with adolescents, as well as several specific implications for practice.

3.4.1 Sensitivity to the developmental challenges and changes faced by all adolescents

If a program works with a population of children and adolescents spanning a wide range of ages – say 12 to 25 – and works with individuals over a period of several years, developmentally appropriate practice will need to be sensitive to particular developmental stages, transitions, tasks and challenges faced by adolescents and the ways these change over time.

Young people with alcohol and drug problems continue to be engaged in identity formation, value clarification, cognitive skill development, learning consequential thinking and responsible decision-making, identifying and understanding vocational strengths and inclinations, and forming relationships outside of the family.

Developmentally appropriate services are sensitive to the fact that most adolescents place substantial emphasis on these tasks and can experience considerable anxiety around their achievement. The capacity of service providers to understand and be sensitive to these general themes, as well as the specific concerns of individuals, will influence their ability to successfully engage and retain young people (Barry et al., 2002; Bruun, 2008). This is likely to be equally true for prevention and early intervention programs.

3.4.2 Continuous assessment of client capacity

A key implication for practice in maintaining sensitivity to developmental changes is the need for continuous assessment of client capacity. Adolescents are constantly evolving and can make marked developmental gains in relatively short periods. Youth AOD workers need to be aware of emerging developmental capacity and continually revise their assessment of clients' ability to cope with stressors and calculate and respond to risks.

Workers also should not assume that older adolescents necessarily have accurate information, knowledge and the skills required for coping and age-appropriate participation in community life. Many young people project an image as an agent who is in control, competent and mature, even when they and others realise that this is not the case.

3.4.3 Developmentally appropriate expectations

Services that maintain sensitivity to developmental changes express developmentally appropriate expectations. In general, adolescents require a consistent, reliable service that is uncomplicated and simple to understand. Adolescents require certainty and are very sensitive to injustice and being let down by adults, particularly when they have been exposed to inconsistent parenting.

Early-stage adolescents are more amenable to direction and in the main require more structured programming. Middle-stage adolescents are expected to benefit from structure but become sensitive about direction from adults. AOD workers need to ensure the young person feels they are in the 'driver's seat'. In late adolescence, young people need to be allowed progressively more say in managing their own circumstances.

Expectations around the ability to consider and plan for the future also need to shift. Older adolescents can be expected to be more interested in the future and more able to make and enact long-term plans. (This is still subject to the availability of meaningful opportunities.) Early-stage adolescents and those moving into the middle stage are often cited as having an intense 'here and now focus', which increases the propensity for these clients to miss appointments and be difficult to locate. This developmental attribute calls for a service response such as more assertive outreach and more assertive support and follow-up around referrals. In contrast, it is fair to expect older adolescents to take greater personal responsibility for their participation.

Young people entering and moving through middle adolescence are expected to be more discerning about the identities they are prepared to consider and the values they adopt. "Value clarification and thinking beyond the present helps reduce risk behaviours" (Aronowitz, 2005; p207). This process becomes increasingly important as clients develop more capacity for reflection.

Age and the accumulation of experience also interact with general developmental processes to influence the expectations that young people might have for themselves. Older adolescents whose difficulties have become entrenched – particularly those who have become disconnected from school and work – may acquire a sense of learned helplessness that dampens their expectations of themselves and the world around them. Younger adolescents frequently have more hope and optimism about the future (MacLean, Bruun, Mallett, & Green, 2011).

3.4.4 Duty of care and confidentiality

Young people in the early and middle adolescent stages are legally considered to be minors. This requires adults in professional roles to be mindful of threats to their safety, health and ongoing development. A service must have suitable, developmentally attuned risk assessment processes and relevant policies about how the tertiary service system will be engaged. AOD workers are well positioned for 'unobtrusive monitoring' of clients (Aronowitz, 2005), whereby exposure to risk and capacity for adaptive coping can be identified and action taken. This has been shown to have a strong protective effect (Aronowitz, 2005).

Adolescent clients are expected to be sensitive about their privacy. Clients need to be made aware that the AOD service respects their right to confidentiality. Information held should only be released with client consent. The only exception would be when the health and safety of clients or others would be compromised if information is withheld.

As young people move through middle into the late adolescent stage, both socially and legally there is greater expectation for them to care for themselves. While the AOD services retain a duty of care, there are differences in how it is structured for younger compared with older clients.

3.4.5 Developmentally appropriate modes of interaction

Young people, particularly early and middle stage adolescents, are most likely to learn through direct experience rather than through vicarious experience or counselling. This is consistent with the view that behaviourally oriented interventions focused on development of skills are more effective than purely cognitive and talking-based therapies (see Section 3.7). Whenever appropriate, young people should be encouraged to 'do' for themselves. The degree to which AOD workers undertake tasks on behalf of young people should be determined through continuous assessment of their capacity to manage (see Section 3.4.2).

AOD workers should strive to work alongside clients, positioning themselves to provide direct, real-time feedback that recognises pro-social participation and interaction with others. This approach also enables workers to identify, highlight and facilitate naturally occurring rewards for pro-social interactions (see description of the Community Reinforcement Approach (CRA) in Section 4.3). Through guided experience, clients can develop the emotional, cognitive, and behavioural skills that reinforce healthy development and promote pro-social behaviour.

3.4.6 Awareness of differing developmental trajectories

Young people with AOD problems have frequently had experiences that can alter their developmental trajectory in significant ways. Experiences such as insufficiently attentive, unpredictable, overly harsh or neglectful parenting, family conflict, lack of responsible adult role modelling, frequent physical relocations, lack of a stable and structured learning environment at home, and exposure to substance abuse in the family cause substantial disruptions in the bio-psycho-social processes that drive development.

Young people require structure and guided experience. Those that have no control over the pace of change and transition are highly susceptible to developmental problems (Coleman & Hendry, 1990). Without the necessary experiences, young people's development can lose synchronisation with the patterns that characterise the general population.

Developmentally appropriate practice for this client group aims to provide alternative experiences that help them catch up or reshape areas that have been disrupted. This involves providing, or helping young people to find, opportunities to develop the personal and social assets needed to move through the transitions to adulthood.

A major component of this work is providing regulated experience. Many young people have not had or do not have anyone to provide the sense of structure and support that the limit-setting and caring role offers. When this is lacking from parents or caregivers, then workers, particularly those with a statutory responsibility or in residential care roles, are required to do so. Limits are most often set around behaviours that are believed to compromise safety, health and future prospects. Limit setting – linked with fair consequences – provides structure, a sense of containment and a clear set of rules that young people can test out and define themselves against.

3.4.7 Managing tensions in developmentally appropriate practice for vulnerable youth

There are several tensions that practitioners will confront over time if they use the principles and practices outlined above. These tensions are further complicated if viewed in the wider context of the other characteristics of effective programs and services described in sections 3.2 to 3.11.

1. *Balancing self-determination (a key value in client-centred practice) with protection or duty of care.* The individual's level of maturity needs to be considered when making choices, such as encouraging independent decision-making versus setting limits. This balance is particularly pertinent to harm reduction in substance use.
2. *Balancing the value of promoting optimism and raising expectations for the future with building realistic expectations about capacities.* Developmentally appropriate practice involves gearing expectations of the client to his or her stage of development (see Section 3.4.3).
3. *Finding a balance between fostering healthy dependence and promoting independence.* While we must always look towards helping the client move towards independence or autonomy, a stage of dependency on others is a necessary part of healthy development. This experience has often been badly disturbed for highly vulnerable youth. Experiencing safe, dependable relationships may be a critical therapeutic intervention for some vulnerable young people.
4. *Balancing between the need to let young people make mistakes and the need to protect them from experiences of failure that can reinforce negative self-beliefs.* Being allowed to fail is essential to the development of true autonomy and the ability to take responsibility. On the other hand, for young people who have repeated experiences of failure and lack of support, new and damaging failures are unhelpful.

The ways in which 'deviant' behaviours such as problematic substance use are viewed in mainstream society can mean that the existing strengths of young people are overlooked. Recognising and building on existing external and internal assets is vital for the development of all young people. It is important to recognise the drive towards healthy development that lies underneath some of the behaviours that are generally labelled as deviant and disordered (Ungar, 2005a, 2005b). One way to understand these behaviours involves considering the developmental functionality of drug use for young people, such as providing pleasure, alleviating boredom, self-regulation and management, individuating identity, conforming to norms, and facilitating social bonding (Bruun, 2008; Toumbourou et al., 2007).

Developmentally appropriate and sensitive services and programs also need to be aware of the risks and opportunities inherent in key transitions created by service systems. For example, developmentally appropriate programs for persistent AOD problems will incorporate careful transition planning for young people moving from youth-specific services to the adult system.

Another high-risk transition at the early intervention stage concerns adolescents leaving the child protection system. Research has shown that many young people lose access to services such as mental health care when they leave child protection (Dworsky & Courtney, 2009; McMillen & Raghavan, 2009). For vulnerable young people who are beginning to develop problems with substance use, a sudden loss of support at this transition point will not help their situation.

3.4.8 Application to prevention and early intervention

Many of the considerations described in Sections 3.4.1 to 3.4.7 apply equally to the design of prevention and early intervention programs. It is also imperative that these programs are delivered neither too early nor too late in the individual's development (Nation et al., 2003; Small et al., 2009). Primary prevention programs targeting problem behaviours that are delivered in schools may be delivered too early to reach youth who are disconnected from school. Corrective interventions linked to the criminal justice system may be delivered too late to achieve best effect.

The idea of developmental transitions and key transition points has been well elaborated. Transition points are ideal opportunities for intervention because individuals tend to be more open to advice and learning (Spooner, Hall, & Lynskey, 2001). For young people exposed to multiple risk factors, the transitions from school and the child protection system may be particularly important windows of opportunity. Early interventions seeking to change behaviours such as substance misuse need to be sensitive to individuals' personal readiness or 'stage of change'.

3.5 Comprehensive, holistic, ecological, multi-systemic and integrative

Most research on evidence-based interventions for AOD problems among young people, as well as closely associated issues such as depression, anxiety disorders and offending behaviour, have focused on a small number of discrete treatment models, particularly variations of cognitive behaviour therapy and family therapy.

Reviews of this work indicate that these approaches are generally effective in improving outcomes within these problem domains. However, they are less effective for young people with multiple and complex needs (ARCS (UK), 2008; Cameron & Karabanow, 2003; Chassin, 2008; Muck et al., 2001; Toumbourou et al., 2007). Opinion and evidence is accumulating that for this population, a comprehensive or multi-systemic approach is more effective (Brannigan et al., 2004; Bruun, 2008; Chassin, 2008; Crome, Christian, & Green, 2000; Kidd, 2003; Muck et al., 2001; Slesnick, Kang, Bonomi, & Prestopnik, 2007; Spooner et al., 2001).

Writers vary in their vision of the range of dimensions or systems that should be included in multi-systemic treatment. Involving families is one of the most widely endorsed aspects, but other systems or domains are gaining regular recognition. Attending to concomitant mental health problems is one of these (Mark et al., 2006), as are issues of offending behaviour, homelessness, unemployment, and exclusion from school.

Most adolescents with AOD problems requiring treatment tend to have one or more of these issues, but no one of these issues applies to every single adolescent with AOD problems. These issues may be better understood in the more inclusive notion of "multiple and complex needs" (Mitchell, 2011).

An important trend that is consistent with this multi-systemic understanding is the emergence of integrative treatment models. One of the most well-known examples is the Comprehensive Continuous Integrated System of Care (CCISC) model for co-occurring disorders, which is being implemented by an increasing number of jurisdictions in the United States (Minkoff & Cline, 2004).

This model embraces the principle that individuals with mental illness and substance use disorders, combined with co-occurring problems such as homelessness

and offending behaviours, are not identical. There is no single correct intervention for members of this population and interventions must be individualised. As such, the CCISC must incorporate an extensive range of best practices (Minkoff & Cline, 2004).

Another related trend is the emergence of treatment models that combine therapeutic elements derived from different traditions and which target different systems. Integration of elements from family therapy (targeting the family system) and cognitive-behaviour therapy (targeting the individual) has been a strong focus. Examples include Multidimensional Family Therapy (MDFT) and Multi Systemic Therapy (MST) (Liddle, 2004).

Other programs such as the Adolescent Community Reinforcement Approach (ACRA) and Community Reinforcement and Family Training (CRAFT) are combining these elements with motivational interviewing and contingency management (Godley et al., 2001; Waldron, Kern-Jones, Turner, Peterson, & Ozechowski, 2007).

Dialectical Behaviour Therapy as adapted for adolescents combines elements of cognitive behaviour therapy (skill development), family therapy, person-centred counselling (emotional validation and acceptance), and mindfulness meditation (Hawkins, 2009; Lynch, Trost, Salsman, & Linehan, 2007; Rathus & Miller, 2002; Woodberry & Popenoe, 2008).

Meta-analyses and reviews of evidence-based treatment programs for adolescent behaviour problems (including substance abuse and misuse) are finding that these integrative models generally demonstrate consistent effectiveness in clinical trials, including for populations of hard-to-reach youth with complex needs (Dennis et al., 2004; Hawkins, 2009; Sukhodolsky & Ruchin, 2006; Waldron & Turner, 2008).

There is also some direct evidence of superior, or longer lasting outcomes for integrative treatment models compared with singular approaches (Liddle, 2004; Waldron, Slesnick, Brody, Turner, & Peterson, 2001). Integrative models that combine elements from different therapeutic traditions and which target different life domains could also constitute a valuable approach to developing therapies that simultaneously treat co-occurring disorders such as AOD and mental health problems (Hawkins, 2009).

Complexity operates in at least two ways to reduce the effectiveness of singular treatments and indicate the need for a multidimensional approach. First, epidemiological evidence shows that closely associated problems such as alcohol and drug use, depression, offending behaviour and homelessness have multiple and interlinked determinants including biological, psychological and social factors operating at the levels of individuals, families, communities and whole societies (Spooner et al., 2001; Spooner, Mattick, & Howard, 1996).

Second, these problems and determinants reduce young people's ability to access and engage with treatment services (Chan, Godley, Godley, & Dennis, 2009; Crome et al., 2000; De Rosa et al., 1999; Meade & Slesnick, 2002; Rosenthal, Mallett, Milburn, & Rotheram-Borus, 2008; Statham, 2004). Homelessness acts as a particularly pernicious barrier. For homeless young people, a comprehensive approach may demand the provision of the basic necessities such as food, shelter and attention to physical ailments (Kidd, 2003).

Responsibility for the provision of holistic and multidimensional treatment and support rests within individual services and at service system level, because few services are comprehensive enough to meet all the needs of their clients. This shared responsibility may be one reason why comprehensive care remains elusive.

In addition to providing interventions such as treatment for AOD problems, individual services, especially those that provide primary care or have initial contact with young people, have critical roles in:

- Facilitating initial access to the service system;
- Assessment of needs;
- Engagement in treatment and other forms of assistance;
- Referral and advocacy to assist vulnerable young people to access other needed services; and
- Ongoing coordination of care or case management.

Some of these activities are covered in other sections (e.g. Engagement retention and strategies), so just a few examples will be discussed here.

Individual services can contribute to comprehensive service provision by screening and assessing issues related to but outside of their core domain. For example, screening for substance use problems is recommended for all adolescents in the youth justice system (Chassin, 2008), homeless youth (Kidd, 2003), and youth involved in mental health services (Aarons, Brown, Hough, Garland, & Wood, 2001).

Conversely, AOD services should ideally screen all clients for mental health problems and housing stability. Even if a service does not offer interventions for issues identified in screening and assessment, holistic care demands recognition and sensitivity to interrelated concerns as opposed to compartmentalisation of social, educational, and health care needs (Cameron & Karabanow, 2003; Statham, 2004).

Better understanding of clinical complexity may inform treatment plans and goals and improve the ability to address the unique needs of each young person (Aarons et al., 2001). By assessing multiple dimensions, the underlying individual and systemic aspects related to drug use can be addressed in a holistic, targeted approach to treatment. Where available, other services can be brought in when the young person is ready to address these other issues (Crome et al., 2000). This is not a straightforward task.

It is critical to allocate some time to care coordination or case management for young people with complex needs (Schuetz & Berry, 2009). Adolescents generally do not know what assistance is available or how to find what they need. For clients referred from statutory authorities, supervision and support are needed to help young people understand expectations and meet their obligations.

Feelings of alienation from society and resentment towards authority may also stop these young people from actively seeking and receiving treatment for AOD and mental health issues (Meade & Slesnick, 2002). Voluntary and involuntary clients may need persistent encouragement and personal support to realise what their needs are and how they will benefit from services provided.

It is increasingly recognised that having some services that provide a variety of different interventions is important to the overall capacity of service systems to provide holistic, multidimensional care for clients with complex needs. The widespread use of narrow problem definitions to determine eligibility for services is a pervasive barrier (Ungar, 2005a). Providing a variety of services at single locations such as drop-in centres or primary health care services has been repeatedly identified as an effective service model for transient and homeless youth with AOD and mental health problems (Barry et al., 2002; Busen & Engebretson, 2008; Slesnick et al., 2007; Statham, 2004).

In the field of prevention and early intervention, there is also a growing awareness that interventions need to be comprehensive and multidimensional. For example, it is now widely recognised that education-based interventions that rely primarily on information provision or knowledge development are unlikely to be effective on their own (Nation et al., 2003; Small et al., 2009).

Similarly, programs that attempt to target a single problem behaviour such as substance misuse or violence tend to fail if they do not address the whole set of life circumstances contributing to this and other connected problems (Burt, 2002; Mitchell et al., 2001; Muck et al., 2001; Spooner et al., 2001; Statham, 2004). Behavioural health problems are more likely to become entrenched within particular populations when underlying risk conditions operating across multiple systems work to reinforce each other. Interventions targeting a single system may fail to produce positive outcomes because of countervailing forces within other systems (Farmer & Farmer, 2001).

To be effective, preventive interventions need to address the multiple interlinked psychosocial systems, settings or contexts within which risk and protective factors operate and reinforce each other (Bond & Hauf, 2007; Burt, 2002; Casey & Lindhorst, 2009; Farmer & Farmer, 2001; Gilvarry, 2000; Hage et al., 2007).

Key systems that need to be addressed, and some of the key risk and protective factors operating within them, include:

- **Individuals** – cognitive style, interpersonal skills, impulse control, anger management skills;
- **Families** – parental attitudes, quality of communication, boundary setting;
- **Peers** – social attitudes, social norms, levels of social support;
- **Schools** – inclusive health-promoting culture, anti-bullying programs, health and sex education, good links to community agencies;
- **Services** – youth services, youth-friendly primary health care services, access to mental health services, police-youth education and liaison programs;
- **Risk environments** – locations where triggers of behaviour problems exist; and
- **Whole communities** – range of recreational options, opportunity structures, social capital.

One way to build a comprehensive, holistic approach may be to implement prevention programs as adjuncts to services that provide an ongoing safety net or long-term developmental support for vulnerable adolescents, such as homeless shelters, social services, mental health or drug treatment services (Arnold & Rotherham-Borus, 2009).

3.6 Family involvement

Until recently, the relative importance of involving parents and families in the treatment of drug and alcohol problems among adolescents had not been well recognised by practitioners (Liddle, 2004). Even now, the family system might be considered as just one of several systems that should be included in multi-systemic interventions, alongside the individual, peer groups and communities.

However, over the past decade opinion and evidence in support of its importance has accumulated to the extent that family involvement is now almost universally

included in literature that discusses characteristics of effective programs. Brannigan et al. (2004) and Henderson et al. (2007) include family involvement as a separate key element of effective adolescent drug treatment, in addition to a comprehensive and integrated treatment approach, in their consensus-based lists of such elements.

There is a solid theoretical rationale for including a strong focus on family in treatment and prevention programs because risk and protective factors operating within the family system are among the most significant predictors of AOD and related psychosocial difficulties among young people (Copello, Velleman, & Templeton, 2005; Kumpfer et al., 2010; Luthar, 2006; Mitchell et al., 2001; Spooner et al., 2001).

Many aspects of the family environment and dynamics are related to risk of substance misuse. Factors such as maltreatment, neglect, parental substance misuse and coercive or inconsistent parenting are all risk factors, but family strengths can provide a buffer or promote resilience in the presence of environmental risk factors (Vimpani & Spooner, 2003). Key family strengths found to be most influential in positive youth outcomes include cohesion or bonding, communication of positive family values, and active and interested supervision (Kumpfer et al., 2010).

Meta-analyses, reviews and recent research studies consistently report that involving family members in AOD treatment increases the likelihood of adolescent engagement and a positive outcome (Chassin, Knight, Vargas-Chanes, Losoya, & Naranjo, 2009; Copello et al., 2005; Muck et al., 2001; Schuetz & Berry, 2009; Waldron et al., 2007; Williams & Chang, 2000).

In recognition of this, numerous practice guidelines underscore the importance of working with the parents and families of adolescent substance misusers (Liddle, 2004). From a purely practical perspective, securing caregiver involvement (or at least support) may often be essential to engage younger adolescents in AOD services, because they tend to be dependent on parents or caregivers for the basic necessities of life.

Even when relationships with family members have been fraught and disappointing, most adolescents actually want to improve relationships and to get more care and support from their families, including the setting of appropriate boundaries (Green, Mitchell, & Bruun, under review). Enhancing the capacity of parents and caregivers to fulfil the parental role is a key goal of family-focused AOD interventions, particularly family therapy.

There is a rapidly growing body of research demonstrating the effectiveness of several types of family therapy or family-based interventions in the treatment of AOD and related problems in adolescents (Austin et al., 2005; Chassin et al., 2009; Dennis et al., 2004; Hogue & Liddle, 2009; Liddle, 2010; Muck et al., 2001; Vaughn & Howard, 2004). Several of these are now recognised as 'well-established' (Multidimensional Family Therapy) (Austin et al., 2005; Dennis et al., 2004; Hogue & Liddle, 2009; Liddle, 2010; Vaughn & Howard, 2004) or 'possibly' (Functional Family Therapy) (Austin et al., 2005; Vaughn & Howard, 2004) efficacious evidence-based treatments for substance abuse in adolescents.

In addition, a variety of family-based interventions have been found to be effective in reducing risk factors and enhancing protective factors for substance misuse (Gilvarry, 2000; Kumpfer, Alvarado, Tait, & Turner, 2002; Leung et al., 2010; Loxley et al., 2004; Mitchell et al., 2001), reducing the initiation of drug use by adolescents (Kumpfer et al., 2010; Leung et al., 2010) and reducing the amount of alcohol use (Leung et al., 2010).

Family Therapy is costly, not widely available, and beyond the role of youth AOD services. It should generally be limited to identifying and securing one or more forms of support that the family or caregivers can provide to help the adolescent move away from problematic AOD use and maintain a pro-social lifestyle.

Leaving aside Family Therapy, there is a variety of realistic options available for youth AOD workers to promote family involvement. These include provision of printed information, education sessions, informal conversations about how family members might support their adolescent through their drug treatment, modelling of communication skills, conflict resolution sessions, and support for family members in their own right.

Involving families can be challenging. Many young people may have little or no connection with their families. Others may have parents facing drug problems of their own, difficulties with availability, or who do not support their adolescent (Chassin, 2008; Schuetz & Berry, 2009; Waldron et al., 2007). However, given the evidence of positive effects on engagement and outcomes, the potential benefits may frequently outweigh the costs involved in pursuing family involvement.

Special efforts may be necessary to make family involvement more accessible and feasible for 'hard-to-reach' families. Statham (2004) has argued that vulnerable families are more likely to maintain attendance if they feel respected and supported, and if they perceive that a range of their life concerns are being listened to such as job stress, health problems and personal worries. There is considerable evidence that specially designed, culturally sensitive strategies can be very effective in achieving high rates of family engagement (Liddle, 2004).

Assessment and intervention planning with adolescents need to be family inclusive or at least family sensitive. It should consider whether and how the family system, or relationships between the adolescent and particular family members, may be strengthened to enrich the social supports available to the adolescent. Family inclusive assessment and care planning would involve direct communication with those family members. Family sensitive assessment and care planning would consider how family connections can be improved but stop short of involving them if that is the limit of what is possible or the preference of the adolescent.

If immediate family members are unavailable, the potential contribution of other significant adults should be considered. Social systems such as schools, alternative education organisations, sports clubs and other social institutions are also vitally important to build a viable network of supports around adolescents.

3.7 Sufficient duration and intensity

Participants need to be exposed to enough of the intervention for it to have an effect (Nation et al., 2003) and for changes to endure over time (Small et al., 2009). Programs need to reach a certain level of intensity and duration. Research into the effectiveness of AOD treatment has consistently shown that the length of treatment is directly linked to the reduction of drug use over time (Schuetz & Berry, 2009). Some studies suggest three months as a minimum for effective treatment, but for adolescents with complex needs and multiple developmental challenges a much longer duration is required (Schuetz & Berry, 2009).

A shortage of long-term outcomes research makes it difficult to make clear prescriptions. Reviews indicate that intensity needs to match the severity of problems and the risks faced by the individual (Nation et al., 2003; Schuetz & Berry, 2009). There is strong consensus among practitioners and researchers that adolescents with more problems and fewer supports require greater intensity and duration of intervention, be it treatment or early intervention (Muck et al., 2001; Small et al., 2009).

To ensure that young people receive treatment and support of the duration and intensity they need, they must remain engaged with services and actively involved in the therapeutic process. 'Continuing care' is included on expert consensus-based lists of elements of effective substance abuse treatment programs for adolescents (Brannigan et al., 2004; Mark et al., 2006), reflecting the same underlying principle of ensuring sufficient duration of an intervention.

Prevention and early intervention programs also need to consider duration and intensity. Universally targeted primary prevention programs may lack sufficient intensity or duration to achieve lasting positive outcomes for more vulnerable young people who have already developed behavioural health problems (Gilvarry, 2000; Small et al., 2009).

Despite the importance of intensity and duration of an intervention, there is still a place for brief interventions with young people with multiple and complex needs. Indeed, the observation that most clients attend psychological services for only a few sessions (O'Connell, 2005; Perkins, 2006) applies to this population as much as any other.

Adolescents with complex needs frequently attend services intermittently and in brief bursts. A service model that is geared only towards long-term interventions will waste many opportunities. The emergence and growing popularity of interventions such as Brief Solution Focused Therapy shows that useful work can be done in one or a few sessions (O'Connell, 2005; Perkins, 2006; Tevyaw & Monti, 2004).

The key is to ensure each contact is used to maximum effect. If the client does not return in the short term, it is possible that they will return later or will attend another service down the track. The experience of receiving help one or more times will encourage help-seeking in the future. The effects of the previous contacts may eventually lead to renewed engagement.

Having said this, the youth AOD service system should ideally be structured to provide treatment and support for extended periods when required. Young people completing a stay in an acute or long-term residential program should be offered continuing care, especially when there are indications that their home and community environment lacks the resources and assets to support the changes they have made during treatment.

There is good evidence that continuing care can sustain the positive effects of initial or more intensive phases of AOD treatment (McKay, 2009). The Victorian youth AOD system is variable in its availability of continuing care. Outreach and day programs are best positioned to provide it, but day programs are scarce and outreach is unevenly distributed.

A systematic review of the continuing care literature conducted by McKay (2009) found that direct attempts to bring therapeutic intervention to the client, such as through assertive outreach, have a clear advantage over office-based approaches. Telephone contact was also found to be an effective vehicle for assertive engagement.

Many of the studies with positive findings for continuing care have included an active component

based upon Cognitive Behaviour Therapy (McKay, 2009). For adolescents, assertive continuing care using the Adolescent Community Reinforcement Approach (ACRA) has been found to improve substance use outcomes following a residential stay (Godley, Godley, Dennis, Funk, & Passetti, 2002). In addition to CBT-based skills training, ACRA focuses on improving social connections with family members and the community and reinforcing positive changes that the young person has made.

A variety of continuing care options need to be available to suit individual clients. Flexible or adaptive protocols are recommended so that supports can be adjusted as needs change over time (McKay, 2009).

3.8 Engagement and retention strategies

A young person's duration of treatment and involvement in the therapeutic process are central to achieving program or intervention delivery (Brannigan et al., 2004; Crago et al., 2004; De Rosa et al., 1999; Henderson et al., 2008; Henderson et al., 2007; Henggeler, Pickrel, Brondino, & Crouch, 1996; Kazdin, 1990; McKay, Stoewe, McCadam, & Gonzales, 1998; Pead, Virins, & Morton, 1999; Waldron et al., 2007). Evidence shows that young people who remain in treatment do better than those who drop out, regardless of the level of impairment (Gilvarry, 2000).

Similarly, for prevention and early intervention programs to be effective they must reach young people most at risk, and they must reach a sufficient proportion of the target population for the exposure to have self-sustaining effects (Kutcher & McDougall, 2009; Tandon, Marshall, Templeman, & Sonenstein, 2008; Wolfe, Dozois, Fisman, & DePace, 2008; Woodland, 2008).

Young people are less proactive than adults in seeking treatment for health concerns, particularly psychosocial concerns. Studies of service use for substance and mental health problems generally find that adolescents have lower access or use than adults (Sawyer & Patton, 2000).

For young people with multiple and complex needs, issues around access to services are complex. While there is some evidence that adolescents with co-morbid substance use and mental disorders are more likely to receive substance use treatment compared with adolescents who have substance use disorders alone (Ozechowski & Waldron, 2010), other dimensions of need appear to complicate this picture.

Previous or current involvement with statutory authorities is common for youth with AOD combined with other psychosocial difficulties. However, contact with this particular component of health and social care systems does not necessarily translate into appropriate or adequate access to other parts such as AOD and mental health services.

Youth in child protection and youth justice systems tend to have higher rates of AOD and mental health problems than the general population (Aarons et al., 2001; Aarons et al., 2008; Chassin, 2008; Dworsky & Courtney, 2009; Keller, Salazar, & Courtney, 2010), as well as higher rates of service use for these problems (Keller et al., 2010; Ungar, 2005a).

However, studies have found unacceptably high proportions of young people with AOD and mental health problems in these systems who are not receiving appropriate services (Chassin, 2008; Dworsky & Courtney, 2009). Adolescents' substance use problems are often undetected by service providers in youth justice, primary care, mental health, education and social service systems (Ozechowski & Waldron, 2010).

Furthermore, two studies have found a dramatic decline in use of mental health services as young people leave the child protection system (Dworsky & Courtney, 2009; McMillen & Raghavan, 2009). These findings highlight the importance of formal transition protocols between service systems such as child to youth and youth to adult.

More generally, there is a body of opinion that many youth with complex needs miss out on the types of services they need relative to youth with less complex needs (Barry et al., 2002; Busen & Engebretson, 2008; Crome et al., 2000; Muck et al., 2001; Statham, 2004; Ungar, 2005a; Waldron et al., 2007).

In particular, several studies have found that homeless youth have very high rates of substance use and mental disorders, but very low rates of access to services relative to need (Busen & Engebretson, 2008; De Rosa et al., 1999; Rosenthal et al., 2008). Even when adolescents with complex needs do access services, they are often very difficult to engage and are highly likely to drop out of treatment (Chassin, 2008; Crome et al., 2000; Kazdin, 1990).

Social research has identified barriers to service access for youth with complex needs. Chassin (2008) observes that adolescents rarely perceive a need for treatment of AOD problems. Adolescents also lack knowledge of what assistance is available or how to find what they need.

Statham (2004) has observed that one reason children and young people in special circumstances miss out on services is that they do not have advocates (such as parents or stable carers) to request assessment and treatment. Meade and Slesnick (2002) point out that these adolescents have limited resources and diminished power in an adult-centred system.

Mistrust of professionals can create reluctance to ask for help, while a lack of confidence or interpersonal skills can make it difficult for youth with complex problems to negotiate access (Karabanow & Clement, 2004) or advocate for themselves (Barry et al., 2002), especially for health services. Meade and Slesnick (2002) argue that many treatment providers are not equipped to address the range of problems these youth face.

In recognition of these issues, researchers compiling consensus-based characteristics of effective AOD treatment programs have included use of focused engagement and retention strategies on their lists (Brannigan et al., 2004; Henderson et al., 2007).

Several strategies have been identified as necessary and effective in enhancing access and engagement of youth with complex needs.

- Young people in general want attractive, youth-friendly spaces in accessible central locations (Barry et al., 2002; Crago et al., 2004; Ensign & Gittlelsohn, 1998).
- Young people are sensitive to the potential for stigmatisation, so it is important that services are inclusive and do not make young people feel different from their peers (Statham, 2004).
- For young people experiencing instability in their lives, a space that is physically and emotionally safe and provides respite from violence at home or the dangers of street life is a critical starting point (Barry et al., 2002; Karabanow & Clement, 2004; Meade & Slesnick, 2002). Various writers have observed that feeling safe and secure is an important prerequisite for resolving AOD problems (Bruun, 2008).
- Enabling access to services for highly marginalised youth may often require providing for basic needs such as clothing, food, washing facilities, accommodation and practical help. Until these basic needs are met, the effectiveness of AOD counselling or skill building will be minimal (Karabanow & Clement, 2004; Statham, 2004).
- Another way to make access easier is to provide assertive outreach or mobile services in a wide variety of settings where vulnerable youth may be found (Barry et al., 2002; Busen & Engebretson, 2008; Ozechowski & Waldron, 2010), as well as providing a variety of different services in a single location (Meade & Slesnick, 2002).
- In the absence of multipurpose services, care coordination or case management is critical to the ongoing engagement of young people with complex needs (Schuetz & Berry, 2009).
- Strong referral networks, awareness raising, and collaborative links among gateway service systems (such as youth justice, mental health, child welfare, school counselling and homeless support) also help to identify and refer young people to AOD services (Ozechowski & Waldron, 2010).

Things to avoid when promoting access and engagement include:

- Overly clinical settings and cumbersome intake and assessment processes (Bruun, 2008);
- Harsh exclusion policies for disruptive behaviour (Busen & Engebretson, 2008); and
- Focusing too much on the past and assigning blame (Arnold & Rotherham-Borus, 2009).

Various provider characteristics that help engage youth with complex needs include reliability, a respectful attitude, enthusiasm, an accepting attitude, taking the time to listen and respond, and the ability to give support (Barry et al., 2002; Ensign & Gittlelsohn, 1998; Statham, 2004). These characteristics are the foundations upon which the practitioner/client relationship is built, as is the provision of a safe and caring space where young people can find respite from the chaos that often pervades their lives (Bruun, 2008; Karabanow & Clement, 2004).

Many transient and homeless adolescents, even those with troubled families, maintain regular contact with family members and turn to them for advice and assistance (Ensign & Gittlelsohn, 1998). For youth who are still maintaining contact with their families, family involvement has been found to enhance youth engagement in AOD treatment (Chassin, 2008; Copello et al., 2005; Waldron et al., 2007). Parental involvement also appears to help recruit homeless adolescents into primary health care prevention programs (Arnold & Rotherham-Borus, 2009).

Several effective interventions have been developed to help family members learn skills that support them in encouraging substance-misusing members into treatment (Copello et al., 2005). Interventions that teach parents skills that enhance their own psychosocial and interpersonal functioning can improve the family environment and encourage young people to maintain engagement with family and with services (Copello et al., 2005).

Advocates of family involvement acknowledge that it may be difficult or unhelpful if family members are themselves involved in substance use or criminal activities (Chassin, 2008; Waldron et al., 2007). For disconnected youth whose families experience these problems, families may be unavailable or unwilling to participate (Schuetz & Berry, 2009). However, there is now considerable evidence that specially designed,

culturally sensitive strategies can be effective in achieving high rates of family engagement (Liddle, 2004).

Finally, an increasing number of researchers and other writers are expressing the view that services will become more accessible, engaging and effective if they recognise the energy, creativity, experience and other strengths of these young people and build youth participation into service development processes (Barry et al., 2002; Bell, 2006; Ensign & Gittlelsohn, 1998; Munford & Sanders, 2008).

3.9 Behavioural, experiential and skill focused

While a program needs to be comprehensive to be effective, at least one domain or dimension of its content is particularly critical in effecting behaviour change. This is the use of active learning techniques that provide hands-on experience aimed at building skills (Arnold & Rotherham-Borus, 2009; Nation et al., 2003; Small et al., 2009).

Simply providing information or education is usually insufficient to create and sustain lasting behaviour change, even in prevention programs (Small et al., 2009). Program participants need to be actively engaged with the content, exposed to new experiences, and given opportunities to learn and practise new behaviours (Nation et al., 2003; Small et al., 2009). Bessant points out the necessity of giving young people opportunities to build a "repertoire of experiences" from which they learn how events are connected to emotions, and from this the chance to develop their capacity for good judgment (Bessant, 2008).

Findings from program evaluations and qualitative research suggest that young people with drug use problems and other complex needs may particularly value, prefer and benefit from experiential programs (Bell, 2006; Russell & Evans, 2009; Wallerstein & Bernstein, 1988). Young people believe that effective services provide fun activities (Russell & Evans, 2009), experiences that offers "stuff you can do on the weekend", and build a productive life passion (Bell, 2006; p431).

Youth with AOD problems and complex needs have a high prevalence of externalising (acting-out) behaviour problems, which often makes experiential and behavioural approaches most appropriate. Skills-based interventions such as training in social skills, anger control and problem solving are the most effective treatments for youth with acting-out behaviours involved in the youth justice system (Sukhodolsky & Ruchin, 2006). Such skills-based training is also a common factor in proven and promising prevention programs for young people at high risk, such as homeless youth (Arnold & Rotherham-Borus, 2009).

For multiply disadvantaged youth, skills development programs are more effective when used in combination with other approaches (Cameron & Karabanow, 2003).

3.10 Building on strengths

The idea that practice should be 'strengths-based' has gained widespread recognition and acceptance in the behavioural health care community, although it was not cited as a characteristic of effective services for adolescents in the expert consensus studies that were published in the mid-2000s (Brannigan et al., 2004; Henderson et al., 2007; Mark et al., 2006).

If we put forward the proposition that practice should (wherever possible) identify, elicit, reinforce and build upon the strengths that the client brings to the therapeutic encounter, then it is probably safe to say there is near-universal agreement with this notion among practitioners.

The idea of strengths-based practice is deeply infused in the social work practice literature, particularly on young people with multiple and complex needs (Aronowitz, 2005; Karabanow & Clement, 2004; Kidd, 2003; Munford & Sanders, 2008; Pichot, 2001; Ungar, 2006). It has had a profound influence upon practice philosophy in youth services over the past 10 to 15 years.

Proponents vary in the specifics of the definition they apply to the strength-based construct, but there are some common themes in the literature. Strengths-based practice rests upon an expressed attitude that clients are competent and have the strengths and resources necessary to solve their problems (Hubble, Duncan, & Miller, 1999). A key part of the work is to listen for evidence of these strengths and resources, bring them to the attention of the client, demonstrate curiosity about them, affirm them, encourage the client to elaborate, and help the client make connections between these strengths and the potential solutions to their problems.

Helping the client to get in touch with their own strengths is often identified as essential to drawing the client into an active and collaborative process of solution-finding (Munford & Sanders, 2008; Pichot, 2001; Ungar, 2006). It is closely linked with the client-focused approach and therapeutic engagement. Moos argues that grounding the intervention in the client's perspective, affirming their strengths, and eliciting their ideas about change, all support the client's responsibility and self-efficacy for change (Moos, 2007).

Strengths-based practice is a key feature of Solution Focused Therapy (SFT). As well as searching for competencies or strengths, SFT emphasises collaboration between the worker and client in setting

goals and driving the therapeutic work (Kim, 2008). The practitioner adopts a stance of a 'non-expert', meaning they do not assume that they know what is best for the client based on their preconceptions about them (Pichot, 2001).

Instead, knowledge is co-created out of conversations between the client and the therapist (O'Connell, 2005). This is central to recognising, respecting and valuing the tools and skills that the client already possesses.

The strong association of the strengths-based approach with Solution Focused Therapy has led to the mistaken assumption that a focus on strengths is opposed to a focus on problems. It is important to separate the solutions-problems dichotomy from the strengths-deficits dichotomy.

It is more accurate to contrast the strengths-based approach with the approach that focuses on deficits and dysfunctions within the client, which has characterised traditional medical-model psychiatric practice for many decades. The strengths-based approach challenges the discourse of the 4-Ds that is often applied to young people with multiple and complex needs – "dangerous, delinquent, deviant and disordered" (Ungar, 2005a, 2005b).

While strengths-based practice rejects the notion that emotional and behavioural difficulties are best explained by dysfunctions within individuals, it does not necessarily reject the value of including a focus on problems. A potential danger with dismissing problems is that insufficient time may be given to exploring the young person's experiences, their perceptions of their issues, and their understanding of their situation.

Glossing over problems may be damaging to the foundational work of building a therapeutic relationship. Active attention to 'problem'-oriented concerns is particularly critical when working with a client population that experiences relatively high exposure to risk factors that pose serious threats to safety and health in the short and long term. Attention to problems does not preclude active attention to identifying and reinforcing strengths.

The notion of building on strengths is well represented in the fields of prevention and early intervention into behavioural health problems. Two long-standing examples of this are the strong emphasis on protective factors alongside risk factors, and the profound influence of work focused on building community capacity and empowerment to take responsibility for addressing public and population health issues (Goodman et al., 1998; Laverack & Wallerstein, 2001; Veazie et al., 2001).

More recent literature focused on individual and community resilience and positive youth development builds upon these earlier lines of work (Armstrong, Birnie-Lefcovitch, & Ungar, 2005; Committee on Community-Level Programs for Youth, 2002; Luthar, 2006; Ungar, 2005a). The Resources and Assets dimension of the framework for resilience-based intervention (see Section 6.2) is informed by this literature.

3.11 Use of theory and evidence to guide program design and refinement

Monitoring of treatment outcomes is a key element of effective adolescent drug treatment practice, according to expert consensus processes (Brannigan et al., 2004; Henderson et al., 2007; Mark et al., 2006). In the prevention and early intervention literature, 'theory-driven' programs are a key element of effectiveness in addition to outcome evaluation (Nation et al., 2003) or commitment to evaluation and refinement (Small et al., 2009). Nation et al. define theory-driven programs as having a theoretical justification, being based on accurate information, and supported by empirical research.

Small et al. (2009) distinguish two types of theory base. One involves well-established, empirically supported theory about the etiology and maintenance of behaviour patterns such as Family Systems Theory, Ecological Systems Theory, Social Learning, and Stress and Coping Theory (Moos, 2007). These sorts of theories provide vital rationale for the selection of program content or activities (Moos, 2007).

A second type of theory base involves a well thought out and logical program theory that describes how the program's activities are connected to clearly identified and realistic outcomes (Small et al., 2009). Often such program theory models are based on intuitive logic or informed by practice wisdom, but ideally the links suggested between activities and outcomes should be supported by empirical evidence (Small et al., 2009).

When an intuitive program theory lacks empirical evidence (for example, when new interventions are being trialled), rigorous evaluation including outcomes monitoring is critical. Theory and evaluation are best used together to have the greatest impact on program design and refinement. Ideally, theory guides decisions about what outcomes to measure.

Evaluation is also valuable when evidence-based programs are being adapted to new populations and contexts for which effectiveness is not yet demonstrated (Small et al., 2009). Monitoring and evaluation provide regular feedback to program managers that can be used to adjust implementation to ensure quality and best response to local context (Bond & Hauf, 2007; Hage et al., 2007; Nation et al., 2003; Small et al., 2009; Wandersman, 2009).

Table 1: Characteristics of effective service provision for young people with AOD & other behavioural health problems

CHARACTERISTIC	APPLIED TO	DEFINITIVE FEATURES/KEY EVIDENCE	KEY REFERENCES
1. Client-centred Individualised Needs-led	Treatment & support	• Interventions are tailored to the individual needs of the client • Comprehensive assessment, individualised treatment plans, & regular case review are key vehicles for individualised intervention • The client drives, is actively involved, or consulted in the design of the treatment plan • Practitioners seek to understand the subjective experience of the young person, especially their understandings of 'problem behaviours', before attempting to create change or intervening to reduce any harm associated with them • Regular needs assessment, evaluation, & client participation at the agency level enhances the capacity of a service to be client-centred at the individual level	(Aronowitz, 2005; Barry et al., 2002; Bell, 2006; Bruun, 2008; Clark, 2001a, 2001b; Kidd, 2003; Marsh et al., 2007; Miller & Duncan, 2000; Moos, 2007; Munford & Sanders, 2008; Pichot, 2001; Schuetz & Berry, 2009; Ungar, 2005a, 2006)
Socio-culturally relevant	Prevention & early intervention programs	• Target problems of most relevance & concern to particular communities • Culturally appropriate ways of engaging & communicating with targeted communities • Politically feasible • Sensitive to community readiness • Input from potential program participants & from community stakeholders helps improve socio-cultural relevance	(Bond & Hauf, 2007; Kumpfer et al., 2010; Nation et al., 2003; Woodland, 2008)
2. Relationship-based	Treatment & support	• The program nurtures a healthy working relationship between the client & practitioner or team/service • The working relationship is viewed as therapeutic in its own right • The working relationship is a key vehicle for the organisation & delivery of other interventions • The quality of the therapeutic alliance is a significant predictor of therapy outcome for children & adolescents • Young people place high value on having quality relationships with workers	(Bruun & Hynan, 2006; Karabanow & Clement, 2004; McLeod & Weisz, 2005; Moos, 2007; Rodd & Stewart, 2009; Russell & Evans, 2009; Schuetz & Berry, 2009; Ungar, 2005a)

CHARACTERISTIC	APPLIED TO	DEFINITIVE FEATURES/KEY EVIDENCE	KEY REFERENCES
Focus on relationships	Prevention & early intervention programs	• Effective prevention programs foster safe, trusting relationships between participants & staff • Positive relationships with a program facilitator, family members, peers & concerned others provide motivation to resist risky behaviours • Providing opportunities for youth to develop strong, positive relationships is consistently associated with positive outcomes • Formation of a strong, continuous relationship with at least one adult outside of the family is particularly critical to effective early intervention with young people exposed to multiple risk conditions. They have often experienced dysfunctional relationships with family members & had few alternative positive experiences	(Arnold & Rotherham-Borus, 2009; Nation et al., 2003; Small et al., 2009)
3. Developmentally appropriate	Treatment & support	• Tailored to the requirements of young people at a particular developmental stage • Responsive to subtle variations in developmental stage among participating youth • Appropriately address key developmental themes of adolescence • Sensitive to an individual's personal readiness or 'stage of change' • Transition planning for young people moving from child & youth systems to adult systems	(Barry et al., 2002; Brannigan et al., 2004; Bruun, 2008; Henderson et al., 2008; Henderson et al., 2007)
	Prevention & early intervention programs	• Tailored to the requirements of young people at a particular developmental stage • Responsive to subtle variations in developmental stage among participating youth • Delivered neither too early nor too late in the individual's development • Delivered during important windows of opportunity such as key developmental transitions	(Nation et al., 2003; Small et al., 2009)
4. Comprehensive Holistic Ecological Multi-systemic Integrative	Treatment & support	• Comprehensive with respect to diverse needs or integrated with services in other sectors • Address the needs of the 'whole' young person rather than compartmentalising social, educational & health care needs • Programs that attempt to target a single problem behaviour such as substance misuse or offending behaviour tend to fail if they do not address the whole set of life circumstances contributing to this problem & others • Target factors operating within & across multiple systems such as individual, family, peers, school &/or community • Integrative treatment models that combine elements of different intervention approaches (e.g. family therapy & cognitive behaviour therapy) appear to outperform singular approaches for clients with complex needs • For homeless young people, a comprehensive approach to services may demand the provision of the basic necessities such as food, shelter & attention to physical ailments	(Brannigan et al., 2004; Bruun, 2008; Burt, 2002; Cameron & Karabanow, 2003; Chan et al., 2009; Crome et al., 2000; Henderson et al., 2008; Kidd, 2003; Liddle, 2004; Muck et al., 2001; Schuetz & Berry, 2009; Statham, 2004; Waldron et al., 2007; Williams & Chang, 2000).

CHARACTERISTIC	APPLIED TO	DEFINITIVE FEATURES/KEY EVIDENCE	KEY REFERENCES
	Prevention & early intervention programs	• Target a variety of risk & protective factors & include a variety of different types of interventions • Interventions address all relevant psychosocial domains including cognitive, psychological, emotional, physical, behavioural, social & civic • Addresses the multiple interlinked psychosocial systems, settings or contexts within which risk & protective factors operate & reinforce each other • Interventions targeting a single system may fail to produce positive outcomes due to countervailing forces within other systems • Key systems that need to be addressed include: individuals; families; peers; schools; services; risk environments; whole communities	(Bond & Hauf, 2007; Burt, 2002; Casey & Lindhorst, 2009; Farmer & Farmer, 2001; Gilvarry, 2000; Hage et al., 2007; Nation et al., 2003; Small et al., 2009).
5. Family involvement	Treatment & support	• Meta-analyses, reviews & recent research studies consistently report that involving family members in AOD treatment increases the likelihood of engagement & a positive outcome • Numerous practice guidelines underscore the importance of working with the parents & families of adolescent substance misusers • Interventions work best when family members have their concerns listened to, & feel respected & supported • Specially designed, culturally sensitive strategies can be very effective in achieving high rates of family engagement • Several types of family therapy or family-based treatments are recognised as well-established or probably efficacious evidence-based treatments for AOD & related problems	(Austin et al., 2005; Brannigan et al., 2004; Chassin, Knight, Vargas-Chanes, Losoya, & Naranjo, 2008; Copello et al., 2005; Hogue & Liddle, 2009; Liddle, 2004; Schuetz & Berry, 2009; Statham, 2004; Vaughn & Howard, 2004; Waldron et al., 2007; Waldron & Turner, 2008; Williams & Chang, 2000)
	Prevention & ear ly intervention programs	• Risk & protective factors operating in the family system are among the most significant predictors of AOD & related psychosocial difficulties among young people • The family is the most influential system in terms of direct & indirect environmental influences upon development of substance misuse • A variety of family-based interventions are effective in reducing risk factors & enhancing protective factors for substance misuse, as well as reducing substance use	(Leung et al., 2010; Loxley et al., 2004; Luthar, 2006; Mitchell et al., 2001; Small et al., 2009; Spooner et al., 2001)

CHARACTERISTIC	APPLIED TO	DEFINITIVE FEATURES/KEY EVIDENCE	KEY REFERENCES
6. Sufficient duration & intensity	Treatment & support	• Adolescents with more problems require greater intensity & duration of intervention • For a given degree of severity or functional impairment, adolescents require greater intensity of treatment than adults • Higher-risk clients should receive more intensive treatment • Higher-intensity programs yield proportionally greater gains than low-intensity programs • A variety of long-term continuing care options should be available	(Godley et al., 2002; Lennings, Kenny, & Nelson, 2006; McKay, 2009; Muck et al., 2001; Schuetz & Berry, 2009; Statham, 2004)
	Prevention & early intervention programs	• Only sustained interventions have sustained effects • Participants need to be exposed to enough of the intervention for it to have an effect & for changes to endure over time • Universally targeted primary prevention programs may lack sufficient intensity or duration to achieve lasting positive outcomes for more vulnerable young people who have already developed behavioural health problems • More vulnerable youth, & higher-risk families, need more intensive & more prolonged interventions to achieve lasting behaviour changes	(Arnold & Rotherham-Borus, 2009; Bond & Hauf, 2007; Gilvarry, 2000; Kumpfer et al., 2010; Muck et al., 2001; Small et al., 2009).
7. Engagement and retention strategies Reach and access	Treatment and support	• Engaging young people in treatment for a sufficient length of time & ensuring their involvement in the therapeutic process are central to achieving program or intervention delivery • A range of strategies have been identified as necessary & effective in enhancing access & engagement of youth with complex needs • Key provider characteristics include reliability, a respectful attitude, enthusiasm & genuine listening • Family involvement is highly effective at promoting adolescent engagement	(Brannigan et al., 2004; Crago et al., 2004; De Rosa et al., 1999; Ensign & Gittlelsohn, 1998; Henderson et al., 2008; Henderson et al., 2007; Henggeler et al., 1996; Kazdin, 1990; McKay et al., 1998; Pead et al., 1999; Waldron et al., 2007)
	Prevention & early intervention programs	• The program needs to reach those young people & other potential participants most at risk • The program needs to reach a critical mass or sufficient proportion of the target population for the exposure to have self-sustaining effects • Even among homeless youth, parental involvement & providing fun activities aid recruitment to primary health care prevention programs	(Arnold & Rotherham-Borus, 2009; Kutcher & McDougall, 2009; Tandon et al., 2008; Wolfe et al., 2008; Woodland, 2008)

CHARACTERISTIC	APPLIED TO	DEFINITIVE FEATURES/KEY EVIDENCE	KEY REFERENCES
8. Behavioural, experiential & skill focused	Treatment & support	• Clear advantages have been found for behavioural over non-behavioural methods • Qualitative research with young people has found that they place high value on fun activities & prefer experiential approaches • For multiply disadvantaged youth, skill development programs are more effective when combined with other approaches	(Bell, 2006; Cameron & Karabanow, 2003; Chorpita, Daleiden, & Weisz, 2005; Russell & Evans, 2009)
	Prevention & early intervention programs	• While programs need to be comprehensive to be effective, the use of active learning techniques that provide hands-on experience aimed at building skills appears to be necessary • Education-based interventions that rely primarily on information provision or knowledge development are unlikely to be effective on their own	(Arnold & Rotherham-Borus, 2009; Gilvarry, 2000; Kumpfer et al., 2010; Nation et al., 2003; Small et al., 2009).
9. Building on strengths Resources & assets	Treatment & support	• Practice should (wherever possible) identify, elicit, reinforce & build upon the strengths that the client brings to the therapeutic encounter • Strengths-based practice rests upon an expressed attitude that clients are competent & have the strengths & resources necessary to solve their problems	(Aronowitz, 2005; Barry et al., 2002; Ensign & Gittlelsohn, 1998; Hubble et al., 1999; Karabanow & Clement, 2004; Munford & Sanders, 2008; Ungar, 2006)
10. Use of theory & evidence to guide the design & evolution of the program	Prevention & early intervention programs	• Protective factors are just as important as risk factors in determining health & well-being • Community capacity building is a well-recognised strategy underpinning population-based primary prevention programs • Growing resilience & positive youth development are about building resources & assets in the social ecology of the young person	(Armstrong et al., 2005; Committee on Community-Level Programs for Youth, 2002; Goodman et al., 1998; Laverack & Wallerstein, 2001; Luthar, 2006; Ungar, 2005a; Veazie et al., 2001)
	Treatment & support	• The program uses research-supported treatment approaches (e.g. Cognitive Behaviour Therapy, family-based treatments) • Ongoing assessment of treatment outcomes • Monitoring is helpful to ensure that evidence-based programs are being implemented with fidelity	(Brannigan et al., 2004; Henderson et al., 2008; Henderson et al., 2007)
	Prevention & early intervention programs	• The program as a whole or defined components of the program are informed by well-established, empirically supported theory about the etiology of problems being addressed, & evidence for the effectiveness of program components • There is a well thought out & logical program theory that describes how program activities are connected to well-defined outcomes • Rigorous evaluation is particularly critical when new, untested interventions are being trialled & when evidence-based programs are being adapted to new populations & contexts for which effectiveness is not yet demonstrated • Monitoring & evaluation provide regular feedback to program managers that can be used to adjust implementation to ensure quality & best response to local context	(Cato, 2007; Hage et al., 2007; Kumpfer et al., 2010; Nation et al., 2003; Peters, Kok, Ten Dam, Buijs, & Paulussen, 2009; Small et al., 2009; Wandersman, 2009)

References

Aarons, G. A., Brown, S. A., Hough, R. L., Garland, A. F., & Wood, P. A. (2001). Prevalence of adolescent substance use disorders across five sectors of care. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40(4), 419-426.

Aarons, G. A., Monn, A. R., Leslie, L. K., Garland, A. F., Lugo, L., Hough, R. L., & Brown, S. A. (2008). Association between mental and physical health problems in high-risk adolescents: a longitudinal study. *Journal of Adolescent Health*, 43, 260-267.

Aarons, G. A., & Palinkas, L. A. (2007). Implementation of evidence-based practice in child welfare: service provider perspectives. *Administration and Policy in Mental Health & Mental Health Services Research*, 34, 411-419.

ARCS (UK). (2008). *Reducing offending: A critical review of the international research evidence*. Belfast: Criminal Justice Policy Division, Statistics and Research Branch.

Armstrong, M. I., Birnie-Lefcovitch, S., & Ungar, M. (2005). Pathways between social support, family well-being, quality of parenting, and child resilience: what we know. *Journal of Child and Family Studies*, 14(2), 269-281.

Arnold, E. M., & Rotherham-Borus, M. J. (2009). Comparisons of prevention programs for homeless youth. *Prevention Science*, 10, 76-86.

Aronowitz, T. (2005). The role of "envisioning the future" in the development of resilience among at-risk youth. *Public Health Nursing*, 22(3), 200-208.

Austin, A. M., Macgowan, M. J., & Wagner, E. F. (2005). Effective family-based interventions for adolescents with substance use problems: A systematic review. *Research on Social Work Practice*, 15(2), 67-83.

Barry, P. L., Ensign, J., & Lippek, S. L. (2002). Embracing street culture: Fitting health care into the lives of street youth. *Journal of Transcultural Nursing*, 13(2), 145-152.

Bell, E. (2006). Self, meaning and culture in service design: using a hermeneutic technique to design a residential service for adolescents with drug issues. *International Journal of Drug Policy*, 17, 425-435.

Bessant, J. (2008). Hard wired for risk: neurological science, 'the adolescent brain' and developmental theory. *Journal of Youth Studies*, 11(3), 347-360.

Bond, L. A., & Hauf, A. M. C. (2007). Community-based collaboration: An overarching best practice in prevention. *The Counselling Psychologist*, 35(4), 567-575.

Brannigan, R., Schackman, B. R., Falco, M., & Millman, R. B. (2004). The quality of highly regarded adolescent substance abuse treatment programs. *Archives of Pediatric and Adolescent Medicine*, 158, 904-909.

Bruun, A. (2008). Effective practice for young people experiencing alcohol and other drug-related harm. In D. Moore & P. Dietze (Eds.), *Drugs and public health: Australian perspectives on policy and practice* (pp. 115-126). South Melbourne: Oxford University Press.

Bruun, A., & Hynan, C. (2006). Where to from here? Guiding for mental health for young people with complex needs. *Youth Studies Australia*, 25(1), 19-27.

Burt, M. R. (2002). Reasons to invest in adolescents. *Journal of Adolescent Health*, 31(6S), 136-152.

Busen, N. H., & Engebretson, J. C. (2008). Facilitating risk reduction among homeless and street-involved youth. *Journal of the American Academy of Nurse Practitioners*, 20, 567-575.

Cameron, G., & Karabanow, J. (2003). The nature and effectiveness of program models for adolescents at risk of entering the formal child protection system. *Child Welfare*, LXXXII(4), 443-474.

Casey, E. A., & Lindhorst, T. P. (2009). Toward a multilevel, ecological approach to the primary prevention of sexual assault: prevention in peer and community contexts. *Trauma Violence & Abuse*, 10(2), 91-114.

Cato, B. (2007). From theory to practice in the design and evaluation of youth development programs: a case study. *Journal of Physical Education, Recreation & Dance*, 78(1), 46-53.

Chan, Y.-F., Godley, M. D., Godley, S. H., & Dennis, M. L. (2009). Utilization of mental health services among adolescents in community-based substance abuse outpatient clinics. *Journal of Behavioral Health Services & Research*, 36(1), 35-51.

Chassin, L. (2008). Juvenile justice and substance use. *The Future of Children*, 18(2), 165-183.

Chassin, L., Knight, G., Vargas-Chanes, D., Losoya, S. H., & Naranjo, D. (2008). Substance use treatment outcomes in a sample of male serious juvenile offenders. *Journal of Substance Abuse Treatment*, 36(2), 183-194.

Chassin, L., Knight, G., Vargas-Chanes, D., Losoya, S. H., & Naranjo, D. (2009). Substance use treatment outcomes in a sample of male serious juvenile offenders. *Journal of Substance Abuse Treatment*, 36(2), 183-194.

Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005). Identifying and selecting the common elements of evidence based interventions: A distillation and matching model. *Mental Health Services Research*, 7(1), 5-20.

Clark, M. D. (2001a). Change-focused youth work: The critical ingredients of positive behaviour change. *Journal of the Center for Families*, Children & The Courts, 3, 59-72.

Clark, M. D. (2001b). Influencing positive behavior change: Increasing the therapeutic approach of juvenile courts. *Probation*, 65(1), 18-27.

Coleman, J., & Hendry, L. (1990). *The nature of adolescence*. London: Routledge.

Committee on Community-Level Programs for Youth. (2002). *Community Programs to Promote Youth Development*: National Research Council and Institute of Medicine.

Copello, A. G., Velleman, R. D. B., & Templeton, L. J. (2005). Family interventions in the treatment of alcohol and drug problems. *Drug and Alcohol Review*, 24, 369-385.

Crago, A., Wigg, C., & Stacey, K. (2004). Youth-friendly practice in mental health work. *Youth Studies Australia*, 23(2), 38-45.

Crome, I., Christian, J., & Green, C. (2000). The development of a unique designated community drug service for adolescents: policy, prevention and education implications. *Drugs: Education, Prevention and Policy*, 7(1), 87-108.

De Rosa, C. J., Montgomery, S. B., Kipke, M. D., Iverson, E., Ma, J. L., & Unger, J. B. (1999). Service utilisation among homeless and runaway youth in Los Angeles, California: Rates and reasons. *Journal of Adolescent Health*, 24, 449-458.

Dennis, M. L., Godley, S. H., Diamond, G., Tims, F. M., Babor, T., Donaldson, J., Liddle, H. A., Titus, J. C., Kaminer, Y., Webb, C., Hamilton, N., & Funk, R. R. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized controlled trials. *Journal of Substance Abuse Treatment*, 27, 197-213.

Dworsky, A., & Courtney, M. (2009). Addressing the mental health service needs of foster youth during the transition to adulthood: How big is the problem and what can states do? *Journal of Adolescent Health*, 44, 1-2.

Ensign, J., & Gittlelsohn, J. (1998). Health and access to care: perspectives of homeless youth in Baltimore City, USA. *Social Science and Medicine,* 47(12), 2087-2099.

Farmer, T. W., & Farmer, E. M. Z. (2001). Developmental science, systems of care, and prevention of emotional and behavioral problems in youth. *American Journal of Orthopsychiatry*, 71(2), 171-181.

Garland, A. F., Hurlburt, M. S., & Hawley, K. M. (2006). Examining psychotherapy processes in a services research context. *Clinical Psychology: Science and Practice*, 13, 30-46.

Garner, B. R. (2009). Research on the diffusion of evidence-based treatments within substance abuse treatment: A systematic review. *Journal of Substance Abuse Treatment*, 36, 376-399.

Gilvarry, E. (2000). Substance abuse in young people. *Journal of Clinical Child & Adolescent Psychiatry*, 41(1), 55-80.

Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R. R., & Passetti, L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. Journal of Substance Abuse Treatment, 23, 21-32.

Godley, S. H., Meyers, R. J., Smith, J. E., Karvinen, T., Titus, J. C., Godley, D., Dent, G., Passetti, L., & Kelberg, P. (2001). Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Goodman, R. M., Speers, M. A., McLeroy, K., Fawcett, S., Kegler, M., Parker, E., Rathgeb-Smith, S., Sterling, T. D., & Wallerstein, N. (1998). Identifying and defining the dimensions of community capacity to provide a basis for measurement. *Health Education and Behavior*, 25(3), 258-278.

Green, R., Mitchell, P., & Bruun, A. (under review). For better or worse: Perspectives of service-connected young people on the value of relationships in addressing their needs. *International Journal of Drug Policy*.

Hage, S. M., Romano, J. L., Conyne, R. K., Kenny, M., Matthews, C., Schwartz, J. P., & Waldo, M. (2007). Best practice guidelines on prevention practice, research, training, and social advocacy for psychologists. *Counseling Psychologist*, 35(4), 493-566.

Hawkins, E. (2009). A tale of two systems: co-occurring mental health and substance use disorders treatment for adolescents. *Annual Review of Psychology*, 60, 197-227.

Henderson, C. E., Taxman, F. S., & Young, D. W. (2008). A Rasch model analysis of evidence-based treatment practices used in the criminal justice system. *Drug and Alcohol Dependence*, 93(1-2), 163-175.

Henderson, C. E., Young, D. W., Jainchil, N., Hawke, J., Farkas, S., & Davis, R. M. (2007). Program use of effective drug abuse treatment practices for juvenile offenders., 32, 279-290.

Henggeler, S. W., Pickrel, S. G., Brondino, M. J., & Crouch, J. L. (1996). Eliminating (almost) treatment dropout of substance abusing delinquents through home-based Multisystemic Therapy. *American Journal of Psychiatry*, 153(3), 427-428.

Hogue, A., & Liddle, H. A. (2009). Family-based treatment for adolescent substance abuse: controlled trials and new horizons in services research. *Journal of Family Therapy*, 31, 126-154.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999). *The heart and soul of change: what works in therapy.* Washington, DC: American Psychological Association.

Karabanow, J., & Clement, P. (2004). Interventions with street youth: a commentary on the practice-based research literature. *Brief Treatment and Crisis Intervention*, 4(1), 93-108.

Kazdin, A. E. (1990). Premature termination from treatment among children referred for antisocial behavior. *Journal of Child Psychology and Psychiatry*, 31(3), 415-425.

Keller, T. E., Salazar, A. M., & Courtney, M. E. (2010). Prevalence and timing of diagnosable mental health, alcohol, and substance use problems among older adolescents inthe child welfare system. *Children and Youth Services Review*, 32, 626-634.

Kidd, S. A. (2003). Street youth: coping and interventions. *Child and Adolescent Social Work Journal*, 20(4), 235-261.

Kim, J. S. (2008). Examining the effectiveness of solution-focused brief therapy: a meta-analysis. *Research on Social Work Practice*, 18(2), 107-116.

Kumpfer, K. L., Alvarado, R., Tait, C., & Turner, C. (2002). Effectiveness of school-based family and children's skills training for substance abuse prevention among 6-8-year-old rural children. *Psychology of Addictive Behaviors*, 16(4S), S65-S71.

Kumpfer, K. L., Whiteside, H. O., Greene, J. A., & Allen, K. C. (2010). Effectiveness outcomes of four age versions of the Strengthening Families Program in statewide field trials. *Group Dynamics: Theory, Research and Practice*, 14(3), 211-229.

Kutcher, S., & McDougall, A. (2009). Problems with access to adolescent mental health care can lead to dealings with the criminal justice system. *Paediatrics & Child Health*, 14(1), 15-18.

Larner, G. (2004). Family therapy and the politics of evidence. *Journal of Family Therapy*, 26, 17-39.

Lave, J., & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. Cambridge: Cambridge University Press.

Laverack, G., & Wallerstein, N. (2001). Measuring community empowerment. *Health Promotion International*, 16(2), 179-185.

Lennings, C. J., Kenny, D. T., & Nelson, P. (2006). Substance use and treatment seeking in young offenders on community orders. *Journal of Substance Abuse Treatment*, 31, 425-432.

Leung, R., Kennedy, V., Kelly, A., Toumbourou, J., & Hutchinson, D. (2010). *Preventing alcohol harms in young people: family-based interventions.* A resource for workers. Sydney: prepared by the Australian Drug Foundation for NSW Health.

Liddle, H. A. (2004). Family-based therapies for adolescent alcohol and drug use: research contributions and future research needs. *Addiction*, 99(Suppl 2), 76-92.

Liddle, H. A. (2010). Multidimensional family therapy: a science-based treatment system. *The Australian and New Zealand Journal of Family Therapy,* 31(2), 133-148.

Loxley, W., Toumbourou, J., & Stockwell, T. (2004). *The prevention of substance use, risk and harm in Australia: a review of the evidence*. Canberra: Australian Government Department of Communications, Information Technology and the Arts.

Luthar, S. S. (2006). Resilience in development: a synthesis of research across five decades. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology: Risk, disorder and adaptation* (2nd ed., Vol. 3). New York: Wiley.

Lynch, T. R., Trost, W. T., Salsman, N., & Linehan, M. M. (2007). Dialectical behavior therapy for borderline personality disorder. *Annual Review of Clinical Psychology*, 3, 181-205.

MacLean, S., Bruun, A., Mallett, S., & Green, R. (2011). *Social contexts of substance use for vulnerable 13-15 year olds in Melbourne: Youth Drug Reporting System*. Melbourne: Turning Point Alcohol and Drug Centre, YSAS & Key Centre for Women's Health, University of Melbourne.

Mark, T. L., Song, X., Vandivort, R., Duffy, S., Butler, J., Coffey, R., & Schabert, V. F. (2006). Characterizing substance abuse programs that treat adolescents. *Journal of Substance Abuse Treatment*, 31, 59-65.

Marsh, A., Dale, A., & Willis, L. (2007). *Evidence based practice indicators for alcohol and other drug interventions: literature review.* Perth: Drug and Alcohol Office of Western Australia.

McHugh, R. K., Murray, H. W., & Barlow, D. H. (2009). Balancing fidelity and adaptation in the dissemination of empirically-supported treatments: The promise of transdiagnostic interventions. *Behavior Research and Therapy*, 47, 946-953.

McKay, J. R. (2009). Continuing care research: What have we learned and where are we going. *Journal of Substance Abuse Treatment*, 36, 131-145.

McKay, M. M., Stoewe, J., McCadam, K., & Gonzales, J. (1998). Increasing access to child mental health services for urban children and their caregivers. *Health and Social Work*, 23(1), 9-15.

McLeod, B. D., & Weisz, J. R. (2005). The therapy process observational coding system-alliance scale: measure characteristics and prediction of outcome in usual clinical practice. *Journal of Consulting and Clinical Psychology,* 73(2), 323-333.

McMillen, J. C., & Raghavan, R. (2009). Pediatric to adult mental health service use of young people leaving the foster care system. *Journal of Adolescent Health*, 44, 7-13.

Meade, M. A., & Slesnick, N. (2002). Ethical considerations for research and treatment with runaway and homeless adolescents. *The Journal of Psychology*, 136(4), 449-463.

Miller, S. D., & Duncan, B. L. (2000). Paradise lost: from model-driven to client-directed, outcome-informed clinical work. *Journal of Systemic Therapies*, 19(1), 20-35.

Minkoff, K., & Cline, C. (2004). Changing the world: The design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. *Psychiatric Clinics of North America*, 27(4), 727-743.

Mitchell, P. F. (2011). Evidence-based practice in real-world services for young people with complex needs: new opportunities suggested by recent implementation science. *Children and Youth Services Review*, 33, 207-216.

Mitchell, P. F., Spooner, C., Copeland, J., Vimpani, G., Toumbourou, J., Howard, J., & Sanson, A. (2001). The role of families in the development, identification, prevention and treatment of illicit drug problems. Canberra: National Health and Medical Research Council.

Moos, R. H. (2007). Theory-based active ingredients of effective treatments for substance use disorders. *Drug and Alcohol Dependence*, 88, 109-121.

Muck, R., Zempolich, K. A., Titus, J. C., Fishman, M., Godley, M. D., & Schwebel, R. (2001). An overview of the effectiveness of adolescent substance abuse treatment models. *Youth & Society*, 33(2), 143-168.

Munford, R., & Sanders, J. (2008). Drawing out strengths and building capacity in social work with troubled young women. *Child and Family Social Work*, 13(1), 2-11.

Nation, M., Crusto, C., Wandersman, A., Kumpfer, K. L., Seybolt, D., Morrissey-Kane, E., & Davino, K. (2003). What works in prevention - principles of effective prevention programs. *American Psychologist*, 58(6-7), 449-456.

O'Connell, B. (2005). *Solution-focused therapy*. London: Sage.

Ozechowski, T. J., & Waldron, H. B. (2010). Assertive outreach strategies for narrowing the adolescent substance abuse treatment gap: implications for research, practice and policy. *The Journal of Behavioral Health Services & Research*, 37(1), 40-63.

Pead, J., Virins, I., & Morton, J. (1999). *Evaluation of the Youth Alcohol and Drug Outreach Services.* Melbourne: Drug & Health Protection Services, Public Health Division, Department of Human Services Victoria.

Perkins, R. (2006). The effectiveness of one session of therapy using a single session therapy approach for children and adolescents with mental health problems. *Psychology and Psychotherapy: Theory, Research and Practice*, 79, 215-227.

Peters, L. W. H., Kok, G., Ten Dam, G. T. M., Buijs, G. J., & Paulussen, T. (2009). Effective elements of school health promotion across behavioral domains: a systematic review of reviews. *Bmc Public Health*, 9.

Pichot, T. (2001). Co-creating solutions for substance abuse. *Journal of Systemic Therapies*, 20(2), 1-23.

Rathus, J. H., & Miller, A. L. (2002). Dialectical behavior therapy adapted for suicidal adolescents. *Suicide & Life Threatening Behavior*, 32(2), 146-157.

Rodd, H., & Stewart, H. (2009). The glue that holds our work together: the role and nature of relationships in youth work. *Youth Studies Australia*, 28(4), 4-10.

Rosenthal, D., Mallett, S., Milburn, N., & Rotheram-Borus, M. J. (2008). Drug use among homeless young people in Los Angeles and Melbourne. *Journal of Adolescent Health*, 43, 296-305.

Russell, S., & Evans, E. (2009). *Looking beyond dual diagnosis.* Melbourne: Research Matters.

Sawyer, M., & Patton, G. (2000). Unmet need in mental health service delivery: children and adolescents. In G. Andrews & S. Henderson (Eds.), *Unmet need in psychiatry: Problems, resources, responses* (pp. 330-344). Cambridge: Cambridge University Press.

Schuetz, S., & Berry, M. (2009). *Review of best practice around behaviour change in young offenders with alcohol and other drug issues.* Melbourne: Caraniche for Australian Community Support Organisation.

Slesnick, N., Kang, M. J., Bonomi, A. E., & Prestopnik, J. L. (2007). Six- and twelve-month outcomes among homeless youth accessing therapy and case management services through an urban drop-in center. *Health Services Research*, 43(1), 211-229.

Small, S. A., Cooney, S. M., & O'Connor, C. (2009). Evidence-informed program improvement: using principles of effectiveness to enhance the quality and impact of family-based prevention programs. *Family Relations*, 58(1), 1-13.

Spooner, C., Hall, W., & Lynskey, M. (2001). *Structural determinants of youth drug use: A report prepared by the National Drug and Alcohol Research Centre.* Woden: Australian National Council on Drugs.

Spooner, C., Mattick, R. P., & Howard, J. (1996). *The nature and treatment of psychoactive substance use disorders among adolescents.* Kensington National Drug and Alcohol Research Centre.

Statham, J. (2004). Effective services to support children in special circumstances. *Child: Care, Health & Development,* 30(6), 589-598.

Stirman, S. W., Crits-Christoph, P., & DeRubeis, R. J. (2004). Achieving successful dissemination of empirically supported psychotherapies: A synthesis of dissemination theory. *Clinical Psychology: Science and Practice*, 11(4), 343-359.

Sukhodolsky, D. G., & Ruchin, V. (2006). Evidence-based psychosocial treatments in the juvenile justice system. *Child and Adolescent Psychiatric Clinics of North America*(15), 501-516.

Tandon, S. D., Marshall, B., Templeman, A. J., & Sonenstein, F. L. (2008). Health access and status of adolescents and young adults using youth employment and training programs in an urban environment. *Journal of Adolescent Health*, 43(1), 30-37.

Tevyaw, T. O. L., & Monti, P. M. (2004). Motivational enhancement and other brief interventions for adolescent substance abuse: foundations, applications and evaluations. *Addiction, 99*(Supplement 2), 63-75.

Toumbourou, J. W., Stockwell, T., Neighbours, C., Marlatt, G. A., Sturge, J., & Rehm, J. (2007). Interventions to reduce harm associated with adolescent substance use. *The Lancet, 369*(9570), 1391-1401.

Ungar, M. (2005a). Resilience among children in child welfare, corrections, mental health and educational settings: recommendations for service. *Child and Youth Health Forum,* 34(6), 445-464.

Ungar, M. (2005b). A thicker decription of resilience. *The International Journal of Narrative Therapy and Community Work*(3&4), 89-96.

Ungar, M. (2006). *Strengths-based counselling.* Thousand Oaks, CA: Corwin Press.

Vaughn, M. G., & Howard, M. O. (2004). Adolescent substance abuse treatment: a synthesis of controlled evaluations. *Research on Social Work Practice*, 14(5), 325-335.

Veazie, M. A., Teufel-Shone, N. I., Silverman, G. S., Connolly, A. M., Warne, S., King, B., Lebowitz, M., & Meister, J. (2001). Building community capacity in public health: the role of action-oriented partnerships. *Journal Public Health Management Practice*, 7(2), 21-32.

Vimpani, G., & Spooner, C. (2003). Minimizing substance misuse by strategies to strengthen families. *Drug and Alcohol Review*, 22, 251-254.

Waldron, H. B., Kern-Jones, S., Turner, C. W., Peterson, T. R., & Ozechowski, T. J. (2007). Engaging resistant adolescents in drug abuse treatment. *Journal of Substance Abuse Treatment*, 32, 133-142.

Waldron, H. B., Slesnick, N., Brody, J. L., Turner, C. W., & Peterson, T. R. (2001). Treatment outcomes for adolescent substance abuse at 4- and 7-month assessments. *Journal of Consulting and Clinical Psychology,* 69(5), 802-813.

Waldron, H. B., & Turner, C. W. (2008). Evidence-based psychosocial treatments for adolescent substance abuse. *Journal of Clinical Child and Adolescent Psychology,* 37(1), 238-261.

Walker, K. (2003). Why evidence-based practice now?: a polemic. *Nursing Inquiry,* 10(3), 145-155.

Wallerstein, N., & Bernstein, E. (1988). Empowerment education: Freire's ideas adapted to health education. *Health Education Quarterly,* 15(4), 379-394.

Wandersman, A. (2009). Four Keys to Success (Theory, Implementation, Evaluation, and Resource/System Support): High Hopes and Challenges in Participation. *American Journal of Community Psychology,* 43(1-2), 3-21.

Weisz, J. R., Jensen-Doss, A., & Hawley, K. M. (2006). Evidence-based youth psychotherapies versus usual clinical care: a meta-analysis of direct comparisons. *American Psychologist,* 61(7), 671-689.

Wenger, E. (1998). *Communities of practice: Learning, meaning, and identity.* Cambridge: Cambridge University Press.

Williams, R. J., & Chang, S. Y. (2000). A comprehensive and comparative review of adolescent substance abuse treatment outcome. *Clinical Psychology: Science and Practice,* 7(2), 138-166.

Wolfe, V. V., Dozois, D. J. A., Fisman, S., & DePace, J. (2008). Preventing depression among adolescent girls: Pathways toward effective and sustainable programs. *Cognitive and Behavioral Practice,* 15(1), 36-46.

Woodberry, K. A., & Popenoe, E. J. (2008). Implementing dialectical behavior therapy with adolescents and their families in a community outpatient clinic. *Cognitive Behavioral Practice,* 15, 277-286.

Woodland, M. H. (2008). Whatcha doin' after school? A review of the literature on the influence of after-school programs on young Black males. *Urban Education,* 43(5), 537-560.

4. Guide to effective psychosocial therapeutic interventions

4.1 Introduction

4.1.1 Purpose

This section describes a set of therapeutic practice approaches or models that may be appropriate for use within youth AOD services. The selection is based on several considerations: evidence of effectiveness; practice wisdom; client characteristics; and the structural characteristics of the Victorian youth AOD service system that may affect the feasibility of implementation.

Seven different therapeutic models are described. Five have a strong evidence base supporting their effectiveness for use in the treatment of youth AOD problems and related difficulties, such as common mental health problems and offending behaviours. Two additional models are included because they are highly consistent with practice wisdom about the characteristics of effective services and programs for young people (see Section 3), and because they have already received substantial acceptance and implementation within youth AOD services.

The primary purpose of presenting this material is to encourage readers to consider the relevance and usefulness of these models within therapeutic practice frameworks that might be developed within their own organisations or at the level of state policy.

Existing literature on evidence-based practice tends to focus heavily on presenting and critically analysing the nature and quality of the evidence for and against the effectiveness of particular interventions or treatment models.

An assumption underpinning this approach seems to be that decision-makers should adopt and support one or more models that have accumulated the strongest base of evidence for effectiveness. However, this resource proposes that a variety of different therapeutic models could be applicable. Decision-makers need to choose which ones to support within a comprehensive practice framework that is relevant to their own context.

At a state level, we propose that all of the practice models described here should be adopted and implemented. Two principles justify and guide this decision process: (i) an integrative approach to evidence-based practice (Section 4.1.2) and (ii) intentional eclecticism (Section 4.1.3).

The content of Sections 4.2 to 4.8 is organised to introduce readers to each of the therapeutic models. Each section will:

- Describe the key defining features of the model;
- Provide some theoretical and philosophical background;
- Outline the evidence for effectiveness and relevance of the model for young people with AOD problems and other complex needs;
- Explain how the model is consistent with one or more of the characteristics of effective services and programs;
- Point to some limitations; and
- Assess the extent to which the model can be applied to two key service modalities in the Victorian youth AOD sector (outreach and residential services).

The material touches on issues of application that may be of interest to practitioners, but does not extend to detailed therapeutic content from a practice perspective. This material is being developed in a separate resource (Mitchell, in preparation) that will ultimately be published in a web-based format.

4.1.2 An integrative approach to evidence-based practice

An integrative approach to evidence-based practice (EBP) is advocated by the Institute of Medicine in the United States and the American Psychological Association, which defines EBP as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" (American Psychological Association, 2005).

There are substantial areas of psychosocial therapeutic practice pertaining to young people with AOD problems, for which there is little research-based evidence available. This is particularly true for those with multiple and complex needs. Therefore, the current approach to evidence-based practice also includes consideration of what theory suggests is likely to be effective.

This resource also considers the work of a wide range of AOD and youth work practitioners who may not identify as 'clinicians'. We seek to articulate and integrate practice-based knowledge that may be generalised across a variety of disciplines and service contexts. Thus we prefer the term 'practice wisdom' over 'clinical expertise'.

This resource defines EBP as therapeutic practice that is based on the integration of the best available research evidence, theory, practice wisdom and client values.

- The 'best available research evidence' includes, wherever possible, evidence from replicated randomised controlled trials (RCTs) testing the efficacy of particular treatments. It may also include evidence from other types of research, such as descriptive studies and those using qualitative methods. Weight has been placed on evidence from research that has included young people with multiple and complex needs.
- Relevant 'theory' includes theory about (i) adolescent development; (ii) the development and maintenance of AOD problems and the variety of other psychosocial problems that frequently co-occur with them; and (iii) the mechanisms by which particular interventions are presumed to ameliorate these problems.
- 'Practice wisdom' is practice-based knowledge or practice-based evidence that has emerged and evolved primarily from practical experience rather than empirical research. It may include local knowledge developed by practitioners within youth AOD services, or distributed knowledge acquired through communities of practice such as social work and youth work, child and adolescent mental health services, child protection, and youth justice. Practice wisdom may be informed by research evidence, but its development and dissemination are driven by processes of practice rather than research.
- Client values are reflected in the personal preferences of clients, including their goals and objectives for service provision and their choices of the modality and nature of interventions.

Researchers investigating the implementation of EBP in child and youth-focused AOD, mental health and youth justice service settings are increasingly favouring an integrative approach. A significant line of research has examined the ways, extent and reasons why manual-based treatments developed in clinical research settings are adapted by practitioners when implemented in real-world practice settings (Aarons & Palinkas, 2007; Hogue et al., 2008; McHugh, Murray, & Barlow, 2009; Stirman, Crits-Christoph, & DeRubeis, 2004).

These researchers emphasise that modification of new treatments is inevitable, because client characteristics, needs and contexts vary from those in which the treatments were originally developed and tested. Another line of research has examined how both interventions and practice contexts are mutually adapted to achieve a fit that is appropriate to each unique service context (Aarons & Palinkas, 2007; Chamberlain, Price, Reid, & Landsverk, 2008; McHugh & Barlow, 2010; Stirman et al., 2004; Weisz, Southam-Gerow, Gordis, & Connor-Smith, 2003).

This approach tends to view EBP as a complex system that extends beyond the focused interaction between client and practitioner to interactions between players at multiple levels in service systems.

The literature review examines material from clinical effectiveness research as it relates to material based on practice wisdom, theory and research into young people with multiple and complex needs, as well as local knowledge of the Victorian policy and service context.

Particular attention is paid to exploring if and how components of psychosocial treatment models are consistent with the consensus and principle-based characteristics of effective programs reviewed in Section 3. Material from these various sources is integrated to evaluate the likely value of particular therapeutic approaches in the Victorian context, and to explain issues that should be considered in implementation decision processes.

4.1.3 Intentional eclecticism

If therapeutic interventions are to be client-centred, developmentally appropriate and comprehensive, then the Victorian youth AOD service system needs a diverse variety of options ready to deploy. A single model of therapeutic intervention is not enough to meet the diverse and changing needs of the young people seen in real-world services. Therapeutic practice frameworks must incorporate a high degree of eclecticism, drawing on a variety of different therapeutic models and traditions.

Therapeutic practice frameworks should be based upon intentional eclecticism – that is, eclecticism guided by principles that are linked to therapeutic intentions at a service level. Much therapeutic practice is primarily shaped by professional training, previous experience, and the personal preferences of individual practitioners. This approach is sub-optimal in service settings where clients are supported by teams of practitioners and collaborative team work is required.

There are several important advantages in focusing on a limited set of carefully chosen interventions and investing in their development. These include:

- Concentration of scarce resources on interventions that research evidence suggests are more effective;
- Reinforcement of critical therapeutic content (e.g. key understandings and skills) by different workers will produce a more intensive intervention and potentially increase clients' engagement in their therapeutic experience;

- Increased efficiency in the use of valuable training and supervision resources; and
- Increased capability to evaluate interventions that have not yet been subject to rigorous effectiveness research.

The interventions described in this section have been selected based on three main criteria:

- Their presence in published lists of well-established, 'evidence-based interventions' or 'evidence-based treatments' for AOD problems among young people;
- Their presence in published lists of well-established, evidence-based interventions for other behavioural health problems commonly experienced by young people with AOD problems (particularly high prevalence mental health problems and offending behaviour); and
- They address needs not fully met by other interventions and demonstrate several characteristics of effective service provision as outlined in Section 3.

All of the therapeutic models considered are consistent with key aspects of established theory about the development and maintenance of AOD and related psychosocial problems among adolescents.

Table 4.1a: Criteria for inclusion of therapeutic interventions

CRITERION FOR INCLUSION	INTERVENTIONS
1. Well-established 'evidence-based interventions' for (AOD) problems	• Motivational Interviewing • Cognitive Behaviour Therapy • Community Reinforcement Approach • Multidimensional Family Therapy
2. Well-established and promising 'evidence-based interventions' for other commonly associated behavioural health problems	• Cognitive Behaviour Therapy • Community Reinforcement Approach • Multidimensional Family Therapy • Dialectical Behaviour Therapy
3. Address other critical purposes and demonstrate several characteristics of effective service provision	• Narrative Therapy • Solution-Focused Therapy

Table 4.1b: Major purposes of different therapeutic interventions

PURPOSE	INTERVENTIONS
Engagement and building the therapeutic relationship	• Motivational Interviewing • Narrative Therapy • Multidimensional Family Therapy • Dialectical Behaviour Therapy
Enhancing motivation for change **Instilling hope and confidence for the future** **Empowerment**	• Motivational Interviewing • Solution-Focused Therapy • Narrative Therapy
Modifying cognitions, perceptions and beliefs **Increasing knowledge and understanding** **Building skills**	• Cognitive Behaviour Therapy • Community Reinforcement Approach • Dialectical Behaviour Therapy • Multidimensional Family Therapy • Narrative Therapy • Solutions-Focused Therapy
Strengthening relationships **Enabling participation** **Modifying contingencies**	• Community Reinforcement Approach • Multidimensional Family Therapy • Narrative Therapy • Dialectical Behaviour Therapy
Navigating to and negotiating for health and community services	• Community Reinforcement Approach

4.2 Motivational Interviewing

4.2.1 Motivational Interviewing in brief

Most young people who come into contact with AOD services are ambivalent about stopping or reducing their substance use. They see benefits and disadvantages of changing. The purpose of Motivational Interviewing is to help the client recognise, understand and resolve their ambivalence towards change. It does not try to persuade the client to change (Miller, 1996).

The developer of Motivational Interviewing (MI) defines it as "a collaborative person-centred form of guiding to elicit and strengthen motivation for change" (Miller & Rollnick, 2009; p137).

Although Motivational Interviewing was originally developed for adult alcohol drinkers, it has been used effectively with adolescents experiencing various types of AOD problems, as well as people who might benefit from changing various other behaviours.

MI was developed as a brief intervention involving one or two sessions. Miller and Rollnick (2009) point out that 2-3 hours of MI is about as much as people can tolerate. As such, MI was not intended to be a school of psychotherapy or a comprehensive treatment approach. Rather, MI is a tool for addressing a particular problem when a person might benefit from making a behaviour or lifestyle change, but is ambivalent about doing so or reluctant to start a change program (Miller & Rollnick, 2009).

Motivational Interviewing is usually a single, brief, structured interview, delivered in settings such as emergency departments or general practice where individuals are recognised as potentially needing assistance with AOD problems. However, in youth AOD settings MI needs to be used regularly as young people move through a process of addressing a variety of issues over time.

The five key tenets or principles of MI (Miller, 1996; Tevyaw & Monti, 2004) are:

- *An empathic, non-judgmental stance* – which enables practitioners to connect more easily with 'rebellious' or 'oppositional' teens, in contrast with authority figures;
- *Reflective listening* – which demonstrates the empathic stance and informs the development of individually tailored or person-centred strategies;
- *Developing discrepancy* – helps the person develop awareness of how the behaviour in question may contradict or undermine achievement of life goals;
- *Rolling with resistance and avoiding argument* – fosters a unified viewpoint and a collaborative approach on the side of the individual; and
- *Supporting self-efficacy for change* – by providing affirmative statements.

Miller and Rollnick (2009) have emphasised that MI does not equate with the use of particular techniques; rather, sticking to the "spirit" of MI is most important.

A similar intervention called Motivational Enhancement Therapy (MET) has also been developed by Miller and colleagues. This is based on the same clinical principles as MI, but the form was modified to four sessions over 12 weeks to match the total length of intervention to that used in control conditions in effectiveness research. MET may include a technique to provide structured personal feedback based on information collected at assessment (Miller & Rollnick, 2009).

Consistent with this history, subsequent interventions called Motivational Enhancement are generally based on similar principles to MI and cover similar content, but they may use other modalities (e.g. group work), incorporate a wider variety of techniques, and be delivered over longer periods of time.

4.2.2 Theory and philosophy

The key theoretical source for MI is Rogerian client-centred therapy. They share:

- A philosophical foundation in humanism and a corresponding emphasis on accurate empathy or reflective listening;
- Support for client autonomy;
- Collaboration with the client; and
- A desire to evoke and work with the client's own views and experiences of change.

MI departs from the traditional client-centred counselling in being consciously goal-focused or having an intentional direction towards change (Miller & Rollnick, 2009). In this sense MI is more directive than traditional client-centred approaches[1] (Crits-Christoph et al., 2009), but unlike some strongly directive approaches popular in AOD counselling MI carefully avoids confrontation (Miller, 1996). Instead of trying to persuade directly, the MI counsellor helps the client to draw out, explore and resolve their own ambivalence (Miller, 1996).

Some author also portray MI as having theoretical roots within Social Learning Theory and Cognitive Behaviour Therapy (Macgowan & Engle, 2010). Miller and Rollnick (2009) point out that MI differs in critical ways from CBT, primarily because CBT involves providing clients with something that they are presumed to lack while MI is about drawing out from people that which is already present (p.134).

MI comprises techniques that are often described with the acronym OARS: open questioning; affirmations; reflections; and summaries (Macgowan & Engle, 2010). However, in practice interventions that are called MI often include cognitive and behavioural techniques, which has blurred the distinction between the two approaches over time (Miller & Rollnick, 2009).

More recently MI has been framed within Self-Determination Theory, which views self-determined behaviour as intrinsically reinforced by satisfaction of innate needs for autonomy, competence and relatedness (McMurran, 2009).

4.2.3 Relevance to client need and evidence for effectiveness

Motivational Interviewing, or some form of intervention aimed at stimulating and sustaining motivation for change, is vitally important to effective delivery of treatments for AOD use problems. This is particularly so for adolescents because they are less likely than adults to view themselves as having an AOD 'problem' and they are less likely to present themselves for treatment (Chassin, 2008; Muck et al., 2001).

For young people, there can be strong positives in substance use. Often all their friends are substance users. Substance use can be an important emotion-focused coping strategy for young people exposed to trauma (Staiger, Melville, Hides, Kambouropoulos, & Lubman, 2009). The fear of losing friends (social

[1] The strong intent of Motivational Interviewing can be perceived as posing a philosophical tension with the client-centred approach, which does not necessarily favour change in any particular direction. This tension has been noted by youth AOD workers in training. It might be mitigated by reinforcing harm minimisation and building resilience as the ultimate guiding frameworks for therapeutic intentionality (see Section 6). In this context, the aim of MI is to reveal and clarify the client's own varied motivations and reinforce any existing motivations for change consistent with harm reduction and resilience.

isolation) and something that helps make their situation tolerable (a key coping strategy) can be powerful disincentives to quitting or reducing substance use.

Even youth with lives filled with problems closely connected to AOD use, such as homelessness, have relatively low rates of perceived need for treatment of AOD problems (Rosenthal, Mallett, Milburn, & Rotheram-Borus, 2008). Rates of dropout from drug treatment are very high irrespective of age. Even among those attending mandated programs in the justice system, 68 per cent do not 'complete' it, and outcomes are worse for 'non-completers' across a variety of measures (Evans, Li, & Hser, 2009). Low motivation for treatment is the main reason given by offenders for dropping out, followed by the treatment being too difficult or strict to complete (Evans et al., 2009).

As noted in Section 4.4.5, highly structured and demanding evidence-based interventions such as CBT, which require clients to confront difficult behaviours and do homework, depend on strong engagement and motivation to be effective. Young people with complex needs have many issues other than drug use competing for their attention and energy. Without additional efforts to build motivation, AOD treatment may be wasted.

The emergence and rapid adoption of the Trans-theoretical Model of Behaviour Change in the 1980s led to major changes in how health professionals think about and facilitate change, particularly in AOD treatment (Miller & Rollnick, 2009). It was recognised that most existing treatments assumed that clients were ready and committed to change, but that this assumption could no longer be justified.

Health professionals began to realise that treatments needed to be adjusted to account for the clients' stage of change, and that they needed to take responsibility for enhancing and supporting motivation (Miller & Rollnick, 2009). This substantial shift in attitudes within AOD services provided a positive climate for rapid adoption of Motivational Interviewing, which was developed and disseminated at the same time as the Trans-theoretical Model was gaining wide acceptance (see Section 5).

In the early stages of its development, Miller and his colleagues wanted to develop a brief intervention for problem drinkers who were not seeking formal treatment. For this purpose, MI stands alone as a brief intervention. Early research demonstrated that it can be effective in reducing alcohol consumption among this population (Miller, 1996).

Only later was MI further developed to enhance motivation and engagement among clients actually beginning a course of treatment. Several early trials also demonstrated that when added to the front end of a longer treatment program, clients randomised to receive MI or MET were more motivated and involved and experienced better outcomes at follow-up (Miller, 1996).

Numerous reviews and several meta-analyses of MI and MET research have been conducted. Much of this research has focused on testing the efficacy (in terms of behaviour change outcomes) of MI or MET compared with either treatment as usual or other established treatments for AOD problems. The results of these studies have been mixed (Crits-Christoph et al., 2009).

The most recent extensive meta-analysis, which included 119 studies (the majority focusing on AOD use), found that MI is certainly more effective than no treatment, but not significantly better than other specific treatments (Lundahl, Kunz, Brownell, Derrick, & Burke, 2010).

An important problem with some meta-analyses is that they have not distinguished between studies focusing on people who are seeking or presenting to treatment services versus those not yet presenting. Many of the interventions in MI research, such as those focusing on university students, are more suitably categorised as prevention or early intervention. It would be more useful to consider these separately from treatment of individuals with long-established AOD problems. This latter population is of most concern to the present analysis.

Surprisingly little research has examined what value MI adds to other AOD treatments, including its contribution to engagement and retention. Tevyaw and Monti (2004) report one study where the addition of MI to the front-end of an existing treatment was found to increase length of retention for adults with substance use problems. A systematic review of 19 studies of MI with offenders found four studies in which "results look promising" for MI in enhancing retention (McMurran, 2009; p95). However, concrete inducements appear more effective in improving engagement.

A study comparing Motivational Enhancement Therapy (MET) to Counselling as Usual (CAU) found no differences in the number of sessions attended (Crits-Christoph et al., 2009). An ongoing Randomised Control Trial (RCT) of MI integrated with CBT, compared with standard care, obtained a high retention rate at 24 months in a sample of adults with long histories of psychosis and substance misuse. The majority of those allocated to MI+CBT (76 per cent) attended at least 11 sessions (Barrowclough et al., 2009). This compares with dropout rates of more than 50 per cent for other dual-diagnosis treatment programs. This study also used assertive outreach to schedule appointments, with an emphasis on fostering engagement for all clients. Retention rates for the standard care condition are not reported.

There has also been very little research on the potential mechanisms of action of MI within the client, but there is some empirical support for the mechanisms identified in theory. One recent review focusing on this question reports findings that MI leads to high levels of intention to change (one study), increased readiness to change (one study), increased client engagement/involvement (two studies), reduced resistance (one study), and experience of discrepancy (two studies) compared with comparison conditions (most of these being minimal or placebo) (Apodaca & Longabaugh, 2009).

These client behaviours (except readiness to change, which has not been appropriately studied) have been linked to better outcomes (Apodaca & Longabaugh, 2009). McMurran's (2009) review of MI with offenders found eight studies providing evidence that "MI can lead to improvements on measures of readiness or motivation to change" (p95), but two studies provided contrary evidence. Although they do not explore this in depth, Lundahl et al. (2010) also conclude that MI increases clients' engagement in treatment and their intention to change.

4.2.4 Articulation with characteristics of effective services and programs

Client-centred √

Engagement and retention strategies √

Developmentally appropriate √

Use of theory and evidence √

Consistent with their philosophical basis within humanism and client-centred therapy, Motivational Interviewing and similar interventions are tailored to the needs and issues of the individual (Tevyaw & Monti, 2004). Consistent with Rogerian client-centred therapy, Miller and Rollnick (2009) emphasise that MI begins with the assumption and honouring of personal autonomy – the belief "that people make their own behavioural choices, and that such power of choice cannot be appropriated by another" (p131).

MI and ME have been identified as particularly appropriate for developing adolescents, because they are inherently sensitive to the individual's personal readiness or stage of change. Individuals are not required to 'admit' to having an AOD problem before considering behaviour change and do not have to commit to abstinence (Macgowan & Engle, 2010).

Because adolescents are less likely than adults to view themselves as having an AOD problem (Chassin, 2008; Muck et al., 2001), avoiding a 'confrontation-of-denial' approach may be an important reason why adolescents are perceived as responding particularly favourably to MI and ME (Macgowan & Engle, 2010). Similarly, abstinence is widely recognised as a less attractive or realistic goal for adolescents than adults (Toumbourou et al., 2007). It can be argued that programs with flexible goals are more developmentally appropriate.

4.2.5 Limitations of Motivational Interviewing

As with most other treatments for AOD problems, there has been much less research on adolescents than on adults, and even less on youth with complex needs. Macgowan and Engle (2010) reviewed 12 well-designed studies of MI in the treatment of adolescents with substance abuse problems. They conclude that MI does not yet meet criteria for a "well-established" or "probably efficacious" treatment (p537), but it does for a "promising" intervention. It is important to note that the MI interventions included in this review were very brief. Eight studies involved a single session, three studies involved two sessions and one study involved four sessions.

The authors note that given the brevity of the interventions, it is significant that positive effects were found at all. All of the studies reported reductions in at least one indicator of AOD use. Several of the studies involved homeless and hard-to-reach youth. These yielded less positive results than the studies involving university and college students.

Macgowan and Engle (2010) conclude that "it is likely that [Brief Motivational Interviewing] alone is not enough to cause lasting change in AOD use", particularly for youth with more severe problems and various additional unmet needs (p536).

The brevity of the interventions included in this review is consistent with the original design of MI. What is puzzling is that reporting of the results of these studies has focused on outcomes such as reduced use of alcohol and other drugs, less harmful use, and reductions in other consequences. These types of outcomes go beyond the original purpose of MI as an intervention for enhancing motivation and commitment to change.

A fairer test of the effectiveness of MI would focus on measuring the original objective of increasing motivation. This objective should translate into outcomes such as increased retention in treatment over time, and increased active participation by the client in the various therapeutic interventions that are actually designed to change behaviours and other processes that maintain problematic AOD use.

Macgowan and Engle (2010) also reviewed interventions involving combination treatments, nine of which involved MI and CBT. MI interventions added 1-2 sessions onto CBT, ranging from three to more than 20 sessions. Only three of these studies yielded significantly

improved outcomes for the combined (MI+CBT) condition compared with CBT alone. Again, reported outcomes focused on reduced AOD use. It is also worth noting that most of these studies, including the three with significant effects for MI, had small sample sizes (about 20), making the results promising that MI may add significant value.

Further research is clearly warranted focusing on adolescents with more severe and complex presentations. The Macgowan and Engle (2010) review included no studies targeting dually diagnosed youth. Future research should explore the contribution of MI in multidimensional treatment programs. It also needs to be more specific in clarifying the goals of using MI with adolescents who have complex needs and particular sets of needs.

Is the aim to increase the likelihood of entry to treatment, retention in treatment, participation in treatment activities, or changes in substance use behaviour? We also need more information about questions such as when, how often, for whom and in what context MI is most effective in achieving particular aims.

For youth with complex needs, it may be more appropriate to evaluate MI's contribution to engagement, retention and other process indicators (e.g. goal setting and progress through goals) rather than its direct contribution to clinical outcomes. MI's contribution to clinical outcomes is likely to be indirect, moderating exposure to and active participation in other therapeutic processes. Statistical analyses designed to detect such indirect effects on outcomes may be more sensitive and provide a more realistic picture of the potential contribution of MI.

Given the mixed results of efficacy studies (Crits-Christoph et al., 2009), it is also possible that the effectiveness of MI as a treatment add-on may be limited to, or more pronounced for, particular types of clients, such as those who begin treatment with low levels of motivation or who are difficult to engage. This possibility is supported by findings such as the superiority of MI over CBT for clients with high anger, a positive effect that appears to be mediated by MI's non-directive qualities (Apodaca & Longabaugh, 2009). Very little research has examined moderating or mediating conditions of MI effectiveness.

4.2.6 Application to outreach and residential settings

MI and ME have been deliberately developed as brief interventions for a wide variety of settings where individuals with AOD problems may be found, including emergency departments, criminal justice settings, primary care settings and schools (Macgowan & Engle, 2010; Tevyaw & Monti, 2004).

Unlike some structured AOD treatment programs (e.g. Multidimensional Family Therapy), there is no trademarking, copyright licensing or restriction on the use of MI. Its developers do not advocate for the use of strict guidelines or protocols specifying particular modalities, content or techniques. Rather, they emphasise the importance of several well-articulated principles. Two large-scale meta-analyses of the effectiveness of MI have found significantly smaller effect sizes when it is manual guided compared with when it is not (Hettema, Steele, & Miller, 2005; Lundahl et al., 2010).

This built-in flexibility of MI is encouraging. The basic principles can be readily used in a variety of modalities, including ones that do not involve fixed-length sessions. The various core therapeutic components can be usefully applied at numerous points throughout episodes of care. The various conversations aimed at building empathy – using reflective listening, developing discrepancy by exploring goals and how AOD use may interfere, and building self-efficacy by providing affirmation – can all be undertaken in any place or situation. They can also be used by different practitioners or mentors.

It is also likely that reiteration of the same pieces of conversation over time as a worker or team gets to know the young person better will be more effective than a concentrated 'interview' of 1-2 sessions. We are aware of no research that has explored this highly plausible hypothesis.

The outreach modality provides many opportunities to initiate or revisit conversations at critical or 'teachable' moments, such as following a relapse. Frequently a young person who has recently quit misusing substances begins to consider going back to their old lifestyle [2]. The decisional balance matrix is a valuable technique to revisit at this point.

[2] Bruun and colleagues refer to this event as 'reverse motivation' because the motivational forces that have driven the young person towards quitting or reducing use are beginning to weaken relative to the motivational forces for continuing use, and the balance of motivational forces may move into reverse (Bruun et al., 2002).

The need for Motivational Enhancement interventions continues after young people enter residential treatment. Many young people do not complete residential stays and may return several times before completing a full intervention. Young people, like adults, may cycle through the various stages of change repeatedly before they make substantial and lasting changes in their life. This means that the need for and receptiveness to motivational conversations arises repeatedly.

Box 4.2: Elements of Motivational Interviewing that are readily applied in outreach and residential settings

- Orientating to the style & spirit of Motivational Interviewing
- Person-centred guiding & active listening
- Rolling with resistance & avoiding argument
- Evoking & working with the clients' own views & experiences of change
- Developing awareness of discrepancy
- Eliciting & exploring ambivalence about change
- Feedback, personalised & normative

These 7 practice elements are described in detail in (Mitchell, in preparation).

Compared with outreach, residential settings may provide a better opportunity for the more intensive and formal components of MI. The stable and structured environment gives young people time to reflect, focus, and set and work towards realistic goals. This may make it easier to use techniques such as the decisional balance matrix in the process of goal setting, provision of normative and personalised feedback, and conversations that foster awareness of discrepancy between current behaviour and future goals.

4.3 Community Reinforcement Approach

4.3.1 The Community Reinforcement Approach in brief

The Community Reinforcement Approach (CRA) works systematically to change a person's day-to-day environment in ways that reinforce abstinence or less harmful patterns of substance use and promote healthy behaviours for positive development and resilience. CRA emphasises building self-esteem through positive reinforcement rather than confrontation, consistent with MI (Thorpe & Olson, 1997).

A practitioner works with the client to help them identify the causes and consequences of their problem behaviours and to learn about the conditions under which these behaviours occur (Wong, Silverman, & Bigelow, 2008). Clients are then counselled to restructure their daily activities to minimise contact with known triggers of their problem behaviours and to promote healthy alternatives.

CRA supports clients to develop a new social network of people who are involved in healthy, pro-social pursuits. Wong et al. (2008) observe that CRA-based programs tend to provide assistance in a variety of lifestyle-related domains such as education and training, employment, and social and recreational activities. Active participation in these domains provides reinforcement for activities inconsistent with AOD use, offending, and other problem behaviours.

The overarching treatment goal is "to systematically weaken the influence of reinforcement derived from substance use and its related lifestyle, and to increase the frequency and magnitude of reinforcement derived from healthier alternative activities" (Stanger & Budney, 2010; p548). Individualised interim goals have a strong place in CRA. Stanger and Budney recommend that these should be "specific behavioural goals that have a high probability of successful completion" (p551).

A version of CRA has been developed specifically for adolescents. The Adolescent Community Reinforcement Approach (ACRA):

- Takes into account the differences between the contingencies that shape patterns of AOD use among adolescents compared with adults;
- Addresses areas of life that are developmentally important for adolescents; and
- Adds procedures for working with parents and caregivers (Garner et al., 2009; Godley, Meyers et al., 2001).

ACRA seeks to increase the reinforcers for recovery present in family, social, and educational/ vocational systems.

4.3.2 Theory and philosophy

CRA grew out of early work involving contingency management. Applied to the treatment of substance use problems, contingency management used operant conditioning principles to shape behaviour change.

Contingency management is theoretically and empirically rooted in an extensive scientific literature demonstrating a strong role for operant conditioning in the origin and maintenance of drug use, including repeated use, abuse and dependence. Operant learning or conditioning comes into play when a behaviour becomes reliably associated with either positive or negative consequences. When it is followed by positive consequences (rewards or positive reinforcement) the behaviour is performed more frequently. When it is followed by negative consequences (punishment) performance of the behaviour decreases.

Numerous studies demonstrate that such conditioning occurs in animals as well as humans. This research has also shown that, like other forms of operant responding, drug use is malleable and sensitive to environmental consequences even in highly dependent individuals (Higgins & Silverman, 2008).

Studies involving adults have demonstrated the effectiveness of contingency management techniques, particularly positive reinforcement, in reducing substance use or inducing and maintaining abstinence for periods of time (Stanger & Budney, 2010; Wong et al., 2008).

Building on the theoretical roots within operant conditioning, the Adolescent Community Reinforcement Approach (ACRA) integrates insights from Bronfenbrenner's Social Ecological Systems Theory (see Section 2.1.4), which understands behavioural trajectories as the result of processes taking place within defined settings (micro-systems) and in response to interactions between groups of interlocking settings (the meso-system) (Slesnick, Prestopnik, Meyers, & Glassman, 2007).

The critical factor in micro-systems is the web of relationships between people in a specific ecological context. Key examples of micro-systems are families, schools and community organisations. Examples of meso-systems are a family within a neighbourhood or the industries that provide employment in a geographical region. Working with contingency processes operating within these ecological systems, ACRA attempts to change the relationship between the adolescent and their micro and meso-systems (Slesnick et al., 2007).

4.3.3 Relevance to client need and evidence for effectiveness

Although few RCTs have been conducted as yet, ACRA has consistently demonstrated effectiveness. In a series of large-scale RCTs comparing several treatments for substance abuse in adolescents, ACRA achieved outcomes comparable to Motivational Interviewing combined with Cognitive Behaviour Therapy (MI+CBT) and Multidimensional Family Therapy (MDFT). ACRA proved the most cost effective at 12-month follow-up (Dennis et al., 2004).

Process research has shown that adolescents exposed to more of the intervention (12 or more of the ACRA procedures) were significantly more likely to be in recovery at follow-up compared with adolescents exposed to less (55% vs 35%) (Garner et al., 2009). Exposure to ACRA procedures was also a significant mediator of a positive relationship between treatment retention and outcome (Garner et al., 2009).

There is also evidence from an RCT that ACRA is effective for hard-to-reach youth with multiple and complex needs. Slesnick et al. (2007) compared ACRA and treatment as usual (TAU) provided in a drop-in centre setting for 180 street-living homeless youth aged 14-22. Youth in both conditions improved in many domains, but the ACRA group reported significantly greater reductions in substance use, depression, and increased social stability at the six-month follow-up compared with the TAU group (Slesnick et al., 2007).

Few empirically supported treatments for street-living youth are available. CRA has also been found to be appropriate for engaging and supporting homeless youth to access the resources and assets needed to address health issues such as HIV prevention (Arnold & Rotherham-Borus, 2009).

Just as important as evidence of effectiveness, studies of implementation have found that with 3-4 days of training followed by weekly supervision, practitioners in youth substance abuse services actually use the procedures as planned (Garner et al., 2009).

ACRA has been recommended by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) as one of several evidence-based practices under the Juvenile Treatment Drug Courts (JTDC) program [3] and the Offender Reentry Program (ORP) [4].

[3] http://www.chestnut.org/li/JTDC/

[4] http://www.chestnut.org/li/ORP/

Although CRA was developed subsequently to more simple forms of contingency management, and has a much broader set of aims, there may still be a place for more simple and direct forms of contingency management within youth AOD services. Early trials of contingency management focused upon two main types of behaviour – attendance at treatment sessions and abstinence from substance use. Several trials have supported the effectiveness of contingency management in enhancing these outcomes (Krishnan-Sarin, Duhig, & Cavallo, 2008). Given that engagement and attendance remain a challenge for youth AOD services, there may be room for increased use of contingency management (CM).

CM-based interventions that have demonstrated effectiveness in enhancing attendance have emphasised positive reinforcement, specifically the use of tangible rewards such as payment of money or vouchers for food and other goods and services (Krishnan-Sarin et al., 2008; Stanger & Budney, 2010).

Within the Victorian youth AOD service system, few if any tangible rewards are provided for adolescents to attend services. Overt contingencies essentially involve negative reinforcement (e.g. avoidance of harsher penalties for offending behaviour), while positive reinforcements are extremely subtle (e.g. practical assistance with basic necessities such as clothing, food and housing; the listening, understanding and respect experienced within positive relationships with workers; and the rewards inherent in progress towards personal goals).

These types of positive contingencies may work well with young people whose life circumstances are extremely adverse and who experience severe social marginalisation, but they are unlikely to be enough to engage the larger cohorts of youth who experience and perceive few harms or disadvantages associated with their drug use. If Victorian youth AOD services are to shift towards more early intervention as indicated in government policy, it may be necessary to expand the range of positive incentives for engagement with programs.

Furthermore, if youth AOD services are to implement more systematic evidence-based interventions (such as those described in this resource), young people with multiple and complex needs may need stronger incentives to attend programs regularly.

It will be important to ensure that more overt reinforcements for attendance do not undermine existing subtle contingencies. While direct monetary rewards for mere attendance are not appropriate, alternatives may be. These could include:

- Tuition fees for short courses
- Clothes or shoes for job interviews
- Access to enjoyable structured activities such as outdoor adventure, team sports, art or music classes or workshops
- Free or highly subsidised health-promoting goods and services.

4.3.4 Articulation with characteristics of effective services and programs

CRA – where contingencies are understood and addressed within the context of the person's whole life – is an approach that is consistent with the holistic and client-focused approach to youth AOD treatment predominant in Australia.

Client-centred or individualised √
Developmentally appropriate √
Behavioural, experiential and skill-focused √
Multi-systemic, ecological and integrative √
Family involvement √
Engagement and retention strategies √
Use of theory and evidence √

CRA was developed for the express purpose of managing contingencies in the client's day-to-day environment. As such, the intervention is inherently individualised to the client's unique situation. The manual that describes ACRA procedures (Godley, Meyers et al., 2001) also contains strategies that assist the practitioner to individualise interventions.

Diverse domains of life are assessed and discussed collaboratively with the client to set personal goals and develop an individual treatment plan. The intervention approach is modular – most of the procedures are relatively independent – and can therefore be introduced and reinforced at times and places that suit the individual needs of the client (Chorpita, Daleiden, & Weisz, 2005b).

For example, developers of ACRA recommend that practice elements such as communication skills and anger management be introduced and revisited whenever the adolescent raises a communication or anger problem (Godley, Meyers et al., 2001).

ACRA was developed specifically for use with adolescents. The emphasis on developing contingencies associated with fun activities, the focus on building the skills that are necessary for rewarding relationships, and the addition of procedures for working directly with parents or caregivers are examples of this (Garner et al., 2009; Godley, Meyers et al., 2001). As such, ACRA

strives to be **developmentally appropriate** and conducive.

ACRA is highly **behavioural, experiential and skill-focused** in its orientation. The core therapeutic practice elements are focused on building the skills (e.g. communication and problem-solving) required for new behaviours and/or providing opportunities for new experiences (e.g. pro-social recreation planning) that will reinforce movement away from old patterns towards a more positive and rewarding lifestyle.

Although ACRA is not a wholly comprehensive treatment program, as it is strongly oriented towards behaviour change and skill development, it is certainly **multi-systemic, ecological and integrative**. ACRA includes a diverse range of components covering individual and external/environmental factors, as well as motivation, knowledge, cognitions and skills. The assessment, goal setting and treatment planning tools explore 16 different domains of life. "As the areas are reviewed with the adolescent it becomes clear that you want to help him or her with problems in multiple areas" (Godley, Meyers et al., 2001; p69).

In its ecological systems, ACRA attends to the individual, the family or caregiver system, and the wider community of the young person. ACRA includes skill-building sessions with parents and caregivers and integrates these components with joint sessions. Parents, caregivers and significant others are actively engaged and equipped as supporters of change for the young person. ACRA practitioners are expected to develop a thorough knowledge of health and social resources in the community and to help young people navigate towards and negotiate for access to these resources.

Family involvement is one of the key strategies identified in the literature as facilitating **engagement and retention** of adolescents in treatment. ACRA includes specific procedures focused on engaging and motivating parents/caregivers. Rapport-building techniques include allocating time for listening to caregivers about their concerns and feelings and demonstrating empathy.

Caregiver motivation techniques focus on trying to keep the interaction positive by curtailing blame, emphasising family strengths, and searching for 'exceptions' (situations when problems are not present).[5] As outlined in Section 4.3.3, contingency management approaches have been used to enhance **engagement and retention** in AOD treatment and potential exists to increase the use of such techniques in Victorian services.

In **use of theory and evidence**, contingency management is theoretically and empirically rooted in an extensive scientific literature that demonstrates a strong role for operant conditioning in the origin and maintenance of drug use, including repeated use, abuse and dependence.

CRA is further informed by insights from Social Learning Theory and Social-Ecological Systems Theory (Slesnick et al., 2007). Taken together, this tells us that learning will be most effective when it takes place within (or targets factors operating in) multiple systems comprising the daily environment of the client. As outlined in Section 4.3.3, ACRA has demonstrated effectiveness in treating AOD problems among adolescents. Positive outcomes span AOD use, depression and social stability.

4.3.5 Limitations of the Community Reinforcement Approach

Developers and researchers of ACRA have expressed concern that retention in treatment has proven to be a significant challenge (Godley, Garner, Smith, Meyers, & Godley, 2011). To address this problem, program developers have advocated that ACRA be delivered as assertive continuing care that adds case-management in home and community-based settings (Godley et al., 2011).

On the positive side, there is evidence that retention may not be a problem for youth with multiple and complex needs, provided appropriate engagement strategies are used. It is noteworthy that ACRA delivered to street-living homeless youth achieved 84% retention (i.e. completion of six-month follow-up assessment), very similar to case management as usual (88%).

Furthermore, ACRA achieved attendance at more sessions (average 6.8) than usual case management (average 3.4) provided through a drop-in centre (Slesnick et al., 2007). These researchers suggest that "an open door policy, engagement of youth slowly and without pressure through a drop-in centre, and employing charismatic, informed therapists can contribute to effective engagement and maintenance of these youth in treatment" (p1249). As already noted, retention might also be enhanced by adding contingencies based upon more direct tangible positive reinforcement for attendance, engagement with particular program tasks, and/or achieving particular goals.

[5] These latter strategies are drawn from Solution Focused Therapy (see Section 4.8)

4.3.6 Application to outreach and residential settings

ACRA was designed to target youth aged 12 to 22 years. ACRA is an individually based treatment that is generally delivered with 10 individual sessions for adolescents, two with caregivers and two with adolescents and caregivers combined. The total duration of face-to-face contact required here is feasible in the Victorian youth AOD system as many clients maintain contact with services for long periods. However, unless clients are under involuntary orders, contact is often episodic at best and frequently sporadic. This means that it can be difficult to deliver a substantial number of sessions in a sequence over a period of 10 to 14 weeks. Introduction of stronger incentives for attendance could be beneficial (see Section 4.3.3).

SAMSHA in the United States has provided grants to services of $US60,000 over three years to support implementation of ACRA, which includes training and supervision of seven workers and purchase of an extensive range of resources from the program developers [6]. This level of technical support for implementation of a new Empirically Supported Treatment (EST) is unlikely to be available in the Victorian youth AOD system. Therefore, it would not be feasible for many services to implement the entire program.

However, senior youth AOD workers are already familiar with the principles of contingency management as applied to adolescents and are actively intervening to shape contingencies in the socio-ecological environments of young people. Most services also frequently use many of the core procedures of CRA articulated in the ACRA intervention (Dennis et al., 2004; Godley, Meyers et al., 2001). These include:

- Functional analysis to identify the antecedents and consequences of substance use and pro-social behaviours
- Identifying and reviewing clear, simple and obtainable goals
- Identifying and reinforcing pro-social behaviours that compete with substance use and other problem behaviours
- Relapse prevention skills training.

Relapse prevention skills training is routinely provided in residential services including short-term episodes of residential withdrawal/intensive residential support (up to two weeks) and long-term residential rehabilitation (up to six months). Identification and review of goals is formally built into routine care through reporting of Significant Treatment Goals. Much of the structure built into residential treatment settings is based on principles of contingency management, with the aim of encouraging pro-social behaviour and discouraging problem behaviours.

Although less formally structured, AOD workers regularly help young people explore the reasons why they use substances and the factors associated with episodes of problematic use. They consistently support young people to explore and engage with alternative pro-social activities and reinforce their participation. These latter two core components of CRA could be strengthened by more detailed articulation of CRA procedures, further training, and systematically incorporating CRA into supervision and reflective practice sessions.

Within outreach settings, additional organisational and resource supports would be needed to introduce incentive systems for engagement with services and to promote more regular attendance at structured programs. Ideally, these rewards should be tailored to individual needs and goals, consistent with the ACRA model in general. Flexible funding pools would be an appropriate mechanism.

Other key components of ACRA include communication skills training, problem-solving skills training and anger management. These procedures are drawn from Cognitive Behaviour Therapy, which is described in detail Section 4.4.

[6] http://www.chestnut.org/li/JTDC/JTDC_ACRAACC.html

Box 4.3: Elements of the Adolescent Community Reinforcement Approach that are readily applied in outreach and residential settings

- Functional analysis to identify the antecedents & consequences of substance use & other problem behaviours
- Functional analysis to identify the antecedents & consequences of desired alternative behaviours
- Caregiver rapport building & motivation
- Goal setting
- Review of goals
- Develop a schedule for contingency management
- Pro-social recreation planning/activity scheduling
- Systematic encouragement
- Recruit support people in the community to contribute to contingency management
- Implement or manage contingencies
- Regular evaluation or review
- Communication skills training
- Problem solving skills training
- Anger management
- Relapse prevention skills training

These 15 practice elements are described in detail in (Mitchell, in preparation).

4.4 Cognitive Behaviour Therapy

4.4.1 Cognitive Behaviour Therapy in brief

Cognitive Behaviour Therapy (CBT) is a diverse and complex collection of therapeutic ideas, methods and techniques. It is actually a synthesis of two forms of therapy that emerged from different theoretical traditions. Behaviour Therapy and Cognitive Therapy both continue to be practised separately and in combination, with either behavioural or cognitive techniques given differential emphasis depending on the problem, the person and the context.

CBT has been successfully applied in the treatment or management of a wide range of diagnostic conditions affecting children, adolescents and adults. For the purpose of this discussion the range includes substance use disorders, depression and anxiety (internalising) disorders, conduct (externalising) disorders, and post-traumatic stress disorder.

Several studies have also demonstrated the effectiveness of CBT-based treatments for clients experiencing AOD problems combined with these particular additional disorders (Macgowan & Engle, 2010). The wide applicability of CBT is perhaps partly because it possesses a large number and range of therapeutic techniques designed to target symptoms, symptom-clusters, or emotional-behavioural problems that are prevalent across these diagnostic categories.

To understand how and why CBT can be best applied in the youth AOD sector, it is useful to think in terms of how it applies to the management of emotional-behavioural problems that are not restricted to any particular 'diagnostic category', are interrelated, and are etiologically linked with a range of associated outcomes.

These include problems of addictive behaviours, substance use, anger and aggression, problems with adaptive coping that contribute to antisocial behaviour or social withdrawal, problems with affect regulation, and relationship problems.

Six main categories of CBT have been used to help clients change patterns of thinking and behaving that characterise these problems:

- Assertiveness training
- Anger and aggression control training
- Coping and problem-solving skills training
- Motivational enhancement
- Contingency management
- Emotion regulation.

This section considers the first three categories of CBT. Motivational enhancement and contingency management are addressed in sections 4.2 and 4.3 and emotion regulation in Section 4.6.

Many young people with AOD problems are likely to benefit from one or more of these types of CBT, depending on their developmental experiences, whether they have had sufficient opportunities to learn these particular skills, and how they understand their situation.

Many books, practitioner guides and manual-based treatment and prevention programs have been developed based on these CBT categories. These six types of CBT are closely related to one another and there is considerable overlap in their therapeutic content and techniques.

They essentially involve a 'mix and match' from a large pool of cognitive and behavioural techniques. For example, Bedell and Lennox have illustrated how most types of CBT can be broken down into four essential groups of techniques irrespective of the 'content' (i.e. the particular cognitive or behavioural skills to be learned) of the program. These four groups are:

- Instruction (including verbal description or explanation and modelling)
- Supervised practice (including rehearsal and role play)
- Feedback (including reinforcement and reflection on ways to improve)
- Independent practice in the real world.

Bedell and Lennox demonstrate how these techniques can be applied to the work of developing the cognitive and behavioural skills comprising effective communication and problem-solving, which includes self-awareness, other-awareness, making requests, responding to requests from others, assertiveness, and emotional regulation (Bedell & Lennox, 1997).

The three types of CBT outlined below complement one another. Anger and aggression control builds upon basic assertiveness skills, and problem-solving skills will enhance the ability to be assertive and to control anger and aggression, especially over the long term.

a. Assertiveness training. Effective assertiveness training interventions include the cognitive skills of learning to differentiate between assertiveness, aggression and passive behaviour, and the behavioural skills involved in communicating assertively (Bedell & Lennox, 1997).

Cognitive restructuring processes may also be evoked. Cognitive restructuring is a general term for several techniques designed to help the client to abandon unhelpful thinking patterns (e.g. excessive desire for approval, excessive self-criticism) and begin to think more constructively about situations, behaviours or personal characteristics that have caused difficulties (Thorpe & Olson, 1997). Cognitive restructuring involves exploring and challenging negative schemas that maintain passive behaviour and modelling and rehearsing positive self-statements [7] (Thorpe & Olson, 1997).

[7] Exploring and challenging negative schemas (or narratives), and rehearsing positive self-statements (or narratives) are examples of 'practice elements' (see Section 7.5) that are shared by Cognitive Therapy and Narrative Therapy.

b. Anger and aggression control training. Two main alternative CBT approaches have been used. In the *structured learning approach*, specific skills are taught through the behavioural techniques of modelling, role playing, performance feedback, and transfer of training (Merrell & Gimpel, 1998).

The *cognitive problem-solving approach* focuses more on changing thinking processes. Clients are taught cognitive skills to recognise how unhelpful thinking patterns contribute to anger, and how to generate coping self-statements to help deal with the perceived stressors and ward-off old responses, such as aggressive behaviour (Thorpe & Olson, 1997). This is sometimes known as stress inoculation training and can be applied to the management of various negative emotions, including anxiety (Thorpe & Olson, 1997).

c. Coping and problem-solving skills training. Problem-solving skills training involves a combination of cognitive and behavioural techniques aimed at:

- Recognising when a problem exists based on thinking, feeling and behavioural cues, and defining a problem in objective, non-judgmental and solvable terms
- Generating a set of alternative solutions
- Evaluating the solutions against a set of criteria for likely effectiveness
- Making a decision
- Implementing the solution
- Verifying the effect of the solution (Bedell & Lennox, 1997).

As with any form of cognitive and behavioural skills, Bedell and Lennox illustrate how these skills can be taught through the four sets of techniques involved in instruction, supervised practice, feedback and independent practice.

4.4.2 Theory and philosophy

Contemporary Behaviour Therapy is based within Social Learning Theory, which proposes that problem behaviours are essentially maladaptive patterns that have been learned through mechanisms such as classical and operant conditioning. Behaviour Therapy seeks to alter maladaptive patterns by helping the person learn new responses and new skills. Social Learning Theory also recognises a critical role for the social context or environment in both shaping behaviour and in providing standards or referents for how adaptive the behaviour is (Thorpe & Olson, 1997).

Cognitive Therapy is based within Cognitive Theory, which argues that excessively stressful states and painful emotional patterns such as depression, anxiety and anger are often maintained and exacerbated by exaggerated or biased ways of thinking. The role of the therapist is to help the person recognise unhelpful patterns of thinking and modify these through the application of evidence and reasoning (Leahy, 2003).

These theoretical insights and processes are integrated within Cognitive Behaviour Therapy (CBT), which proposes that thoughts, feelings and behaviours all work in concert with one another, usually in cycles. Painful emotional patterns and problematic behaviours are said to arise from, and be maintained by, combinations or cycles of particular thoughts, feelings and behaviours that are learned and which become entrenched over time if they are not corrected by alternative learning experiences[8]. The therapeutic purpose of CBT is to teach clients behaviours and cognitive skills to manage emotional distress and change unwanted patterns of behaviour (Scott, 2009).

a. Assertiveness skills training. Difficulties with assertiveness are theorised to stem from maladaptive cognitions such as excessive need for approval from others, beliefs that others will reject or abandon the person if she expresses disagreement or challenges the status quo, fears of being or appearing demanding or burdensome to others, and beliefs that one is unworthy. These cognitive distortions are thought to lead to pervasive fear and anxiety associated with authentic self-expression.

b. Anger and aggression control training. Children and adolescents with conduct disorders and other aggressive behaviour problems are thought to have deficiencies in perceiving and evaluating social cues, may fail to use relevant social cues, make negative or hostile attributions about the intent of others in ambiguous situations, generate fewer and less effective solutions to social problems, and expect rewards from aggressive behaviours (Merrell & Gimpel, 1998).

c. Coping and problem-solving skills training. Difficulties with coping and problem solving are thought to arise from both cognitive distortions and lack of opportunities to learn skills. Key cognitive distortions include a tendency to see problems as abnormal, bad and something to feel anxious and guilty about. Another is a tendency to see problems as overwhelming and unsolvable, leading to a tendency to give up.

The philosophy that underpins the CBT approach to problem solving is based on principles that challenge these distortions. Thus one principle is that 'problems are natural'. Another principle is that 'most problems can be solved', which counteracts the tendency to give up before attempting to solve problems. A principle to 'state what you can do, not what you can't do' acknowledges that efforts to simply stop certain behaviours (e.g. don't argue any more) often lead to further problems, such as a lot of uncomfortable silences, and encourages people to formulate positive creative actions instead[9]. In terms of behavioural learning, children who grow up in an environment where adults fail to model effective problem solving tend not acquire the necessary skills.

4.4.3 Relevance to client need and evidence for effectiveness

a. Assertiveness training. Assertive behaviour is the socially appropriate verbal and motor expression of any emotion other than anxiety (Thorpe & Olson, 1997). Assertiveness skills are widely recognised as very important to the ability of individuals to resist social pressure to misuse alcohol and other drugs. They are also necessary to negotiate access to most of the social and economic resources needed to maintain a healthy and productive lifestyle.

b. Anger and aggression control training. Many young people with AOD problems experience difficulties with anger and aggression. It is universally recognised that excessive alcohol consumption is associated with loss of inhibition and violent behaviour. Conversely, many individuals report using alcohol and other drugs to help alleviate the psychological discomfort associated with feelings of anger. Difficulties associated with regulating arousal may play a significant role in exacerbating problems in maintaining nurturing relationships and negotiating access to social and economic resources, such as health services.

Sukhodolsky and Ruchin (2006) include anger and aggression control training in their review of evidence-based psychosocial treatments for adolescents in the youth justice system. They observe that several research programs have demonstrated its effectiveness in reducing relatively mild forms of antisocial behaviour and improving psychosocial functioning (Sukhodolsky & Ruchin, 2006).

[8] These painful entrenched patterns could be understood as very similar or closely related to the concept of 'problem-saturated' and 'deficit-infused' narratives (see Section 4.7).

[9] These painful entrenched patterns could be understood as very similar or closely related to the concept of 'problem-saturated' and 'deficit-infused' narratives (see Section 4.7).

In their review of best practice for youth with AOD problems in the justice system, Schuetz and Berry (2009) report one study of an intervention combining anger control and interpersonal problem solving, which was found to be associated with higher reductions in recidivism (Landenberger & Lipsey, 2005; cited in Schuetz & Berry, 2009).

c. Coping and problem-solving skills training. In addition to social pressure to drink, which requires assertiveness skills to resist, and problems with anger and aggression, individuals seeking greater control over their AOD use experience a variety of other problems that can threaten their sobriety and ability to manage their life.

Some of the problems that frequently trigger relapse to problematic AOD use among young people include interpersonal conflict, difficulties at work, negotiating with service providers (particularly income support) and maintaining a functioning home or household. Experiences of strong emotions such as anger and anxiety could also be viewed as problems to be solved and amenable to similar problem-solving procedures.

Young people with behavioural health problems including AOD use have been identified as frequently lacking the cognitive capacity for effective problem-solving behaviour, including: sensitivity to interpersonal problems; the ability to choose the desired outcome of a social exchange (means-end thinking); the ability to anticipate and consider the likely outcomes of their actions (consequential thinking); and the ability to generate different ways to achieve the desired outcome (alternative thinking) (Hollin, 1998).

Sukhodolsky and Ruchin (2006) observe that several controlled studies, including one of adolescents in detention, have demonstrated the efficacy of problem-solving skills training in teaching these types of skills and reducing relatively mild forms of antisocial behaviour. Hollin (1998) also observes that several studies provide evidence that social problem-solving skills training can lead young offenders to generate more solutions to social problems.

4.4.4 Articulation with characteristics of effective services and programs

Behavioural, experiential and skill-focused √

Use of theory and evidence √

CBT is an essential component of any multidimensional treatment package if it to realise the characteristics of being 'behavioural, experiential and skill-focused' and 'use of theory and evidence'. Clear advantages have been observed for behavioural over non-behavioural methods in treatment of AOD and other psychosocial problems of children and adolescents (Chorpita, Daleiden, & Weisz, 2005a).

4.4.5 Limitations of Cognitive Behaviour Therapy

Skills-based CBT – such as assertiveness training, anger and aggression control training and problem-solving skills training – is a highly focused and highly structured form of intervention (Hollin, 1998). The high level of structure means that such programs are very difficult to deliver effectively if adolescents are not already highly motivated and engaged in treatment.

The specific focus means that they are not comprehensive treatments in themselves; rather, they concentrate with precision upon the development of particular skills. CBT is also a highly demanding form of intervention, with effectiveness often depending on the client completing homework or practising elements between sessions (Scott, 2009).

Scott observes that clients will not participate in the necessary practice between sessions if they have low self-efficacy (i.e. if they believe either that the tasks will make no difference or that they do not have the capacity to perform them). Many adolescents will require additional support and encouragement to practise newly learned skills.

Skills-based CBT interventions generally do not include an engagement or motivational component. This means that CBT interventions cannot suffice – in themselves – as treatments for AOD problems among adolescents, particularly those with complex issues. Several advocates have observed that CBT interventions are most effective when they are delivered as components of multimodal (Hollin, 1998) or multidimensional (Thorpe & Olson, 1997) treatment packages.

4.4.6 Application to outreach and residential settings

Residential AOD settings are particularly well suited to the implementation of CBT. Indeed, for clients with complex needs there are several advantages offered by residential settings. First, residential workers have the opportunity to directly observe young people's behaviour intensively in a variety of interactive social situations. Second, workers can provide instruction and feedback in real time as young people struggle to change unwanted patterns of thinking and behaving and practise new skills.

Behavioural assessment to inform design of a tailored skills training package ideally begins with a detailed examination of environmental influences on the client's behaviour (Thorpe & Olson, 1997). This includes conditioning and learning phenomena such as behavioural contingencies, reinforcers, stimulus pairings operating in the client's daily environment, and their responsiveness to such events.

In office-based CBT, guided by theory, the therapist inquires about the situations in which the problem behaviour occurs, about possible pairings of stimuli within those situations, and about the possible reinforcing or punishing consequences of the problem behaviour (Thorpe & Olson, 1997).

In residential environments, this detailed verbal inquiry can be supplemented with direct observation. This is likely to be particularly helpful for adolescents who are not yet clear about which behaviours they want to change, or who have limited insight into the environmental factors that affect candidate traits for behaviour change.

Direct observation in a variety of situations is also virtually essential for clarifying questions about the primary causes or relative contributions of factors that have important implications for intervention. For example, failure to 'perform' or 'demonstrate' competency in social situations or to solve problems or cope with difficulties might be explained in terms of a skill deficit model (based on the idea that the requisite social skills have never been learned) or a competing emotions model (based on the idea that the skill is in the person's repertoire but he or she does not demonstrate it adequately because of emotional states and negative thought patterns that inhibit it).

In reality, these two types of problematic mechanisms are often intertwined and quite difficult to separate (Merrell & Gimpel, 1998). However, by carefully observing and evaluating an adolescent's social behaviour, combined with timely questioning to assess their emotional and cognitive states at the time, it may be possible to determine which type of process is most important (Merrell & Gimpel, 1998) or which is dominant for particular skills and in particular contexts.

If competing emotions are a dominant factor in suppressing particular behaviours, a strong focus on teaching new skills is unlikely to be the most productive approach. In this case CBT would most profitably focus on emotion regulation.

Residential settings also provide opportunities for practitioners to organise supervised practice and graduated, real-life practice of new or alternative behaviours in relatively or fully natural social settings. Groups can be readily constructed to provide dynamic social interactions for young people.

A potential limitation of residential settings is that there are many and varied activities taking place. The capacity of a particular worker to focus on the cognitive-behavioural learning tasks of a particular young person may be limited. On the other hand, the social demands of living harmoniously in a residential AOD treatment facility require that young people demonstrate or learn a range of social problem-solving skills. All residential workers who spend time with the young person have the opportunity to observe and assess their needs directly.

These imperatives focus attention upon the social and problem-solving skills that young people need to develop. Many residential youth AOD workers are likely to be practising essential CBT techniques to some extent. Practice development efforts aimed at identifying areas of strength and introducing and refining additional CBT techniques could be highly cost-effective.

Several of the benefits of residential settings for the planning and delivery of CBT also apply in outreach settings. Outreach provides opportunities to observe young people's behaviour in many and varied situations and contexts. Workers can promptly communicate observations to young people, teach new skills in real-life contexts, and provide on-the-spot reinforcement when desired behaviours are demonstrated.

Outreach applied as aftercare following a residential stay can be particularly beneficial, enabling the client to practise in a series of real-life situations that gradually become more challenging.

Box 4.4: Elements of Cognitive Behaviour Therapy that are readily applied in residential and outreach settings

Technique elements

- Instruction (e.g. explanation, modelling)
- Supervised practice (e.g. rehearsal, role play)
- Feedback (e.g. reflection, reinforcement, challenge)
- Independent practice in the real world

Assertiveness training

- Self-awareness
- Other awareness
- Organise and process information to plan goal-directed expression
- Articulate goal-directed expressions in a clear and understandable way

Anger and aggression control training

- Recognising anger
- Identifying the antecedents and consequences of anger and aggression
- Taking time to 'cool down'
- Fostering empathy

Coping and problem-solving skills training

- Recognising a problem
- Defining a problem
- Generating alternative solutions
- Deciding on one solution
- Trying out the chosen solution
- Evaluating the outcome

These 18 practice elements are described in detail in (Mitchell, in preparation).

4.5 Multidimensional Family Therapy

4.5.1 Multidimensional Family Therapy in brief

Multidimensional Family Therapy (MDFT) is an integrated treatment system that was developed specifically for adolescents with substance use problems and related behavioural or emotional difficulties. It is multidimensional in the sense that it targets multiple domains of adolescent development in which the precursors of substance use and related problems develop and operate. MDFT is also an integrated treatment system in that interventions in these different domains are planned and coordinated.

The overarching goal of MDFT is to "alter the developmental trajectory of the adolescent and his or her social context in a way that establishes healthy and pro-social socialisation and development" (Liddle, 1999; p528). All other objectives specific to particular domains are secondary to this primary goal.

The family system (encompassing its interactional patterns) is one of four domains targeted in MDFT. The other three are the individual adolescent, parent(s) and other individual family members, and extra-familial systems (Liddle, 1999). The adolescent is addressed as an individual, a member of a family, and a member of a peer network (Liddle, 2010). Interventions target both intra-personal and interpersonal or relational issues (Rowe, 2010).

For parents and other key family members, MDFT addresses their functioning as individuals and in their parenting role (Rowe, 2010), including personal mental health, alcohol and drug use issues (Liddle, 1999), and parenting skills and practices. With the family system, MDFT focuses on the family environment and family relationships manifested as day-to-day transactional patterns (Liddle, 2010). Other family members such as siblings, extended family members or adult friends can also be important in family transactions and the change process, and therefore may be included in assessment and family interventions (Liddle, 2010).

A fourth domain of operation is extra-familial systems such as peer groups, school, the youth justice system, and other service organisations that are actual or potential sources of influence upon the youth and their family (Liddle, 1999, 2010; Rowe, 2010). Re-establishing a young person's connection with some aspect of school, work or pro-social recreation are integral aspects of the MDFT treatment system (Liddle, 1999).

4.5.2 Theory and philosophy

MDFT combines aspects of several theoretical frameworks for understanding adolescent development and the development of substance use problems. These include Family Systems Theory, ecologically oriented developmental psychology, developmental psychopathology, and the risk and protective factor model (Austin, Macgowan, & Wagner, 2005; Liddle, 1999). Developmental Theory is particularly important as an integrating theme and as a theory of change.

Drug use and other related problem behaviours are defined as problems of development. Interventions are considered effective when they contribute to shifting or resolving these developmental problems (Liddle, 2010). Shifts may come about when interventions create everyday outcomes that are incompatible with previous ways of moving through life or when new competencies emerge, assisting progress towards previously compromised developmental tasks (Liddle, 2010).

The ecological orientation is evident in the recognition that problems appear because of risk and protective factors emerging from and interacting among multiple systems, including the individual, parents, family interactions, and extra-familial systems. Consistent with contemporary Developmental Systems Theory (see Section 2.1.4), these systems are interconnected and mutually influential 'nested structures' (Liddle, 1999).

This ecological orientation underpins recognition of the need for interventions to address these systems simultaneously or in a highly coordinated fashion. The challenge for the practitioner is to understand the working of each system level or domain as both a whole in itself and as a part of a larger ecology (Liddle, 1999).

The risk and protective factor framework is particularly important as a guide for assessment and individualised treatment planning. Interventions are chosen to focus on the risk and protective factors that are most relevant in the ecology of the adolescent and their family (Liddle, 1999). This perspective is highly consistent with the framework for resilience-based intervention described in Section 6 of this resource.

4.5.3 Relevance to client need and evidence for effectiveness

MDFT is one of the most heavily researched treatment programs for substance use problems among adolescents. At least 10 completed randomised controlled trials have tested MDFT against a variety of comparison adolescent drug abuse therapies. MDFT has demonstrated superior outcomes to several other state-of-the-art, active treatments (Liddle, 2010; p142).

A particularly important feature of the evidence base is that study participants have not been narrowly defined, rarefied research samples. Participants have been active drug users and have generally experienced comorbidity and justice system involvement (Liddle, 2010). They have come from a variety of different ethnic groups. Significantly, MDFT appears to have superior outcomes compared with CBT for youth who experience more severe drug use problems and more comorbidity (Liddle, 2010; Rowe, 2010).

Reviews of the evidence for MDFT have found positive outcomes in several different domains including: treatment engagement and retention; levels of substance use; substance abuse-related problems such as antisocial, delinquent and externalising behaviours; school functioning; psychiatric symptoms; association with delinquent peers; and family functioning (Liddle, 2010; p144).

These findings strongly suggest that MDFT is likely to be effective for the highly complex population of young people using youth-specific AOD services in Victoria.

The fact that MDFT is an integrated treatment system is important in the Victorian context. Its consistent effectiveness compared with other interventions, particularly for clients with complex needs, may be in large part due to its multiple dimensions and the integration of its various components (Rowe, 2010). For example, family therapy (which is used to address family transactional patterns) and behaviour therapy (which is used to teach adolescents and parents new skills) are not delivered in isolation. Rather, interventions from family therapy and behaviour therapy are delivered as and when needed to complement and reinforce each other. Rowe (2010) notes that one of the reasons why MDFT may be so successful is that it addresses common root factors underlying a range of emotional and behavioural problems that co-occur with substance misuse.

MDFT is inherently flexible; as a treatment system that combines or supports multiple interventions. Various interventions can be added as needed, enhancing, and being enhanced by, the treatment system. For example, Rowe (2010) reports an RCT where an HIV/STD prevention intervention for juvenile detainees was added into MDFT and found to be significantly more effective in reducing unprotected sex acts than an alternative, high-quality standard HIV prevention program. Ideas from narrative therapy are also being incorporated into the work, with therapists drawing out the young person's "life story" early in individual sessions. Liddle (2010) notes that this is an important assessment and engagement strategy.

The Family Therapy component of MDFT is substantially important in its own right. The other therapeutic interventions described in Section 4 address two of

the four key domains of adolescent development (individual and extra-familial systems) and most of the other purposes targeted by MDFT. Without the Family Therapy component of MDFT, the purpose of strengthening and restructuring relationships would be inadequately addressed. While Narrative Therapy and Solution Focused Therapy come from the Family Therapy tradition and can be applied with the aim of improving relationships, they are used in youth AOD services primarily in work with individuals. Dialectical Behaviour Therapy also aims to restructure relationships, but its focus of direct action is the relationship between the young person and the therapist. Family Therapy that works directly in the domains of parents and family systems is an important complement to these other therapies.

4.5.4 Articulation with characteristics of effective services and programs

Individualised and socio-culturally relevant √
Focus on relationships √
Developmentally appropriate √
Engagement and retention strategies √
Behavioural, experiential and skill-focused √
Multisystemic and integrative √
Family involvement √
Use of theory and evidence √

Multidimensional Family Therapy attends directly to most of the ten characteristics of effective services and programs described in Section 3. Its most obvious strengths in being **multisystemic and integrative** have already been noted. MDFT intentionally attends to a broad range of risk and protective factors in four domains so as to ensure that all major contributors to problems are targeted. MDFT also mobilises and actively coordinates the efforts of many different systems affecting the young person's life (Rowe, 2010).

Use of theory and evidence to guide program design and refinement has been a strong feature in the literature on MDFT. Liddle (1999) provides a detailed exposition of how its theoretical base has expanded over a 20-year period and how developments in various fields such as Family Systems Theory and developmental psychology have informed clinical refinements in the model.

With developmental psychology as a theoretical cornerstone, substance use problems understood as problems of development, and the goals of therapy essentially being to help adolescents and families to get back onto adaptive developmental pathways, MDFT is well positioned to deliver **developmentally appropriate** interventions.

While the interventions incorporated into MDFT have generic or universal aspects, there is a strong emphasis on **individualising** them to each person and situation and ensuring that they are **socio-culturally relevant**. The family's background, history, interactional style, culture, language and experiences are dimensions on which interventions are customised (Liddle, 2010; p135).

Attention to individual circumstances is likely to be essential to ensuring that interventions are geared to the unique developmental challenges facing each adolescent and family at the time they come to therapy. Austin et al. (2005) note further that **individualisation** may extend to the development of personal treatment objectives for each member of the family.

Proponents of MDFT frequently discuss the importance of building **therapeutic relationships**. The first stage of MDFT – engagement – focuses primarily on the formation of therapeutic alliances (Austin et al., 2005). Therapists are expected to create individual working relationships with the adolescent, the subsystem of the individual parent(s) or caregiver(s), and individuals outside of the family who are or should be involved with the youth (Liddle, 2010; p135). Strong therapeutic alliances are viewed as creating a foundation for change.

MDFT has demonstrated considerable success in retaining adolescents in treatment. A recent study with a sample of youth who began MDFT while in detention and continued as outpatients after release retained 87 per cent of this sample in treatment for at least three months post-detention, compared with 13 per cent in the services-as-usual condition (Liddle, 2010). The high retention rate was consistent with previous studies.

Finally, MDFT is behavioural, experiential and skill focused in its therapeutic orientation. Teaching and coaching in problem-solving, decision-making and parenting skills are a major focus of MDFT's second phase (Austin et al., 2005). A key technique of MDFT from Structural Family Therapy, called 'enactment', is highly experiential. Enactment is both a clinical method and a set of ideas about how change occurs. As a clinical technique, it involves uncovering issues that are important in the everyday life of the family and training family members to discuss and try to solve these problems in new ways. The method actively guides, coaches and shapes increasingly positive and constructive family interactions (Liddle, 2010; p139).

4.5.5 Limitations of Multidimensional Family Therapy

Family Therapy that directly targets parents and family systems is not feasible for all clients. For adolescents with substance use problems combined with other complex needs, family systems have often been so severely damaged that either the adolescent or the parent(s) are unwilling to take part in therapy that involves direct interaction. In these situations, Narrative Therapy and Dialectical Behaviour Therapy are valuable alternatives that work directly with the adolescent to change their perceptions, build skills, and alter patterns of relating.

One of the key strengths of MDFT – its multisystemic and integrated characteristics – also produces one of its key limitations. An important mechanism for integrating the various components (particularly the individual, parent and family therapy) is that a single therapist is responsible for delivering them. This enables a wealth of therapeutic insights to be communicated between contexts and brought into the work with other family members.

This requirement poses a significant barrier to the implementation of MDFT in service settings that lack the resources to employ practitioners who are qualified in individual and family therapy. The developers of MDFT do not condone separation of the delivery of individual, parent and family therapy components between different therapists (Dakoff, G., 8 July 2010; personal communication).

Few adolescent AOD services are in a position to offer single-therapist delivery. Unless resources can be obtained to employ and support (e.g. supervise) such highly qualified family therapists, the best that could be done is to provide individual adolescent and extra-familial interventions, and to supplement these with parent and family therapy sourced separately from specialist family therapy services.

4.5.6 Application to outreach and other settings

MDFT is an outpatient program that can be delivered at home or in the community. While much of the work involves appointment-based sessions with families, therapists also work flexibly with each adolescent. Sessions can involve diverse activities such as going to a café, the movies, or a guided tour of the teen's neighbourhood (Liddle, 1999).

The first phase of MDFT – engagement – is particularly suited to outreach. Engagement is a traditional role that outreach was largely designed to perform. Outreach workers are ideally placed to make initial contact and then to visit young people, family members and individuals in extra-familial systems in the natural environments in which they interact. They build relationships and collect a diverse range of information that can contribute to comprehensive assessment.

The outreach modality is also being used in MDFT to engage and begin treatment for adolescents in youth detention (Liddle, 2010). It would theoretically be appropriate for delivery of counselling and behavioural change interventions in a variety of settings such as home, school or detention.

The outreach modality is also ideally suited to the MDFT component that focuses on the extra-familial systems domain. This essentially involves helping the young person and/or the parent(s) to contact and develop productive relationships with individuals who control access to the social and economic resources the young person needs if they are to shift to and stay on a pro-social developmental pathway. This is the traditional domain of social-ecological case work (Ungar, 2011) that is already strongly embedded in youth AOD services in Victoria.

It would be a major challenge to incorporate intensive family therapy interventions into outreach service components of Victorian youth AOD services. The vast majority of outreach workers have no formal training in family therapy and relatively few would be in a position to acquire such qualifications.

Box 4.5: Elements of Multidimensional Family Therapy that are readily applied in outreach settings

- Engaging the adolescent in AOD treatment including family therapy
- Engaging parent(s) & other family members in family therapy
- Preliminary assessment of family transactions & readiness for family therapy
- Social-ecological casework aimed at linking the adolescent & family members with social & economic resources

MDFT also involves a substantial component of office-based therapeutic intervention. To integrate this into youth AOD services in Victoria, ways would need to be found to support more office-based work. The AOD service structure is based primarily upon outreach and residential modalities. To fully implement MDFT, these modalities would need to be supplemented with more appointment and office-based time and space.

MDFT has been integrated successfully into a day treatment program for adolescent drug abusers. Evaluation showed high fidelity (Liddle et al., 2006). In Victoria, appointment- and office-based primary health care has been successfully incorporated into residential and day program facilities. This suggests that MDFT (and other therapy) sessions could be similarly supported within present infrastructure.

Implementation of the parent and family-focused therapeutic components of MDFT would require the employment of qualified family therapists within youth AOD services (see *Limitations of MDFT* in Section 4.5.5). Alternatively, family therapy services might be extended to include outreach-based engagement and case work or linked with extra-familial resources, as well as individual therapy for adolescents. The configuration of family therapy services in Victoria at present is not amenable to these modalities. Options that rely upon a single therapist would be very costly to implement widely in Victoria because of the substantial start-up costs for infrastructure and workforce deployment.

An alternative approach, which would be more economically feasible in the current environment, is a collaborative program that coordinates outreach and day program youth AOD services with office-based family therapy services. However, the therapy delivered by this model could not be called Multidimensional Family Therapy because the individual, parent, and family components would not be delivered by the same therapist.

4.6 Dialectical Behaviour Therapy

4.6.1 Dialectical Behaviour Therapy in brief

Dialectical Behaviour Therapy (DBT) was originally developed as a comprehensive treatment for adult women with borderline personality disorder (BPD), particularly those with persistent suicidal behaviour and ideation. At least seven RCTs across four independent research groups have established the efficacy of DBT in the treatment of BPD, including reductions in suicidal behaviour and various other outcome measures (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006; McMain, 2007). It is recognised as an empirically supported treatment for such by the American Psychological Association.

The adult version of DBT is a substantial treatment package involving four modalities: weekly individual psychotherapy; weekly group skills training; telephone coaching between sessions when needed; and a therapist consultation team meeting (McMain & Korman, 2001; Robins & Chapman, 2004). Therapy usually extends over 12 months.

The skills are taught in four modules: mindfulness, interpersonal effectiveness, emotion-regulation and distress tolerance. Telephone consultation is provided between sessions as needed to improve implementation and generalisation of skills in daily living. Clients are also encouraged to telephone therapists as a means of reducing suicidal crises (Lynch et al., 2006).

Individual psychotherapy includes supportive counselling and therapy focusing on the client's personal experiences of dysregulated emotions, behavioural responses and crises. A mix of acceptance and change-focused strategies is used (see Section 4.6.2).

The standard version of DBT for adults has been modified slightly for application with BPD women with substance misuse problems. The key changes include: incorporation of engagement and retention strategies; case-management for women experiencing serious difficulties with housing, finances, legal matters, abusive relationships, etc.; and additional training in life management skills such as structuring free time, getting and maintaining work, developing adaptive social relationships, and reducing drug-related cues in the environment (Robins & Chapman, 2004).

A randomised controlled trial using this model found that treatment engagement over 12 months was significantly better in the DBT condition, and that DBT clients had significantly greater decreases in a range of impulse control behaviours including substance misuse, binge eating, gambling and reckless driving (Robins & Chapman, 2004). A more recent review has confirmed the effectiveness of DBT in the treatment of co-occurring BPD and substance use disorders (Pennay et al., 2011). Several studies have demonstrated the effectiveness of DBT among other complex populations including clients with: co-occurring BPD and eating disorders; BPD and post-traumatic stress disorder, and adolescents with symptoms of BPD combined with persistent suicidality (Pennay et al., 2011).

Various modifications have been made to DBT for use with adolescents. Early in its history, the program was shortened from 12 months to 15 weeks, a family therapy component was added, and the adult skill development lessons were simplified and adapted to fit the developmental needs and interests of adolescents (Miller, Rathus, Linehan, Wetzler, & Leigh, 1997).

The family therapy component is very similar to the standard DBT content of mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance. Unless clinically inappropriate, at least one caregiver is asked to commit to 15 weeks of skills training. A key aim of including parents or caregivers is to help them coach their adolescent and to improve their own skills in interacting with adolescents.

4.6.2 Theory and philosophy

A fundamental tenet of DBT is that the core dysfunction in BPD involves problems with emotional regulation. Symptoms reflecting the dysregulated emotional response are the diagnostic criteria for BPD and they include affective lability, chronic feelings of emptiness, and intense and under-controlled anger (McMain & Korman, 2001). The extreme problematic and impulsive behaviours that are common to this population (e.g. suicide, self mutilation without intent to die, substance abuse) are viewed as consequences of, or attempts to control, strong negative moods (McMain & Korman, 2001).

Emotional dysregulation is theorised to develop through the transaction between a biological vulnerability and exposures to aversive social or environmental conditions. A biological vulnerability is thought to exist in parts of the central nervous system responsible for the experience and regulation of emotion, possibly due to genetics, events during foetal development or early-life trauma.

The environmental factor is thought to be a pervasively invalidating environment in which the patient's behaviour or reports of their thoughts or feelings are frequently met with responses that suggest they are invalid, faulty or inappropriate, or in which the ease of solving life problems is oversimplified (Robins & Chapman, 2004). This type of environment inhibits the development of healthy emotional regulation because accurate identification and assessment of emotional responses, one's own and others', is central to the regulation process (McMain & Korman, 2001).

The biologically based emotional vulnerability is thought to manifest initially in high sensitivity to emotional stimuli, emotional intensity, and slow return to emotional baseline. Over time these responses are met with dismissal, trivialisation, criticism or punishment, as well as intermittent reinforcement. Therefore, the emotional responses are sometimes intensified, sometimes suppressed, contributing the pattern of self-invalidation, difficulty identifying emotions, and oscillation between extreme expression of emotion versus suppression or numbing so often seen in BPD (McMain & Korman, 2001; Robins & Chapman, 2004). The child fails to learn effective strategies to manage his or her emotions.

A subtle but important elaboration of this theory outlined by the developer of DBT – Marsha Linehan – and emphasised by other writers is that the most problematic dysfunction in BPD is not an excessive intensity of emotional responses, but the fact that BPD individuals experience a breakdown of their cognitive, behavioural and emotional systems when they experience intense emotions (Lynch et al., 2006).

It is the breakdown of these systems, and ineffective attempts to regain control, that lead to the most extreme and dysfunctional behaviours such as suicide, self harm, substance misuse, other self-injurious behaviours, aggression and violence (McMain & Korman, 2001). Therefore, patient change in DBT is conceptualised primarily as helping the client to engage in functional, life-enhancing behaviour, even when intense emotions are present.

Dialectical Behaviour Therapy involves a combination of, and a dialectic between, two complementary therapeutic component processes. The first involves radical acceptance or validation of the person and her experience, while the second involves change-oriented strategies aimed at developing the skills to manage emotions. Focusing too early on change is thought to repeat the invalidating environment of the individual's early experience (Thorpe & Olson, 1997).

Validation involves being awake to, accurately reflecting, and conveying acceptance of the patient's behaviour, thoughts or feelings. It also involves interacting with the client in a genuine manner (Lynch et al., 2006). The acceptance component draws primarily from client-centred and emotion-focused therapeutic traditions, as well as acceptance-based practices of Buddhism and other contemplative spiritual traditions (McMain & Korman, 2001; Robins & Chapman, 2004).

Change strategies are grounded in Cognitive Behaviour Therapy and involve skills in problem-solving (Thorpe & Olson, 1997), interpersonal effectiveness (Nelson-Gray et al., 2006), and emotion regulation (Nelson-Gray et al., 2006). All of the various therapeutic strategies and techniques centre around the processes of acceptance / validation or change / skill development, but all are ultimately intended to help the person regulate emotion or reduce "ineffective action tendencies linked with dysregulated emotion" (Lynch et al., 2006; p459) and replace these with behaviours that promote well-being.

4.6.3 Relevance to client need and evidence for effectiveness

While it is often inappropriate to diagnose adolescents with BPD, many adolescents with substance use problems demonstrate emotional and behavioural patterns consistent with BPD as specified in DSM-IV (Woodberry & Popenoe, 2008). Epidemiological studies have also demonstrated reliable associations between meeting diagnostic criteria for BPD in early adolescence and development of substance use disorders (SUDs) in later adolescence and adulthood (Cohen, Chen, Crawford, Brook, & Gordon, 2007), even after controlling for other SUD risk factors such as parental substance abuse and conduct disorder.

For some young people, particularly those with more severe and chronic difficulties, substance abuse can be usefully understood as just one of a range of impulsive, high-risk behaviours that they demonstrate. Others include suicide attempts, self-harm, high-risk sexual behaviour, eating disorders, conduct disorders, outbursts of aggression and violence, and other types of offending behaviour. For these reasons, combined with the paucity of effective treatments for these adolescents, several research groups have proposed DBT as a highly promising treatment candidate for these adolescents (Hawkins, 2009; Miller et al., 1997; Nelson-Gray et al., 2006; Trupin, Stewart, Beach, & Boesky, 2002; Woodberry & Popenoe, 2008).

Several studies examining the effectiveness of DBT modified for adolescents have been reported and reviewed in the literature (Woodberry & Popenoe, 2008). All but the most recent of these have been based on very small samples, but despite this have consistently found positive results for DBT. In three studies, advantages for DBT were found over a control group.

One of these studies by Rathus and Miller (2002) used a quasi-experimental study design comparing 12 weeks of DBT (n=29) to 12 weeks of treatment as usual (TAU) consisting of supportive psychodynamic individual therapy (n=82). Both conditions involved twice-weekly sessions for the adolescent and weekly family therapy. Even though the DBT group had more severe pre-treatment symptoms, during treatment this group had significantly fewer psychiatric hospitalisations (0% compared with 13%) and a significantly higher rate of treatment completion (63% compared with 40%). A smaller percentage of DBT clients made suicide attempts (3.4%, n=1) than in the TAU group (8.6%, n=7) but this difference was not significant. Within the DBT group there were significant pre-post treatment reductions in suicidal ideation, general psychiatric symptoms and symptoms of BPD. Given the small sample size, these effects can be considered particularly robust (Rathus & Miller, 2002).

Another small, quasi-experimental pilot studied the feasibility of implementing DBT in an adolescent psychiatric inpatient unit (Katz, Cox, Gunasekara, & Miller, 2004). Based on bed availability at the time, adolescents presenting for suicide attempts or ideation were admitted to a unit that was implementing a DBT protocol (n=26) or a unit that was using treatment as usual (TAU) (n=27). The mean length of stay in hospital was 18 days and the DBT program ran for two weeks. Focused sessions comprised 10 daily DBT skills training sessions and twice-weekly individual DBT psychotherapy. There was also a DBT milieu on the ward with DBT-trained nursing staff to facilitate generalisation of skills. The TAU condition consisted of daily psychodynamic group therapy, individual psychodynamic therapy at least once a week, as well as a psychodynamic milieu.

In the DBT condition there were significantly fewer behavioural incidents on the ward during admission. At one-year follow-up both groups demonstrated highly significant reductions in parasuicidal behaviour, depressive symptoms and suicidal ideation, and there were no differences between the groups (Katz et al., 2004).

A partially controlled study of DBT for female adolescent offenders compared changes in problem behaviours and staff behaviours in different units at a detention centre that received different amounts of training in DBT (Trupin et al., 2002). In a mental health unit where staff received 80 hours of DBT training, there was a significant reduction in problem behaviours during the 10 months of the DBT study. In comparison, there was no significant reduction in problem behaviours on a general population unit where staff received only 16 hours of DBT training (Trupin et al., 2002). While the study was poorly controlled, the result within the mental health unit is impressive considering that the treatment program itself was implemented for only four weeks.

DBT has also been tested for Oppositional Defiant Disorder in a small pre/post trial conducted in an outpatient setting (Nelson-Gray et al., 2006). The study began with 54 youths, of which 32 completed 12 of the 16 sessions. Of these 32, 34% also met criteria for conduct disorder, 31% met criteria for ADHD and 8% met criteria for depression. Six of the 11 outcome measures showed statistically significant improvements. Caregivers' reports of their adolescent's ODD symptoms and externalising symptoms reduced, while their reports of interpersonal strength increased. The youth themselves reported significant reductions in internalising symptoms and in depression, and in the total Achenbach Youth Self Report score (Nelson-Gray et al., 2006).

Woodberry and Popenoe (2008) conducted a small, uncontrolled, pre/post trial implementing DBT with adolescents in a community outpatient setting. Initial participants were 45 adolescents aged 13 to 18 years who showed behavioural patterns similar to those of adults with BPD, including suicidality and self-injury. They were recruited from various sources by advertising in services. Treatment was for 15 weeks. Complete data were collected from 28 (61%) of the adolescents and only 19 (41%) of both the adolescents and parents. Significant change was found across multiple areas of functioning including suicidal and life-threatening behaviours, behaviours that interfere with therapy, and a range of symptom areas – reported anger, depression, depression/anxiety, dissociative symptoms, impulsive/addictive behaviour, and overall symptoms. There

were improvements in daily living skills, functional impairment, role functioning, and functioning in relationships. Parent data (n=19) generally corroborate the improvements reported by adolescents and also suggest that parents themselves may have benefited from inclusion in the DBT skills training (Woodberry & Popenoe, 2008).

An even smaller uncontrolled trial based in a community setting examined the effectiveness of DBT in treating persistent deliberate self harm (DSH) in adolescent females (James, Taylor, Winmill, & Alfoadari, 2008). Sixteen clients aged 15 to 18 years were recruited from referrals to a specialist DBT clinic in Oxfordshire England. All had 18 to 24 month histories of DSH and had not responded to other psychiatric treatments including medication. All would have qualified for a diagnosis of BPD if they had been over 18 years of age. The study focused on Stage 1 DBT only, which aims to stabilise the patient and achieve behavioural control. Treatment was provided over a period of 12 months. There were marked and significant reductions in self reported depression scores, hopelessness, episodes of DSH, and an increase in general functioning (James et al., 2008).

Finally, McDonell et al. (2010) report results from a pilot study examining outcomes for multi-problem youths admitted to a long-stay inpatient psychiatric unit. The 106 youths allocated to the DBT condition were admitted between 2000 and 2005, and these were compared with a group of 104 historical controls admitted between 1995 and 1999. The youths in the DBT condition experienced multiple problems, including: a history of suicidality (73%); being wards of the state (34%); a history of child protection involvement (66%); sexual abuse (52%); and juvenile justice system involvement (68%). In comparison to the controls, the DBT group demonstrated greater reductions in non-suicidal self-injurious behaviour (NSIB) in a group of youth with the most severe histories of such. The clients who received DBT experienced statistically significant improvements across time in global functioning and reductions in prescribed medications (McDonell et al., 2010). Control data were not available for these outcomes.

An important feature of this study was that the intensity of the DBT intervention was scaled to the particular needs of the adolescent based on clinical judgment. The most severe group (mostly females with persistent NSIB and high rates of PTSD, sexual abuse histories, and cluster B personality disorder traits) received full DBT including skills group, individual psychotherapy and DBT milieu on the ward. The least severe (psychotic illness or developmental disability) received only the milieu, and a middle group (mostly males with externalising disorders) received milieu and skills group, but no individual therapy.

While results from a large-scale randomised controlled trial are yet to be published, the results from these early studies trialling DBT with adolescents suggest that it is a particularly promising intervention. It has potential to reduce impulsive, high-risk behaviours strongly associated with substance use problems such as suicidality, self-harm and externalising behaviours, as well as improving social and role functioning (Hawkins, 2009; Woodberry & Popenoe, 2008). To the extent that substance abuse and misuse involve problems of impulse control or emerge as consequences of emotional dysregulation, DBT can also be expected to be effective in reducing substance abuse and misuse in adolescents as well as in adults.

Hawkins (2009) identifies DBT as a very promising model for the treatment of co-occurring substance abuse and mental health disorders affecting adolescents, one that merits further research. A notable merit of DBT research identified by Hawkins is that it has often deliberately sought out adolescents with severe symptoms and high levels of comorbidity – clients that are often excluded from other clinical studies.

4.6.4 Articulation with characteristics of effective services and programs

Client centred √
Relationship-based √
Developmentally appropriate √
Engagement and retention strategies √
Sufficient duration and intensity √
Behavioural, experiential and skills-focused √
Multisystemic and integrative √
Use of theory and evidence √

Dialectical Behaviour Therapy is highly consistent with most of the characteristics of effective programs and services, especially for young people with multiple and complex needs. Most notably, the therapy design is closely linked to theory about the etiology and maintenance of the problems that it targets. The targeted problems are tightly specified and each of the treatment components is logically connected to specific etiological processes. The empirical evidence for DBT is substantial and expanding. As would be expected from its roots in CBT, DBT has a strong focus on skill development.

Another fundamental feature that fits with the characteristics of effective programs is its substantial duration and intensity. The adult version extends for 6 or 12 months and involves at least two face-to-face sessions per week, with telephone contact between

sessions as needed. For adolescents, DBT has been shortened to 12 to 16 weeks, a more realistic length for adolescent commitment. While the research base is still small, this length of treatment appears to be sufficient to achieve significant improvements. Any shorter than this appears to diminish effectiveness or narrow the range of positive outcomes. More research is needed to clarify the types and extent of outcomes that can be expected after shorter versus longer durations of DBT treatment.

Although it was not originally developed specifically for adolescents with substance use problems, the modifications as described in various studies have been informed by theory and research about characteristics thought to be instrumental to effectiveness of treatment programs for young people with behavioural health problems, including substance use.

Materials have been modified to be developmentally appropriate, engagement and retention strategies and case management have been added, and family involvement has been incorporated in a form that assists parents or carers with their own issues as well as their capacity to support their adolescent.

While it does not qualify as a comprehensive and holistic treatment program, these modifications and additions ensure that DBT addresses multiple interlinked psychosocial systems or contexts in which etiological factors operate and reinforce each other.

4.6.5 Limitations of Dialectical Behaviour Therapy

DBT does not yet qualify as a well-established treatment for substance misuse disorders among adolescents. Randomised controlled trials have not yet tested DBT in this aim against another focused, established treatment.

4.6.6 Application to outreach and residential settings

Adaptations of DBT have demonstrated feasibility with adolescents in a variety of settings including outpatient, psychiatric inpatient and detention centres. Residential settings involving stays of up to two weeks place limitations on the duration for focused psychotherapy. However, at least one study has demonstrated the feasibility of implementing a two-week DBT program for adolescents in an inpatient setting (Katz et al., 2004).

This suggests it would be feasible to introduce daily DBT-based skills groups and individual DBT psychotherapy into residential youth AOD programs. It is also feasible to develop a DBT milieu, in which youth AOD staff are trained and supported to reinforce the practice of DBT-based skills (such as mindfulness, interpersonal effectiveness, distress tolerance and emotion regulation) and to help young people generalise these skills to a range of life situations.

Widespread use of a validating communication style would be an essential feature of a residential DBT milieu. Youth AOD residential services already place substantial emphasis on this style of communication and interaction, which involves workers being awake to, accurately reflecting and conveying acceptance of clients' behaviours, thoughts and feelings, as well as interacting in a genuine manner (Lynch et al., 2006). With this favourable orientation, youth AOD workers are likely to be highly receptive to workforce development aimed at formalising and expanding the skill set involved in providing validation.

While a single two-week exposure to DBT is unlikely to be effective in creating sustained behaviour change, clients of youth AOD services tend to make repeated use of residential services. Therefore, returning clients would receive repeated 'booster sessions' over time.

The telephone consultation modality of DBT is likely to be feasible in residential settings. Clients who have attended residential programs are already encouraged to keep in touch with workers via telephone to maintain supportive relationships. This contact could be readily formalised to include coaching aimed at facilitating use and generalisation of newly learned skills. Alternatively, key workers operating within outreach modalities may be best placed to take on this role.

Implementation of a structured DBT program is particularly well suited to a long-term residential rehabilitation program, such as that offered at Birribi.

To implement DBT effectively it is estimated that, at a minimum, residential services would require access to an experienced sessional therapist trained in DBT. Sessional staff would deliver skills groups, individual psychotherapy, and provide training and supervision to youth AOD workers. This will help the workers to provide effective telephone consultation support to clients and to maintain a milieu that is conducive to practice and generalisation of new skills.

A case can be made that most clients of youth AOD services demonstrate behavioural problems attributable to difficulties with emotion regulation, and hence they are likely to benefit from learning skills to moderate excessive responses to strong affective states.

The severity of these problems varies substantially across individuals. Our review found only one poorly controlled pilot study that has attempted to adjust the intensity of DBT to different levels of severity and complexity of need among adolescents (McDonell et al., 2010). This study demonstrated that such adjustment is feasible in an inpatient setting, but it reported against a very limited range of outcome measures.

Research is needed to examine whether briefer and less intensive forms of DBT intervention – such as skills groups and a DBT milieu delivered to all or the majority of clients in residential AOD programs – could be effective in reducing problem behaviours during and after residential stays.

A smaller proportion of clients demonstrate patterns of active and persistent suicidality and other symptoms of BPD. Research is needed to accurately estimate the number of such clients within residential AOD services at any one time who are likely to benefit from focused and intensive DBT.

With appropriate training and supervision, youth AOD outreach workers are in a position to coach clients in the practice and generalisation of new skills. Versions of DBT adapted for clients with substance use problems have included additional engagement strategies, a case management component and a life skills component (Robins & Chapman, 2004). These functions are already being performed by youth AOD workers on an outreach basis.

Box 4.6: Elements of Dialectical Behaviour Therapy that are readily applied in residential and outreach settings

Acceptance-based elements	**Change-based elements**
• Validation strategies • Reciprocal communication style	• Irreverent communication style • Chain analysis
Distress tolerance elements	**Mindfulness**
• Radical acceptance of painful events • Distraction from pain • Self-soothing and relaxation	• Focusing on the present moment • Recognising and focusing on thoughts, emotions and physical sensations
Emotion regulation	**Interpersonal effectiveness**
• Recognising your emotions • Overcoming the barriers to healthy emotions • Reducing physical vulnerability to overwhelming emotions • Reducing cognitive vulnerability • Increasing positive emotions	• Mindful attention to interaction with others • Recognising passive and aggressive behaviour • Knowing what you want • Asking for what you want in a way that protects the relationship • Negotiating conflicting wants • Getting information about the other person • Saying no in a way that protects the relationship • Acting according to your values • Identifying blocks to using interpersonal skills

These 23 practice elements are described in detail in (Mitchell, in preparation).

4.7 Narrative Therapy

4.7.1 Narrative Therapy in brief

Narrative Therapy is an approach to counselling that uses narrative or storytelling as a metaphor for understanding how individuals come to experience and understand problems that affect their lives. It is a vehicle for shaping alternative understandings, experiences and actions.

Central to the model is the idea that the stories we tell ourselves and others profoundly affect our experience of the past and present and constrain our expectations about, and capacities to shape, our future. Problems brought to helping professionals are understood as being maintained and worsened by 'problem-saturated self-stories' (Payne, 2000) or 'deficit-infused personal narratives' (Wolter, DiLollo, & Apel, 2006).

Narrative Therapy was developed within the field of Systemic Family Therapy and is theoretically grounded within a social constructionist philosophy. This views problems as produced or manufactured in the social, cultural and political contexts that serve as the basis for life stories that people construct and tell about themselves (Besley, 2002). As such, narrative approaches are often applied within family work. In families, problem-saturated stories are said to be based on 'thin descriptions' and 'thin conclusions' that often involve blaming, are regularly framed as weaknesses, deficits, and dysfunctions attributed to other family members, and leave little room for the complexities and contradictions of life (Morgan, 2000). Narrative Therapy involves the therapist working collaboratively with the person or family to challenge these dominant problem-saturated stories and co-author alternative stories that assist to break from the influence (Morgan, 2000) or fight the effects (Kelley, Blankenburg, & McRoberts, 2002) of the problems they are facing.

In its therapeutic aims, Narrative Therapy places strong emphasis on empowerment and building a more empowered self-concept or identity. When problem-saturated self-stories become entrenched, a young person's identity may become overwhelmed by simplistic or (thin) perjorative labels (e.g. 'trouble-maker', 'weakling', 'stupid' and 'useless'). The goal of Narrative Therapy is to replace the impoverished or weakened self-concept with an empowered self-concept that emphasises the person's strengths (i.e. a competent and effective person) (Wolter et al., 2006).

4.7.2 Theory and philosophy

Narrative Therapy is philosophically grounded in post-structuralism, and more specifically within social constructionism. Structuralism holds that the phenomena of human life cannot be understood except in relation to one another. The interrelationships between phenomena constitute a structure. Structuralism further posits that there are consistent patterns or laws that apply across time and across contexts that give rise to these structures, despite surface variation (Blackburn, 1994). Psychological theories positing abstract but relatively fixed structures such as human nature, the unconscious, and the ego, arise from a structuralist position (Payne, 2000).

Michael White, one of the developers of Narrative Therapy, firmly rejects structuralism and places Narrative Therapy as post-structuralist (Payne, 2000; p32). Post-structuralism agrees with structuralism that psychological and social phenomena can only be understood in terms of interrelationships among one another, but rejects the idea that there are relatively stable patterns or structural laws that operate across time and culture that give rise to fixed structures (Blackburn, 1994). Post-structuralists criticise structuralism for being ahistorical, deterministic, and lacking sensitivity to culture.

Social constructionism is a philosophical position within the broader school of post-structuralism. Within sociology, social construction of reality theory proposes that social order is developed through interpersonal interaction and understandings that are built up over time from shared experience, and maintained because of at least partial consensus about how things should be perceived (Hatch, 1997).

Within psychology, social constructionism places strong emphasis on the roles that language and meanings based in culture play in framing our notions of the self and identity (Besley, 2002). "Social constructionism emphasises the interaction between persons, and the social and cultural influences and norms which permeate and activate those interactions, rather than theoretical individual dynamics conceived as within the person" (Besley, 2002; p34).

"Social constructionist psychologists … focus not on theories of assumed 'inner' damage or pathology, but on the social and cultural processes through which we gain our views of the world, and the nature of those views, which in turn influence our actions. … They propose that we continually 'construct' our view of reality via these norms, through the influences of our culture and of other people" (Besley, 2002; p35).

Applied to Narrative Therapy, social constructionism highlights the social construction of narratives and the overlaying of narratives framed in different social ecologies. Thus the self-story of a young person will be shaped by narratives that have emerged within his or her family and influential social settings such as school.

Language has a central role in the social constructionist view. Besley points out that White and Epston argue "that people inadvertently contribute to their problems by the way they construct specific meaning of their experiences, that the meaning that people attribute to events determines their behaviour, that meaning is not made for us, but is produced through language and its context and the way that language is used to convey thoughts, emotions and histories" (Besley, 2002; p132).

The developers of Narrative Therapy, White and Epston, also drew heavily upon the ideas of Michel Foucault, particularly his ideas about power, to argue that the therapy literature has given inadequate attention to issues of power (Besley, 2002). As a post-structuralist philosopher, Foucault is best known for his rejection of the structuralist understanding of power as a binary opposition between the powerful and the powerless. Rather, for Foucault power operates in a capillary fashion. "Power is not regarded as being solely possessed or exercised by individuals, but is part of what people negotiate in their everyday lives and social relationships where power is about 'positioning' in relation to discourse" (Besley, 2002; p138).

This post-structuralist view of power as a distributed and negotiated phenomenon is central to the credibility of Narrative Therapy in terms of its intention to empower clients. A structuralist position that views power as a binary opposition might see clients as inherently powerless victims of inherently powerful oppressors. Viewed in this way, the situation is hard to change. In contrast, from its post-structuralist position, Narrative Therapy seeks to uncover instances in which clients have successfully negotiated for power and build these instances into an alternative empowered narrative, thereby increasing the likelihood that the client will successfully negotiate for power in the future.

The view that power is not inherent to individuals does not imply that there are no inequalities in its distribution. To the contrary, the field Narrative Therapy is very concerned with power imbalances. Social constructionism emphasises that in the world of socially constructed stories there are competing truth claims, and some stories are more privileged than others (Little, Hartman, & Ungar, 2008).

Discourses that privilege the knowledge and perspectives of adults, particularly 'experts' such as magistrates, medical practitioners and psychologists, are examples of narratives that can marginalise the concerns and voices of young people involved in behavioural health care service systems. A key role for Narrative Therapy is to help clients to understand the roles that socially dominant discourses might have played in shaping their own self-stories, particularly self-stories saturated with relatively fixed and stable problems such as delinquency and disorder.

Foucault's ideas about power also have ethical implications for the conduct of the therapist. Because of their role as co-authors of alternative narratives, the Foucauldian position reminds narrative therapists that they are active participants in the field of power relations and negotiations. On this view, therapists must be aware of the role they may be playing in social control and must work to demystify and unmask the hidden power relations implicated in their practices (Besley, 2002).

4.7.3 Relevance to client need and evidence of effectiveness

Narrative Therapy has not been systematically studied for its effectiveness. Several small, mostly qualitative studies have been conducted (Kelley et al., 2002; Wolter et al., 2006), but these are not experimental and would not qualify as meeting generally recognised criteria for evidence-based interventions. The lack of systematic evaluation of Narrative Therapy might be due to the fact that post-structuralists reject the assertion that reality that can be objectively described or measured, and the rational basis of effectiveness research, particularly in terms of client outcome measurement, depends on such an assertion.

Despite the lack of systematic evaluation, narrative approaches to counselling and psychological therapy have become increasingly popular and widely used over the past 20 years (McLeod, 2006). This popularity reflects a growing appreciation of the importance of narrative and subjective experience within philosophy, the humanities and social sciences more generally (Bekerman & Tatar, 2005; Besley, 2002; McLeod, 2006).

Use of the narrative metaphor and narrative techniques are strongly embedded in the practice philosophy of the disciplines comprising the youth AOD workforce including social work (Ellem & Wilson, 2010; Kondrat & Teater, 2009; Levy, 2004), youth work (Kelley et al., 2002) and family therapy (Dowling & Vetere, 2005; Payne, 2000). Within the wider psychotherapy community, it reflects a growth of interest in social constructionism and a concern about the harmful effects of pathologising language (Avdi, 2005).

Post-structuralist philosophy emphasises the importance of interactions between individual, social and cultural factors in shaping human experience. Combining this with recognition of temporal/cultural fluidity and the variability of outcomes may explain the strong

appeal of Narrative Therapy to practitioners concerned with understanding their clients' experiences in their interpersonal and social systems.

This philosophy is also particularly well suited to practitioners who work to enhance the empowerment of clients who have experienced exclusion and marginalisation from dominant or mainstream social forms and discourses. The post-structuralist position enables practitioners to recognise the influence of social and cultural factors in oppressing their clients, while simultaneously validating efforts to effect change by working on the subjective experience of individuals and the interactions within small social groups such as families.

Rejecting structuralist notions of fixed and universal social and psychological structures (such as class, the unconscious and objective truth) in favour of constructs such as discourses and narratives provides much flexibility for practitioners and clients to be creative in constructing new ways of experiencing.

Narrative Therapy differs considerably in its approach from other psychosocial therapeutic models that have been widely used in treatment and support for young people with AOD problems and related difficulties. The other models tend to be strongly behavioural in their orientation. In contrast, Narrative Therapy focuses upon the subjective experiences of the young person as well as the meanings that these experiences have in the psychological, social and cultural context. Many individuals seeking assistance for emotional pain place great value on the experience of a helping professional demonstrating deep interest in their subjective experience and assisting them to explore it.

Beyond this, Narrative Therapy provides a set of tools for working with subjective experience in ways that are theoretically grounded. Theoretical rationale is an important element of evidence-based practice. For many clients, this approach is likely to be a valuable alternative or supplement to other more behaviourally oriented interventions.

Furthermore, behind the surface of the language that is used to describe Narrative Therapy and despite very different theoretical roots, many of its aims, processes and practices are actually very similar to those of Cognitive Therapy, particularly the processes of cognitive restructuring.

The strong influence of social constructionist philosophy and narrative ideas within the academic disciplines responsible for educating human service providers means that practice frameworks for the youth AOD field must address these influences, despite the fact that Narrative Therapy has not been evaluated using experimental methods and hence cannot be counted as an empirically supported treatment. Therapeutic concepts and practices based within this model are pervasive in practice settings, and to ignore them risks alienating large numbers of practitioners.

4.7.4 Articulation with characteristics of effective services and programs

Client centred √
Developmentally appropriate √
Builds on strengths and fosters empowerment √
Experiential √
Multisystemic and ecological √

Narrative Therapy is highly consistent with several of the characteristics of effective service provision, especially in addressing the needs of young people with multiple and complex needs.

First, Narrative Therapy emphasises several key features of **client-centred care**. Universally, narrative therapists emphasise the critical importance of infusing therapy with deep listening in order to understand the person's unique world view, meanings and values (Levy, 2004).

Some narrative therapists emphasise that "[the] client's experience is privileged over that of the therapist or referrer in defining the problem" (Little et al., 2008). Others place more emphasis on Narrative Therapy being collaborative, with the client playing a significant part in mapping the direction of the therapeutic journey (Kelley et al., 2002; Morgan, 2000). A person-focus is also underlined in the language of Narrative Therapy, which tends to replace the word 'client' with 'person' (Besley, 2002; Payne, 2000).

Narrative Therapy also meets a key requirement of **developmentally appropriate** practice in that it places strong emphasis on a central developmental task of adolescence – identity formation, particularly an empowered and self-directed adult identity.

A key idea in Narrative Therapy is that problems become unmanageable and overwhelming for affected individuals when problem-saturated narratives come to dominate the person's identity or sense of self. A central task of Narrative Therapy and other self-story based approaches is to separate the person from such pathological identities and foster their ability to position themselves flexibly among a variety of alternative narratives (Avdi, 2005).

Young people affected by AOD problems, especially when combined with mental health problems and involvement in the justice system, often develop a sense of self based on pejorative labels applied by society such as 'uncontrollable', 'junkie', and 'delinquent'. Narrative Therapy approaches that deconstruct these

deficit-infused identities are particularly useful in service settings where empowerment and strength recognition are key practice principles or intended outcomes (Kelley et al., 2002; Morgan, 2000).

In relation to **building on strengths and fostering empowerment**, Narrative Therapy is purposeful. Narrative therapists position this as centring people as the "experts in their own lives" (Kelley et al., 2002; Morgan, 2000). In the opening paragraphs of her book 'What is Narrative Therapy?', Ann Morgan states that Narrative Therapy "assumes people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives" (p2).

The philosophical basis of Narrative Therapy within social constructionism highlights the ways in which ideas and discourses of powerful others come to shape the personal self-narratives of individuals with personal deficits or dysfunctions (Kondrat & Teater, 2009; Levy, 2004; Payne, 2000). While many therapeutic traditions are viewed as reinforcing these stigmatising and disempowering constructions of self, Narrative Therapy intentionally seeks to avoid this.

Indeed, the goal of Narrative Therapy is to empower the client by assisting them to shed socially constructed self-narratives and create an authentic sense of self through self-organisation (Kondrat & Teater, 2009). Case studies are available describing how a Narrative Therapy approach is applied to this goal (Kondrat & Teater, 2009; Levy, 2004; Wolter et al., 2006).

These considerations, emphasised so strongly in Narrative Therapy, are highly relevant to the barriers to empowerment experienced by many young people with AOD and other complex issues. Bruun (2006) has pointed out that the coping strategies and competencies required for adaptation in marginalised environments are often viewed as maladaptive and dysfunctional in mainstream settings. Thus young people seldom appreciate the value of their own efforts to cope and adapt in difficult circumstances. A large part of the 'guide' role of youth workers as described by Bruun involves helping young people to construct competent identities for themselves, beginning with recognition of the ways in which they have successfully adapted and coped in the past.

Finally, while Narrative Therapy is more cognitive and emotional than behavioural in its focus of action, there is a strong **experiential** dimension. Several authors emphasise the importance of people 'performing' or 'practising' behaviours consistent with their new or alternative narratives. Practice or performance is seen as important to 'thickening' alternative stories. For example, Little, Hartman and Ungar (2008) stress the importance of programmed activities that give young people opportunities to 'take their new identities out for a test run' (p329). The practice of 're-membering' is another experiential element. Here the client is invited to look at the past and to remember people who had recognised 'exceptions' and 'unique outcomes' and who would be pleased to witness the emergence of the alternative narrative. Ways of joining or re-enlisting these people into the person's 'club of life' are explored (Besley, 2002; Little et al., 2008; Payne, 2000). The practices of 'spreading the news' (Kelley et al., 2002) to significant others or inviting them to 'witness' events or ceremonies involving the new story (Payne, 2000) are also key experiential features.

Emerging from social constructionism, the philosophical roots of Narrative Therapy are **multisystemic and ecological**. "Social constructionism emphasises the interaction between persons, and the social and cultural influences and norms which permeate and activate those interactions, rather than theoretical individual dynamics conceived as within the person" (Payne, 2000; p34).

Therefore, problems and problem-saturated stories are understood as constructed and situated within nested systems or ecologies of social interaction. This is why Narrative Therapy is sometimes referred to as a 'systemic' therapy. It has been argued that in practice Narrative Therapy has moved away from its systemic roots and become too focused on the individual narrative (Dowling & Vetere, 2005). However, the theoretical grounding in social constructionism means that systemic narrative approaches can be readily applied within social groups such as families, school settings, and organisations (Dowling & Vetere, 2005; Little et al., 2008).

4.7.5 Limitations of Narrative Therapy

Narrative Therapy has not been systematically studied for its effectiveness. Several small, mostly qualitative studies have been conducted (Kelley et al., 2002; Wolter et al., 2006), but these are not experimental and would not qualify as meeting generally recognised criteria for evidence-based interventions.

Even though the philosophical basis of Narrative Therapy may be inconsistent with the use of effectiveness research (see Section 4.7.3), there is no empirical reason why it could not be more systematically evaluated using qualitative methods and a social constructionist framework consistent with the value placed upon the subjective experience of clients.

Another limitation of Narrative Therapy is that it is not a comprehensive or holistic intervention model. Although it acknowledges the influence of factors in a range of domains, in practice intervention is narrowly focused upon one or two domains – the subjective experience of the client and/or family interactions.

As such, Narrative Therapy should not be viewed as a fully self-sufficient intervention for treating AOD problems in young people, particularly those with complex needs. Rather, Narrative Therapy should be used as one component of a multidimensional treatment approach or support package. This is also the case with other intervention models reviewed here, such as Motivational Interviewing (Section 4.2.5) and Cognitive Behaviour Therapy (Section 4.4.5).

4.7.6 Application to outreach and residential settings

While originally developed for use within session-based therapeutic modalities, Narrative Therapy techniques can be adapted to outreach modalities based on less structured and more varied types of interactions between workers and clients.

Morgan (2000) states that Narrative Therapy techniques should not be approached like a recipe to be compiled in a particular order, but rather sampled from like a smorgasbord of delicacies. While the theory underpinning Narrative Therapy does suggest a series of stages in the therapy process (e.g. clarification of problem narratives, de-construction of problem narratives, construction of alternative narratives), in practice these theoretical stages are likely to overlap and cycle back upon each other, with 'earlier' processes needing regular reinforcement.

The key goal of AOD outreach is to build relationships with young people that promote trust and facilitate active self-directed engagement with the various forms of assistance available through other forms of AOD service, as well as other parts of the service system. Narrative therapists have described the use of the narrative approach to achieving this type of goal in outreach with homeless people (Levy, 2004) and persons experiencing severe mental disability (Kondrat & Teater, 2009).

Various techniques of Narrative Therapy are readily applied to these key tasks in outreach settings, but there are aspects of these settings that call for care and perhaps modification in the ways that these techniques are applied. Narrative therapists note that when people first begin to speak to a counsellor they are usually very willing, ready and able to relate the problem-saturated narratives that provide the primary material for therapy. However, in outreach settings potential 'clients' often do not understand or talk about their issues in ways that fit neatly with the language of service provision. This is particularly true in outreach settings focused on youth who are using alcohol and other drugs. Young people rarely view themselves as having AOD problems, even when their lives are clearly negatively affected through, for example, referral to AOD services from the youth justice system (Chassin, 2008; Muck et al., 2001).

Some young people may actually talk about themselves using language that adults, particularly counsellors, may view as 'inflated', characterised by bravado and bragging (Kelley et al., 2002). In these circumstances, outreach workers may need to spend a considerable length of time building trust before a problem-saturated or deficit-infused narrative emerges.

An initial key task is to develop a conversation based on language that respects the world view of the young person, while at the same time introducing them to ideas and possibilities of change that they may not have previously considered. Levy (2004) describes the skilful work of developing a 'common language' starting with active or reflective listening to the person's words, values and meanings in order to genuinely understand the client's point of view about their issues or concerns [10].

This first phase is very similar to the practice of 'joining', also described in Solution Focused Therapy (O'Connell, 2005). Only when this client-centredness has been established, and the client's trust won, can the outreach worker move on to broadening the conversation or providing context around the narrative. The worker builds linguistic 'bridges' between the client's initial narrative and the ways in which the worker talks about the services that could be provided (Levy, 2004). Levy also describes how this conversation may involve 'deconstructing and reconstructing the language of available helping resources' (p378) as a way to facilitate alternative understandings of the problem that may encourage engagement with services.

The outreach modality is highly conducive to the narrative task of joining and bridge building through development of a common language. With the freedom to meet young people on their own terms and the opportunity to spend considerable time sharing relatively mundane activities, conversations between youth outreach workers and young people tend to be natural, expressive and free flowing (Bruun & Hynan, 2006). Youth outreach workers often find themselves receiving and responding to disclosures that they would surely not receive in more formalised settings (Bruun & Hynan, 2006).

[10] Based on the work of Leonard (1994, 1997), Pease argues that this form of 'dialogical' communication is essential to constructing alternative forms of knowledge that are truly client-centred and which challenge the dominance of professional expertise that can be disempowering for service users (Pease, 2002).

If and when a shared understanding of the problem has been established, it may be helpful for the practitioner to make a written record of the initial problem-saturated narrative. This should define the problem in precise terms and describe how the young person positions themselves. This will help the practitioner to develop a clear picture of what the problem is that the young person is coping with, how they are coping, and what aspects of the story are amenable to narrative intervention. This step is part of the broader process of case formulation that should be conducted irrespective of the intervention model being used. Defining the problem in writing also helps to put some boundaries around it for the practitioner, which can directly inform subsequent steps of the therapeutic process.

A second key task of outreach generally is to reinforce motivation and engagement by building a sense of confidence that change is possible and that the young person possesses the personal qualities and social assets needed to begin the change process. In this regard, an important narrative process involves 'externalising' the problem.

This begins with naming the problem and then using language that reinforces the view of the person and the problem as separate entities. If a person has internalised problems and taken on an identity of pejorative labels, externalisation is the process of separating the person from the problem (Kelley et al., 2002; Payne, 2000; Wolter et al., 2006). Successful externalisation can have a powerful effect, enabling the person to assess their problems more objectively and to begin the work of gaining control. A specific type of questioning technique, called 'relative influence questioning', can be used here (Payne, 2000). It maps the influence of the problem on the person and the influence of the person on the problem.

A key task of the counsellor during the early stages is to identify and note any details that contradict narratives dominated by problem-saturated descriptions or deficit-infused language. These contradictory details are known as 'unique outcomes' (Payne, 2000), 'exceptions' (Wolter et al., 2006) or 'sparkling moments' (Levy, 2004). These are times when the person has managed to get the upper hand against the problem or to deal satisfactorily with similar problems. When explored in depth for their meanings, they point to strengths possessed by the individual that have not been adequately recognised. Unique outcomes and the strengths they point to can provide the foundations for reconstructing an alternative, more empowered narrative.

Most of the young people attending residential AOD services have acknowledged that they have problems with AOD use and other related issues, and will be at least partly engaged in taking responsibility for change. Hence the nature of therapeutic work to be conducted in residential settings is of a different order.

However, having said this, the work of engagement and developing a view of the problem that is most conducive to positive change is likely to take a long time. In addition, some young people come to residential services without connection to an outreach worker. For these reasons, most of the narrative practice elements described for outreach will still be relevant in residential settings.

Once a common language has been formulated, an externalised positioning established, and key strengths identified, workers in residential settings may be able to use additional narrative techniques focused on stimulating and reinforcing change.

The detailed assessment process that takes place in residential settings, combined with the intensive contact with AOD workers, provides an ideal opportunity to use techniques that narrative therapists call deconstruction of problem-saturated stories (Kelley et al., 2002; Kondrat & Teater, 2009; Payne, 2000) and co-authoring of alternative stories.

These involve detailed exploration of the nature of unique outcomes and exceptions. The aim is to challenge the problem-saturated narrative and enrich the associations and interpretations attached to the unique outcomes so that they come to occupy a place that has meaning and power for the future.

An important concept within Narrative Therapy that distinguishes it from most psychological therapies is that narrative is viewed as performance or action rather than merely a cognitive or psychological phenomenon (McLeod, 2006) . This perspective points to a potentially powerful benefit of residential settings for Narrative Therapy. Because young people and workers spend so much time together sharing a diverse range of activities, there are many opportunities to observe young people 'performing' problematic narratives in different situations and to explore and challenge these immediately when relevant action takes place.

Similarly, this sort of environment provides many opportunities for workers to directly observe 'exceptions' or 'sparkling moments', when young people perform actions that are inconsistent with problem narratives and indicative of preferred alternative narratives. The availability of such social 'contexts for action', which provide opportunities and resources for efficacious action and building self-esteem, has been observed as vital to the ability of individuals to engage in intentional self-change (Kiecolt, 1994), including change around drug use problems (Bruun, 2008; Granfield & Cloud, 2001). Narrative Therapy gives further formal recognition to this through its emphasis on the importance of other people

'witnessing' (Payne, 2000) the changes that the person makes in their self-narrative.

The amenability of the narrative techniques to the modality of behavioural performance or activity through informal interactions makes the narrative approach particularly appropriate for many young people with AOD problems who are not interested or ready to engage in personal counselling. Through informal interactions, various narrative techniques can be applied in small bits in the course of other conversations, chipping away at fragments of problem-focused stories that might become dominant problem-saturated narratives if left unchallenged.

Entry to residential withdrawal has long been viewed as indicating that a person has actually or potentially reached a critical turning point in their life. The reality of a problem has been recognised and a decision to take responsibility for change has been made. Payne (2000) identifies an equivalent turning point in the process of Narrative Therapy, at which the person is 'invited to take a position' (p15).

The person can decide to remain dominated by their problem-saturated story or they can decide to take into account the richer story that includes the elaborated unique outcomes. It may or may not be the right time to take a new direction. More work may need to be done to reduce the power of the problem (Payne, 2000). The decisions that a young person makes at this point are critically important indicators of readiness for engagement with additional forms of therapeutic intervention and will inform the development of an aftercare or continuing care plan.

However, for young people with AOD issues, the motivational and supportive narrative work aimed at dislodging the old dominant disempowering narrative and establishing the primacy of an alternative empowering narrative will need to continue well past an initial residential stay.

4.8 Solution Focused Therapy

4.8.1 Solution Focused Therapy in brief

Solution Focused Therapy (SFT) is strongly oriented towards discovering and creating solutions and it spends little or no time uncovering and analysing problems. This is based on a strongly held view that lengthy review of problems can be unhelpful for many clients. This insistence on moving as quickly as possible towards solutions is a unique feature that distinguishes SFT from many other psychotherapeutic models.

The core therapeutic task of SFT varies somewhat across its key proponents and investigators, but most put building on strengths or positive personal growth at the centre. Gingerich and Eisengart (2000) state that "[t]he main therapeutic task is helping the client to imagine how he or she would like things to be different and what it will take to make that happen" (p478). O'Connell (2003) sees the therapeutic task as raising clients' awareness of the constructive solutions already operating in their lives and helping them find ways to expand upon these solutions (p5). In discussing the application of SFT to substance abuse, Pichot (2001) repeatedly suggests that the therapeutic task is to help clients reach the goals that they have set for themselves.

SFT evolved from a confluence of work that was taking place within the fields of Systemic Family Therapy and Brief Therapy. Although it shares, with Narrative Therapy, a philosophical grounding in social constructionism, SFT evolved much more from practice and pragmatism than from theory (Simon & Berg, 2004). The developers of this model, based at the Brief Family Center in Milwaukee, built it inductively over time as they practised and learned from their clients.

While the focus on solutions rather than problems is somewhat definitive of SFT, several additional principles that guided its development (and which have come to characterise it) have had a powerful influence on the wider field of psychotherapy in the past two decades. Key among these are the client-centred approach, strengths-based practice and, to a lesser extent, future focus.

Foundational to Steve de Shazer's pioneering work on SFT in the early 1980s was Milton Erickson's radical idea of using the client's own language and world view as the starting point and ongoing focus of the work (Simon & Berg, 2004). This led Erickson to design therapy differently for each client, and ultimately evolved into what we understand as the client-centred or person-centred approach and the principle of individualising therapy. SFT emphasises and responds overtly to the assumption that every human being, relationship, situation and problem is different. Thus the process of fitting the therapy to the client requires client input and feedback.

Another foundational principle was Erickson's equally radical assumption of the competency of clients. This evolved into the widely endorsed principle of strengths-based practice. SFT assumes that clients are the experts on themselves and their situation and that they already possess all the knowledge and resources necessary for change. In contrast, the expertise of the therapist is located primarily in facilitation of a process that assists clients to access this knowledge and harness these resources.

SFT also assumes that change is constant and inevitable, and that clients have already begun a process of positive change by the time they come to therapy

(Simon & Berg, 2004). Hence the role of therapy is not to initiate or create change, but to discover where it is occurring and reinforce it (O'Connell, 2005).

Another important characteristic of SFT is a strong orientation towards the future rather than the past. SFT argues that little can be learned by understanding the reasons why problems developed or processing past traumas. Analysis of the past is generally restricted to learning about past successes rather than past defeats. The model developers discovered that clients felt empowered as they described what they wanted to happen in their lives (O'Connell, 2005). "The helper stimulates clients to develop powerful visualisations of their desired future and invites them to experience aspects of it. Clients are facilitated to talk their way into a better future" (O'Connell, 2003; p4). This focus on the future, and especially the experiential aspect of envisioning solutions, is perhaps the feature that distinguishes SFT most clearly from similar approaches.

Envisioning the future that will follow the implementation of solutions is the key therapeutic process associated with the 'miracle question' – the therapeutic technique most widely recognised as characterising and distinguishing SFT.

4.8.2 Theory and philosophy

Although Solution Focused Therapy was developed inductively from practice, it shares a common philosophical base with Narrative Therapy in social constructionism. SFT places great emphasis on the power and function of language in shaping our perception of past and present experience as well as our future reality.

Rather than merely representing reality, language is understood as creating reality (Simon & Berg, 2004). Specifically, conversations form contexts in which people create meanings from the words they use. Talking and doing are understood as happening simultaneously and as being inseparable components of action that constructs social reality.

Applied to the problems of living and the therapy context, social constructionism assumes that problems are produced and maintained by the constructs through which difficulties are viewed, and by repetitive behavioural responses surrounding them (O'Connell, 2005). Like Narrative Therapy, SFT proposes that certain types of narrative are more likely to motivate and support a client towards change than others; these are future-focused, and competence or strengths-based narratives (O'Connell, 2005).

Both Narrative and Solution Focused Therapy seek to help the client shift the focus of their awareness and energy towards these sorts of strength-based narratives and away from problem-focused narratives. However, in contrast to Narrative Therapy, SFT spends very little time analysing or deconstructing problems, preferring to move very quickly onto the construction of solutions.

Therapeutic approaches based on social constructionism also give precedence to the client's perceptions and ways of talking, rather than to facts and professional language. They affirm the unique experience and expertise of the client and invite therapists to disown their privileged position of knowledge and power (O'Connell, 2005). Practitioners adopt a stance of a 'non-expert' or 'not-knowing', meaning that they do not assume that they know what is best for the client based on a pre-conceived body of knowledge (Pichot, 2001).

Instead, knowledge is co-created out of conversation between the client and the therapist (O'Connell, 2005). Thus, similar to Narrative Therapy, a key strategic priority for SFT is 'joining with' the client to "find a common language to describe what the client wants to change and begin to explore how those changes would affect the client's life" (O'Connell, 2005; p28). "Practitioners do not need to have the answers to a client's problem because they collaborate with the client to identify the problems, to define goals, and to look for solutions to meet those goals" (Kim, 2008; p107).

SFT also has strong roots in the more recent tradition of Brief Therapy, a modality that is often used by family therapists. Brief Therapy, particularly the Single Session Therapy (SST) approach, is based on the pragmatic recognition that clients mostly expect and want limited therapy, and most attend 3-4 sessions at most (Perkins, 2006).

The SST approach does not necessarily limit client-therapist contact to a single session, but it approaches the first session as if it may be the only one and each subsequent session as if it might be the last. Hence, the practitioner:

- Plans each contact as a self-contained episode aimed at providing rapid help
- Has a pragmatic focus on the here and now or the focal issue presented by the client
- Seeks to establish a good working relationship as soon as possible
- Takes a much more active role
- Encourages the client to keep working on their problem in their own time (O'Connell, 2005; Perkins, 2006).

The brief or single session approach to SFT appears highly suitable to working with the large proportion of adolescents who drop out of treatment prematurely or who engage with services for very brief periods intermittently and erratically.

4.8.3 Relevance to client need and evidence of effectiveness

While Solution Focused Therapy shares important features with other therapeutic models described here, it possesses several unique features that are likely to be particularly helpful for some young people and, in certain circumstances, for young people with complex needs.

With its foundation in Brief Therapy, SFT is designed for delivery in short episodes that are focused on providing practical assistance in a short time. The ability to provide practical assistance in response to what clients directly ask for is recognised as important to effective engagement of youth and families in difficult circumstances (Meade & Slesnick, 2002; Statham, 2004).

This feature makes SFT particularly suitable for assisting the many young people who attend services intermittently. Providing practical assistance, or achieving small wins swiftly, can be highly effective in promoting more secure engagement with this population (Statham, 2004) or enhancing motivation to work on deeper issues.

Various authors have described the use of brief SFT in terms of building a sense of hopefulness and confidence in clients' ability to manage their problems (Perkins, 2006) or to build an expectancy of change (Pichot, 2001). "The SFT approach is to find a small but significant starting point for initiating change. This is based on the principle that small changes can lead to bigger changes" (O'Connell, 2005; p478).

Adolescents' strong desire to project a competent or resilient identity (Ungar, 2005) and their reluctance to confess to a lack of control over their behaviour also strongly recommends strengths-based therapeutic approaches in promoting and maintaining their engagement.

When used within the modality of an SST approach, SFT also appears well adapted to the intermittent and erratic pattern of service use typical of many adolescents. When workers cannot be confident of seeing the young person again soon, it is more important to maximise the impact of every contact by making the interaction as complete as possible. If young people perceive that something positive has been gained from their contact with a service provider they will be more likely to return for further assistance.

Another feature that increases the importance of SFT is its flexibility and applicability to a diversity of issues. There are indications that SFT can be applied to building solutions for a wide variety of problems experienced by a diverse variety of client populations. Authors have described the use of an SFT approach for clients experiencing problems associated with mental illness, substance misuse, domestic violence, sexual abuse, couples counselling, parenting and school difficulties, and business (O'Connell, 2005).

The SFT approach has also demonstrated acceptability as an intervention for children and adolescents experiencing a variety of mental health problems (Kim, 2008; Perkins, 2006), as an early intervention for children and families at risk (Worrall-Davies, Cottrell, & Benson, 2004), and for adolescent girls who are survivors of sexual abuse (Kruczek & Vitanza, 1999).

The wide applicability of the SFT approach can be explained by its operation outside the problem-focused paradigm. SFT's aim is not so much to alleviate the symptoms of disorders or ameliorate dysfunction, but to assist clients to identify and develop their coping and problem-solving skills and to instil a sense of hopefulness and confidence in their ability to manage their problems (Kruczek & Vitanza, 1999; Perkins, 2006).

SFT's flexibility also manifests in its application through a range of modalities. It has been incorporated into: single session therapy for individuals and families (Perkins, 2006); up to eight sessions for individuals and families (Worrall-Davies et al., 2004); group work (Kruczek & Vitanza, 1999; Pichot, 2001); and brief client-centred case work involving varied modalities (Pichot, 2001).

Within these various modalities SFT has also been combined with other therapeutic approaches such as Motivational Interviewing (Pichot, 2001), Cognitive Behaviour Therapy (Worrall-Davies et al., 2004), Art Therapy, Bibliotherapy and Ericksonian techniques (Kruczek & Vitanza, 1999). This flexibility is particularly valuable for the many youth-focused AOD services that use diverse modalities beyond standard face-to-face office-based sessions.

There has been limited research into the effectiveness of SFT. A key limitation of most studies conducted to date has been small sample size, which limits the ability to detect statistically significant effects, and poor control, which limits the ability to attribute effects to the unique characteristics of the treatment. Nevertheless, the results of work conducted thus far are cause for optimism that SFT may be at least as effective as other treatments, provided that certain conditions are met and outcomes are appropriately conceptualised.

The first comprehensive literature review of outcomes studies focused on Solution-Focused Brief Therapy (SFBT) (Gingerich & Eisengart, 2000). Fifteen studies were found, of which five were assessed as well controlled (random assignment to groups and established outcome measures). All five of these studies reported significant benefits and four found SFBT to

be significantly better than no treatment or standard institutional services.

The issues addressed in these four studies were parenting skills, rehabilitation of orthopaedic patients, an adult prison population and antisocial adolescent offenders. The other well-controlled study compared SFBT to another known treatment (Interpersonal Therapy) for depression and found both treatments to be equally effective. Participants were mildly to moderately depressed female college students and treatment in both conditions involved a single 90-minute session (Gingerich & Eisengart, 2000). The other 10 studies in this review were moderately or poorly controlled, but the direction of the results was judged consistent with the hypothesis of SFBT effectiveness.

A meta-analysis of controlled studies of SFBT was reported by Kim (2008). Kim made considerable effort to include unpublished studies so as to minimise reporting bias. A total of 22 studies was included, 11 of which were unpublished dissertations. These studies also targeted a variety of different problems, but the meta-analysis grouped them into externalising, internalising and family and relationship problems. The meta-analysis focused on effect sizes as a uniform outcome measure. For studies with multiple outcome measures, effect sizes for all the different measures were calculated and averaged.

Eight of the 22 studies examined externalising behaviours. Only two of the eight studies had significant effect sizes, both in favour of the SFBT group. Across the eight studies the average difference in effect size between SFBT and control groups was not significant. Twelve of the 22 studies examined internalising behaviours. Only two of these 12 had significant effect sizes, both in favour of SFBT. Across the 12 studies the average effect size for SFBT was reliably greater than for the control group, but this effect was small. Eight of the 22 studies examined family and relationship problem outcomes. Two of the eight studies had significant effect sizes, both in favour of the SFBT group. Across the eight studies the average difference in effect size between SFBT and control groups was not significant (Kim, 2008).

Kim (2008) concludes that the meta-analytic review demonstrated small but positive effects in favour of SFBT compared with control conditions, but that reliable evidence of effectiveness is present only for internalising disorders such as depression, anxiety, self-concept and self-esteem. Kim observes that the small effect sizes found in his meta-analysis are "only slightly smaller than effect sizes calculated for psychotherapy and other social work practice models" (p113). He also notes that most of the studies were conducted in real-world settings, and that other meta-analyses have found that effect sizes are smaller in real-world settings compared with clinical research settings. "Given the model transfer problems common in interventions tested in optimal efficacy trials, the small effect sizes for SFBT should not be dismissed as unimpressive" (Kim, 2008; p114).

A further factor to take into consideration in relation to this meta-analysis concerns the method of averaging effect sizes across diverse outcome measures. This averaging procedure is problematic in that information about the potential specificity of outcomes is lost. If relatively ambitious outcomes (e.g. remission from mental disorders) are pooled with relatively modest outcomes (e.g. instilling hope and building problem-solving skills), this is likely to bias against finding significant overall effects. In the case of SFBT delivered on its own in the absence of other focal treatments, it may be inappropriate to measure outcomes in terms of remission from mental disorders.

Only a few outcome studies have focused on treatment of emotional and behavioural difficulties of young people with complex needs. One of the earliest was a well-controlled study of SFBT for "antisocial adolescent offenders" (n=40), with concomitant diagnoses of psychosis and a history of refusal to take medication (Seagram, 1997; cited in Gingerich & Eisengart, 2000). Eighty-five per cent of these young people had a history of violent offending and 90% were repeat offenders. Ten SFBT sessions (one per week) were offered in addition to standard services in a custodial setting.

Various outcome measures found that youth in the SFBT group, compared with controls made more progress in solving problems, had higher confidence in their ability to maintain changes, had significantly more optimism for the future, greater empathy, fewer antisocial tendencies, less substance abuse, and significantly less difficulty with concentration. Within a six-month follow-up period, four (20%) of the SFBT group versus eight (42%) of the control group had re-offended (run away, or were moved from open to secure custody) (Gingerich & Eisengart, 2000; p485).

A seven-session, solution-focused group work intervention for teenage girls who were survivors of sexual abuse was evaluated using in a pre-post study design (Kruczek & Vitanza, 1999). This study found significant change in pre to post measures of adaptive functioning but not in skill mastery. Improvement in adaptive functioning was sustained at a three-month follow-up point.

Perkins (2006) reports a study evaluating the effectiveness of a single session of therapy using a solution-focused approach for children and adolescents with mental health problems aged 5-15 years (n=216). This study used an RCT design with a waitlist control group. Results are reported at one-month follow-up.

For the parent and clinician measures, clinical levels of psychopathology were found at intake with significant improvement one month after a single session of treatment. Ratings of the severity and frequency of the problem decreased more for the treatment than the control group, and the effect size was medium to large.

4.8.4 Articulation with characteristics of effective programs

Client-centred √
Relationship-based √
Behaviourally oriented √
Builds on strengths and fosters empowerment √
Fosters engagement √

Several proponents of Solution Focused Therapy have placed strong emphasis on explicating its foundational principles. These are highly consonant with the characteristics identified as critical to the effectiveness of programs for young people with multiple and complex needs (see Section 3).

SFT places particularly strong emphasis on the principle of **client-centredness**. O'Connell (2005) stresses that "[t]he closer the therapist can keep to the client's agenda, the more likely it is that the client will feel motivated to change" (p28). Clients are also recognised as the main drivers of change and as the primary experts in what they want for the future and what will work to realise this future (Pichot, 2001). To underscore the expertise of the client, the therapist is expected to adopt the position of a non-expert who does not assume they know what is best for the client based on a pre-conceived body of theory or expert knowledge (O'Connell, 2005; Pichot, 2001).

Another aspect of **client-centred** practice advocated in SFT is individualising interventions to the unique needs of the client. While SFT has a particular well-defined set of interventions or therapeutic techniques, these are used in a highly flexible and creative way. "If the helper is skilful he or she will be flexible to the needs of the client and be willing to adapt the model to fit the situation" (O'Connell, 2003; p5-6). Kim (2008) identifies the flexibility of SFT as one of the features that has led practitioners to embrace it with such enthusiasm.

Like many other therapeutic models, solution-focused therapists recognise the fundamental importance of the **therapeutic relationship** and use it as a platform for delivering additional unique interventions. The strong emphasis placed upon relationship building is closely linked to achievement of client-centred practice. The repertoire of therapeutic practice elements includes the element of 'joining', which comprises techniques such as matching the client's language, offering positive feedback and adapting the interviewing style to suit the client (O'Connell, 2005).

The concept of joining and the non-expert positioning of the helper point to the collaborative nature of the relationship that is fostered in SFT. "The solution-focused therapist aims to develop a cooperative 'joining' with the client in a warm, positive, accepting relationship that includes the adoption of a 'one-down' (non-expert) position in which the client teaches the therapist about his view of the world and how the therapist could co-operate with him" (O'Connell, 2005; p24-25).

While all therapeutic approaches ultimately seek to **empower** the client, solution-focused therapy places stronger and more direct emphasis on this than any other therapeutic approach outlined, apart from Narrative Therapy. The assumption that the client already possesses all the knowledge and resources necessary for change, and that the role of therapy is to reveal and mobilise these resources rather than to generate them, is radically **strengths-based** and quite different from most other therapeutic approaches.

While an emphasis on the strengths and resources already possessed by the client is shared with similar models such as Narrative Therapy, it can be argued that SFT takes this orientation a few steps further. A core assumption is that clients have already begun to implement the solutions that are needed to overcome their problems, and the role of the helper is to raise awareness of these solutions and find ways to expand upon these (O'Connell, 2003).

Several techniques of SFT are explicitly designed to raise this awareness. One of these involves asking clients to identify any changes that take place between the time that they make an appointment and coming to the first session ('asking about pre-treatment change') (Gingerich & Eisengart, 2000; O'Connell, 2003). Another involves listening for times when the problem is not present or is managed better ('looking for exceptions') (Gingerich & Eisengart, 2000; O'Connell, 2003; Pichot, 2001). When the helper notices these times, questioning is directed to helping the client identify what they may have done differently so that pre-existing solutions are realised and existing strengths uncovered ('competence seeking') (O'Connell, 2003).

While it is theoretically based within the philosophical tradition of social constructionism, in practice SFT is also **behaviourally oriented**. O'Connell (2005) stresses that SFT focuses on the here and now and actual behaviours rather than paths travelled and psychological explanations. In finding solutions, the therapist helps the client to identify which behaviours are helping and how to expand the use of the most effective ones.

Finally, as elaborated in Section 4.8.3, the pragmatic here and now focus of SFT, its equalising collaborative stance, and its emphasis on highlighting strengths is likely to make it particularly **engaging** for adolescents.

4.8.5 Limitations of Solution Focused Therapy

Solution Focused Therapy on its own, particularly in a single session or other brief modality, is unlikely to be effective in substantially reducing AOD and related psychosocial problems for adolescents with multiple and complex needs.

There is strong consensus among experts concerned with this population that adolescents with more problems, and those exposed to more risk factors, require greater intensity and duration of intervention. For this population, higher-intensity programs yield proportionally greater gains than low-intensity programs (Lennings, Kenny, & Nelson, 2006; Muck et al., 2001; Schuetz & Berry, 2009; Statham, 2004).

For adolescents with multiple and complex needs, SFT used within a single-session modality is probably best suited for working with relatively focal problems, such as crisis presentations, or discrete problems, such as conflict between a young person and their family or school.

Steenbarger (1994; cited in O'Connell, 2005) concluded from his review of various studies that brief therapy is most suitable for clients who are highly aware of focal problem patterns. Clients who present with broad, diffuse and poorly understood patterns and who need considerable time to form a trusting alliance are more likely to need an extended period of exploratory work. The nature of multiple and complex needs is such that it is often difficult to define and separate the issues requiring solutions and to decide in what order they should be tackled.

Having said this, the fact that brief SFT has been applied with a wide range of client groups in many different settings and has actually demonstrated positive results suggests that the brief therapy modality has a significant contribution to make. Further research is necessary.

While diffuse and complex problems demand a comprehensive, ecologically based approach over the long term, they can also be addressed one step at a time. The ability to detect clinically meaningful, positive effects may depend on brief SFT being applied to particular focal problems agreed by the client and the practitioner and the use of outcome measures specific for those problems.

A further limitation to the use of SFT concerns the fundamental assumption that clients already possess the skills and resources needed to solve their problems. This assumption may not always be justified or useful. Among their strengths (often overlooked), adolescents with established AOD issues (especially those with complex needs) frequently lack some of the necessary knowledge, skills and other resources because they have not had the opportunities to develop them. Guided experience is needed for the development of these skills and resources.

Another potential limitation of brief SFT is that speedy movement to a focus on solutions may be inappropriate for young people who need to spend some time exploring and coming to terms with problems. Above all, adolescents value being listened to and understood. An excessively proactive shift to solutions may risk alienating young people who are not yet ready.

4.8.6 Application to outreach and residential settings

As with Narrative Therapy, the outreach setting is well suited to the application of SFT in both a brief and longer-term modality. The brief approach may be particularly beneficial for adolescents whose crises bring them into contact with AOD services for the first or second time, or who present intermittently. These adolescents are generally looking for rapid practical assistance and reassurance that a solution to the crisis is within reach. Brief interventions that focus on what can be done now, and which draw attention to the strengths and other resources that adolescents can draw on immediately, may work rapidly to instil a sense of safety and hope.

Even though it is was originally designed to be brief, the SFT approach can be used repeatedly over the long term. Most of the elements can be used at varied points in the therapeutic process, depending on the individual client needs and the natural unfolding of the unique relationship between the client and the practitioner.

An obvious role for a solution-focused approach in outreach is in the process of engagement. A likely first step will be to initiate a cooperative 'joining' in a warm, positive, accepting relationship in which the client is invited to teach the practitioner about their view of the world and how the practitioner could co-operate with them (O'Connell, 2005). O'Connell also stresses that joining involves the practitioner adopting a non-expert position, matching the client's language, offering positive feedback, and displaying a willingness to adapt their interviewing style (p25).

Another practice used in SFT to promote engagement and set a tone for the therapeutic encounter is 'problem-free talk'. This is simply discussion that is completely unrelated to the presenting problem. Problem-free talk conveys the message that there is more to this person than their problem. It can provide insights into beliefs, values, qualities and skills that can be harnessed in the development of solutions (O'Connell, 2003).

The joining or engagement process sets the foundation for the next set of tasks. These involve collaborating with the client to clarify the problem(s) that have brought the client to the service, to identify and define the goals that the client wants to achieve, and to work out solutions to achieve those goals (Kim, 2008).

Goal-setting in SFT typically aims to keep the work focused on the client's agenda, contain the problem, and reaffirm client control in the process. Even if a young person is not committed to engaging with services to work on solutions for AOD issues, goal setting can be used in outreach settings. Establishing future-oriented goals is a developmental task that is often particularly challenging for young people who have experienced many setbacks in life and who have received little encouragement. Many vulnerable young people have very low expectations of what it is possible to achieve in life, or they become stuck in highly self-defeating self-beliefs and behaviour patterns.

The 'miracle question' is a central practice element in the SFT repertoire (O'Connell, 2003). It invites clients to use their imagination to describe in some detail what their lives will be like when the problem no longer dominates or controls it. The imaginary format of the miracle question may be particularly beneficial in helping young people with low expectations begin to get in touch with alternative pathways that they had not previously considered possible. By working backwards from the imagined future to explore what is necessary to get there, pathways that may otherwise appear too onerous can be broken into small steps. Realistic goals can be devised on the basis of these small steps.

The scaling question is another element of SFT that is closely connected to goal setting but more focused on the here and now. The scaling question asks the client to rate on a 10-point scale how things are today (Gingerich & Eisengart, 2000). Ten on the scale represents 'no problem' and zero represents the worst the problem has been, or perhaps how the client felt before contacting the helper. Used in combination with the future-focused miracle question, the scaling question helps clients set small, identifiable goals, measure progress, and establish priorities for action. The scaling question can also be used to assess motivation and confidence. It contains the problem and gives clients a sense of ownership and control (O'Connell, 2003; p9).

The scaling question technique is a useful trigger for awareness and reflection upon times when the problem was not present or was better than now. These moments offer opportunities for 'exception seeking' and eliciting solutions that have been tried in the past.

'Exceptions' are times when the problem was not present or times when the client was managing the problem more effectively. The solution-focused therapist is constantly on the lookout for possible exceptions. Exploring the circumstances around exceptions, such as what the client was doing differently, then provides clues about solutions that could be revisited or developed further (Kim, 2008; O'Connell, 2003; Pichot, 2001). Exploration of exceptions also provides opportunities for 'competence-seeking' to find skills, strengths and other qualities that the client possesses but may have forgotten about.

At the end of their time together, a solution-focused practitioner seeks to ensure that the client leaves with an understanding of one or more steps that can be taken towards the solution, no matter how small, and increased confidence that they have the ability to make these steps.

For clients with complex needs, one of these steps may be to return to the service again soon. Checking in with the client about whether the session has been helpful may provide reassurance that the worker is listening and genuinely wants to understand the situation from the client's perspective. It may also stimulate the client to reflect further upon what has been discussed and return again with more ideas.

Box 4.8a: Elements of Solution Focused Therapy readily applied in outreach settings

- 'Joining', or matching the client's language
- Collaborating with the client
- 'Exception' seeking
- Eliciting, affirming & reinforcing existing solutions
- Goal setting
- Competence-seeking or looking for strengths

These 6 practice elements are described in detail in (Mitchell, in preparation).

Residential settings offer the opportunity for intensive work over a period of up to two weeks (acute residential services) or six months (long term residential rehabilitation). The SFT approach applied to ongoing contact will share many of the features of a Narrative Therapy approach as described by Morgan (2000).

Thus, solution-focused content and techniques can be understood as tools in a large toolbox that can be drawn from as needed over time and revisited. All the practices identified as suitable for outreach can also be applied in the residential setting, but there is an opportunity for the worker to go into more depth and consolidate new perspectives and skills over time.

Residential settings, which allow the young person to step out of their usual routine and environment, offer a unique opportunity for therapeutic work that involves getting in touch with a different perspective on life. The work of reframing problems and envisioning the future is particularly suited to residential settings, when the client is away from the stimuli and situations associated with problems. Also called 'context-changing talk' by therapists, reframing involves building a different frame of reference around the problem to make it more solvable, or jointly negotiating a meaning to the client's situation that will enhance the possibility of change (O'Connell, 2005; p35). "The active role of the practitioner is to ask questions to help the client look at the situation from a different perspective" (Kim, 2008; p107).

Spending time in a new environment also provides an excellent context for envisioning the future, reframing and developing new perspectives. The process of the 'change discourse' described by O'Connell (2005) may be useful here because it suggests the idea of becoming immersed in new and different ways of thinking and talking. Because they are surrounded by peers who are also considering and working to make changes in their lives, residential settings can provide and support a change experience that is immersive in quality and imbued with change discourse.

Practical techniques that can be applied by practitioners to support the 'change-discourse' and envision a different future include asking questions about how the future might look, such as 'the miracle question' (O'Connell, 2003; Pichot & Dolan, 2007), helping young people to focus on and detail their goals, stimulating conversations about the future, and elaborating the elements of exception-seeking and competence-seeking into 'competence-talk'.

The work of actually developing solutions is another element of SFT that can be well supported in residential settings, especially long-term residential rehabilitation. The 24-hour supervision and support provide a secure base from which to plan solutions, practise specific skills, test out selected solutions in real life, then return to debrief, evaluate and regroup.

This type of work is very similar to what O'Connell (2005) calls the 'strategy discourse'. It involves a complex set of processes that are unlikely to be completed satisfactorily within a brief intervention, especially for highly vulnerable young people who have relatively few reliable resources and assets in their natural environments. Four central processes include:

- *'Strategy development'* – identifying and committing to what is already proving to be helpful as well as incremental changes that may enhance the effectiveness of these strategies; identifying and abandoning existing strategies that are not working
- *'Mobilisation'* – of the client's experiences, values, skills, and feelings in pursuit of desired goals
- *'Reiteration' and 'task setting'* – summarising the key strategies identified in recent interactions, reinforcing progress, and setting a specific task for the client to carry out in the next few days
- *Evaluation or checking-in* – during and after each session, or at other regular intervals, the worker checks in with the client whether what they are doing together is proving helpful.

When the client intends to engage with the service for an extended period of time, several of the solution-focused elements comprising the strategy discourse are widely recognised as essential to providing planned and coordinated care, and should be incorporated into individual treatment plans (ITPs).

Box 4.8b: Elements of Solution Focused Therapy readily applied in residential settings

In addition to elements used in outreach settings, the following elements can be used in residential care settings:

- Envisioning the future & the 'miracle question'
- Reframing & perspective taking
- Deconstructing the problem
- Developing solutions or the 'strategy discourse'
- Evaluation

These 5 practice elements are described in detail in (Mitchell, in preparation).

4.9 Comments on implementation

4.9.1 Matching intervention approaches to service settings

Sections 4.2 to 4.8 have described seven highly developed intervention approaches or therapeutic models that have been applied in work with young people experiencing problems with AOD use and related psychosocial problems.

Most of these models have demonstrated effectiveness in meeting their stated aims. The others are grounded in theory that is highly relevant to issues confronting our population of concern. Several of these intervention models are also comprehensive in their coverage of the therapeutic aims likely to be of concern to youth AOD services. All of these models have utility. They have significant strengths, as well as some limitations. There is some significant overlap in their key techniques, procedures or elements.

Two questions arise at this point:

(1) Is it necessary to make choices among these intervention approaches? Are there some that are more suitable than others?

(2) If so, what criteria should be used to choose between these models?

We propose that the Victorian youth AOD system as a whole endorse and provide practical support for all seven of these therapeutic approaches. Clearly, individual services should not be expected to implement all of them. Choices need to be made at the service level.

For some youth AOD services the need for such choices may be clear and the cogency of particular criteria may be obvious. Factors such as organisational culture and the values and principles that guide practice, combined with the nature of the client population, may necessitate and guide these choices.

For example, an agency that adheres strongly to the principle of strengths-based practice and which prefers a brief intervention approach may find it natural to choose Solution Focused Therapy as the primary therapeutic model for its services. A service that specialises in working with young people who have experienced trauma and who are troubled by self-harming behaviours may be drawn to Dialectical Behaviour Therapy. A service that is founded on client-centred, relationship-based and holistic service provision is likely to give greater consideration to models that are aligned with these particular principles.

The mainstream EBP literature tends to focus strongly on the scientific rigours of demonstrating clinical effectiveness or the technical challenges involved in dissemination, implementation and maintenance of fidelity. It rarely explores the nexus between clinical science and practice wisdom. This disconnect may be one factor contributing to the slow uptake of empirically supported treatment (EST) models within real-world services (Mitchell, 2011).

The discussion provided above under the heading of 'Articulation with characteristics of effective services and programs' is designed to bridge this nexus, demonstrate the ways in which certain ESTs are consistent with principles widely endorsed by practitioners, and encourage further reading.

However, most of the models described here are highly consistent with most of the practice wisdom-based characteristics of effective programs described in Section 3, and they all have considerable utility across therapeutic aims that are relevant to the sector.

For youth AOD services that have diverse therapeutic aims and which seek to adhere to all 10 characteristics, choosing between these models is not straightforward. There are also several substantial barriers to the adoption and implementation of evidence-based practice treatments that need to be acknowledged and addressed. These barriers are exacerbated for agencies serving clients with multiple and complex needs.

4.9.2 Barriers to the use of empirically supported treatment models

Evidence-based therapeutic interventions are usually developed in research settings as 'integral programs' that combine a variety of interrelated techniques and content into a functional whole, often represented in the form of a manual (Chorpita et al., 2005b). These types of treatments will be referred to as integral or manualised empirically supported treatments (ESTs).

While manualised ESTs have demonstrated efficacy in controlled clinical trials, dissemination and implementation into community-based services has been slow (Aarons, Wells, Zagursky, Fettes, & Palinkas, 2009; Garland, Hurlburt, & Hawley, 2006; Godley, White, Diamond, Passetti, & Titus, 2001; Liddle et al., 2006; Rosenberg, 2009; Stirman et al., 2004). Research examining efforts to implement ESTs in varied child and youth service settings (including AOD, mental health and correctional) has observed substantial barriers (Mitchell, 2011).

A substantial set of barriers centres around the attitudes of providers, who frequently find manual-based programs inflexible and difficult to tailor to individual client needs (Aarons & Palinkas, 2007; Garland et al., 2006; Godley, White et al., 2001; Weisz, Jensen-Doss, & Hawley, 2006).

Successful implementation of a new EST generally demands extensive training of practitioners and ongoing support such as clinical supervision, secondary consultation and case reviews (Aarons, Sommerfeld, & Walrath-Greene, 2009; Fixsen, Blase, Naoom, & Wallace, 2009; Henderson, Taxman, & Young, 2008; McHugh & Barlow, 2010; Weisz et al., 2003).

To achieve sustained implementation, workforce development strategies need to be supplemented by incentives, material resources, administrative support, and changes in organisational procedures and structures (Fixsen et al., 2009). These forms of capacity building demand long-term investment of substantial amounts of money and other resources (Kazak et al., 2010; Liddle et al., 2006; McHugh & Barlow, 2010; Stirman et al., 2004).

Because ESTs generally focus on interventions for particular disorders or narrowly defined problems, agencies serving a client population with multiple and complex needs face rapidly escalating costs if they wish to implement an EST targeting more than one or two disorders or problems (Mitchell, 2011).

A 'modular practice elements' approach to EBP incorporates features that may substantially mitigate these barriers to implementation. Some relevant features of such an approach are described in Section 7.5.

References

Aarons, G. A., & Palinkas, L. A. (2007). Implementation of evidence-based practice in child welfare: service provider perspectives. *Administration and Policy in Mental Health & Mental Health Services Research*, 34, 411-419.

Aarons, G. A., Sommerfeld, D. H., & Walrath-Greene, C. M. (2009). Evidence-based practice implementation: the impact of public versus private sector organization type on organizational support, provider attitudes, and adoption of evidence-based practice, *Implementation Science* (Vol. 4, pp. 13).

Aarons, G. A., Wells, R. S., Zagursky, K., Fettes, D. L., & Palinkas, L. A. (2009). Implementing evidence-based practice in community mental health agencies: a multiple stakeholder analysis. *American Journal of Public Health*, 99(11), 2087-2095.

American Psychological Association. (2005). *American Psychological Association Policy Statement on Evidence-Based Practice in Psychology*. Available: http://www.apa.org/practice/resources/evidence/evidence-based-statement.pdf [2010, 3 December].

Apodaca, T. R., & Longabaugh, R. (2009). Mechanisms of change in motivational interviewing: a review and preliminary evaluation of the evidence. *Addiction*, 104, 705-715.

Arnold, E. M., & Rotherham-Borus, M. J. (2009). Comparisons of prevention programs for homeless youth. *Prevention Science*, 10, 76-86.

Austin, A. M., Macgowan, M. J., & Wagner, E. F. (2005). Effective family-based interventions for adolescents with substance use problems: A systematic review. *Research on Social Work Practice*, 15(2), 67-83.

Avdi, E. (2005). Negotiating a pathological identity in the clinical dialogue: discourse analysis of a family therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 78, 493-511.

Barrowclough, C., Haddock, G., Beardmore, R., Conrad, P., Craig, T., Davies, L., Dunn, G., Lewis, S., Morang, J., Tarrier, N., & Wykes, T. (2009). Evaluating integrated MI and CBT for people with psychosis and substance misuse: recruitment, retention and sample characteristics of the MIDAS trial. *Addictive Behaviors*, 34, 859-866.

Bedell, J. R., & Lennox, S. S. (1997). *Handbook for communication and problem-solving skills training: a cognitive-behavioural approach*. New York: John Wiley & Sons Inc.

Bekerman, Z., & Tatar, M. (2005). Overcoming modern-postmodern dichotomies: some possible benefits for the counselling profession. British Journal of Guidance & Counselling, 33(3), 411-421.

Besley, A. C. (2002). Foucoult and the turn to narrative therapy. *British Journal of Guidance & Counselling*, 30(2), 125-143.

Blackburn, S. (1994). *Oxford dictionary of philosophy* (2nd ed.). Oxford: Oxford University Press.

Bruun, A. (2008). Effective practice for young people experiencing alcohol and other drug-related harm. In D. Moore & P. Dietze (Eds.), *Drugs and public health: Australian perspectives on policy and practice* (pp. 115-126). South Melbourne: Oxford University Press.

Bruun, A., & Hynan, C. (2006). Where to from here? Guiding for mental health for young people with complex needs. *Youth Studies Australia*, 25(1), 19-27.

Bruun, A., Karametos, C., Jones, B., Tattersall, A., Fairbairn, R., Wilson, S., & Palmer, T. (2002). *Working with clients who have alcohol and other drug issues: Youth Substance Abuse Service accredited training manua*l. Melbourne: YSAS Pty Ltd.

Chamberlain, P., Price, J., Reid, J., & Landsverk, J. (2008). Cascading implementation of a foster and kinship parent intervention. *Child Welfare*, 87(5), 27-48.

Chassin, L. (2008). Juvenile justice and substance use. *The Future of Children*, 18(2), 165-183.

Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005a). Identifying and selecting the common elements of evidence based interventions: A distillation and matching model. *Mental Health Services Research,* 7(1), 5-20.

Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005b). Modularity in the design and application of therapeutic interventions. *Applied and Preventive Psychology*, 11, 141-156.

Cohen, P., Chen, H., Crawford, T. N., Brook, J. S., & Gordon, K. (2007). Personality disorders in early adolescence and the development of later substance use disorders in the general population. *Drug and Alcohol Dependence*, 88S, S71-S84.

Crits-Christoph, P., Gallop, R., Temes, C. M., Woody, G., Ball, S. A., Martino, S., & Carroll, K. M. (2009). The alliance in motivational enhancement therapy and counseling as usual for substance use problems. *Journal of Consulting and Clinical Psychology*, 77(6), 1125-1135.

Dennis, M. L., Godley, S. H., Diamond, G., Tims, F. M., Babor, T., Donaldson, J., Liddle, H. A., Titus, J. C., Kaminer, Y., Webb, C., Hamilton, N., & Funk, R. R. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized controlled trials. *Journal of Substance Abuse Treatment*, 27, 197-213.

Dowling, E., & Vetere, A. (2005). Narrative concepts and therapeutic challenges. In A. Vetere & E. Dowling (Eds.), *Narrative therapies with children and their families: a practitioner's guide to concepts and approaches.* Hove: Routledge.

Ellem, K., & Wilson, J. (2010). Life story work and social work practice: a case study with ex-prisoners labelled as having an intellectual disability. *Australian Social Work*, 61(1), 67-82.

Evans, E., Li, L., & Hser, Y.-I. (2009). Client and program factors associated with dropout from court mandated drug treatment programs. *Evaluation and Program Planning*, 32(32), 204-212.

Fixsen, D. L., Blase, K. A., Naoom, S. F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice*, 19(5), 531-540.

Garland, A. F., Hurlburt, M. S., & Hawley, K. M. (2006). Examining psychotherapy processes in a services research context. *Clinical Psychology: Science and Practice*, 13, 30-46.

Garner, B. R., Godley, S. H., Funk, R. R., Dennis, M. L., Smith, J. E., & Godley, M. D. (2009). Exposure to Adolescent Community Reinforcement Approach treatment procedures as a mediator of the relationship between adolescent substance abuse treatment retention and outcome. *Journal of Substance Abuse Treatment*, 36, 252-264.

Gingerich, W. J., & Eisengart, S. (2000). Solution-focused brief therapy: a review of the outcome research. *Family Process*, 39(4), 477-498.

Godley, S. H., Garner, B. R., Smith, J. E., Meyers, R. J., & Godley, M. D. (2011). A large scale dissemination and implementation model for evidence-based treatment and continuing care. *Clinical Psychology: Science and Practice*, 18(1), 68-84.

Godley, S. H., Meyers, R. J., Smith, J. E., Karvinen, T., Titus, J. C., Godley, D., Dent, G., Passetti, L., & Kelberg, P. (2001). *The adolescent community reinforcement approach for adolescent cannabis users*. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Godley, S. H., White, W. L., Diamond, G., Passetti, L., & Titus, J. C. (2001). Therapist reactions to manual-guided therapies for the treatment of adolescent marijuana users. *Clinical Psychology: Science and Practice*, 8, 405-417.

Granfield, R., & Cloud, W. (2001). Social context and "natural recovery": the role of the social capital in the resolution of drug-associated problems. *Substance Use and Misuse*, 36(1), 1543-1570.

Hatch, M. J. (1997). *Organization theory: modern, symbolic and postmodern perspectives*. New York: Oxford University Press.

Hawkins, E. (2009). A tale of two systems: co-occurring mental health and substance use disorders treatment for adolescents. *Annual Review of Psychology*, 60, 197-227.

Henderson, C. E., Taxman, F. S., & Young, D. W. (2008). A Rasch model analysis of evidence-based treatment practices used in the criminal justice system. *Drug and Alcohol Dependence*, 93(1-2), 163-175.

Hettema, J., Steele, J., & Miller, W. R. (2005). Motivational interviewing. *Annual Review of Clinical Psychology*, 1, 91-111.

Higgins, S. T., & Silverman, K. (2008). Introduction. In S. T. Higgins & K. Silverman & S. H. Heil (Eds.), *Contingency management in substance abuse treatment* (pp. 1-15). New York: The Guilford Press.

Hogue, A., Henderson, C. E., Dauber, S., Barajas, P. C., Fried, A., & Liddle, H. A. (2008). Treatment adherence, competence, and outcome in individual and family therapy for adolescent behavior problems. *Journal of Consulting and Clinical Psychology*, 4(4), 544-555.

Hollin, C. R. (1998). Working with young offenders. In K. Cigno & D. Bourn (Eds.), *Cognitive-behavioural social work in practice* (pp. 127-142). Aldershot: Ashgate Publishing Limited.

James, A. C., Taylor, A., Winmill, L., & Alfoadari, K. (2008). A preliminary community study of Dialectical Behaviour Therapy (DBT0 with adolescent females demonstrating persistent, deliberate self-harm (DSH). *Child and Adolescent Mental Health*, 13(3), 148-152.

Katz, L. Y., Cox, B. J., Gunasekara, S., & Miller, A. L. (2004). Feasibility of Dialectical Behavior Therapy for suicidal adolescent inpatients. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(3), 276-282.

Kazak, A. E., Hoagwood, K., Weisz, J. R., Hood, K., Kratochwill, T. R., Vargas, L. A., & Banez, G. A. (2010). A meta-systems approach to evidence-based practice for children and adolescents. *American Psychologist*, 65(2), 85-97.

Kelley, P., Blankenburg, L., & McRoberts, J. (2002). Girls fighting trouble: re-storying young lives. Families in Society: *The Journal of Contemporary Human Services*, 83(5/6), 530-540.

Kiecolt, K. J. (1994). Stress and the decision to change oneself: a theoretical model. *Social Psychology Quarterly*, 57(1), 49-63.

Kim, J. S. (2008). Examining the effectiveness of solution-focused brief therapy: a meta-analysis. *Research on Social Work Practice*, 18(2), 107-116.

Kondrat, D. C., & Teater, B. (2009). An anti-stigma approach to working with persons with severe mental disability: seeking real change through narrative change. *Journal of Social Work Practice*, 23(1), 35-47.

Krishnan-Sarin, S., Duhig, A. M., & Cavallo, D. (2008). Adolescents. In S. T. Higgins & K. Silverman & S. H. Heil (Eds.), *Contingency management in substance abuse treatment* (pp. 120-139). New York: The Guilford Press.

Kruczek, T., & Vitanza, S. (1999). Treatment effects with an adolescent abuse survivor's group. *Child Abuse & Neglect*, 23(5), 477-485.

Leahy, R. L. (2003). *Cognitive therapy techniques: a practitioner's guid*e. New York: The Guilford Press.

Lennings, C. J., Kenny, D. T., & Nelson, P. (2006). Substance use and treatment seeking in young offenders on community orders. *Journal of Substance Abuse Treatment*, 31, 425-432.

Levy, J. S. (2004). Pathway to a common language: a homeless outreach perspective. *Families in Society: The Journal of Contemporary Human Services*, 85(3), 371-378.

Liddle, H. A. (1999). Theory development in a family-based therapy for adolescent drug abuse. *Journal of Clinical Child Psychology*, 28(4), 521-532.

Liddle, H. A. (2010). Multidimensional family therapy: a science-based treatment system. *The Australian and New Zealand Journal of Family Therapy*, 31(2), 133-148.

Liddle, H. A., Rowe, C. L., Alina, G., Henderson, C. E., Dakof, G. A., & Greenbaum, P. E. (2006). Changing provider practices, program environment, and improving outcomes by transporting Multidimensional Family Therapy to an adolescent drug treatment setting. *The American Journal on Addictions*, 15, 102-112.

Little, A., Hartman, L., & Ungar, M. (2008). Creating a narrative-based practice culture across a youth serving agency: the Phoenix Youth Program's story. *Residential Treatment for Children and Youth*, 25(4), 319-332.

Lundahl, B. W., Kunz, C., Brownell, C., Derrick, T., & Burke, B. L. (2010). A meta-analysis of motivational interviewing: twenty-five years of empirical studies. *Research on Social Work Practice*, 20(2), 137-160.

Lynch, T. R., Chapman, A. L., Rosenthal, M. Z., Kuo, J. R., & Linehan, M. M. (2006). Mechanisms of change in Dialectical Behavior Therapy: theoretical and empirical observations. *Journal of Clinical Psychology*, 62(4), 459-480.

Macgowan, M. J., & Engle, B. (2010). Evidence for optimism: Behavior therapies and motivational interviewing in adolescent substance abuse treatment. *Child and Adolescent Psychiatric Clinics of North America*, 19, 527-545.

McDonell, M. G., Tarantino, J., Dubose, A. P., Matestic, P., Steinmetz, K., Galbreath, H., & McClellan, J. M. (2010). A pilot evaluation of dialectical behavioural therapy in adolescent long-term inpatient care, *Child and Adolescent Mental Health*.

McHugh, K. R., & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments: a review of current efforts. *American Psychologist*, 65(2), 73-84.

McHugh, R. K., Murray, H. W., & Barlow, D. H. (2009). Balancing fidelity and adaptation in the dissemination of empirically-supported treatments: The promise of transdiagnostic interventions. *Behavior Research and Therapy*, 47, 946-953.

McLeod, J. (2006). Narrative thinking and the emergence of postpsychological therapies. *Narrative Inquiry*, 16(1), 201-210.

McMain, S. (2007). Effectiveness of psychosocial treatments on suicidality in personality disorders. *Canadian Journal of Psychiatry*, 52(Supplement 1), 103S-114S.

McMain, S., & Korman, L. M. (2001). Dialectical behavior therapy and the treatment of emotion dysregulation. *Journal of Clinical Psychology In Session: Psychotherapy in Practice*, 57(2), 183-196.

McMurran, M. (2009). Motivational interviewing with offenders: a systematic review. Legal and Criminological Psychology, 14, 83-100.

Meade, M. A., & Slesnick, N. (2002). Ethical considerations for research and treatment with runaway and homeless adolescents. *The Journal of Psychology*, 136(4), 449-463.

Merrell, K. W., & Gimpel, G. A. (1998). *Social skills of children and adolescents: conceptualization, assessment and treatment*. Mahwah, New Jersey: Lawrence Erlbaum Associates.

Miller, A. L., Rathus, J. H., Linehan, M. M., Wetzler, S., & Leigh, E. (1997). Dialectical behavior therapy adapted for suicidal adolescents. *Journal of Practical Psychiatry and Behavioral Health*, 3(2), 78-86.

Miller, W. R. (1996). Motivational interviewing: research, practice, and puzzles. *Addictive Behaviors*, 21(6), 835-842.

Miller, W. R., & Rollnick, S. (2009). Ten things that Motivational Interviewing is not. *Behavioural and Cognitive Psychotherapy*, 37, 129-140.

Mitchell, P. (in preparation). *Therapeutic practice elements for the Youth Support and Advocacy Service: Definitions and Descriptions*. Melbourne: Youth Support and Advocacy Service.

Mitchell, P. F. (2011). Evidence-based practice in real-world services for young people with complex needs: new opportunities suggested by recent implementation science. *Children and Youth Services Review*, 33, 207-216.

Morgan, A. (2000). *What is narrative therapy?* Adelaide: Dulwich Centre Publications.

Muck, R., Zempolich, K. A., Titus, J. C., Fishman, M., Godley, M. D., & Schwebel, R. (2001). An overview of the effectiveness of adolescent substance abuse treatment models. *Youth & Society*, 33(2), 143-168.

Nelson-Gray, R. O., Keane, S. P., Hurst, R. M., Mitchell, J. T., Warburton, J. B., Chok, J. T., & Cobb, A. R. (2006). A modified DBT skills training program for oppositional defiant adolescents: promising preliminary findings. *Behaviour Research and Therapy*, 44, 1811-1820.

O'Connell, B. (2003). Introduction to the solution-focused approach. In B. O'Connell & S. Palmer (Eds.), *Solution-focused therapy* (pp. 1-11). London: Sage Publications.

O'Connell, B. (2005). *Solution-focused therapy*. London: Sage.

Payne, M. (2000). *Narrative therapy: an introduction for counsellors*. London: Sage.

Pease, B. (2002). Rethinking empowerment: a postmodern reappraisal for emancipatory practice. *British Journal of Social Work*, 32, 135-147.

Pennay, A., Cameron, J., Reichart, T., Strickland, H., Lee, N., Hall, K., & Lubman, D. I. (2011). A systematic review of interventions for *co-occurring substance use disorder and borderline personality disorder.* Journal of Substance Abuse Treatment, 41, 363-373.

Perkins, R. (2006). The effectiveness of one session of therapy using a single session therapy approach for children and adolescents with mental health problems. *Psychology and Psychotherapy: Theory, Research and Practice*, 79, 215-227.

Pichot, T. (2001). Co-creating solutions for substance abuse. *Journal of Systemic Therapies*, 20(2), 1-23.

Pichot, T., & Dolan, Y. (2007). *Solution-focused brief therapy: Its effective use in agency settings*. Binghamton: The Haworth Clinical Practice Press.

Rathus, J. H., & Miller, A. L. (2002). Dialectical behavior therapy adapted for suicidal adolescents. *Suicide & Life Threatening Behavior*, 32(2), 146-157.

Robins, C. J., & Chapman, A. L. (2004). Dialectical behavior therapy: current status, recent developments, and future directions. *Journal of Personality Disorders*, 18(1), 73-89.

Rosenberg, L. (2009). The reality of implementing evidence-based practices. *Journal of Behavioral Health Services and Research*, 37(1), 1-3.

Rosenthal, D., Mallett, S., Milburn, N., & Rotheram-Borus, M. J. (2008). Drug use among homeless young people in Los Angeles and Melbourne. *Journal of Adolescent Health*, 43, 296-305.

Rowe, C. L. (2010). Multidimensional family therapy: Addressing co-occurring substance abuse and other problems among adolescents with comprehensive family-based treatment. *Child and Adolescent Psychiatric Clinics of North America*, 19, 563-576.

Schuetz, S., & Berry, M. (2009). *Review of best practice around behaviour change in young offenders with alcohol and other drug issues.* Melbourne: Caraniche for Australian Community Support Organisation.

Scott, M. J. (2009). *Simply effective cognitive behaviour therapy: a practitioner's guide.* East Sussex: Routledge.

Simon, J. K., & Berg, I. K. (2004). Solution-focused brief therapy with adolescents. In F. W. Kaslow (Ed.), *Comprehensive handbook of psychotherapy* (Vol. 3). New York: Wiley.

Slesnick, N., Prestopnik, J. L., Meyers, R. J., & Glassman, M. (2007). Treatment outcome for street-living, homeless youth. *Addictive Behaviors,* 32, 1237-1251.

Staiger, P. K., Melville, F., Hides, L., Kambouropoulos, N., & Lubman, D. I. (2009). Can emotion-focused coping help explain the link between posttraumatic stress disorder severity and triggers for substance use in young adults? *Journal of Substance Abuse Treatment*, 36(2), 220-226.

Stanger, C., & Budney, A. J. (2010). Contingency management approaches for adolescent substance use disorders. *Child and Adolescent Psychiatric Clinics of North America*, 19, 547-562.

Statham, J. (2004). Effective services to support children in special circumstances. *Child: Care, Health & Development,* 30(6), 589-598.

Stirman, S. W., Crits-Christoph, P., & DeRubeis, R. J. (2004). Achieving successful dissemination of empirically supported psychotherapies: A synthesis of dissemination theory. *Clinical Psychology: Science and Practice*, 11(4), 343-359.

Sukhodolsky, D. G., & Ruchin, V. (2006). Evidence-based psychosocial treatments in the juvenile justice system. *Child and Adolescent Psychiatric Clinics of North America*(15), 501-516.

Tevyaw, T. O. L., & Monti, P. M. (2004). Motivational enhancement and other brief interventions for adolescent substance abuse: foundations, applications and evaluations. *Addiction, 99*(Supplement 2), 63-75.

Thorpe, G. L., & Olson, S. L. (1997). *Behavior therapy: concepts, procedures and applications* (2nd ed.). Needham Heights, MA: Allyn and Bacon.

Toumbourou, J. W., Stockwell, T., Neighbours, C., Marlatt, G. A., Sturge, J., & Rehm, J. (2007). Interventions to reduce harm associated with adolescent substance use. *The Lancet, 369*(9570), 1391-1401.

Trupin, E. W., Stewart, D. G., Beach, B., & Boesky, L. (2002). Effectiveness of a Dialectical Behaviour Therapy program for incarcerated female juvenile offenders. *Child and Adolescent Mental Health*, 7(3), 121-127.

Ungar, M. (2005). A thicker decription of resilience. *The International Journal of Narrative Therapy and Community Work*(3&4), 89-96.

Ungar, M. (2011). *Counseling in challenging contexts: Working with individuals and families across clinical and community settings*. Belmont: Brooks/Cole.

Weisz, J. R., Jensen-Doss, A., & Hawley, K. M. (2006). Evidence-based youth psychotherapies versus usual clinical care: a meta-analysis of direct comparisons. *American Psychologist,* 61(7), 671-689.

Weisz, J. R., Southam-Gerow, M. A., Gordis, E. B., & Connor-Smith, J. (2003). Primary and secondary control enhancement training for youth depression. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 165-183). New York: The Guilford Press.

Wolter, J. A., DiLollo, A., & Apel, K. (2006). A narrative therapy approach to counselling: A model for working with adolescents and adults with language-literacy deficits. *Language, Speech and Hearing Services in Schools*, 37, 168-177.

Wong, C. J., Silverman, K., & Bigelow, G. E. (2008). Alcohol. In S. T. Higgins & K. Silverman & S. H. Heil (Eds.), *Contingency management in substance abuse treatment* (pp. 120-139). New York: The Guilford Press.

Woodberry, K. A., & Popenoe, E. J. (2008). Implementing dialectical behavior therapy with adolescents and their families in a community outpatient clinic. *Cognitive Behavioral Practice*, 15, 277-286.

Worrall-Davies, A., Cottrell, D., & Benson, E. (2004). Evaluation of an early intervention Tier 2 child and adolescent mental health service. *Health and Social Care in the Community*, 12(2), 119-125.

5. Behaviour Change

5.1 Introduction

The complexity of youth AOD practice requires overarching frameworks that enable practitioners to make accurate assessments and apply effective, timely interventions that suit the goals of clients and others involved in their care.

Browning and Thomas (2005) identify that behaviour change models or frameworks in social and public health are focused either on the individual or broader environmental influences. Individual models emphasise perceived behavioural control or self-efficacy concepts as a predictor of action. In contrast, health promotion models tend to focus on the role of social, economic, cultural and environmental influences on health and illness.

Youth AOD services seek to address the harmful substance use of clients as an individual health-comprising behaviour while also responding to the developmental vulnerability of clients, which is largely determined by social/ecological factors. No one behaviour change theory or model adequately incorporates these aspects. As such, any individual health behaviour change framework used to guide youth-specific AOD assessment and intervention planning must be augmented by a developmentally attuned, social-ecological framework that addresses client vulnerability and the determinants of AOD problems. The 'Framework for Resilience Based Intervention' that is outlined and explored in Section 6 is recommended for the purpose.

The individual health behaviour change framework found to be most relevant and applicable for youth AOD work in Australia is the 'Transtheoretical Model of Change', The reason for recommending a model conceptualised well over 30 years ago, that has several limitations (see 5.2.4), is that the 'Stages of Change' (The model's construct) continues to be recognised by critiques and advocates alike as a useful way to understand the change process and how people are positioned in relation to change. This can enhance a practitioner's ability to be client-centred, which is a key characteristic of effective youth AOD programs (see section 3). Further, it is widely understood and used by Australian AOD practitioners and is yet to be superseded.

5.2 The Transtheoretical Model

5.2.1 Overview of the Transtheoretical Model

The Transtheoretical Model of Change (Prochaska & DiClemente, 1984; Prochaska, DiClemente & Norcross, 1992; Prochaska & Velicer, 1997) describes how people either modify problem behaviours or adopt new, more healthy behaviours. The model provides youth AOD practitioners with a framework for understanding the dynamics of behaviour change.

Change is viewed as a process that unfolds over time rather than an event, and the focus is on the decision making of each individual. The Transtheoretical Model enables practitioners to assess each young person's motivation and readiness to change and informs the composition of meaningful interventions that can be used to assist change.

The model has three integrated dimensions. The first is the **'Stages of Change'**, which delineates a series of five stages that people move through as they change. Second, the **'Processes of Change'** are 10 cognitive and behavioural activities that facilitate the movement of people through each of the stages. Third, the **'Levels of Change'** consist of interactive areas of an individual's life (i.e. intrapersonal, interpersonal and/or situational) that influence and are influenced by changes. The 'Levels of Change' represent complicating problems that can hinder change, but if worked through can reinforce healthy change over the long term.

Two further constructs are integrated within the Transtheoretical Model: 'Decisional Balance' and 'Self-Efficacy'. Both are integral in determining how change is initiated and maintained.

'Decisional Balance' is a state that individuals find themselves in as they weigh their positive and negative valuations of substance-using behaviour together with the perceived costs and benefits of change.

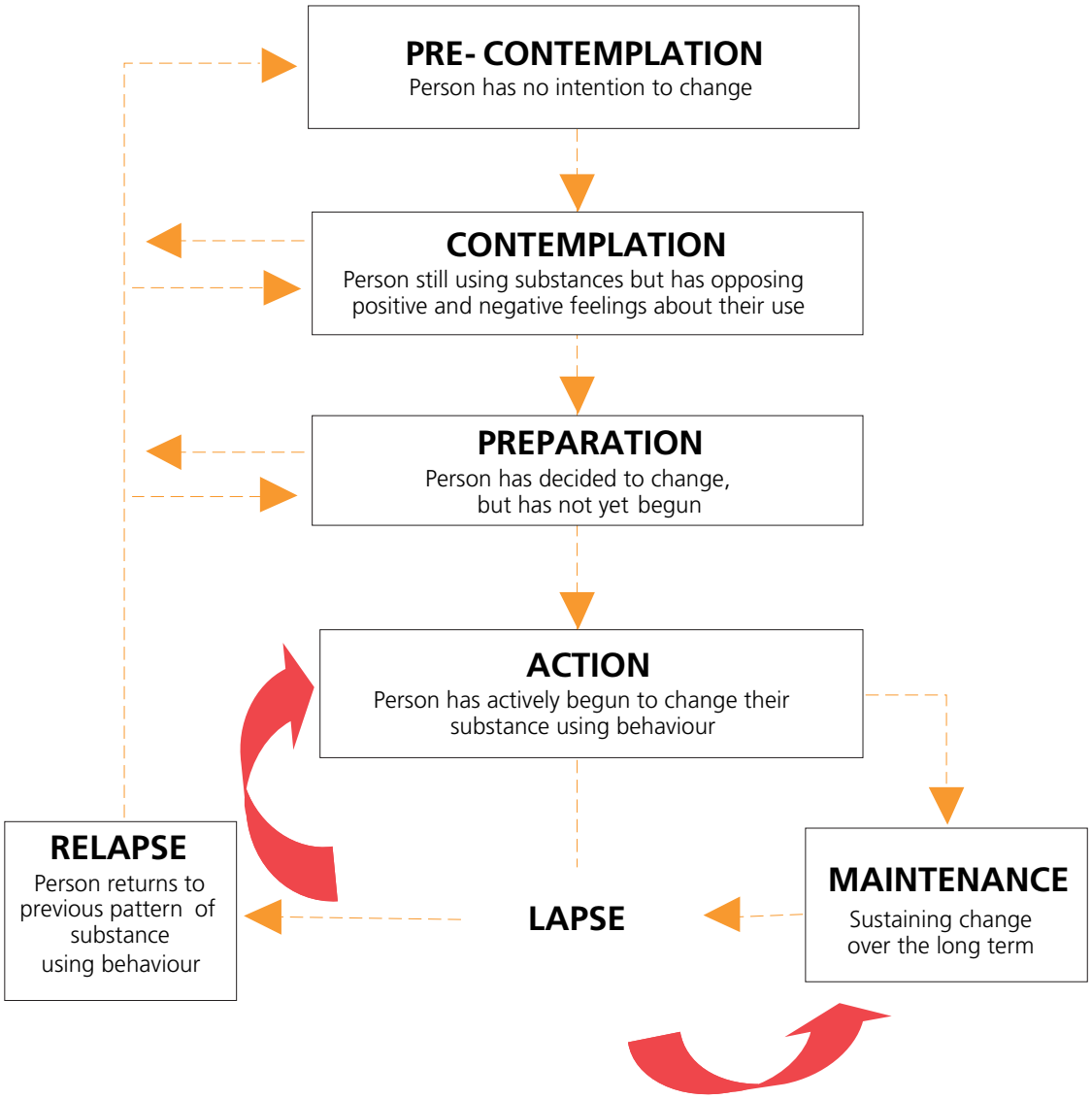
'Self-Efficacy' is an individual's impression of their own ability to complete the tasks and meet the challenges involved with changing the target behaviour. Self-efficacy is thought to be predictive of the amount of effort an individual will expend in initiating and maintaining a behavioural change. Self-efficacy is an important element of many behaviour change theories (see Browning & Thomas, 2005). It is also a key component of the Framework for Resilience Based Intervention (see Section 6). The Levels of Change are not explored in this section as they are also subsumed by the Framework for Resilience Based Intervention.

5.2.2 The Stages of Change

The Transtheoretical Model's central organising construct is the 'Stages of Change' (see Figure 5.1). Each of the stages denotes a certain orientation towards change that will be reflected in the decisions a young person makes about their substance use. By examining these decisions, youth AOD practitioners can gauge a young person's motivation to change. Motivation is identified as a critical factor in the success of people who modify their substance-using behaviour (Miller & Rollnick, 2002) and has been shown to strongly influence help-seeking behaviour and treatment participation (DiClemente, 1999).

Miller and Rollnick (2002) describe motivation as ''...a state of readiness or eagerness to change, which may fluctuate from one time or situation to another" (p14). Fluctuations in young people's motivation to change are likely to be more common than for adults. Clark (2001) points out that young people are constantly changing, as are the severity, magnitude and frequency of the problems they face. As such, it is common for young people in the process of changing to move between stages. Youth AOD practitioners are therefore advised to continually gauge young people's motivation and readiness for change and customise their approach accordingly.

Figure 5.1: The Stages of Change Model



Adapted from: Prochaska,and DiClemente (1986)

Pre-contemplation

Pre-contemplators are not intending to change their substance-using behaviour in the foreseeable future. Young people in this stage are not interested in changing and will either be or appear unconcerned about their substance-using behaviour. This can be the case even when the adverse consequences of their substance use are obvious and concerning to others. For this reason parents, guardians and courts commonly exercise their duty of care and compel young people in their care to modify their substance-using behaviour. This often provokes resistance from the young person and leads to their erroneous characterisation as "unmotivated". Rather, resistance signifies that different motivations are driving a young person's actions.

Young people's apparent motivation can be influenced by a range of factors associated with developmental stage and level of vulnerability. Young people may:

- Not care about the consequences of substance use
- Intentionally give the impression that they don't care about the consequences of substance use to project an image that they are in control even when they clearly are not
- Be uninformed or under-informed about the consequences of their substance use
- Have limited experience and are only beginning to develop the capacity for insight into the link between actions and consequences.

Further, young people with backgrounds of social disadvantage who continue to live at the margins of society often develop a capacity to tolerate adversity. For such young people and those closest to them, problems stemming from substance use can be seen as a natural part of life.

In general, young people who don't believe that change is possible are also likely to be pre-contemplative. This orientation towards change can be reinforced when a young person is unaware that programs and services exist that cater for their needs and preferences.

Contemplation

Young people in the contemplation stage continue to focus on what for them are the benefits of substance use; what they like about it. However, contemplators have also experienced and give weight to the adverse consequences; the things that they don't like about substance use.

People who are contemplators may also be considering the benefits associated with changing but are likely to be acutely aware of what it will cost them in effort, energy and loss (DiClemente & Velasquez, 2002). This balance between consideration of the costs and benefits of changing can produce profound ambivalence that can keep young people stuck in this stage for long periods of time.

The desire to resolve the internal conflict and dissonance experienced as a result of this ambivalence can spur a person on to make changes (DiClemente & Velasquez, 2002), but can also result in a young person resorting to the short-term solution that substance use offers (Bruun, 2008).

As with those young people who are not interested in change, contemplators might also mask their true state of mind. Again there is potentially a developmental component stemming from young people's:

- Acute need for privacy and reluctance to share personal details about themselves until trust and regard has been built with another
- Sensitivity regarding the image they project, with both young men and women often feeling it necessary to hide vulnerability
- Inexperience and being either uninformed, under-informed and/or ill-informed.

Preparation/planning (also known as Determination or 'Ready for Action')

The intention of a young person in 'preparation' is to make changes in the immediate future. The model's underpinning theory holds that people form this intention when the costs associated with substance use substantially outweigh the benefits, and/or the benefits of changing outweigh the costs. A move into the 'preparation' stage brings the model's 'Self-Efficacy' construct into focus. Adapted from Bandura (1977, 1982), it represents the confidence a person has in achieving a specific outcome.

Intending to change is very different from making changes. A strong sense of self-efficacy increases the likelihood of transition from the 'preparation' to the 'action' stage. This transition is particularly challenging when substance use has been ubiquitous in a young person's life and when it continues to be for others in their immediate social network.

These young people may need assistance to understand that alternatives to a substance-using lifestyle exist and could be a realistic option for them. If and when such alternative pathways are embraced, specific goals may be set and alternative strategies for pursuing them explored and mapped out.

A young person may have been at the point of changing several times in the past. Change is motivated either by the desire to resolve or escape problems (avoidance) or to achieve some benefit (approach). Where a young person's lifestyle has featured

problematic substance use, avoidance rather than approach factors are likely to have a stronger influence. The decision to change is often made when young people reach or exceed the limits of their tolerance for the complications associated with substance use.

Practitioners are advised to be mindful of how demoralising it can be for young people who have formed the view that change is required but not possible. Substance use might be used as a mechanism for coping with these feelings and there is a strong possibility of regression. Further, there is heightened potential that a young person in such circumstances will engage in other 'risk' behaviours and may feel suicidal.

Action

'Action' is the stage in which people apply themselves to the task of changing a behaviour and make observable modifications to their lifestyle. Action requires considerable commitment and an investment of energy into change processes. It involves implementing viable strategies to achieve goals set in the preparation stage.

In the action stage, self-efficacy is expressed through coping with high-risk situations and not regressing to an earlier stage. Youth AOD practitioners should remember that the changes a young person makes on the first attempt may not last. It is far more common for people to make multiple attempts to change substance-using behaviour before finally succeeding (Polivy & Herman, 2002).

Maintenance

Maintenance is the stage in which people consolidate the achievements attained during the action stage. The transition from 'action' to 'maintenance' is gradual, requiring sustained change for a sufficient period. Maintenance is signified by a young person feeling relatively stable and more confident in continuing to pursue their goals.

Even so, those in maintenance remain attached in some way to their former substance-using behaviour. This necessitates ongoing efforts to prevent 'lapsing' or 'relapsing', but less frequent application of change processes than would be required in the action stage. While young people's decision to change is most often made in response to the negative consequences of substance use (avoidance motivation), it is essential that young people have constructive options to work towards (approach motivation).

People can overcome their emotional and physical attachment to substance-using behaviour (Prochaska et al, 1992). This signifies a completion of the change process, also known as 'exit'. This is typically associated with significant lifestyle change and reflected in the achievement of several significant treatment goals. Even so, for some the attachment to substance-using behaviour is continuous. In such cases, people remain in maintenance.

Lapse and Relapse

Relapse involves regression from action or maintenance to an earlier stage and is evidenced by a return to previous problematic patterns of behaviour. Relapse is both an outcome and a process that at some stage involves an initial setback or 'lapse' (Witkiewitz & Marlett, 2004). A lapse is a brief or limited incident of substance use. This brief return to substance use does not constitute a relapse. Further, lapse does not automatically lead to relapse but is a step in that direction.

Most young people in the process of changing and significant others in their social network will invariably view any regression negatively. The loss of perceived control often results in self-blame and a diminished sense of self-efficacy. The presence of these feelings after the breaking of a strong resolution to change is known as the 'abstinence violation effect' (Curry, Marlatt & Gordon, 1987).

Both 'lapse' and 'relapse' present an excellent opportunity for the kind of self-discovery and learning necessary for sustained changes over the long term. People generally learn more from their setbacks than from their successes. Further, studies repeatedly demonstrate that attempts to modify a range of behaviours, including substance use, result in at least one lapse followed by relapse (Polivy & Herman, 2002). While lapse and relapse are not guaranteed, both should be seen as a natural part of the change process.

5.2.3 The Processes and Levels of Change

The Processes of Change are covert and overt activities that people use to move through the Stages of Change. They are independent variables that have been demonstrated to support change. This means that young people 'can' rather than 'need' to apply them to support their efforts to change.

Prochaska, DiClemente and Norcross (1992) identify 10 processes, five that are experiential and five that are behavioural.

The efficacy of each process is likely to be maximised when tailored to a young person's stage of change. Studies have been conducted into which change processes and styles of intervention match best with particular stages of change (Miller & Rollnick, 2002; Perz et al, 1996; Thornton et al, 1998). The five experiential change processes have been demonstrated to be most effective for people in the pre-contemplation or contemplation stages. They accord with non-confrontational interventions that are delivered with empathy and take account of young people's perspective.

Processes that are behavioural in nature (i.e., counter-conditioning, stimulus control, contingency management) have been found to be more effective for individuals in the preparation, action or maintenance stages. These processes accord with action-oriented interventions that focus on the development of skills and strategies that support and reinforce change.

The same researchers found that adopting a passive, non-action approach with people in later stages of change is likely to be counterproductive. Conversely, applying action-oriented, behavioural approaches with people in the pre-contemplation or contemplation stages is unlikely to win cooperation. "Confronted with the need for change, an ambivalent person naturally responds with the other side of the decisional balance, with the end result being a misinterpretation of this response as 'denial' or 'resistance' " (Giovazazolias & Davies, 2005) (p174).

Each of the Levels of Change identified by Prochaska, DiClemente and Norcross (1992) can influence and are influenced by the changes people make. The levels are situational and symptomatic, relating to the cognitions of the person making changes and interpersonal problems they may experience, including family and system conflicts. In this resource, these influential factors and how they interact to either nurture or interfere with behaviour change are dealt with in Section 6.

Table 5.1: The Processes of Change

EXPERIENTIAL PROCESSES	ACTION ORIENTED/BEHAVIOURAL PROCESSES
Consciousness Raising [Increasing awareness] involves increased awareness about the causes, consequences and potential ways of dealing with problematic substance-using behaviour	**Stimulus Control** removes cues or triggers for unhealthy substance-using behaviour and adds prompts for healthier alternatives. It involves creating the conditions that support change and reduce risks for relapse.
Dramatic Relief [Emotional arousal] involves people being moved emotionally by the impact of substance use in their lives. This might stem from a growing or sudden awareness of the connection between their actions and consequences experienced as negative. Strong grief reactions often result which, if dealt with constructively, can be a catalyst for change.	**Helping Relationships** [Supporting] provide support for healthy behaviour change. These relationships most commonly feature openness, trust and acceptance.
Environmental Re-evaluation [Social reappraisal] combines both affective and cognitive assessments of how substance use affects one's social environment.	**Counter Conditioning** [Substituting] requires substituting problematic substance use with rewarding healthy behaviours.
Social Liberation [Re-engineering] requires an increase in social opportunities or alternatives, especially for people who are relatively deprived or oppressed.	**Reinforcement Management** [Rewarding] provides predictable consequences for taking steps in a particular direction. This includes both rewards and punishments. Philosophically, the Transtheoretical Model orients practitioners to working in harmony with how people change naturally. This involves enabling young people to understand the logical consequences of particular decisions, actions and consequences.
Self Re-evaluation combines both cognitive and affective assessments of how substance use shapes one's self-image and one's image in the eyes of others.	**Self-liberation** [Committing] relates directly to the belief that change is possible, stemming from both enhanced self-efficacy & the perception that social and environmental conditions are conducive to change. Self-liberation involves a continuous process of committing to act on the belief that change is beneficial possible.

5.2.4 Limitations

The Transtheoretical Model, in particular the Stages of Change construct, has become popular in several fields to guide interventions addressing a wide range of problem behaviours. Even so, the model has limitations that practitioners, service planners and policy makers should aware of.

Littell and Girvin (2002) reviewed 87 studies on the Stages of Change across problem behaviours. They concluded that, while the staged model has considerable heuristic value, its practical utility is limited by concerns about the validity of stage assessment. Further, they found little experimental evidence for sequential movement through discrete stages in studies of specific problem behaviours, such as smoking and substance abuse.

West (2005) elaborates on this theme, contending that the dividing lines between stages are too arbitrary. He questions the reliability of the model in making predictions about behaviour change. Adams and White (2005) found the methods applied to gauge an individual's stage of change are not standardised, compared empirically or validated.

West (2005) also believes the model is based on a flawed assumption that individuals typically make coherent and stable plans for changing problem behaviours. He asserts that the choice to make health behaviour change is contingent on opportunities within the individual's social and physical environment and on motivations, which are subject to a range of variables including "…desires, urges, needs, habits, evaluations and level of commitment to any prior resolutions" (p1059).

DiClemente (2005) acknowledges that some of the claims regarding the utility and scope of the Transtheoretical Model have been exaggerated and believes that critics have raised valid concerns that need further exploration. Even so, DiClemente strongly defends the value of the Stages of Change construct as a device for understanding and exploring the process of change with individuals.

He believes that the momentary influences on an individual's behaviour identified by West (ibid) are part of a larger change process that can be guided intentionally. He also points out that anomalies in how a construct is operationalised are to be expected. He contends that both momentary change and sustained change are associated with a compilation of tasks and accomplishments that relate to the Transtheoretical Model's stages and processes.

A meta-analysis of 57 studies of interventions tailored to the Transtheoretical Model (Noar, Benac & Harris, 2007) supports DiClemente's comments on the ongoing utility of the model as a guide for practitioners and not a predictor of change. They found that programs tailoring interventions and responses according to each of the key constructs within the Transtheoretical Model (i.e. stage) achieve behaviour change and do better than those that do not (ibid).

There are also basic questions about intentional behaviour change in relation to the age it begins (Prochaska, Redding, & Evers, 2007). It is possible that young people's capacity and motivation to engage in self-directed and intentional behaviour change is limited. This might explain why many young people who are using alcohol and other drugs, including those experiencing problems, are in the pre-contemplation stage.

However, the Stages of Change construct is still a useful way to understand how a young person with intensive usage patterns might be oriented towards their substance use. It is therefore important that practitioners factor each young person's developmental status and capacity into considerations of stage and the types of interventions that might be efficacious (see Section 5.3).

It is worth noting that applied studies in school-based bullying prevention (Prochaska et al., 2007) and early intervention with adolescent smokers using treatments tailored to the Transtheoretical Model produced significant abstinence rates at 24 months that were almost identical to rates found with treated adult smokers (Hollis et al., 2005).

Prochaska, Redding and Evers (2007) also identify that the degree to which the Transtheoretical Model has cross-cultural relevance might be an issue. While there is no conclusive evidence as to the effectiveness of the model with young people from different cultural backgrounds, there are indications that the model has cross-cultural relevance. A meta-analysis of research on the relationships between stages and the pros and cons of changing across 10 countries revealed no significant effect by country (Hall & Rossi, 2008).

5.3 Applying the Stages of Change to assess readiness and guide intervention planning

5.3.1 Intervention matching

A critical assumption of Transtheoretical Model theorists is that sustainable change is most likely to be achieved when interventions (often integrating one or more 'change process') are matched to an individual's stage of change. This assumption is shared widely in the AOD treatment field and is supported by the findings of research suggesting that client-treatment matching according to the stage of motivation can improve overall treatment results (DiClemente et al., 1991; Mattson et al., 1994; Mattson, 1998).

Further, Giovazazolias and Davies (2005) sought the perspectives of clients participating in AOD treatment about their preferred therapeutic interventions according to their stage of motivation. Their research corroborated the approach proposed in the Transtheoretical Model for engaging and responding to substance users. They conclude that "…careful assessment of the stage of motivation and individual-tailored intervention should be an essential element of any treatment program for drug and alcohol addicted clients" (p181).

5.3.2 Interventions with young people in the 'pre-contemplation' stage

The first task is to engage clients in a relationship where communication is open and honest. Approaches that close down communication restrict meaningful engagement and limit the health-promoting influence of practitioners.

To open lines of communication with young people, youth AOD practitioners are advised to begin any discussion about a young person's substance use with questions exploring what they like about it. This puts the attention on what motivates the young person. It is a question that pre-contemplators are usually able to answer given that they are either unaware of or give no weight to the downside of their substance use.

It also demonstrates to the client that the practitioner is interested in understanding their opinion rather than lecturing or judging them; an assumption young people often make as they engage with AOD services. It is crucial to remember that a young person experiencing crisis is unlikely to see the point of a more reflective conversation and will favour action to address urgent and pressing needs.

Box 5.1

INTERVENTION GUIDE: PRE-CONTEMPLATION STAGE		
The primary intentions at this stage are:	**The primary processes of change are:**	**The key psychosocial interventions are:**
• Engagement • Awareness building • Harm reduction • Address determinants of problematic AOD use	• Consciousness raising • Dramatic relief • Environmental re-evaluation	• Motivational Interviewing • Client-centred casework

Once the practitioner's orientation is clear and the young person feels comfortable to talk, several useful and important details concerning their substance use and lifestyle can be elicited (even if they don't want to change). This includes which substances are being used, how, where, when and with whom.

This information positions practitioners to accurately assess and respond to immediate and/or ongoing risk and develop insight into the nature of a young person's attachment to substances use, particularly the function it serves. In collaboration with clients, practitioners can devise and implement feasible, context-sensitive harm reduction strategies and set to work on addressing the issues of most pressing concern.

Practical and useful responses made by practitioners through client-centred casework strengthen engagement and can put a young person in a better position to deal with the determinants of their AOD problems should they find the motivation (see Section 6.3, Domains of need).

Starting collaborative work with a client provides opportunities to use aspects of **Motivational Interviewing** for the purpose of:

- Stimulating awareness of the harms of AOD use and the potential benefits of change (consciousness raising)
- Facilitating emotional connection with past harms to self and/or others (dramatic relief)
- Building client insight into the impact of their AOD use on opportunities and current circumstances (environmental re-evaluation)
- Building a stronger therapeutic alliance and confirming the availability of further assistance should it be required.

5.3.3 Interventions with young people in the 'contemplation' stage

Clients in the contemplation stage have not yet given consent for, or made a commitment to participate in, focused interventions targeting behaviour change around AOD use. Thus interventions at this stage focus primarily on the task of further engaging the client with the service and creating the conditions where the idea of making change can be considered.

Young people who are contemplators require the space and support to work through ambivalence and make decisions about their substance use. Any approach from practitioners and/or significant others that closes down communication is likely to be detrimental at a time when guidance and support are needed.

The aim with young people in contemplation is to assist them to make their own decision to change. This requires young people to recognise change as a possibility.

Young people in this stage perceive and give weight to a downside to their substance-using behaviour, but continue to give equal or more weight to the upside even if is not obvious.

Contemplation is the stage where the Transtheoretical Model's Decisional Balance construct can be used most effectively. This involves eliciting and exploring the client's perspective on the pros and cons of substance use and considering them in the context of the pros and cons of change.

Box 5.2

INTERVENTION GUIDE: CONTEMPLATION STAGE		
The primary intentions at this stage are: • Building a therapeutic relationship • Enhancing motivation • Fostering the belief that change is possible • Harm reduction • Addressing determinants of problematic AOD use	**The primary processes of change are:** • Self re-evaluation • Environmental re-evaluation	**The key psychosocial interventions are:** • Motivational Interviewing • Narrative Therapy • Client-centred casework

As with pre-contemplators, contemplators respond well to an invitation to explain and explore what they like about their substance use and what they dislike. Sequencing questioning in this way maximises the potential that young people will feel they are being given a fair hearing from a practitioner with a balanced rather than pre-conceived view.

Young people who feel their views are being listened to and accepted are more likely to be inclined to investigate the negative aspects of substance use with a practitioner. Miller and Rollnick (2002) recognise the therapeutic value in young people being given the space to hear themselves discussing the downside of their substance use, in their own words.

If clients believe that practitioners are concentrating only on the problems associated with substance use, they will tend to argue the other side of the 'decisional balance' and hear themselves justifying why they should continue using substances. Once a client feels that their view about the pros and cons of continued use is understood and respected, they will be more ready to respond positively when practitioners seek their opinion regarding the pros and cons of change.

As with pre-contemplation, client-centred casework can strengthen engagement and might engender motivation where issues that drive AOD problems are being addressed successfully (see Section 6.3, Domains of need).

Motivational Interviewing aimed at consciousness-raising and dramatic relief at the pre-contemplation stage can be extended and deepened to include processes such as self and environmental re-evaluation. This can involve:

- Fostering belief that change is possible
- Building the therapeutic relationship and minimising resistance by acknowledging that the choice to change is theirs to make (emphasising personal control), even if they are under coercion from others
- Strengthening cognitive understanding and connecting emotionally to the impact substance use has had in their lives and the lives of others
- Exploring the ambivalence and consequent dissonance felt by clients in the contemplation stage.

Narrative Therapy is also ideally suited to the task of self-focused re-evaluation. Further, Narrative Therapy techniques can be used to:

- Establish a relationship based on trust by demonstrating active listening, respect and genuine concern to understand the young person's world view
- Develop a shared or common language for talking about problems and strengths
- Enable the client to externalise key problem/s and put them in their proper context
- Enable a client to identify and separate themselves from problem-saturated narratives that are self-defeating and serve to perpetuate substance-using behaviour
- Develop with the client a narrative based on a realistic appraisal of their strengths, limitations and life opportunities.

5.3.4 Interventions with young people preparing to change

A young person in 'preparation' are making a commitment to participate in focused interventions targeting behaviour change around AOD use. Thus interventions at this stage can move past engagement and motivation-building and extend to building the personal strengths and social assets that can be drawn upon to enact change. The process of self-liberation is concerned primarily with a client's self-beliefs and perceptions about environmental circumstances and how that affects their capacity to make and sustain changes in their life.

'Self-liberation'-focused interventions enable clients to develop new, empowering schemas or narratives that influence and are influenced by skill building and establishing support structures and helping relationships. Young people preparing to change will benefit from goal setting and planning processes to focus their motivation and see that change is a possibility. Finally, young people who are preparing to change are still likely to be using substances, so harm reduction interventions may still be required.

Box 5.3

INTERVENTION GUIDE: PREPARATION STAGE		
The primary intentions at this stage are:	**The primary processes of change are:**	**The key psychosocial interventions are:**
• Goal setting • Empowerment & supporting self-efficacy • Fostering beliefs that support change • Increasing knowledge & understanding • Building skills • Preparing for relapse prevention • Addressing determinants of problematic AOD use	• Self-liberation • Helping relationships	• Narrative Therapy • Community Reinforcement Approach • Client-centred casework

Even though a client is preparing to change, it is crucial that youth AOD practitioners still express interest in and understand their particular motivations for using substances. This empowers the practitioner to work with a young person to identify desirable alternative or substitute behaviours that will address the antecedents and rewards of previous substance-using behaviour.

It also helps the practitioner to develop insight into what a young person might expect to give up as they change and gauge the significance of what could be lost. Together, practitioners and clients can identify high-risk situations post change that can trigger lapse and relapse, thus providing rich information for future relapse prevention efforts.

The application of a **Community Reinforcement Approach** can enable clients to identify:

- A range of potential options for action so that a young person can make well-informed decisions about how to take the first steps in changing
- Clear, simple and obtainable goals
- Personal skills that need to be developed to counteract the antecedents of problematic AOD use and promote alternative behaviours (e.g. assertiveness, coping and problem-solving skills, communication skills, anger management)
- Significant persons in the young person's family or community who could provide encouragement and reinforcement for desirable alternative behaviours.

Further, **Narrative Therapy** might be used to:

- Encourage learning from experience and enhance self-efficacy by inviting clients to identify times when they have been effective in dealing with their substance use and felt more in control
- Foster a belief that change is possible by eliciting stories from the client (or sharing stories with them) of other people who have successfully achieved change (without breaching confidentiality)
- Identify and elaborate on 'unique outcomes' or 'exceptions' that are inconsistent with problem-saturated narratives
- Clarify and detail strengths and assets underlying 'unique outcomes' that can form the basis of an alternative positive narrative
- Encourage and assist the young person to link and contextualise unique outcomes, strengths and assets into the form of a coherent alternative narrative.

5.3.5 Interventions with young people in the 'action' stage

Clients in the action stage are pursuing the goals set when they were preparing for change. It is the most intensive stage for the application of psychosocial interventions targeting behaviour change. Depending on their access to support and resources and the severity of the problem, young people may need to take time out from their previous lifestyle to stabilise and actively participate in therapeutic activities.

The purposeful action that a young person directs towards change is best guided by a plan identifying incremental, achievable goals. Practitioners are advised to provide encouragement for achievements while keeping clients focused and realistic about the challenges ahead.

To make significant changes to entrenched patterns of behaviour, therapeutic interventions will ideally target individual/psychological and environmental factors simultaneously. The Community Reinforcement Approach and family focused interventions target environmental factors, while Cognitive Behaviour Therapy and Dialectical Behaviour Therapy primarily work on individual psychological factors. These approaches can foster constructive change, but practitioners must also make relapse prevention the focus of care planning with clients (see Section 5.3.8).

The **Community Reinforcement Approach** can be used to:

- Establish an activity schedule to reduce exposure to the antecedents of problematic AOD use and increase exposure to the antecedents of alternative, pro-social behaviours
- Establish a schedule to reinforce pro-social behaviours and activities that compete with AOD use and other problem behaviours
- Assist the young person to engage with significant persons in their family or community who can provide encouragement and reinforcement for desirable alternative behaviours.

Techniques from **Cognitive Behaviour Therapy** can be used to:

- Develop skills in assertiveness, coping, problem-solving, communication or anger/ aggression control, depending on individual needs and goals
- Reduce depression or anxiety that may be exacerbating problematic AOD use
- Teach skills to support relapse prevention.

Box 5.4

INTERVENTION GUIDE: ACTION STAGE		
The primary intentions at this stage are:	**The primary processes of change are:**	**The key psychosocial interventions are:**
• Goal setting & review • Changing environmental contingencies • Fostering beliefs that support change • Increasing knowledge & understanding • Building skills • Strengthening or restructuring relationships	• Reinforcement management • Counter conditioning • Stimulus control • Helping relationships	• Community Reinforcement Approach • Family focused interventions • Cognitive Behaviour Therapy • Dialectical Behaviour Therapy

Family focused interventions or **Family Therapy** can be used to:

- Engage parents/caregivers/other relatives as supporters of the young person in their change process
- Build the skills of parents/caregivers/other relatives to provide support to the young person
- Modify transactional processes within the family system to promote developmentally conducive family dynamics.

Techniques from **Dialectical Behaviour Therapy** can be used to develop skills in mindfulness, distress tolerance and emotion regulation that help the young person to both tolerate and moderate strong emotions without needing to use substances or self-harming behaviours.

Further, **Narrative Therapy** might be used to:

- Demonstrate to clients where they are effective in dealing with their substance use and elaborate on 'unique outcomes' or 'exceptions' to problem-saturated narratives
- Clarify and detail strengths and assets underlying 'unique outcomes' that can form the basis of an alternative positive narrative
- Assist the young person to link and contextualise unique outcomes, strengths and assets into the form of a coherent alternative narrative.

It is common for young people, particularly those in the early and middle adolescent years, to move into action with little preparation and with unrealistic expectations of what it takes to make lasting changes. Practitioners can position themselves to provide timely guidance and enable young people to learn from experience. This can promote better problem solving and more realistic goal setting. A client therefore might decide to reorient their goals or make them clearer and more immediate.

Practitioners are encouraged to celebrate with clients as they achieve desired outcomes, but must remember that change can also have a downside. Practitioners are advised to regularly offer a young person the opportunity to discuss the challenging aspects of change, which can involve working through grief reactions. It is also worth remembering that change may not involve giving up all substance use, so attention still needs to be given to harm reduction strategies.

5.3.6 Interventions with young people in the maintenance stage

The maintenance stage for many clients is an active period of consolidation. Even where substantial gains have been made and their sense of self-efficacy strengthened, the realities of life without substance use as a coping mechanism can be difficult to manage. The therapeutic interventions used during the action stage continue to apply, but the focus shifts to embedding the changes that have been made by clients, their family and other social systems.

This involves helping clients to stay motivated, optimistic and hopeful, which is fostered when young people have something constructive to work towards. Clients can benefit from the practitioner's sustained interest in their progress and help to set and pursue longer-term goals.

It is unhelpful for practitioners to assume that a young person no longer needs assistance because they have made it to the maintenance stage (even after an extended period) or to ignore the possibility that at times a young person might be considering and feeling like using substances. Relapse prevention strategies continue to be of prime importance for young people committed to maintaining change (see Section 5.3.8).

Box 5.5

INTERVENTION GUIDE: MAINTENANCE STAGE		
The primary intentions at this stage are:	**The primary processes of change are:**	**The key psychosocial interventions are:**
• Maintaining new environmental contingencies • Reinforcing beliefs that support change and healthy development • Practising & embedding new skills • Strengthening new relationship patterns • Relapse prevention	• Reinforcement management • Counter conditioning • Stimulus control • Helping relationships	• Community Reinforcement Approach • Cognitive Behaviour Therapy • Family focused interventions • Dialectical Behaviour Therapy

During the maintenance stage the **Community Reinforcement Approach** can be used to:

- Revisit and revise the activity schedule to maintain opportunities for, and reinforcement of, alternative behaviours and substitutes
- Assist the young person to engage with social systems such as education, training, employment, sport and cultural pursuits that provide intrinsic reinforcement of new behaviours through meaningful activity
- Assist the young person to make new, healthy connections with peers and caring adults.

Techniques from **Cognitive Behaviour Therapy** can be used for:

- To support a client's efforts in managing high risk situations to prevent relapse
- Reinforcement and progressive exposure to real-life practice, embedding skills in assertiveness, coping, problem-solving, communication or anger/aggression control (depending on individual needs and goals)
- Developing interpersonal skills needed to maintain relationships cable of providing ongoing support
- Continuing to treat depression and/or anxiety where indicated.

Family focused interventions or Family Therapy can:

- Through reinforcement and progressive exposure to real-life practice, embed skills of parents/ caregivers/other relatives to maintain and expand support for the young person
- Reinforce modified transactional processes within the family system.

Techniques from **Dialectical Behaviour Therapy** can:

- Through reinforcement and progressive exposure to real-life practice, embed skills in mindfulness, distress tolerance and emotion regulation that help the young person to both tolerate and moderate strong emotions without needing to use substances or other self-harming behaviours.

5.3.7 Lapse and/or relapse

In times of vulnerability, clients in the action and maintenance stages might 'lapse' or 'slip'. Depending on the quality of the support available at these times and the decisions made by clients, a lapse can evolve into a relapse.

Each person endeavouring to make and maintain change will be exposed to situations that test their resolve and put them most at risk of lapsing. Addy and Ritter (2000) outline eight commonly experienced high-risk situations (see Table 5.2).

Table 5.2

HIGH-RISK SITUATION	DESCRIPTION
Social pressure	Being offered alcohol or drugs by friends, family, peers, co-workers, employers
Testing self	Person stops thinking they have a problem with AOD use
Cravings and urges [1]	Strong desire or craving to use alcohol or drugs
Use of other drugs	Can trigger cravings for alcohol or primary drug, undermine self-control, impair judgment and capacity to implement relapse strategies
Setting	The presence of alcohol or drug-related cues, such as a particular place, person, activity or piece of alcohol or drug paraphernalia
Feelings and mood	Emotional state (depression, anger, anxiety) or good mood and wanting to celebrate
Physical state	Feeling tired, unwell, energetic, excited
Interpersonal conflict	Problems or disagreements with other people

Should either lapse or relapse occur, the critical task for practitioners is to engender a belief that change is still possible. This can be achieved through explaining that lapse and relapse are common and not a sign of failure, but rather an opportunity for learning and development of more effective change strategies. It can be helpful for clients who have lapsed or relapsed to revisit the reasons for their original decision to change.

[1] Cravings and urges are an expected part of giving up alcohol or drugs; are variable and differ in strength; can be persistent and occur unexpectedly; and do not indicate that the person is weak or lacks motivation or will power.

For less experienced clients, knowing that other people have lapsed and relapsed and gone on to achieve their goals can be comforting and motivating at a time when they are prone to feeling deflated (practitioners should take care to ensure this does not breach the confidentiality of others).

If the young person is set to continue using substances, harm reduction strategies should be investigated and their stage of change assessed. Practitioners can then proceed to match interventions appropriately to the young person's circumstances.

5.3.8 Relapse prevention

Relapse prevention is aimed at building the capacity of a young person and others involved in their care to maintain change. Daley and Marlatt (1997) identify that this begins with making lifestyle changes to reduce the need for alcohol or drugs and undertaking healthy activities. They specify the need for clients (and those involved in their care) to develop coping skills for handling high-risk situations and relapse warning signs.

Relapse prevention also involves preparing young people for managing a lapse, if it happens, to minimise the potential adverse consequences and the possibility of it becoming relapse. In line with the work of Daley and Marlatt (ibid) and drawing on clinical treatment guidelines developed by Turning Point Alcohol and Drug Centre Inc (Addy & Ritter, 2000), YSAS (2001) developed seven priorities for effective relapse prevention practice in the youth field.

1. Engage and understand the young person's goals.
2. Identify strategies and modify contingencies to support constructive development.
3. Identify high-risk situations.
4. Develop skills to manage high-risk situations.
5. Prepare for the possibility of a lapse.
6. Manage lapse to prevent relapse.
7. Manage relapse.

Effective relapse prevention practice has both intrapersonal and interpersonal dimensions (Witkiewitz & Marlett, 2004). Coping skills (including coping with cravings and managing emotional states), self-efficacy, outcome expectancy and motivation are all intrapersonal factors that influence an individual's capacity to maintain change.

Interpersonal factors relate to the degree to which an individual has access to high-quality, functional social support and emotional support from others outside their substance use networks. The extent to which an individual is exposed to interpersonal conflict and the pressure to use substances, particularly from significant others, are also identified as key factors.

This brief account of relapse prevention practice is provided as an additional guide for intervention planning. It is beyond the scope and purpose of this resource to provide a detailed account of relapse prevention models and interventions. Instead, *Clinical Treatment Guidelines* (Addy & Ritter, 2000), compiled by Turning Point Alcohol and Drug Centre Inc, and Witkiewitz & Marlett (2004) are recommended publications.

References

Adams, J; White, M. (2005) Why don't stage-based activity promotion interventions work? *Health Education Research*, 20(2):237–43.

Addy, D. & Ritter, A. (2000) Clinical Treatment Guidelines for Alcohol & Drug Clinicians, No 3: Relapse prevention. *Turning Point Alcohol and Drug Centre Inc*, Fitzroy, Victoria

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavior change. *Psychological Review*, 84, 191-215.

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist*, 37, 122-147.

Browning, C., & Thomas, S. (Eds.). (2005). Behavioural change: an evidence-based handbook for social and public health. Edinburgh, London, New York, Oxford, Philadelphia, St Louis, Sydney, Toronto: Elsevier Churchill Livingstone.

Bruun, A.,Karametos,C., Jones, B., Tattersall, A., Fairbairn, R., Wilson, S & Palmer, T. (2002) Working with clients who have alcohol and other drug issues. *Youth Substance Abuse Service accredited training manual*. Melbourne: YSAS Pty Ltd.

Clark, M. (2001). Influencing Positive Behavior Change: Increasing the Therapeutic Approach of Juvenile Courts. *Federal Probation*, 65 (1), 18-28.

DiClemente, CC (1986). Self-efficacy and the addictive behaviors. *Journal of Social and Clinical Psychology*, 4, 302-315.

Curry, S., Marlatt, G. A., & Gordon, J. R. (1987). Abstinence violation effect: Validation of an attributional construct with smoking cessation. *Journal of Consulting and Clinical Psychology*, 55, 145–149.

DiClemente, C. C. (1999). Motivation for change: Implications for substance abuse treatment. *Psychological Science*, 10, 209–213.

DiClemente, C. C., & Velasquez, M. M. (2002). Motivational interviewing and the stages of change. In W. R. Miller & S. Rollnick (Eds), *Motivational interviewing: Preparing people for Change*. New York: Guilford Press.

DiClemene, C.C., (2005) Addiction. A premature obituary for the transtheoretical model: a response to West 2005. Addiction, August;100(8):1046-8; author reply 1048-50.

Giovazazolias, T. and Davies, P. (2005) Matching therapeutic interventions to drug and alcohol abusers' stage of motivation: The clients' perspective *Counselling Psychology Quarterly*, September 2005; 18(3): 171–182

Hall, K. L., and Rossi, J. S. Meta-Analytic Examination of the Strong and Weak Principles across 48 Health Behaviors. *Preventive Medicine*, 2008, 46, 266–274.

Hollis, J. F., and others. (2005). Teen REACH: Outcomes from a Randomized Controlled Trial of a Tobacco Reduction Program for Teens Seen in Primary Medical Care. *Pediatrics*, 115(4), 981–989.

Littell, J.H. and Girvin, H. (2002). Stages of change: a critique. *Behavior Modification,* Apr;26(2):223–73.

Mattson, M. E. (1998). Finding the right approach. In W. R. Miller & N. Heather (Eds), T*reating Addictive Behaviours*. New York: Plenum Press.

Mattson, M. E., and Allen, J. P., Longabaugh, R., Nickless, C. J., Connors, G. J., & Kadden, R. M. (1994). A chronological review of empirical studies matching alcoholic clients to treatment. *Journal of Studies on Alcohol*, 12, 16–29.

Noar, S.M.; Benac, C.N. and Harris, M.S. (2007). Does tailoring matter? Meta-analytic review of tailored print health behavior change interventions. *Psychology Bulletin*, July;133(4):673–93.

Perz, C. A., DiClemente, C. C., & Carbonari, J. P. (1996). Doing the right thing at the right time? Interaction of changes and processes of change in successful smoking cessation. *Health Psychology*, 15, 462–468.

Polivy, J., & Herman, C. P. (2002). If at first you don't succeed: False hopes of self-change. *American Psychologist*, 57, 677–689.

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51, 390-395.

Prochaska, J. and DiClemente, C. (1984). The transtheoretical approach: crossing traditional boundaries of change. *Homewood*, IL: Dorsey Press.

Prochaska, J. and DiClemente, C. (1986). Towards a comprehensive model of change. In: W.Miller & N.Heather., Treating addictive behaviours: *Process of change*. New York: Plenum Press.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behavior. *American Psychologist*, 47, 1102-1114.

Prochaska, J. O., & Velicer, W.F. (1997). The Transtheoretical Model of health behavior change. A*merican Journal of Health Promotion*, 12, 38-48.

Prochaska, J. O., (2007). Efficacy and Effectiveness Trials: Examples from Smoking Cessation and Bullying Prevention. *Journal of Health Psychology*, 12(1), 170–178.

Prochaska, J.O.; Redding, C.A. and Evers, K. E. (2007) The transtheoretical model and stages of change, in Glanz, K. Rimer, B. and Viswanath, K. editors. — Health behavior and health education :theory, research, and practice 4th ed. A Wiley Imprint, San Francisco.

Thornton, C. C., Gottheil, E., Weinstein, S. P., & Kerachsky, R. S. (1998). Patient-treatment matching in substance abuse: Drug addiction severity. *Journal of Substance Abuse Treatment*, 15, 505–511.

Velicer, W. F., DiClemente, C. C., Rossi, J. S., & Prochaska, J. O. (1990). Relapse situations and self-efficacy: An integrative model. *Addictive Behaviors*, 15, 271-283.

West, R. (2005). Time for a change: putting the Transtheoretical (Stages of Change) Model to rest. *Addiction,* Aug;100(8):1036–9.

Witkiewitz, K. and Marlett, G.A. (2004). Relapse prevention for alcohol and drug problems: That was zen, this is tao. *American Psychologist*, 59, 224-235

Yahne, C. E., & Miller, W. R. (1999). Enhancing motivation for treatment and change. In B. S. McCrady & E. E. Epstein (Eds), *Addictions: A comprehensive guidebook*. New York: Oxford University Press.

6. Framework for Resilience Base Intervention

6.1 Introduction

6.1.1 Resilience Based Intervention: an overview

The framework for Resilience Based Intervention emphasises young people's social and emotional well-being and synthesises lines of evidence form both resilience and developmental health research. Further the aims of Resilience Based Intervention, and the central assumptions on which it is based, are aligned philosophically with the harm reduction and health promotion movements.

At its most basic, resilience describes a person's capacity to face, overcome and even be strengthened by life's adversities (see section 2.2). Resilience Based Intervention is focussed on creating the conditions that nurture and support the development of this capacity in young people.

A young person's capacity to be resilient can be protected by altering exposure to risk, influencing the experience of risk, averting chain reactions of negative experience and fostering healthy adaptation and growth (see Section 2.2.4). This reflects "…a concern with the young person in the present as well as the young person as a future adult" (Hamilton & Redmond, 2010; p5).

The Framework for Resilience Based Intervention draws on substantial evidence to identify a range of resources and assets that are demonstrated to foster both resilience and healthy development.

Three categories of resources and assets are articulated. The first category, 'social ecology', includes all external or contextual resources and assets that, if available and provided in culturally meaningful ways, contribute to a young person's capacity for resilience (Ungar, 2006). The second and third categories, 'knowledge, skills and attributes' and 'systems of belief', both pertain to internal resources and assets that are qualities of the individual.

The framework also articulates five domains of need that, if adequately addressed, will enable young people to mitigate the risk of immediate harm and develop resilience. (Bruun, 2008). They are:

- Protection from harm and the capacity to respond to crisis
- Stability and the capacity to meet basic needs
- Participation in constructive activity
- Developmentally conducive connections
- Greater control over health-compromising issues and behaviours (e.g. harmful substance use, mental health problems, offending, etc).

The goals of young people (and of those involved in their care) are invariably needs related and can be themed to fit within one or more domain. The scarcity or availability of meaningful and useable resources and assets either obstructs or nurtures the capacity of clients to achieve these goals.

Where youth AOD services can enable clients to develop or mobilise resources and assets to meet their needs, chain reactions of negative experience can be altered or averted and more positive developmental pathways might emerge.

6.1.2 Resilience Based Intervention and AOD problems

Resilience Based Intervention in AOD work is focussed on reducing or removing the harmful impact of substance on young people's safety, health and development. This is achieved by creating the conditions that build the capacity of clients to exert more control over their substance using behaviour.

Resilience Based intervention is particularly suitable for young people who use substances as a coping mechanism. AOD services can maximise the possibility that young people will make healthy and developmentally constructive by working closely with them to establish viable alternatives to substance use for meeting their needs and responding effectively to unresolved underlying issues that cause distress. The intention is to decrease their reliance on substance use so that rather than being a necessity it becomes one option for coping among a range of others.

This approach takes account of the evidence that young people tend to invest strongly in the notion that for them, using is an active choice (see section 2.3.2).

The five domians of need articulated in the framework for Resilience Based Intervention enable practitioners and service planners to sort the key determinants of problematic substance use into priority action areas. As such, the goals of clients seeking to address substance use problems are likely to align with these domains. Further, the framework provides an evidence informed guide as to the resources and assets that clients and those involved in their care can use to meet their goals.

Epidemiological research has shown that young people who experience significant problems with AOD use frequently experience a lack of, or reduced access to, a large proportion of these resources and assets (Spooner, Hall & Lynskey, 2001). Resilience Based Intervention therefore requires practitioners and service planners to influence public policy and work within the community to ensure that useful, culturally relevant resources are available for young people, their families and significant others within their broader social network.

The availability of relevant resources and opportunities does not necessarily mean that young people will capitalise on them. This requires motivation, skills and knowledge. As such, practitioners and service planners have a key role in facilitating both the development of knowledge and skills (see section 6.2.3) as well as the systems of belief (see section 6.2.4) that underpin the motivation of clients to invest in their own self care and healthy development.

Resilience Based Intervention is focussed on clients developing the capacity to locate relevant resources and assets (navigation) and to develop the ability to apply them for the purpose of meeting their needs and achieving their goals (negotiation). Even so, the degree of adversity faced by many youth AOD clients and the complications that can be related to problematic substance use mean that the resources and assets available to them are insufficient. This requires services to offer access to structured environments and supportive working relationships (see section 7) that provide clients with the resources and experiences required to stabilise and begin working through their substance related issues.

6.2 Resources and assets

6.2.1 Rationale for the selection of categories for resources and assets

Numerous studies show striking consistency in defining a set of fundamental factors that determine the capacity of children and young people to demonstrate resilience. Masten (2009) draws from this extensive and diverse evidence base to identify a short list of such protective factors. They are:

- Effective parents and caregivers
- Connections to other competent and caring adults
- Problem-solving skills
- Self-regulation skills
- Positive beliefs about the self
- Beliefs that life has meaning
- Spirituality, faith and religious affiliations
- Socioeconomic advantages
- Pro-social, competent peers and friends
- Effective teachers and schools
- Safe and effective communities.

Masten (2009) also highlights fundamental protective systems that support human resilience. These systems are instrumental in producing and sustaining the above protective factors in the lives of young people. They are:

- Human intelligence and information processing (a human brain in good working order)
- Motivation to adapt and opportunities for agency (mastery motivation)
- Self-control and emotion regulation (self-regulation)
- Religious and cultural systems that nurture human development and resilience
- Schools and communities that nurture and support human development and resilience.

The protective factors and systems identified by Masten are found either within the individual or their environment, although they have not been categorised in this way. Typically, researchers and theorists, including those that Masten draws from, do make the distinction between external and internal factors and processes.

Grotberg (1999) divides the sources of resilience into three categories:

- *I have* (external support)
- *I am* (the child's internal strength such as feelings, attitudes, values and faith)
- *I can* (interpersonal skills such as communication, problem solving, management of feelings and temperament, social relationships).

Gunnestad (2003), while respectful of Grotberg's delineation of influences, was concerned with a lack of clarity as to which factors fitted naturally within the categories of 'I have', 'I am' or 'I can'. Taking the lead from Grotberg, Gunnestad groups factors into three categories:

- *Network factors* (external support) are elements of external support from people such as family, friends, neighbours, teachers, etc.
- *Abilities and skills* (internal support) represent inner strengths partly from inborn qualities and partly from learned skills making use of these qualities. Abilities are qualities that are largely innate, such as physical and mental strength, temperament and emotional stability, intellect and appearance. Skills include communication skills, social and emotional skills that enable a child to explain themselves, understand others, solve problems and make friends, as well as practical skills in making or doing things, and skills in art, sports, schoolwork, etc. that make a child feel good about themselves and able to help others.
- *Meaning, values and faith* (existential support) are the supports a child has from their understanding, from values and attitudes, and from their faith.

Table 6.1: Framework for Resilience Based Intervention

		RESOURCES & ASSETS			
		EXTERNAL			
		Social Ecology			
		OPPORTUNITY STRUCTURE (I/WE HAVE)			
		Material resources & assets	**Human resources & assets**	**Socio-cultural resources & assets**	**Health & community services**
		Degree to which young person (& / or their carer/s) has access to: • Income • Housing • Food & clothing • Information technology • Transportation • Safe physical environments	**Degree of access to protection, mutual support & expectation from:** • Family system & networks • Friendship networks & partners • Connections with significant adults (e.g. teachers, employers, coaches etc) • Community networks	**Opportunities to contribute through Participation in:** • Education, employment & training • Sport, recreation & leisure • Broader social movements **Connection with:** • Culture • Spiritual & faith based organisations • Enabling places	**Availability & accessibility of:** • Health care • Dental care • Mental health services • AOD services • Homelessness services • Counselling & support services • Emergency services
DOMAINS OF NEED	**Protection from harm & capacity to respond to crisis**				
	Stability & capacity to meet basic needs				
	Participation in constructive activity				
	Developmentally conducive connections				
	Greater control of health compromising issues / behaviours				

Framework for Resilience Based Intervention

RESOURCES & ASSETS					
INTERNAL					
Knowledge / Skills & Attributes				**Beliefs**	
ABILITY (I CAN)				**IDENTITY (I AM) & MOTIVATION (I WILL)**	
Living skills	**Selfmanagement skills**	**Interpersonal skills**	**Attributes**	**Selfconcept & world view**	**Meaning making**
• Self care knowledge • Selfcare skills (budgeting, cooking, etc) • Resourcefulness (ability to access & utilise resources) • Numeracy & literacy	• Insight (self awareness) • Health (mental health) literacy • Regulation of emotion & arousal • Problem solving & decision making skills • Ability to make sense of experiences & put them into context	• Insight (social awareness) • Communication skills • Assertiveness skills • Ability to find a balance between personal needs & the needs of others	• Temperament • Concentration & attention • Intelligence • Physical talents & abilities • Fitness & health • Appearance	• Self esteem • Self efficacy • Gender identity & sexuality • Values & attitudes • Interests & commitments • Core cognitive schemas (re self / world) • Mood & affect	• Sense of security (coherence) • Sense of purpose • Sense of belonging & connectedness (feeling connection to something greater than oneself) • Hope & expectancy

Gunnestad (2003) also factors in the influence of culture on each of his categories. He points out that culture affects "… the way we form networks and the importance we assign to them", and "…decides what skills and activities are appreciated" (p1). Importantly, Gunnestad emphasises that meaning, values and faith are vital expressions of culture.

Like other contemporary methods of conceptualising resilience, Gunnestad makes the distinction between external and internal factors. His delineation of factors pertaining to competence and systems of belief is potentially useful for developing a more nuanced understanding of how resilience factors interact to influence the choices a young person makes and the direction of their developmental pathway.

Distinguishing between innate qualities and learned skills may also assist those seeking to build young people's resilience in making better targeted and more sensitive interventions. Making the influence of culture overt is also a strength.

Gunnestad's typology also has limitations. His categorisation of external assets as 'network factors' refers mainly to the human resources available within one's social ecology and does not cover the range of contextual influences identified in Masten's (2009) shortlist.

For example, Masten's list includes socioeconomic resources and highlights the importance of safe and effective communities that provide young people with opportunities to exercise agency. She also highlights the significance of connection with religious and cultural systems that nurture human development.

Gunnestad's second category, 'skills and abilities', does not include the broad range of living and self-care skills that would enhance a young person's coping ability and capacity for resilience. There is also no investigation of the roles that self-awareness and social insight play in knowing when and how to apply skills most effectively to regulate emotions, communicate, and solve problems.

Within Gunnestad's typology, the category 'meaning, values and faith' does not adequately represent the core schemas or beliefs that shape a young person's motivation to adapt and pursue life opportunities (what Masten refers to as the mastery motivation system). This is also a limitation of Grotberg's categories.

Finally, Gunnestad's categories would need to be structured differently within a therapeutic framework that demonstrates how the promotion of resilience and healthy development can be woven into youth AOD practice. This requires a method for identifying the availability of resources and assets in a young person's life and determining what this means for their prospects.

Despite these limitations, Gunnestad's method of grouping protective factors into three categories has utility. The following describes how these limitations can be addressed across the three categories.

First, Gunnestad's 'network factors' category of human relationships could be broadened to include the full range of external resources and assets that could contribute to resilient adaptation. These include material resources, opportunities for participation in purposeful activity, the availability of enabling environments (Duff, 2011), and relevant health and community services. This broader set of resources and assets are located within young people's 'social ecology', and this term is used as the heading in the Framework for Resilience Based Intervention (see Table 6.1). The availability of these resources comprises a young person's opportunity structure.

Second, Gunnestad's 'skills and abilities' category should include knowledge as well as a grouping of resources and assets that represent key living skills. Further, the term 'attributes' more accurately denotes relatively stable traits or innate qualities such as temperament, intellect and appearance and allows for these assets to be readily differentiated from 'skills' that are can be learned or developed.

Gunnestad's term 'abilities' is better suited to describing the sum total of a young person's knowledge, skills and attributes. Ability can then be considered alongside any challenges a young person might face when striving to achieve their goals.

Third, Gunnestad's category 'meaning, faith and values' accurately represents an important group of factors that influence resilience, but neglects a person's beliefs or core schemas (e.g. self-esteem and self-efficacy), life opportunities and prospects for the future.

Consequently, the Framework for Resilience Based Intervention includes a category for these constructs called 'systems of beliefs'. This encompasses a young person's self-concept and identity as well as their existential orientation (or the meaning that is ascribed to their circumstances and life opportunities). The inclusion of a subjective dimension holds with Gunnestad's method and links the framework conceptually with contemporary 'social and emotional well-being' theory (White & Wyn, 2008).

Each of the three categories of resources and assets within the Framework for Resilience Based Intervention are described in further detail in the next sections.

6.2.2 Social ecology (opportunity structure): external resources and assets

Resilience is not a static, internal quality of individuals; it is an ecologically dynamic and mutually dependent process (Ungar, 2005). The capacity of young people and their carers to cope and thrive depends on the availability and accessibility of resources and assets within their social ecology.

Granfield and Cloud (2001) demonstrate that personal problems and their solutions are embedded within a larger structure of social relations and networks. They studied how people managed to overcome substance dependence without treatment support. They found that those who were able to stay connected to a 'conventional life' while using had markedly better outcomes than those who had become disconnected. The connection to the conventional offered respondents "…access to information, normative expectations, relationships, institutions, and other opportunities that provided useful resources for their personal transformations" (p1553).

Each young person's opportunities to manage risk, pursue goals and gain rewards are structured differently according to a range of macro-envirnmental ('distal') and micro-environmental ('proximal') influences. Distal influences include the "…public and legal/policy context; economic, gender and ethnic inequalities and the political economy of health", whereas proximal influences include "…group norms, rules and values; social networks; peer influences; the immediate social settings of drug use; and the local neighbourhood" (Kerr, Small, Moore & Wood, 2006. p38).

It is also worth emphasising the pervasive influence of poverty and the crucial influence of families. Both distal and proximal influences intersect to determine the nature and quality of resources and assets available to young people and those involved in their care as well as how they are made available.

The framework described in this section identifies four kinds of resources and assets within the social ecology. These are material, human, socio-cultural, and health and community services (see Table 6.2).

Table 6.2: Social ecology (opportunity structure)

A. MATERIAL RESOURCES & ASSETS	B. HUMAN RESOURCES & ASSETS	C. SOCIO-CULTURAL RESOURCES & ASSETS	D. HEALTH & COMMUNITY SERVICES
Degree to which young person (&/or their carers) has access to: • Income • Housing • Food & clothing • Information technology • Transportation • Safe physical environments	**Degree of access to protection, mutual support & expectation from:** • Family system & networks • Friendship networks & partners • Connections with significant adults (e.g. teachers, employers, coaches, etc.) • Community networks	**Opportunities to contribute through participation in:** • Education, employment & training • Sport, recreation & leisure • Broader social movements **Connection with:** • Culture • Spiritual & faith-based organisations • Enabling places	**Availability & accessibility of:** • Health care • Dental care • Mental health services • AOD services • Homelessness services • Counselling & support services • Emergency services

a. Material resources and assets

Each young person (and/or their carers) requires access to adequate income, housing, nutrition, clothing, information technology and transportation. These resources and assets enable young people to participate in constructive action and are essential for dealing effectively with a range of health and behavioural issues such as problematic substance use. Spooner et al. (2001) point to a growing body of evidence demonstrating that inequalities in income and material resources, coupled with the resulting social exclusion and marginalisation, are linked to poor health.

b. Human resources and assets

The human resources available to young people can include parents and family members, friends and partners, and significant others such as teachers, neighbours, employers, coaches and, at times, the parents of friends. For some young people, particularly those with complex social, emotional and behavioural issues, practitioners working in a range of statutory, health and community services may also become an important human resource.

Young people's social networks can have a protective influence and provide the scaffolding that supports constructive development and resilient adaptation. Klee and Reid (1998) found that social support acts as a buffer against stress. In particular, engagement in a connected relationship with a caring, competent and responsible adult has been shown to decrease risk behaviours in adolescents (Aronowitz, 2005).

Such relationships offer young people "…opportunities to develop responsibilities for decision making and increasing autonomy or self-reliance, within the context of supervision, nurturance and acceptance" (Aronowitz, 2005, p24). The natural support networks of young people can also be instrumental in encouraging, reinforcing and maintaining constructive changes (Cox, 2005).

The value an individual gets from their social network has been described as 'social capital' (see Putnam, 2000). One form of social capital, 'bonding capital', derives from an individual's close/local and well-established ties, such as with family and friends who come from the same social context.

Eckersley, Wierenga and Wyn (2006) identify that feeling valued and accepted through participation in mutually supportive, caring relationships is associated with enhanced well-being. They also emphasise that "…access to resources depends upon webs of relationships. This means that young people's well-being depends upon creating conditions of trust and exchange of resources, between young people and significant others, within families, and within communities" (Eckersley et al., 2006, p.19). Relationships capable of facilitating access to different social contexts and new resources and opportunities can provide young people with what Putnam refers to as 'bridging capital'; another form of social capital.

c. Socio-cultural resources and assets

Participation is a vehicle for social inclusion. This is particularly important for those young people who have missed conventional developmental experiences (see Section 2.1). Resilient adaptation is promoted when young people have viable opportunities to participate in meaningful education and training, gainful employment and/or sport and recreational pursuits.

Depending on a young person's background and particular identifications, there is also an emerging but strong body of evidence that their capacity for resilience can be enhanced through connection with culture, faith-based organisations and communities, and broader social movements.

Participation in socially and culturally valued activities with others offers young people a range of benefits:

- the opportunity to find a meaningful role in their community (Ungar, 2011)
- the chance to build a repertoire of experiences, which helps young people learn how events connect to emotions, thus developing their capacity for good judgment (Bessant, 2008). Masten (2009) concurs in recognising that the cognitive capacity for planning and decision making is developed by new experiences.
- practical skills can be learned and competence demonstrated, which contributes to a sense of mastery and self-confidence (Artz, Nicholson, Halsall, & Larke, 2001)
- the opportunity to assist others, contribute to the greater social good and be recognised for doing so (Ungar, 2011).

The places and spaces that young people participate in and develop associations with can also have a therapeutic effect (Duff, 2011; see also Section 6.3.5e).

d. Health and community services

Young people's capacity to be resilient and to gain more control over the problems that restrict their ability to live well is enhanced by the availability of health and community services (Masten 2009; Benson, 2007), including primary health care, dental care, mental health care, AOD services, youth services, homelessness services, emergency services, and counselling and support services. While primary health care, dental care and emergency services are essential for the whole

population, they are particularly important when other resources and assets are lacking in the social ecology or are difficult to access. Young people might also benefit from participation in health promotion initiatives such as drug prevention programs.

6.2.3 Knowledge, skills and attributes (ability): internal resources and assets

All young people are striving to become socially competent individuals who have the skills to cope successfully with life (Balk, 1995). Knowledge, skills and attributes are internal resources and assets processed by young people that range from "…the ability to identify and understand one's feelings, accurately read and comprehend emotional states in others, manage strong emotions and their expression, regulate one's behaviour, experience and express empathy for others, and establish and sustain relationships. Skills and knowledge in the form of insight and self awareness form the basis for self-regulation, enabling children to withstand impulses, maintain focus and undertake tasks regardless of competing interests" (AIHW, 2009; p60).

Knowledge, skills and attributes are crucial assets for young people and their carers seeking to locate necessary resources and to negotiate for them to be provided in meaningful and culturally appropriate ways (Ungar, 2011).

Three groups of these resources and assets are identified: living skills, self-management skills and interpersonal skills. Consistent with the method used by Gunnestad (2003) to categorise protective factors, there is delineation between learned skills and innate qualities. Therefore, a group of assets under the heading 'personal attributes' is included.

a. Living skills

Self-care knowledge and resourcefulness (Klee & Reid, 1998) is a related asset that informs the use of living skills such as budgeting, cooking and includes the practical ability to access and mobilise resources to meet living requirements. These underpin efforts by young people to be relatively self-reliant and achieve relative stability in their lives. Resourcefulness also denotes knowledge of where to access credible information and support from other resources.

Numeracy and literacy skills underpin the development and use of many other skills, as does the knowledge young people have gained through experience.

b. Self management skills

Health literacy (including mental health literacy) is a valuable asset that can help a young person (or another involved in their care) to determine what is required to live well and when help and treatment is best sought out.

Resilience, constructive development and the resolution of substance use-related problems require the ability to direct attention and action strategically to meet needs and manage life stressors. This includes an ability to figure out when and how to use skills to bring a health issue under control.

Skills are needed to regulate emotions and arousal, as well as an ability to solve problems and make effective decisions. In contemporary developmental

Table 6.3: Knowledge, skills and attributes (ability)

A. LIVING SKILLS	B. SELF-MANAGEMENT SKILLS	C. INTERPERSONAL SKILLS	D. PERSONAL ATTRIBUTES
• Self-care knowledge • Self-care skills (budgeting, cooking, etc.) • Resourcefulness (ability to access & mobilise resources) • Numeracy & literacy	• Insight (self-awareness) • Health (mental health) literacy • Regulation of emotion & arousal • Problem solving & decision-making skills • Ability to make sense of experiences & put them into context	• Insight (social awareness) • Communication skills • Assertiveness skills • Ability to find a balance between personal needs & the needs of others	• Temperament • Concentration & attention • Intelligence • Physical talents & abilities • Fitness & health • Appearance

science, these skills are often described under the umbrella concept of executive functions (see Section 2.1). Masten and O'Dougherty Wright (2009) identify that executive functions include "…working memory, selective attention, inhibiting a dominant response in favour of a more adaptive response, delay of gratification, and related self-control capabilities that develop in tandem with brain maturation" (p226).

The exercise of personal agency is aided by the ability to predict and manage the logical consequences of one's actions, together with the cultivation of self-awareness and insight. This involves learning to understand the links between experience, thoughts and feelings and an ability to consider and practice alternative possibilities for action. Confidence in being able to regulate one's emotional responses provides the basis for setting and pursuing goals that have a longer-term effect.

The ability to make sense of experiences and put them into context has also been found to support resilient adaptation (Ungar, 2011; Aronowitz, 2005). A young person who is able to do so is more likely to believe that dealing with distressing circumstances in a constructive way is possible and worthwhile.

Being able to reframe adversities so that the beneficial as well as the damaging effects are recognised (Daniel & Wassell, 2002) can require considerable capacity for thinking and reflection (Masten & O'Dougherty Wright, 2009). It can involve developing the cognitive skills to restructure or modify internal working models or schemas about oneself and the outside world. In turn, this can enable young people to free themselves from the structures or contexts that perpetuate negative identities and problem behaviours.

c. Interpersonal or social skills

The ability to negotiate for relevant resources and assets and to capitalise on life opportunities is greatly enhanced by communication, assertiveness and other social skills. Knowledge and social awareness can offer insight into how and when these skills are best applied.

Young people's social and emotional well-being is believed to depend on their understanding "…of themselves, their culture and what is expected of them as a member of that culture" (Hamilton and Redmond, 2010, p13). An ability to understand what is socially acceptable in particular situations and respond in a way that meets the expectations of others maximises opportunities for rewarding social and economic participation (Doyal & Gough, 1991; White & Wyn, 2008). Ungar (2006) adds that feeling a sense of responsibility to the greater good and an ability to balance personal interests with the needs of others maximises a young person's capability for resilient adaptation.

d. Personal attributes

A range of personal attributes have been found to contribute to a young person's capacity for resilience (Masten, 2009). The attributes that appear most often in the literature relate to temperament, concentration and attention, intelligence (also described as cognitive capital) and attractiveness to others (in personality or appearance). However, talents valued by the individual and others, e.g. being good with your hands, fitness, and physical health, have also been found to have significance.

6.2.4 Systems of belief (identity and motivation): internal resources and assets

"Belief systems imbue life (and death) with meaning and can sustain adaptive behaviour in the face of great adversity" (Masten, 2009, p30). A young person's beliefs are formed through the interpretation of experiences as they occur and are incorporated into the stories they tell about themselves and their world. Stories consist of dominant plots or themes that link events in sequence and across time (Ungar, 2005).

Young people's beliefs can also be shaped by broader social discourses (Ungar, 2005) and by both cultural and religious systems of belief (Masten, 2009). Even so, young people are capable of generating and sustaining ideas independent of more organised belief systems.

Self-beliefs are formed through subjective appraisals of oneself and one's life circumstances. Young people will hold a range of core self-beliefs that strongly influence the way they interpret and respond to events. Many are below the level of awareness.

Self-esteem and self-efficacy can be understood as closely interconnected self-beliefs that strong influence on one's approach to new opportunities and experiences. For example, self-esteem can dictate the extent to which a young person feels worthy of investing in self-care and personal growth. Likewise, self-efficacy is based on a young person's appraisal of their own skills and effectiveness in relation to specific tasks. Low self-efficacy can mean a young person becomes unwilling to take on new experiences for fear of failure.

Young people's beliefs also influence a person's outlook and attitudes. A young person might, for example, be aware of several resources and assets in their social ecology that are available and that could be beneficial, but based on past experience might not believe that they are accessible in ways that have meaning and relevance. Young people's interests and commitments, as well as their values, are also crucial in shaping their motivation for self-care and constructive development.

Further, young people's sense of security, purpose, belonging and hope all profoundly influence, and are influenced by, their experience as they develop and consider their future. These influences are grouped as assets under the heading 'meaning making'.

Together, all resources and assets associated with systems of belief strongly influence a young person's identity and motivation.

Table 6.4: Systems of belief (identity and motivation)

SELF-CONCEPT & WORLD VIEW	MEANING MAKING
• Self-esteem • Self-efficacy • Core cognitive schemas pertaining to self & the world • Values & attitudes • Interests & commitments • Gender identity & sexuality • Mood & affect	• Sense of security (coherence) • Sense of purpose • Sense of belonging & connectedness (feeling connection to something greater than oneself) • Hope & expectancy

a) Self-esteem

Self-esteem derives from a person's sense of their own worthiness. It comprises many aspects, but generally involves "…some comparison by the individual between how they would like to be and how they think they actually measure up" (Gilligan, 2008, pp40-42). According to Rutter (1990), secure and harmonious love relationships and success in accomplishing tasks identified by individuals as central to their interests are the two most significant predictors of self-esteem.

Self-esteem has been found to increase an individual's likelihood of assimilating threatening external events without experiencing excessive negative arousal and disorganisation (Gilligan, 2008). There is evidence that for disadvantaged young people, self-esteem is a salient predictor of adjustment. Gerard and Buehler (2004) found that "…positive self-regard acts as a safeguard against psychological discomfort resulting from disparaging life circumstances" (p1845). Further, high self-esteem might allow the individual to separate negative aspects of his or her life from any personal responsibility" (Gerard & Buehler, 2004).

b) Self-efficacy

Derived from Social Learning Theory (Bandura, 1982), self-efficacy is defined as "judgments of how well one can execute courses of action required to deal with prospective situations" (Armstrong, Birnie-Lefcovitch & Ungar, 2005). It is central to human agency, the capacity for self-regulation, and influences young people's choice of activities and the environments in which they participate.

Bandura (1982) demonstrates that individuals with a more positive view of their own effectiveness exert more effort to succeed. They are also motivated to persist in the face of difficulty or failure, making them more likely to succeed under adverse conditions. Masten (2001; 2009) points to a powerful system of 'mastery/motivation', whereby people experience pleasure in agency, or being effective in the world.

Self-efficacy stems from a sense of mastery and control, combined with an accurate assessment of one's personal strengths and limitations (Daniel & Wassell, 2002). Higher levels of self-efficacy are linked with an 'internal locus of control' and greater likelihood that young people will adopt 'problem-focused' rather then 'emotion-focused' coping strategies in adverse circumstances (see Section 2.2).

The mastery/motivation system is directly linked to increases in adaptive behaviour. It has been implicated as a critical factor in turnaround cases in resilience research (Masten, 2009). Young people extract a positive sense of power and control through experiences of caring for themselves and being able to contribute to the well-being of others (Ungar, 2006; p57). The mastery/motivation system can also be damaged, shut down or hindered by neglect and adversity, particularly where control has been removed and/or experiences of agency are undermined.

Self-efficacy can be influenced by the beliefs and actions of parents and significant others. Clear expressions of encouragement and reinforcement that demonstrate a belief in a young person's own sense of control have a positive effect.

c) Core schemas pertaining to self and the world

Core cognitive schemas are strongly held and highly stable beliefs that exert a powerful influence over thoughts and feelings. They influence the way in which incoming information is perceived, attended to and interpreted.

Core cognitive schemas begin to develop in early life, are elaborated in adolescence, reinforced through repetitive experiences, and perpetuated into adulthood primarily through relational patterns. They are deeply entrenched, central to self, self-perpetuating and difficult to change (Ball, 2007; Riso & McBride, 2007).

Schemas are self-perpetuating because they strongly affect selective attention and memory. The person is more likely to detect, interpret or recall information that is consistent with the schema. Contradictory

information is generally ignored or not perceived at all (Leahy, 2003).

Cognitive schemas involve beliefs about the self (internal), other people or the world (external). They are an asset to a young person when they are positive and realistic. Positive self-schemas involve a person's beliefs or assumptions regarding their own worthiness, competence, ability to be loved, and the skills and abilities that they possess.

Positive world-schemas involve beliefs that the world is reasonably safe, equitable, will provide for our needs, and that people around us will generally be kind, honest and fair-minded. Realism is important for positive schemas to be an asset. Overly optimistic schemas may inflate self-efficacy, trust in others, and expectations of the world to a point where a young person is vulnerable to severe disappointment and exploitation.

More often it is negative (maladaptive or dysfunctional) schemas that are problematic for young people with AOD problems. Maladaptive or dysfunctional schemas are enduring, unconditional, negative beliefs about oneself, others, and the world that organise one's experiences and subsequent behaviours.

These schemas are broad, pervasive themes that develop early in life. Leahy (2003) talks about negative schemas in terms of 'underlying maladaptive assumptions' or rules that are highly rigid, over-inclusive or impossible to live by.

Cognitive therapists often formulate schemas in terms of 'I am', 'If / then' and 'I must' statements. Examples of schemas commonly problematic for young people with emotional and behavioural problems include: 'I am unlovable', 'I am a troublemaker', 'I am never going to succeed at anything', 'If I don't show aggression first, then they will walk all over me', 'If I had been well behaved, then my mother would not have had a breakdown', 'If I don't go along with whatever my friends do then they will abandon me and I'll be lonely', 'I'm never going to get any help from anyone, I must do it all by myself'.

Cognitive schemas clearly have a direct influence upon the degree of optimism or pessimism that a person has about the future, and hence upon their motivation to address difficulties and to work towards goals. Cognitive schemas about the self and the world come together to form the 'world view' that a person develops to make sense of their place and their future prospects.

'World view' has an historical dimension, but most often it is concentrated on present circumstances and the immediate future. White and Wyn (2008) explain that "[e]xpectations of the future and reflections on the past also have a bearing on how people conceive of their present – and how people feel about their present affects how they read their past and future" (p10).

A young person's world view or outlook can affect their motivation to participate in constructive activity and form developmentally helpful connections with others. Health-promoting options that enable young people to meet their needs are worthless if the young person doesn't believe they are available and worthwhile. For example, a young person might see the benefit of further education but be reluctant to pursue this option if they believe that teachers and other young people will ridicule them, or think that they are 'dumb' and incapable of learning.

Aronowitz (2005) draws from the work of Luthar (1999) to make the point that young people often don't see opportunities in their environments, and therefore they can benefit from guidance. Where young people hold the view that constructive and pro-social participation is not possible or worth pursuing, there is a tendency to focus on the immediate rewards provided by substance use or illegal activities (Aronowitz, 2005).

d) Values and attitudes

Central to young people's development is the need to form a clear sense of their values and attitudes. Values provide a foundation for exercising judgment, particularly when moral and ethical issues arise. This is particularly important in contemporary society, because young people are increasingly expected to take personal responsibility for their choices and actions.

Aronowitz (2005) argues that "…value clarification and thinking beyond the present help reduce risk behaviours" (p207). Similarly, White and Wyn (2008) believe that young people's social and emotional well-being is advanced by the development of an identity based on what is valued and held to be good, as well as how they feel about their lives.

Together with commitment to learning, social competence and positive identity, the Search Institute (based in the United States) identifies positive values as a key developmental asset. Six values are identified as assets (Benson, 2007).

- Caring or placing high value on helping others
- A commitment to equality and social justice
- Integrity, which is expressed through acting on convictions and standing up for beliefs
- Honesty, denoting a preparedness to tell the truth even when it is not easy
- Responsibility
- Restraint.

Valuing of social diversity and cultural sensitivity have also been identified as developmental strengths (Resiliency Canada, 2000; cited in Ungar, 2011).

Australian research demonstrates how attitudes are implicated in young people's choices to either use or refrain from using substances (Clark, Scott & Cook 2003). Other large-scale studies at the population level confirm that favourable attitudes towards substance use and antisocial behaviour held by young people and endorsed within the family are risk factors for poor development outcomes, including substance use problems (Gregg, Toumbourou, Bond, Thomas & Patton, 2000; Hawkins, Catalano & Miller, 1992).

e) Interests and commitments

Young people's interests and commitments reflect their passions and can drive their motivation for constructive participation and healthy connections with others. They are also direct expressions of a young person's identity. Where substance use interferes with the commitment a young person feels to a significant person, or the ability to pursue their interests, it can stimulate motivation to change.

f) Gender identity and sexuality

Gender identity and sexuality are integral to the process of forming a self-concept. This is a core task for young people making an adolescent transition. A young person's self-concept includes their own ideas about themselves and their understanding of how they are perceived by others.

Gender identity refers to the way an individual identifies with a gender category; for example, as being either a man or a woman, or in some cases being neither. Gender identity can be distinct from biological sex. The experience of gender dissonance and transitioning from one gender identity to another is increasingly common. It generally involves substantial emotional and behaviour turmoil and vulnerability. At the same time, committing to a process of gender transition usually demands and further builds a highly impressive stock of resilience.

A young person's sexuality is based primarily on their sexual orientation; that is, their attraction towards the opposite sex, same sex, both or neither. There is also a vast diversity of forms in which sexuality can be expressed, and these forms of expression often assume importance at the level of identity. For young people, there is often a great deal of experimentation and changeability before a particular form of sexual identity is adopted (if ever).

In this way, a young person's sexuality, sexual identity and gender identity will have a profound influence on their mood, their affect, and on the schemas that develop to explain their social world and their place within it. When a young person feels comfortable and secure with their gender identity and sexuality, they are more likely to be motivated to participate with others in constructive activity and feel hopeful about their future prospects.

g) Mood and affect

Trzepacz and Baker (1993) describe mood as "…a person's predominant internal state at any one time" and affect as "…the external and dynamic manifestations of a person's internal emotional state" (p39).

A mood is a relatively long-lasting emotional state. Moods differ from emotions in that they are less specific, less intense, and less likely to be triggered by a particular stimulus or event. Moods generally have either a positive or negative quality. In practical terms, young people might speak of being in a good mood or a bad mood.

Unlike acute, emotional feelings such as fear and surprise, moods often last for hours or days and in some cases weeks and months. A mood is an internal subjective state and consequently can only be determined through the description of a young person. Affect, on the other hand, is observable as it is a reflection of one's emotional experience (or expectations of future experience) and is more reactive to events.

Mood and affect have complex, bi-directional relationships with other developmental resources and assets, particularly through the mechanism of social interaction. Biological predisposition towards positive or negative mood states, and affective stability or volatility, have an impact on the capacity for concentration, self-regulation and use interpersonal skills that promote participation and social inclusion. Conversely, opportunities for social inclusion, close connections with significant others, and meaningful participation affect mood state over time.

A relatively positive and stable mood is generally considered to be a positive asset that promotes resilience through negative life events. It provides an ability to do what is necessary to build up other resources and assets within oneself and in one's environment.

For adolescents, high volatility of mood, particularly involving severe and persistent negative mood states (i.e. recurrent depression) can have several negative developmental effects. It can disrupt the formation and maintenance of stable connections with pro-social peers, undermine the motivation and concentration necessary to persist with challenging endeavours over time, exacerbate the development of dysfunctional

cognitive schemas, and disturb the formation of a stable and rewarding sexual identity.

h) Sense of security (coherence)

Young people who feel secure in themselves and the world in which they live are more likely to cope with the vicissitudes of life (Gilligan, 2008). Giddens (1991) emphasises that feelings of security stem from the confidence that most people have in the continuity of their self-identity and in the constancy of their social and material environments; a sense of the reliability of persons and things.

A sense of security helps young people to participate in productive relationships and activities and to meet life's challenges as they arise. Young people feel secure when they are safe, protected from harm and are confident in their capacity to meet basic needs.

Young people's early attachment experiences with caregivers have a profound impact on their sense of security. Masten and O'Dougherty Wright (2009) point out that "…attachment is a universal process in human development that appears first in infancy in relationships with caregivers and later in relationships with friends, romantic partners, and one's own children" (p223).

Young people's experience of attachment in relationships with significant others helps shape "attachment patterns" that will guide their feelings, thoughts and expectations in later relationships (Vaughn, Bost, & Van Ijzendoorn, 2008). It was once thought that the attachment patterns developed in childhood were intractable and continuous, but contemporary developmental science "…indicates that a disorganised or insecure attachment style can become a secure one in the presence of repeated nurturing experiences from committed carers" (Robinson & Miller, 2010).

Gilligan (2008) believes that when a young person's immediate or extended family of origin doesn't provide secure attachments, a network or 'base camp' of social support founded on work, social, educational, recreational and professional helping relationships is probably the best practical alternative (p40).

Gilligan (2008) also makes the connection between young people's feelings of security and the routines and rituals that can provide "…a sense of order in a life which may have been dominated by disorder" (p40). He adds that rituals with symbolic content signify collective identity and continuity and can help to preserve or restore predictability in a young person's life.

For most social researchers, a secure base means a space or spaces that provide asylum and respite. For example, Hiscock and colleagues (2001) identify that all people require a secure base to which they can return if in trouble or fatigued. They make the case that this has profound implications for one's health and well-being.

Others such as Dupuis and Thorns (1998) explore how having a secure base is integral to construction of identities. For Mallett and colleagues (2003), home is associated with safety, relationships that make young people feel safe and secure, and a sense of freedom and control in and over one's living situation.

i) Sense of purpose

A sense of purpose provides motivation for participation in satisfying activities and new experiences that can broaden horizons. This can create the conditions whereby young people might develop a sense of mastery, competence and self-confidence, as well as build social connections. A sense of purpose can focus the interests and energy of a young person in a meaningful direction. Gilligan (2000) believes that "…a sense of where things are leading is very important to young people in troubled circumstances" (p44).

j) Sense of belonging (connectedness)

All young people benefit from feeling like a valued member of the community and living in relationships that provide mutual support and care (Balk, 1995). The degree to which young people feel a sense of inclusion and belonging depends on the nature and depth of their attachments.

A young person might connect with particular people, activities and pursuits, school or work, their cultural heritage and customs, spiritual traditions, broader social movements and places of significance. 'Connectedness' refers to the significance that young people ascribe to these attachments.

Eckersley and colleagues (2006) explain that: "[w]ellbeing comes from being connected and engaged, from being suspended in a web of relationships and interests. These give meaning to our lives. The intimacy, belonging and support provided by close personal relationships seem to matter most; and isolation exacts the highest price" (p19).

The experience of connectedness is associated with feeling part of something greater than oneself (Masten, 2001, 2009; Ungar, 2006). This provides young people with a sense of security and belonging that frees them to explore and learn (Masten, 2009). Connectedness has been shown to engender in young people a sense of identity, contributing to the development of personal values and helping them to envision a future for themselves (Aronowitz, 2005).

k) Hope and expectancy

All young people need to believe in a promising future with real opportunities (Balk, 1995). Resilient individuals report that faith and hope played a key role in sustaining them through adversity. Masten (2009) refers to the classic Kauai Study, where Werner and Smith (1992) noted that the cohort of young people found to be resilient expressed optimism, hope for the future, and a deeply held conviction that life has meaning.

Hope and expectancy is borne out of feeling secure, valued and competent. Many clients of youth AOD services experience social exclusion and a poverty of developmentally conducive experiences. With no reason to believe that their circumstances will improve, it is natural for young people to feel pessimistic about their prospects for future.

This assertion is corroborated by Fisher, Florsheim and Sheetz (2005), who found that homeless adolescents tend to experience high rates of hopelessness and a diminished sense of self-efficacy. The conditions most likely to generate a sense of hope and positive expectation among these young people are also those that contribute to healthy development and resilient adaptation.

On a practical level, setting and pursuing goals, including those aimed at resolving issues of immediate concern (such as finding accommodation), engages young people in future-oriented action. Even very small gains and successes provide tangible reasons to envisage a positive future. Gradually, the accumulation and recognition of goals achieved, combined with the knowledge that useful and reliable assistance is available, can produce a greater sense of hope that change is possible and provide reasons to consider and work towards a better future.

6.3 Domains of need

6.3.1 Overview

The introduction to Section 6 outlined the five domains of need that are articulated in the Framework for Resilience Based Intervention. They are:

- Protection from harm and the capacity to respond to crisis
- Stability and the capacity to meet basic needs
- Participation in constructive activity
- Developmentally conducive connections
- Greater control over health-compromising issues and behaviours (e.g. harmful substance use, mental health problems, homelessness, offending, etc).

These five domains have emerged from the results of qualitative research conducted in 2009 with 36 staff and managers of a large Victorian youth AOD service, supported in qualitative research with 42 clients from the same service (Green, Mitchell & Bruun, in revision). They were also elaborated through an extensive review of the literature on adolescent development, resilience and vulnerability, adolescent substance use, and the determinants of health and well-being for young people (see Section 2).

The relevance of each domain to the youth AOD target group is explored in the following pages. In Section 6.4, the resources and assets that can be applied within each domain to enable young people to achieve their goals are identified.

6.3.2 Protection from harm and the capacity to respond to crisis

Safety is fundamental to healthy development (Bickerton, Hense, Benstock, Ward, & Wallace, 2007). A young person's capacity to be resilient in the face of adversity also requires a degree of safety.

All young people, particularly those who are minors, have a right to be protected from danger and harm. Crisis situations often manifest when the physical and emotional safety of young people is compromised or threatened and those responsible for their care do not have the capacity to deal with stressors and/or provide adequate protection. Masten (2001) points out that it is most often the young people who contend with the greatest adversities that do not have the protections offered by adequate resources and social 'scaffolding' capable of regulating their exposure to risk. Young people in such circumstances must rely on their own capacity to cope with crisis situations.

The experience of disadvantage and social exclusion makes many clients more susceptible to crisis and potential harm (Hayes, Gray & Edwards, 2008). MacDonald and Marsh (2002) are more specific in finding that "…the consequences of personal crisis are likely to be much more drastic for those who are socially excluded because they lack the financial and social supports that can help offset the impact of the crisis and increase the likelihood of recovering" (p34).

Bell (2007) found that prospective youth AOD clients viewed themselves as participating in a kind of 'accidental world'. They characterised themselves as vulnerable to random events but not as victims. Such young people might seek refuge in safe and welcoming environments, spend time at a special place, or find comfort in sharing experiences with friends and family.

The risk conditions experienced by clients can be so extreme that clients require respite in highly structured environments. In addition, there are times when youth

AOD clients show little or no regard for their own safety or the safety of others. A thorough, context-sensitive, risk assessment and response is required. This includes ways of assessing and responding to suicidal ideation and the potential for self-harm. These methods should be culturally appropriate. Practitioners are advised to note particular sensitivities that must be taken into account when dealing with Aboriginal and Torres Straight Islander communities..

Resilience based intervention aims to enable young people to manage and resolve crisis situations and take responsibility for their own safety as well as building the capacity of parents, guardians and significant others to provide adequate support and protection

While the focus in such circumstances is on safety and not long-term development, crisis periods triggered by unpredictable events can become turning points in the lives of young people (see Section 2.2). For this reason, youth AOD workers must have the capacity to hold a dual focus, "one eye on the present, the other on the path" (Bruun & Hynan, 2006, p22)

6.3.3 Stability and the capacity to meet basic needs

Young people, particularly minors, have a right to expect those involved in the their care will provide for them stable conditions in which to develop. The experience of stability creates a sense of coherence (see Giddens, 1991) whereby a young person might come to trust in the reliability of people and the availability of resources and life opportunities. Some degree of stability in life circumstances is a precondition to being able to gain control over the range of health-compromising issues and behaviours that underlie problematic substance use. Rowe (2005) points out that "…often health is not considered a priority in a chaotic life where survival takes precedence" (p32).

Many youth AOD clients have experienced extended periods of instability during their childhood and adolescence, including periods where basic needs may not have been met. This can undermine the young people's stability and sense of coherence. Naidoo and Wills (2000) explain that only when basic needs are met are people free to pursue their goals and achieve their potential. The capacity to meet basic needs has also been found to be integral to the process of resolving substance use problems for disadvantaged young people (Keys, Mallet & Rosenthal, 2006; Cloud & Grandfield, 2004; Grandfield & Cloud, 2001).

Young people experiencing homelessness are often faced with a struggle to meet basic needs. At times some young people may find aspects of a more transient lifestyle exhilarating and even preferable, but when it is not a choice this is rarely the case. A hand-to-mouth existence and the lack of safe physical and social environments make the short-term relief or alternative experience that substance use offers attractive.

Resilience based intervention involves ensuring that young people have the capacity to meet basic needs and have a stable base on which to develop. This involves working to ensure that young people and those involved in their care have access to sufficient resources and possess the skills and motivation to employ them effectively to maintain stability. Further, young people and their carers can learn how to predict and prevent crisis. Planning and preparation can reduce the number of crises and the degree of harm experienced by clients (Robinson & Miller, 2010).

6.3.4 Participation in constructive activity

Positive functioning and healthy development for young people is strongly associated with engagement in structured, pro-social activities (Bartko & Eccles, 2003).

Constructive activity, be it schooling, work or recreational pursuits, can counteract 'boredom' but can also be a vehicle for the "…development and demonstration of new competencies, problem solving, helpfulness and other positive attributes associated with resilience" (Ungar, Dumond, & MacDonald, 2005).

Engagement in constructive activity over time promotes social inclusion and economic participation. It is a means by which a young person might come to be treated as a person of value; "…a capable person who can contribute in the life of the community" (Ungar, 2006; p57). Youth AOD clients who engage in such action can challenge negative social discourses characterising them as either "delinquent, disordered, dangerous or deviant" (Ungar, 2005) and forge a new identity.

The adoption of problematic substance use patterns by young people can also be linked with a lack of opportunities for recreation and participation in activity that is socially integrative (Bonomo, 2003). Young people participating in a major Melbourne based study into youth homelessness "… stressed how all other dominating activities fell by the wayside as drug taking or getting money for drugs became their prime activities" (Keys et al., 2006, p74).

Disconnection from social institutions such as schools, workplaces and sporting clubs means missing crucial development experiences and opportunities to develop new social connections and networks. Premature exclusion from school is strongly associated with the development of substance use problems and involvement in the criminal justice system. (Prichard & Payne, 2005).

Catalano and Hawkins (1996) identify that such social development requires a child or young person first to perceive opportunities for pro-social interaction. Pro-social activity then provides an opportunity for a young person to make healthy bonds with significant others who are in a position to positively reward their participation. This offers a young person the chance to test their capacities and demonstrate qualities that may have been previously unrecognised.

Resilience based intervention involves motivating and enabling young people to either initiate or maintain participation in constructive activity that is varying degrees satisfying, rewarding and socially valued. In most cases, problematic substance use is incompatible with participation in constructive activity. Young people who feel strongly attached to one or more constructive activity have a reason not to let substance use become so problematic if it restricts their involvement.

Over time, continued participation can promote the development of emotional, cognitive and behavioural skills that allow the young person to continue earning and experiencing positive reinforcement (Catalano & Hawkins, 1996). Heightened expectations often result as others with significance in the lives of young people recognise such learning and growth. This has been shown to increase motivation for further participation in pro-social action and encourage young people to envision and work towards a better future (Aronowitz, 2005).

6.3.5 Developmentally conducive connections

Young people, like all of us, desire to support, to value and be valued by people who know them well and have an ongoing commitment to their well-being. Developmentally conducive relationships offer young people protection and care (including an appropriate level of monitoring and discipline), mutual support, fraternity, modelling and guidance, recognition and understanding as well as the opportunity to envisage a positive future (see Aronowitz, 2005). Further, an appropriate level of guidance and reinforcement has been found to create a stronger motivation to learn, solve problems, and engage successfully in the world (Masten, 2001).

Granfield and Cloud (2001) make it clear that very few are able overcome life's many challenges without the assistance of others. Even one positive relationship experience may do much to counter the harm of negative relationships or experiences (Masten, 2009). Aronowitz (2005) points out that "…even in the most difficult situations, having someone to lean on gives a young person the feeling that he/she is valued, competent and able to succeed" (p203).

Young people also derive a sense of belonging and meaning in life through connections with places, their cultural heritage and related institutions, faith-based organisations and broader social movements (see section 6.2.2 social ecological resources and assets).

Connections can also be a source of harm and limit the healthy development of young people. Granfield and Cloud (2001) explain that "…substance use and misuse generally occurs in a larger social context within which individuals are socialised into use, develop the rationales associated with use, and derive meanings from their substance use related experiences" (p1553).

The connections of youth AOD clients with others in their social network may help in coping with the problems of 'social exclusion' and generate a sense of 'inclusion', but can simultaneously limit the possibilities of escaping the conditions of 'social exclusion' (Johnston, et al., 2000; Macdonald & Marsh, 2001). For this reason Green, Mitchell and Bruun (in revision) suggest that services broaden their focus and develop methods of engaging and working with a young person's family, peer group and/or larger social network to enable them to change and grow together.

Resilience based intervention involves enabling young people to develop insight into how their connections influence their capacity to met their needs and achieve their goals. Young people might also need assistance in maximising the helpful influence of their connections and minimising the limiting and sometimes harmful effect. At other times young people might be supported to identify and develop new connections.

a. Parents and caregivers

Young people's attachment with parents and caregivers over time is integral to their development. Although young people are often portrayed as separating from family and establishing independent lives, Robinson and Miller (2010) cite the research of Markiewicz et al. (2006) and Robinson and Pryor (2006) to make the point that while the importance of peer relationships increases, it is not usually at the expense of family relationships.

Robinson and Miller (2010) describe five elements of a secure parent/caregiver-adolescent attachment developed by Schofield and Beek (2009). They are "… availability (helping young people to trust); sensitivity (helping young people to manage feelings and behaviours); acceptance (building the self-esteem of the young person); cooperation (helping young people to feel effective); and family membership (helping young people feel like they belong)" (p9).

The caregivers of clients also have a key role in regulating their experiences as they develop, particularly the degree of risk exposure. Parents or legal guardians have responsibility for protecting young people from harm. For young people who are minors, this is a basic right. Fair and reasonable discipline, matched to a young person's level of development, creates the conditions in which young people can rise to challenges and learn to manage risk without feeling overwhelmed.

Poor family cohesion, parental conflict, lack of affection, and low attachment to family are associated with increased substance misuse (Mitchell et al., 2001). Bonomo (2003) adds that familial attitudes that are favourable to substance use and parental modelling are obvious influences on young people's behaviour.

Among participants in a study conducted by the Youth Substance Abuse Service (YSAS) into client perspectives, Green et al. (in revision) found that most describe family backgrounds featuring significant conflict, disruption and heavy AOD use. The experience of neglect, abuse and trauma was commonplace. Many had first used substances with family members and described their relationships with parents and caregivers as either conflicted or characterised by neglect and a lack of care. Even so, they continued to ascribe significant meaning and importance to family relationships.

b. Role models and significant adults

Aronowitz (2005) demonstrates that adults outside the primary care-giving relationship who have a connection with a young person can support parents and guardians in their efforts to provide discipline. This is the case where connected adults share a common interest in the young person's safety, well-being and future prospects. They are well positioned to unobtrusively monitor safety and well-being.

Older, more experienced people who are connected with a young person might be considered as role models (Ungar, 2005, p90). These relationships are often fostered through participation in constructive activity. Masten (2001) observes that an appropriate level of guidance and reinforcement create a stronger motivation to learn, solve problems, and engage successfully in the world.

According to Aronowitz (2005), connections with role models and mentors (including parents) who model a positive but realistic view of the future and have reasonable but high expectations engender confidence and optimism that stimulate healthy development. Effective modelling has also been found to help young people counter the harmful effect of negative stereotypes and clarify their values (Aronowitz, 2005).

c. Peers and friendship networks

The peer and friendship relationships of young people engaged in problematic substance use are particularly influential. Through affiliation with other substance-using peers, young people develop attitudes and model behaviours that are reinforced through continued participation together (Bonomo, 2003).

Beyond helping them to belong, some young people might use substances to attain status among their peers (Paglia & Room, 1998). Strong peer group associations of this kind may exacerbate other vulnerabilities in some young people (Seidman & Pederson, 2003).

Young people attending youth AOD services have reported that substance use is one of the main activities that members of their social networks do when they are together, and that it is very difficult to remain substance free when they spend time with friends (Green, Mitchell and Bruun, in revision). Young people in this sample of young clients expressed awareness of a need to move away from substance-using peer networks and make new friends, but they also reported very substantial difficulties in doing so. Despite this, it has been observed that interventions aiming to breaking all such contacts will likely be met with resistance and could be of questionable utility (Kidd, 2003).

d. Partners and romantic attachments

It is important not to underplay the influence of romantic attachments on substance use risks and patterns. As with peer relationships, substance use can form the glue that holds romantic relationships together. Partners can reinforce each other's substance-using behaviour. There are times when the one partner might find the prospect of the other partner addressing substance use problems threatening and seek to prevent it.

Among participants in the YSAS client perspectives study (Green et al., in revision), young women commonly described forming relationships with older men who were often suppliers of substances. They reported verbal abuse and/or physical violence in these relationships. Even so, relationships with older partners can be a vital source of support at times and the catalyst for positive change (Keys et al., 2006).

e. Cultural and spiritual connection

Connection with culture, spiritual or faith-based organisations and even broader social movements can foster a sense of being part of something greater than oneself. Ungar (2006) claims that "…adherence to one's local and/or global cultural practices, values and beliefs" (p57) supports resilient adaptation.

Crawford and colleagues (2006) propose that cultural systems, including religions, may work by engaging the fundamental adaptive systems that foster attachment, self-regulation and meaning making.

Cultures and religions incorporate belief systems, rituals and practices that can help people deal with expected and unexpected adversities; for example, rituals for loss and mourning. Being part of a community with shared beliefs and values can provide comfort and support during times of stress and need. It is noted that through their cultural and religious connections, many youth AOD clients and others have had negative experiences. Youth AOD practitioners are advised not to make the assumption that such connections will automatically be positive.

f. Place-based connection (enabling environments)

Another possible connection that can promote better health and well-being for young people is with particular neighbourhoods and/or special places. Such places might produce feelings of security and belonging in young people that can be instrumental in seeing them through tough times. There is an emerging body of theory and evidence demonstrating how the places young people inhabit and feel connected to have a role in producing therapeutic encounters.

Duff (2011) points out that through an active process of association with place, young people can develop a diverse range of social, affective and material resources that might be used in their efforts to live well. He explains that such 'enabling places' are constructed or composed rather than discovered. The influence of place is therefore never fixed and can be fleeting; it can also play a role in experiences that are detrimental to well-being and healthy development (Duff, 2011).

6.3.6 Greater control of health-compromising issues and behaviours

Each young person's capacity for resilience and healthy development can be compromised by a unresolved personal issues and potentially problematic behaviours.

Each young person and their family experience the impact of these issues and behaviours in a unique way. However, it is possible to identify particular issues and experiences that underlie and shape the problems that many youth AOD clients have with substance use. They are:

- Childhood abuse and neglect
- Past and current sexual assault
- Exposure to violence (domestic and other)
- Family breakdown
- Complicated grief
- Physical health complaints (particularly involving persistent pain).

These issues and experiences are often the source of significant trauma for youth AOD clients. Trauma can stem from a single event or multiple events that compound over time. The experience can be dehumanising and terrifying and often includes betrayal by a trusted person or institution.

The associated loss of safety can be experienced repeatedly, inducing powerlessness, hopelessness and fear. It can also result in a person being in a constant state of alert. These effects can damage self-concept, relationships with others and cause recurring feelings of shame, guilt and rage. Traumatic stress is closely associated with difficulties in regulating impulses and emotions.

It is understandable that the effects of trauma and the other issues and experiences mentioned can be the source of considerable distress and are directly related to:

- Substance use problems
- Mental illness and a range of mental health problems
- Problems with anger and aggression
- An antisocial orientation and offending behaviour
- Self-injury
- Persistent suicidality.

There are complex interrelationships between each of these issues and behaviours (including substance use) and all have potential to compromise the well-being of young people and their families. When the issues and the problems associated with particular behaviours become overwhelming and/or intolerable crisis situations can develop. This has the potential to undermine young people's stability, the quality of their relationships and their options for constructive participation.

Daley and Chamberlain (2009) contend that the multifaceted and systemic issues experienced by youth AOD clients cannot be addressed independently or by focusing on the substance use alone. While it might be ideal for one or all of these problems to be resolved, circumstances might dictate that it is not possible. In such cases, interventions may be more usefully focused upon creating conditions that support the agency of the young person to restore, establish and maintain as much control as possible over their health and well-being, rather than fixing their problems (even though at times this will be the result). It is also noted that when issues or behaviours are out of control, a crisis situation might develop.

At the most basic level, the maintenance or restoration of some form of stability in living conditions and emotional state is required is a client is to deal effectively with underlying issues and associated behaviours.

6.4 Resilience Based Intervention: applying resources and assets in building the capacity of clients to achieve their goals within each need domain

6.4.1 Implementation

The case has been made for youth AOD services and practitioners to concentrate on enabling young people to increase control over their own health and well-being and therefore be in position to make changes in their substance-using behaviour. Substance use problems are often associated with heightened vulnerability and exposure to risk (See section 2.3) and responsibility for finding solutions should not reside solely with the young person.

A distinguished AOD treatment expert, Bill Miller, staties that "optimal care is likely to happen within the context of an ongoing relationship in which support and care are provided through the normal ups and downs of life" (Miller, 2002, p22). Further, Miller (2002) believes that care must be "…attuned to the person's particular social context, network of relationships, and the full spectrum of strengths and problems" (p22).

The framework for resilience based intervention charts a range of resources and assets (see Section 6.2) that if accessed and used effectively can enable clients to meet their needs and goals (see Section 6.3). Particular resources and assets can be applicable in meeting a range of goals and needs. For example, planning and decision making skills or a supportive family can be useful in times of crisis but can also assist young people who are pursuing further education.

Clark (2001) contends that "[y]outh care workers are in a position to mobilise, channel and focus what the client brings with them, but, ultimately, the powers for change reside within the client him/herself" (p20). He suggests that this involves meeting three conditions:

- To convey an attitude of positive possibility (hope) without minimising the problems and pain that accompany the client's situation
- To turn the focus of treatment towards the present and future instead of the past
- To instill a sense of empowerment and possibility to counteract feelings of demoralisation and passive resignation.

Masten (2009) points out that resilience research is transforming practices and policies designed for high-risk groups of young people and offers services a positive framework for intervention that represents a major departure from deficit-focused models that dominated earlier practices and policies for young people. She suggests that services frame positive goals for their work with young people, that assets and strengths are assessed for included as outcome measures and that strategies aim to reduce risk, increase resources, and/or mobilize adaptive systems. Masten (ibid) notes that this does not mean that risks, symptoms, vulnerabilities, and disorders are ignored but rather that the overarching assumptions and goals of a resilience framework emphasize positive development and positive processes.

6.4.2 Pathways

Munford and Sanders (2008) describe the way that chance, choice and opportunity can come together to create 'critical moments' (Thomson, Bell, Holland, Henderson, McGrellis et al., 2002) in which a young person might decide to take a new path and begin addressing their problems with substances. Many young people with the right mix of support and opportunity will develop resilience naturally and resolve substance use-related problems without requiring intervention from service providers.

Young people who do require professional assistance often seek help when in crisis and require a timely response to what is often urgent need.

Crisis situations are often associated with particular heath-compromising issues and behaviours, which need to be addressed simultaneously with immediate substance-related harm. This demands that practitioners concentrate their attention on the first two domains of need emphasising safety, harm reduction and stabilisation. The priority is to prevent deterioration of the client's circumstances and to engender an interest in their own self-care. This establishes and/or protects a secure base that supports efforts to develop more constructive ways to cope with life stressors and the issues underlying substance use problems.

A stable and secure base is a prerequisite for being able to pursue positive health and developmental goals. Participation in constructive activity and the availability of developmentally conducive connections (the third and fourth need domains) promote social inclusion and a sense of connectedness. In turn, the sense of achievement and support that young people may experience contributes to a client's ability to increase control over behaviours and issues that drive substance use problems and restrict healthy development.

Alternatively, early intervention with young people who are showing signs that substance use could become a problem is best geared towards strengthening developmentally conducive connections, maintaining participation in constructive activity, and ensuring that health-compromising issues and behaviours are being addressed to avoid crisis and loss of stability.

Each young person's circumstances are unique as is significance of either the presence or lack of resources and assets in their lives. This has a profound influence on a young person's capacity to meet their needs and achieve their goals.

The remainder of this section investigates the relationship of particular resources and assets to each of the 5 domains of need identified in the framework for resilience base intervention.

6.4.3 Resources and assets that offer protection from harm and build capacity to respond to crisis

a. Social ecology

Young people and those involved in their care require a range of external resources and assets to cope effectively with crisis. Clearly, material resources such as income, housing and transport are vital. Perhaps more important is the availability of helpful human relationships and safe places or havens that can provide respite. Where these resources aren't naturally available, young people might require professional assistance.

This might mean that services provide particular resources such as a safe physical environment or transportation. Depending on the nature of the crisis and the young person's specific needs, other agencies can include emergency services, AOD services, mental health services, homelessness services, 24-hour telephone counselling services, and support services that provide material aid.

Box 6.1: Social ecological resources that provide protection from harm and build capacity to respond to crisis

- Material resources (income, housing, safe physical environments, etc.)
- Human resources (providing care, support & reinforcement)
- Caring guardians capable of providing appropriate discipline & monitoring (could be family)
- Cultural/spiritual connections
- Connection with enabling places
- Availability & accessibility of relevant health & community services

Youth AOD clients, particularly those who are minors, require caregivers to protect them from harm and regulate their experiences as they develop. In this way, parents and/or legal guardians have a stake in how the health and safety of youth AOD clients is managed (see Section 6.5, Developmentally conducive connections).

The capacity of parents and guardians to protect those in their care is helped and hindered by aspects of the wider environment (Hyde, 2005; Rhodes, 2002). Services should therefore be capable of providing young people and their carers with meaningful information, support and guidance through times of crisis.

In times of crisis, young people might also draw on cultural and/or spiritual connections with others for support and guidance.

b. Knowledge, skills and attributes

As parents and significant others have a key role in regulating young people's exposure to difficult and often risky circumstances, their level of knowledge and skill will strongly influence young people's ability to manage crisis. It also depends on the degree to which a young person possesses relevant and specific knowledge and skill according to the type of crisis. Knowledge and skill combined with motivation and opportunity are key ingredients for the implementation of harm-reduction strategies.

Box 6.2: Knowledge, skills and attributes that protect from harm and build capacity to respond to crisis

- Insight (self & social awareness)
- Self-care knowledge & skills
- Health literacy
- Regulation of emotion & arousal
- Problem-solving & decision-making skills
- Ability to make sense of experiences & put them into context
- Communication skills
- Assertiveness skills
- An even temperament & intelligence

Self-awareness and health literacy enable young people to regulate their own response in a crisis situation and can be the basis of appropriate and timely help-seeking behaviour. On a practical level, resourcefulness and social awareness are useful assets identifying the resources and services can be drawn on to reinforce a young person's coping.

Clients in crisis are often overwhelmed by strong feelings and experience high levels of stress and arousal. An even temperament is an asset in enabling a relatively quick return to emotional equilibrium. For young people with less stable moods and affect, moving through crisis may require assistance to learn or use skills that reduce arousal and regulate emotions.

Problem-solving and decision-making skills can enable young people to calculate risk and better predict and manage the logical consequences of their actions.

Another characteristic that is helpful during and after a crisis is the ability to make sense of experiences and put them into context. This can minimise unhelpful thought processes, such as over-generalising and catastrophising (see section 6.2.4), and reinforce a belief that addressing distressing circumstances in a constructive way is possible and worthwhile.

Finally, communication and assertiveness skills are likely to be very useful in the process of negotiating for meaningful support and necessary resources.

c. Beliefs (identity and motivation)

A young person's beliefs, expectations and values can be instrumental in how they approach and experience crises.

Young people found to be resilient consistently report that faith and hope have sustained them through adversity (Masten, 2009). Young people are more likely to hold this view when they believe in their own efficacy and/or the efficacy of others (such as parents or practitioners) in dealing with crisis situations.

Self-efficacy has been demonstrated to be a predictor of better adjustment through periods of crisis. Young people with a strong internal locus of control are likely to believe in their ability to work through crises and be motivated to do so. Many youth AOD clients who are unable to trust the systems and people (often because of past experiences) are likely to experience greater distress and be overwhelmed more easily.

This is well illustrated by Robinson and Miller (2010), who use the work of Dwyer and colleagues (2010) to highlight that some young people "…do not expect to be cared for when most vulnerable because this is what their experience has taught them. Therefore, they may respond with an over-determined threat response, such as aggression or avoidance" (p37). Appropriate nurturance and care can soothe young people's distress and guide them in ways to express it more constructively.

Box 6.3: Beliefs that protect from harm and build capacity to respond to crisis

- Sense of security (coherence)
- Sense of belonging & connectedness (feeling connection to something greater than oneself)
- Hope & expectancy
- Self-esteem
- Self-efficacy
- Mood & affect
- Core cognitive schemas about self & the world that support coping & resilience

Self-esteem has also been identified as a safeguard against psychological discomfort resulting from disparaging life circumstances. Many young people exposed to abuse and also family conflict and breakdown tend to blame themselves, which contributes to low self-esteem. This tendency can be generalised by clients who might blame themselves for other crises, further reinforcing negative self-appraisals. Conversely, helping a young person to put experiences in context and more accurately attribute responsibility among those involved can help repair self-esteem.

Crisis can trigger a strong emotional response that is reflected in a young person's affect and influences underlying mood state. In turn, a young person's affect is likely to influence others and either exacerbate or reduce the crisis; their mood will often determine how and if they choose to respond.

Together with mood, a sense of security and belonging can increase the likelihood that a young person will work towards finding constructive solutions to crises.

6.4.4 Resources and assets that can be used to attain stability and meet basic needs

a. Social ecology

The fundamentals supporting human survival and social inclusion are shelter, food and nutrition, clothing and material resources, a reliable and sufficient source of income, safe physical environments, and adequate transportation. Access to information technology and communications has also become an indispensable resource for young people today.

Further, an essential ingredient to maintain stability is being able to exert control over one's living situation. Young people (and their carers) require a place to call home with security of tenure.

Many youth AOD clients, particularly those who are younger, require carers or legal guardians to take responsibility for creating and maintaining stability in their lives. A stable network of relationships and participation in structured activities such as school, work or sport provide some degree of certainty and coherence. Connections with others that offer cultural and/or spiritual care and guidance can also promote a sense of security and have a stabilising effect.

Box 6.4: Social ecological resources that can be used to attain some level of stability and meet basic needs

- Material resources (safe physical environments, sufficient income, housing, transportation, etc.)
- Human resources providing care, support & reinforcement
- Caring guardians capable of providing appropriate discipline & monitoring (could be family)
- Cultural/spiritual connection
- Availability & accessibility of relevant health & community services
- Options for participation (education, employment, sport, etc.)
- Opportunities for connection & sense of belonging (cultural/spiritual, enabling places, etc.)

Connection to a familiar neighbourhood and the availability of spaces (public and private) where young people feel comfortable and welcome have also been linked with healthy development (Malone, 2008). Duff (2011) points out that these 'enabling places' can produce feelings of security and belonging that can be instrumental in seeing them through tough times.

A range of health and community services might also be used proactively minimise the risk a client's stability is undermined by a crisis stemming from, for example, underlying trauma. Community services might also offer young people to access helpful resources and that boost a client's capacity to create and maintain life circumstances that are stable. The same applies for participation in constructive activities.

b. Knowledge, skills and attributes

Young people's carers require sufficient ability to regulate the experiences of those in their care and provide stable circumstances for them. This involves being able to understand risky behaviours and negotiate with their child reasonable, age appropriate boundaries that if transgressed are matched to clear consequences. It is always preferable that any consequences have the effect of promoting growth and development rather than simply being used as punishment.

Some young people need skills in communication and assertiveness to negotiate boundaries with caregivers and peers. These skills also help to create and maintain supportive social networks and participation in community life. At times, difficulties in relationships and an inability to locate resources might generate frustration that can trigger a problematic behavioural response.

In these cases, insight into behavioural triggers and the skills for regulating emotion and arousal can be useful. Given that a range of health-compromising issues and behaviours (e.g. mental health problems and substance misuse) can undermine stability if they develop unchecked, health literacy and help-seeking behaviour are useful assets.

Box 6.5: Knowledge, skills and attributes that promote stability and capacity to meet basic needs

- Self-care knowledge & skills
- Resourcefulness (knowledge & ability to access & mobilise resources to meet needs)
- Numeracy & literacy
- Insight (self & social awareness)
- Health literacy
- Regulation of emotion & arousal
- Problem-solving & decision-making skills
- Ability to make sense of experiences & put them into context
- Communication & assertiveness skills
- An even temperament & intelligence

Box 6.6: Beliefs that promote stability and the capacity to meet basic needs

- Sense of security (coherence)
- Sense of belonging & connectedness (feeling connection to something greater than oneself)
- Interests & commitments & a sense of purpose
- Hope & expectancy
- Self-esteem
- Self-efficacy
- Core schemas regarding self & the world that support coping & resilience
- Relatively stable mood & affect

Youth AOD clients, who often have to fend for themselves in the community, will benefit from self-care knowledge and living skills such as budgeting and cooking. This is assisted greatly by adequate numeracy and literacy skills. Resourcefulness or the ability to locate resources and take advantage of opportunities is another useful asset that is supported through effective interpersonal skills.

An ability to make sense of experiences and put them into context can also help a client to stay on track. Problem-solving and decision-making skills can assist young people to set realistic goals and maintain a steady course in the pursuit of these goals.

c. Beliefs (identity and meaning)

It is common for youth AOD clients to pride themselves on being active in managing their affairs. The desire to construct and project a competent identity can translate into motivation to develop the skills necessary to meet basic needs and stabilise.

Stabilising can involve a shift from reactive to proactive measures to address unresolved problems and take positive developmental steps. Clients who understand that stability is a platform for change are more likely to invest the energy required to build it in their lives. This requires a sense of hope and an expectation that resources are available and circumstances can improve, which in turn helps sustain a belief that addressing problems and the source of any distress is worthwhile.

Such optimism is underscored by positive self-esteem and a strong sense of self-efficacy. Other more specific self beliefs and client's underlying mood state can either add to a young person's stability or undermine it (see section 6.2.4).

Once stabilised, a strong sense of belonging and connectedness with people, culture and places can provide young people with reinforcement and the motivation to continue their efforts to develop and grow. The same is true for participation in constructive activity, which engenders a sense of purpose. This demonstrates the importance of interests and commitments outside of a substance-using lifestyle.

6.4.5 Resources and assets that facilitate participation in constructive activities

a. Social ecology

The participation of young people in education and training, employment, or a range of sporting, recreational and leisure pursuits depends upon the availability of viable opportunities. Resources and assets available within geographic regions and whole communities are particularly pertinent for constructive activity.

Regions that can provide meaningful work and neighbourhoods that have public education and recreational facilities and programs tend to have lower rates of social problems such as misuse of alcohol and other drugs, crime and violence (Williams, Pocock & Bridge, 2009). The same is true where communities create environments and spaces that encourage healthy participation and contributions to community life (Victorian Department of Human Services, 2001).

Clearly participation also depends on the degree to which the individual young person and/or their primary carers have access to material resources, such as income and adequate transportation.

Participation in constructive activity can be promoted and reinforced by significant others in a young person's social network. The act of participating can have the effect of building and strengthening the social network, offering opportunities to make connections with pro-social adults. This can offer clients a passport to future social contact and opportunities in new contexts (Gilligan, 2008, p44).

Box 6.7: Social ecological resources that facilitate participation in constructive activities

- Opportunities for meaningful education & training, gainful employment, sport & recreation
- Opportunities to participate in & contribute in cultural activities & spiritual practices
- Opportunities to connect with & contribute to broader social movements
- Material resources that support participation (income, transport, information technology)
- Human resources (support, connection with opportunities, guidance & reinforcement)
- Health & community services

Depending on a young person's background and particular identifications, they might also benefit from options to participate in cultural activities and/or connect with faith-based organisations or broader social movements.

b. Knowledge, skills and attributes

Once a client has established a stable foundation, youth AOD services can work with clients to facilitate the development of the skills necessary to connect or reconnect with education and other pro-social activities.

Young people's ability to access and make the most of constructive options for school, work and recreation is supported by resourcefulness in locating opportunities and possessing an awareness of the expectations of others.

Young people with an ability to find a healthy balance between their needs and the needs of others have a better chance to sustain constructive involvement. In this way, self-management and social skills promote successful participation and can be enhanced by attributes such as intelligence, an even temperament and appearance or attractiveness. Good numeracy and literacy will also broaden the opportunities for participation.

Participation in constructive activity provides young people with opportunities to build self and other awareness via interactive experiences in a variety of social contexts (Gilligan, 2000, 2008; Kallander & Levings, 1996). Constructive activity is a vehicle for the development of a wider range of skills that assist with more comprehensive social inclusion. Rewarding activity also gives clients tangible reasons, and therefore motivation, to learn and apply the self-management skills required to regulate emotional responses, modify cognitions, make decisions and solve problems.

Unique talents and physical fitness are attributes that clients can use to aid participation. Further, constructive activity can also improve young people's physical fitness (Gilligan, 2008) and have a positive effect on young people's mood state. The physical attributes and talents of clients may increase the chances that activity is rewarding and improve the prospects of young people's contribution being recognised and valued.

Box 6.8: Knowledge, skills and attributes that facilitate participation in constructive activities

- Knowledge & insight (self & social awareness)
- Regulation of emotion & arousal
- Problem-solving & decision-making skills
- Ability to make sense of experiences & put them into context
- Communication & assertiveness skills
- Ability to find a balance between personal needs & the needs of others
- Particular talent & abilities
- Other useful attributes (temperament, concentration & attention, intelligence, appearance)
- Fitness & health
- Numeracy & literacy

c. Beliefs (identity and meaning)

Involvement in constructive activity, be it schooling, work or recreational pursuits, requires motivation. It is far easier to motivate a person when they are pursuing a passionate interest or commitment.

Cloud and Grandfield (2004) found that a common feature among people who had moved on from lifestyles involving substance dependence was their involvement "…in alternative pursuits that engulfed them and gave them new personal meaning" (p190).

Based on research conducted with youth AOD clients, Bell argues that effective services would create new experiences that displace their substance-using lifestyle "…with a richer world of powerful and distracting creative and sensory experiences" (Bell, 2006, p43). In this way, according to Bell, "…the ideal service would socialise through recreation, reinforcing a new sense of being-in-the-world with others through activities…" and eventually lead to tackling "…the risky life tasks of education and work" (p43).

Box 6.9: Knowledge, skills and attributes that facilitate participation in constructive activities

- Sense of security (coherence)
- Sense of purpose
- Sense of belonging & connectedness (feeling connection to something greater than oneself)
- Hope & expectancy
- Self-esteem
- Self-efficacy
- Relative acceptance of & comfort with gender identity & sexuality
- Core schemas that support & reinforce constructive participation
- Pro-social values & attitudes
- Interests, commitments (passions)

Constructive activity can provide structure and a sense of purpose in daily living (Gilligan, 2008). A sense of mastery that comes with success in completing tasks can positively influence a client's estimates of their probability for success in dealing with other problems (Klee & Reid, 1998). Gilligan (2000) illustrates how success in an endeavour that a young person values may do much to combat a sense of failure in other spheres of their life. Greater self-efficacy also has the effect of creating interest in new experiences and further motivation for participation (Daniel and Wassell, 2002).

Success in an activity that the client and others in their social network value "…can ultimately lead to an increase in the youth's self-esteem and confidence" (Karabanow & Clement, 2004). Through constructive action, young people develop a reservoir of experiences that are bound to become incorporated in the stories that define and shape their beliefs about themselves and their environment (Ungar, 2005).

Such experiences may challenge the often self-limiting schemas and internal working models that young people use to understand themselves and their social world. Combined with guidance, positive new experiences may help modify maladaptive cognitive schemas and develop new schemas that support and reinforce ongoing commitment to constructive participation.

Young people who feel secure and connected and are confident that they hold values and attitudes similar to the activity group they are participating in will also be more motivated to maintain involvement. Pro-social activity allows a young person to make bonds with significant others, which can have the effect of engendering pro-social values and attitudes (Catalano & Hawkins, 1996).

Young people who are relatively comfortable with their gender identity and sexuality and hold the view that they will be able to fit in and enjoy themselves are also more likely to be motivated to participate. If an individual believes they will be victimised (this may be for good reason), it is a clear barrier to participation.

Finally, motivation to participate in constructive activity is demonstrated to be stronger in young people who are able to envision and work towards a better future (Aronowitz, 2005).

6.4.6 Resources and assets that support developmentally conducive connections

a. Social ecology

Young people require carers that provide adequate regulation and structure for them. Many youth AOD clients have often had inadequate monitoring and few limits around their substance use. This can be a result of limited parenting skills or possibly parents and other family members struggling to limit their own substance use. Overly restrictive and harsh limit setting can also exacerbate substance use issues. There is increasing recognition of the need to enhance parenting skills and supports, as well as for AOD services to include families (Patterson, 2002).

Maintaining positive peer relationships from childhood to adolescence has also been found to be predictive of later resilience (Collishaw, Messer, Rutter, Shearer, Maugham, et al., 2007). Given that many youth AOD clients have complicated and/or disrupted relationships with their significant adults, peer support takes on extra meaning. Practitioners are advised to investigate and understand how peer networks enhance or detract from a client's capacity to adapt and cope (Kidd, 2003).

Box 6.10: Social ecological resources that promote developmentally conducive connections

- Family networks that reinforce belonging
- Caring guardians capable of providing appropriate discipline & monitoring (could be family)
- Friendship networks & romantic partners
- Significant adults (teachers, employers, coaches, etc.) & role models
- Culture
- Spiritual/faith-based organisations & practices
- Enabling places
- Opportunities to participate in meaningful activities
- Relevant health & community services

Youth AOD clients often experience social exclusion and frequently lack access to potential role models, who tend to be embedded within schools, workplaces, sports clubs, churches and other socio-cultural institutions and organisations. At times, the only developmentally helpful role models or social relationships capable of providing a bridge to new resources and constructive experiences may be health and community services professionals (Green et al., in revision).

Network poverty has been identified as a "…barrier to [the] social support and informal health that we all need to take part in [the] community and to enjoy the standards of living shared by the majority of people" (Vinson, 2009). This underlines the importance of facilitating social inclusion through participation and constructive activity as a way to help young people make positive connections that strengthen their social network.

Depending on the cultural and spiritual identifications of a particular youth AOD client, connection with relevant individuals, groups or organisations can build resilience (see section 6.3.5). It is worth noting that locating resources and assets that are culturally safe and relevant can be a struggle for many young people.

It may be helpful for practitioners to spend time with clients investigating their connection to places of significance. These are places that a young person might visit to lift their spirits or make connections with others. Safe, welcoming and at times exciting physical environments can add to a young person's sense of connectedness and well-being.

b. Knowledge, skills and attributes

As with participation in constructive activity, certain skills and attributes help young people to form and maintain healthy interpersonal relationships. Involvement in healthy relationships helps individuals to further develop and refine these skills and attributes. Therapeutic working relationships with practitioners can provide a space or vehicle in which young people can learn relationship skills through modelling, reflection, live practice and feedback.

Box 6.11: Knowledge, skills and attributes that promote developmentally conducive connections

- Knowledge & insight (self & social awareness)
- Regulation of emotion & arousal
- Problem-solving & decision-making skills
- Ability to make sense of experiences & put them into context
- Communication & assertiveness skills
- Ability to find a balance between personal needs & the needs of others
- Appearance & attractiveness
- Other useful attributes (temperament, concentration and attention, intelligence, appearance)

Youth AOD clients might also benefit from focused assistance to enhance their relationship skills, such as emotion regulation, assertiveness, communication, and social problem-solving or conflict resolution. Various therapeutic models with demonstrated effectiveness in treatment of AOD problems among young people also include a strong focus on developing the skills needed to maintain healthy interpersonal relationships (see Section 4). Knowledge and insight (self and social awareness) can enable a young person to apply such skills in the most timely, appropriate and meaningful way.

Young people with the ability to make sense of experiences and put them into context are more likely to be motivated to overcome any difficulties in relationships, thus maintaining potentially important connections. The same is true for those who have an ability to find a balance between personal needs and the needs of others.

Appearance and attractiveness might be useful attributes in developing connections with others, but skills are required to maintain them and resolve any problems associated with relationships.

c. Beliefs (identity and meaning)

The connections and attachments that young people make as they develop and shape their identities strongly influence how they view their future prospects. Feeling valued and understood has been identified as contributing to young people's self-esteem. Encouragement, expectation and recognition of others have been shown to enhance self-efficacy. Alternatively, a lack of self-esteem and low self-efficacy can constrain a young person's willingness to pursue developmentally conducive connections, as can feelings of pessimism.

Box 6.12: Knowledge, skills and attributes that promote developmentally conducive connections

- Sense of security (coherence)
- Sense of belonging & connectedness (feeling connection to something greater than oneself)
- Hope & expectancy
- Self-esteem
- Self-efficacy
- Relative acceptance of & comfort with gender identity & sexuality
- Pro-social values & attitudes
- Interests, commitments (passions) that can be shared & acted on with others
- Core schemas that support & reinforce constructive connections

Developmentally conducive connections add to a young person's sense of security and can reinforce a sense of purpose and motivation for further personal development. Further, young people's connections can deepen when interests and commitments can become shared passions and acted upon with others.

Motivation to form and maintain developmentally conducive connections is influenced by the core schemas that a young person holds about themselves and their social world. Young people who believe in their ability to function well in social settings and trust that they will be accepted and supported by others are more likely to find making connections easier. Relative comfort with gender identity and sexuality is likely to support motivation for making connections.

6.4.7 Resources and assets that increase control over health-compromising issues and behaviours

a. Social ecology

To gain greater control over health-compromising issues and behaviours young people require stability and a secure base. Without these foundations, problems are more likely to overwhelm clients and create crisis. Consequently, material resources such as safe physical environments, income, housing, food and clothing, access to information technology and adequate transportation are all valuable in enabling a young person to maintain stability.

The effects of poverty, marginalisation and social alienation compound the degree of stress and hardship caused by health-compromising issues and behaviours and can restrict young people's ability to find effective ways to deal with these issues.

A wide range of treatment and other service providers may be called upon for assistance. Youth AOD services may need to ensure that young people are well positioned to make the most of particular treatments and services. Equally, energy may need to be invested in ensuring that services are ready and willing to provide useful assistance.

Practitioners should also make every effort to harness and enhance the sources of motivation, encouragement and practical support for help-seeking and behaviour change that are available within young people's natural support networks (Cox, 2005).

Box 6.13: Social ecological resources that increase control over health-compromising issues and behaviours

- Availability & accessibility of relevant health & community services (e.g. primary health, dental care, mental health services, AOD services, homelessness services, etc.)
- Material resources that build capacity to maintain stability (safe physical environments, income, housing, food & clothing, information technology, transportation, etc.)
- Human resources that offer support, care & reinforcement
- Caring guardians capable of providing appropriate discipline & monitoring (could be family)
- Socio-cultural participation: participation in purposive activity (education, work, sport, etc.)
- Connection with enabling places

There is sound evidence that involving parents/carers in treatment and other interventions for substance misuse, offending behaviour and mental health problems enhances the engagement and outcomes for young people (see Section 3.6 for further discussion). Caring guardians can offer guidance and support plus appropriate discipline and monitoring. This provides structure and containment which can have the effect of engendering a sense of security and coherence. Broader networks of peers and caring adults that the young person is connected with are also a potential source of support, care and reinforcement.

Participation in purposive, rewarding activity and physical exercise prevents or moderates the effects of underlying issues that drive problematic behaviours. The same can be true for young people who connect with and access enabling places.

b. Knowledge, skills and attributes

Problematic substance use and many other interrelated issues and behaviours stem from traumatic experiences and are therefore closely associated with the inability to effectively regulate impulses and emotions. The exercise of personal agency by clients in gaining increased control over these health-compromising issues can be supported by the development of emotional regulation skills.

As with problematic and dependent substance use, clients who engage in behaviours such as self-injury and/or offending will be better positioned to establish or restore a sense of control by learning the triggers that precede episodes. Health literacy and insight (self and social awareness) are therefore critical assets.

Clients might also learn to de-escalate heightened emotional responses by putting words to feelings. Robinson and Miller (2010) identify that this is a key element in "…developing internal control and integrating painful experiences" (p37). They also point out that "…young people who have experienced chronic trauma and disrupted attachment have often not had the opportunity to learn this key emotional developmental competence" (2010, p.37). Further, the ability to find meaning in experiences, even those that are frightening and overwhelming, increases the prospects for resilient reintegration following disruption (Robinson & Miller, 2010).

Box 6.14: Knowledge, skills and attributes that increase control over health-compromising issues and behaviours

- Health literacy
- Self-care knowledge & skills
- Resourcefulness
- Knowledge & insight (self & social awareness)
- Regulation of emotion & arousal
- Problem-solving & decision-making skills
- Ability to make sense of experiences & put them into context
- Communication & assertiveness skills
- Ability to find a balance between personal needs & the needs of others

Enhanced planning and decision-making skills can enable young people to identify and solve problems that might lead to or stem from the occurrence of health-compromising issues and behaviours. Self-awareness can support problem-solving as it enables the timely identification of problems.

Resourcefulness and self-care knowledge and skills can be crucial assets for young people striving to maintain or establish a secure base. To add to this, assertiveness skills can offer young people the confidence to negotiate for viable resources and opportunities necessary for meeting their needs. These skills can be applied to enable young people to find a balance between personal needs and the needs of others and thereby maintain mutually supportive connections.

c. Beliefs (identity and motivation)

A sense of security and coherence, belonging and feeling connected to something greater than oneself can underpin a young person's desire to gain greater control over health-compromising issues and behaviours. A relatively stable and manageable mood can also have a positive influence on a young person's motivation to seek help and their capacity to make the most of it.

Young people with a strong sense of self-efficacy are more likely to be motivated to address issues and control problematic behaviours. Otherwise, the ongoing impact can be a sense of powerlessness and negative self-evaluation, reducing both self-efficacy and self-esteem. Gilligan (2000) points out that individuals who view themselves as being adaptive and have a sense of purpose have been found to be more capable of assimilating threatening external events without experiencing excessive negative arousal and disorganisation.

Box 6.15: Beliefs that increase control over health-compromising issues and behaviours

- Sense of security (coherence)
- Sense of belonging & connectedness (feeling connection to something greater than oneself)
- Sense of purpose/interests & passions (motivation to gain control)
- Hope & expectancy
- Self-esteem
- Self-efficacy
- Core schemas that support & reinforce help seeking
- Relatively stable/manageable mood & affect
- Pro-social values & attitudes

Being able to construe benefits to the self from having learned to cope with a particular trauma has also been linked with better long-term outcomes (Wright, Crawford, & Sebastian, 2007). However, traumatic experiences can have devastating effects on fundamental belief systems that shape a young person's world view. It can lead, for example, to young people believing that no one has control over what happens to them in their life (Masten & O'Dougherty Wright, 2009). This highlights the importance of core schemas that engender hope and support help seeking.

References

AIHW (2009). *A Picture of Australia's Children 2009*. Canberra: Australian Institute of Health and Welfare.

Armstrong, M. I., Birnie-Lefcovitch, S., & Ungar, M. (2005). Pathways between social support, family well-being, quality of parenting, and child resilience: what we know. *Journal of Child and Family Studies, 14*(2), 269-281.

Aronowitz, T. (2005). The role of "envisioning the future" in the development of resilience among at-risk youth. *Public Health Nursing, 22*(3), 200-208.

Artz, S., Nicholson, D., Halsall, E., & Larke, V. (2001). *A review of the literature on assessment, risk, resiliency and need.* Canada: The National Crime Prevention Centre Department of Justice.

Balk, D. E. (1995). *Adolescent development: Early through late adolescence.* Pacific Grove, CA: Brooks/Cole.

Ball, S. (2007). Cognitive-behavioral models for the treatment of substance use disorders. In L. P. Riso, P. L. du Toit & D. J. Stein (Eds.), *Cognitive schemas and core beliefs in psychological problems: A scientist-practitioner guide* (pp111-138). Washington: American Psychological Association.

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist*, 37, 122-147.

Bartko, W., & Eccles, J. (2003). Adolescent participation in structured and unstructured activities: A person-oriented analysis. *Journal of Youth and Adolescence*, 32(4), 233-241.

Bell, E. (2006). Self, meaning and culture in service design: using a hermeneutic technique to design a residential service for adolescents with drug issues. *International Journal of Drug Policy*, 17, 425-435.

Benson, P. (2007). Developmental assets: An overview of theory, research, and practice. In R. Silberstein & R. Lerner (Eds.), *Approaches to positive youth development* (pp33-58). London: Sage.

Bessant, J. (2008). Hard wired for risk: neurological science, 'the adolescent brain' and developmental theory. *Journal of Youth Studies, 11*(3), 347-360.

Bickerton, A., Hense, T., Benstock, A., Ward, J., & Wallace, L. (2007). Safety First: A model of care for working systematically with high risk young people and their families in an acute CAMHS service. *Australian and New Zealand Journal of Family Therapy, 28*(3), 121-129.

Bonomo, Y. (2003). Adolescent substance use. In M. Hamilton, T. King & A. Ritter (Eds.), *Drug use in Australia: Preventing harm* (2nd ed., pp116-126). Melbourne, Victoria: Oxford University Press.

Bruun, A., & Hynan, C. (2006). Where to From Here? Guiding for mental health for young people with complex needs. *Youth Studies Australia, 25*(1), 19-27.

Catalano, R., & Hawkins, D. (1996). The Social Development Model: A theory of antisocial behaviour. In D. Hawkins (Ed.), *Delinquency and Crime: Current theories.* Cambridge: Cambridge University Press.

Clark, G., Scott, N., & Cook, S. (2003). *Formative research with young Australians to assist in the development of the National Illicit Drugs Campaign.* Canberra: Prepared for Commonwealth Department of Health and Ageing.

Clark, M. D. (2001). Influencing positive behavior change: Increasing the therapeutic approach of Juvenile Courts. *Federal Probation, 65*(1), 18-28.

Cloud, W., & Granfield, R. (2004). *A life course perspective on exiting addiction: The relevance of recovery capital in treatment.* Helsinki Finland: Nordic Council for Alcohol and Drug Research.

Collishaw, S., Messer, J., Rutter, M., Shearer, C., Maugham, B., & Pickles, A. (2007). Child Abuse and Neglect. *Resilience to adult psychopathology following childhood maltreatment: Evidence from a community sample. , 31*, 211-229.

Cox, K. (2005). Examining the Role of Social Network Intervention as an Integral Component of Community-Based, Family-Focused Care. *Journal of Child and Family Studies, 14*(3).

Crawford, E., Wright, M. O., & Masten, A. S. (2006). Resilience and spirituality in youth. In P. L. Benson, E. C. Roehlkepartain, P. E. King & L. Wagner (Eds.), *The handbook of spiritual development in childhood and adolescence* (pp355-370). Thousand Oak: Sage.

Daley, K., & Chamberlain, C. (2009). Moving On: Young people and substance abuse. *Youth Studies Australia, 28*(4), 35-43.

Daniel, B., & Wassell, S. (2002). *Assessing and promoting resilience in vulnerable children: The early years, the school years, adolescence.* London: Jessica Kingsley publishers.

Doyal, L., & Gough, I. (1991). *A theory of human need.* Basingstoke Macmillan.

Duff, C. (2011). Networks, resources and agencies: On the character and production of enabling places. *Health & Place, 17*(1), 149-156.

Dupuis, A., & Thorns, D. C. (1998). Home, Home Ownership and the Search for Ontological Security. *The Sociological Review, 46*(1), 24-47.

Dwyer, J., Frederico, M., Jackson, A., & McKenzie, R. (2010). Emotional PAIN Relief for traumatised young people: Description of a tool for providing 'first aid plus'. *International Journal of Child and Family Welfare, 13*(1-2), 81.

Eckersley, R., Wierenga, A., & Wyn, J. (2006). *Flashpoints & Signposts: Pathways to success and wellbeing for Australia's young people*. Melbourne: Australian Youth Research Centre, The University of Melbourne

Fisher, M., Florsheim, P., & Sheetz, J. (2005). That's Not my Problem: Convergence and divergence between self- and other-identified problems among homeless adolescents. *Child & Family Social Work, 34*(6), 292-403.

Gerard, J. M., & Buehler, C. (2004). Cumulative Environmental Risk and Youth Maladjustment: The role of youth attributes. *Child Development, 75*(6), 1832-1849.

Giddens, A. (1991). *Modernity and self-identity.* Cambridge: Polity Press.

Gilligan, R. (2000). Adversity, resilience and young people: the protective value of positive school and spare time experiences. *Children & Society, 14*(1), 37-47.

Gilligan, R. (2008). Promoting resilience in young people in long-term care- the relevance of roles and relationships in the domains of recreation and work. *Journal of Social Work Practice, 22*(1), 37-50.

Granfield, R., & Cloud, W. (2001). Social Context and "Natural Recovery": The role of social capital in the resolution of drug-associated problems. *Substance Use and Misuse, 36*(11), 1543-1570.

Green, R., Mitchell, P., & Bruun, A. (in revision). For better or worse: Perspectives of service-engaged young people on the value of relationships in addressing alcohol and other drug issues. *International Journal of Drug Policy.*

Gregg, E., Toumbourou, J., Bond, L., Thomas, L., & Patton, G. (2000). *Improving the Lives of Young Victorians in Our Community: A Menu of Services.* Melbourne: Centre for Adolescent Health.

Grotberg, E. (1999). Countering depression with the five building blocks of resilience. *Reaching Today's Youth, 4*(1), 66-72.

Gunnestad, A. (2003). *Resilience in a cross-cultural perspective.* Trondheim, Norway: Queen Maud's College.

Hamilton, M., & Redmond, G. (2010). *Conceptualisation of social and emotional wellbeing for children and young people, and policy implications.* Melbourne: A research report for the Australian Research Alliance and for Children and Youth and the Australian Institute of Health and Welfare.

Hawkins, D., Catalano, R., & Miller, J. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin, 112*(1), 64-105.

Hayes, A., Gray, M., & Edwards, B. (2008). *Social Inclusion: Origins, concepts and key themes.* Canberra: Australian Institute of Family Studies.

Hiscock, R., Kearns, A., Macintyre, S., & Ellaway, A. (2001). Ontological security and psycho-social benefits from the home: Qualitative evidence on issues of tenure. *Housing, Theory and Society, 18*, 50-66.

Hyde, J. (2005). From home to street: Understanding young people's transitions into homelessness. *Journal of Adolescence, 28*, 171-183.

Johnston, L., MacDonald, R., Mason, P., Ridley, L., & Webster, C. (2000). *Snakes & ladders: Young people, transitions and social exclusion.* Bristol: Policy Press/JRF.

Kallander, K., & Levings, L. (1996, September 26-29). *Experiential Therapy with Homeless, Runaway and Street Youth.* Paper presented at the Spawning new ideas: A cycle of discovery. Conference proceedings of the 24th Annual International Conference of the Association for Experiential Education Spokane, WA.

Karabanow, J., & Clement, P. (2004). Interventions with street youth: A commentary on the practice-based research literature. *Brief Treatment and Crisis Intervention, 4*(1), 93-108.

Kerr, T., Small, W., Moore, D., & Wood, E. (2007). A Micro-Environmental Intervention to Reduce the Harms Associated with Drug-Related Overdose: Evidence from the evaluation of Vancouver's safer injection facility. *International Journal of Drug Policy, 18*, 37-45.

Keys, D., Mallett, S., & Rosenthal, D. (2006). Giving up on drugs: homeless young people and self-reported problematic drug use. *Contemporary Drug Problems, 33,* 63-98.

Kidd, S. (2003). Street youth: Coping and interventions. *Child and Adolescent Social Work Journal, 20*(4), 235-261.

Klee, H., & Reid, P. (1998). Drugs and youth homelessness: reducing the risk. *Drugs: Education, prevention and policy, 5*(3), 269-280.

Leahy, R. L. (2003). *Cognitive therapy techniques: a practitioner's guide.* New York: The Guilford Press.

Luthar, S. S. (1999). *Poverty and children's adjustment.* Thousand Oaks, CA: Sage.

MacDonald, H., & Marsh, E. (2002). *Report on the youth focus groups on Realising Australia's Commitment to Young People.* Sydney: Access Training and Employment Centre.

MacDonald, R., & Marsh, J. (2001). Disconnected Youth? *Journal of Youth Studies, 4*(4), 373 - 391.

Mallett, S., Edwards, J., Keys, D., Myers, P., & Rosenthal, D. (2003). *Disrupting Stereotypes: Young people, drug use and homelessness.* Melbourne: The Key Centre for Women's Health in Society.

Malone, K. (2008). *Every experience matters: An evidence based research report on the role of learning outside the classroom for children's whole development from birth to eighteen years.* Wollongong: Report commissioned by Farming and Countryside Education for UK Department Children, School and Families.

Markiewicz, D., Lawford, H., Doyle, A., & Haggart, N. (2006). Developmental differences in adolescents' and young adults' use of mothers, fathers, best friends and romantic partners to fulfil attachment needs. *Journal of Youth and Adolescence, 35*(1), 127-140.

Masten, A. S. (2001). Ordinary Magic: Resilience processes in development. *American Psychologist, 56*, 227-238.

Masten, A. S., & O'Dougherty-Wright, M. (2009). Resilience over the lifespan: Developmental perspectives on resistance, recovery, and transformation. In J. W. Reich, A. J. Zautra & J. S. Hall (Eds.), *Handbook of adult resilience* (pp213-237). New York: Guilford Press.

Miller, W. R. (2002). Is "treatment" the right way to think about it?: The expert model. In W. R. Miller & C. W. Meyer (Eds.), *Changing substance abuse through health and social systems.* New York: Kluwer Academic.

Mitchell, P. F., Spooner, C., Copeland, J., Vimpani, G., Toumbourou, J., Howard, J., & Sanson, A. (2001). The role of families in the development, identification, prevention and treatment of illicit drug problems. Canberra: National Health and Medical Research Council.

Munford, R., & Sanders, J. (2008). Drawing out strengths and building capacity in social work with troubled young women. *Child & Family Social Work, 13*(1), 2-11.

Paglia, A., & Room, R. (1998). *Preventing Substance Use Problems Among Youth: A literature review and recommendations.* Toronto, Canada: Addiction Research Foundation Division, Centre for Addiction and Mental Health.

Patterson, J. (2002). Understanding family resilience. *Journal of Clinical Adolescent Psychology(58)*, 233-246.

Prichard, J., & Payne, J. (2005). *Alcohol, drugs and crime: a study of juveniles in detention.* Canberra: Australian Institute of Criminology.

Putnam, R. D. (2000). *Bowling Alone.* New York: Simon and Schuster.

Rhodes, T. (2002). The 'Risk Environment': A framework for understanding and reducing drug-related harm. *International Journal of Drug Policy, 13,* 85-94.

Riso, L. P., & McBride, C. (2007). Introduction: A return to a focus on cognitive shemas. In L. P. Riso, P. L. du Toit & D. J. Stein (Eds.), *Cognitive schemas and core beliefs in psychological problems: A scientist-practitioner guide* (pp3-10). Washington: American Psychological Association.

Robinson, E., & Miller, R. (2010). *Adolescents and their families: Best interests case practice model specialist practice resource.* Melbourne: Victorian Government Department of Human Services.

Robinson, E., & Pryor, R. (2006). Strong Bonds project: Promoting family-aware youth work practice. *Developing Practice: The Child, Youth and Family Work Journal, 15*(28-35).

Rowe, J. (2005). Access health: Providing primary care to vulnerable and marginalised populations. *Australian Journal of Primary Health, 11*(2), 32-37.

Rutter, M. (1990). Psychosocial resilience and protective mechanisms. In J. Rolf, A. S. Masten, D. Cicchetti, K. H. Nüchterlein & S. Weintraub (Eds.), *Risk and protective factors in the development of psychopathology.* New York: Cambridge University Press.

Schofield, G., & Beek, M. (2009). Growing up in foster care: providing a secure base through adolescence. *Child & Family Social Work, 14*(3), 255-266.

Seidman, E., & Pederson, S. (2003). Holistic, contextual perspectives of risk, protection, and competence among low-income urban adolescents. In S. Luthar (Ed.), *Resiliency and vulnerability: Adaptation in the context of childhood adversities* (pp318-342). New York: Cambridge.

Spooner, C., Hall, W., & Lynskey, M. (2001). *Structural Determinants of Youth Drug Use.* Canberra: Australian National Council on Drugs.

Thomson, R., Bell, R., Holland, J., Henderson, S., McGrellis, S., & Sharpe, S. (2002). Critical moments: Choice, chance and opportunity in young people's narratives of transition. *Sociology, 36*, 335-354.

Trzepacz, P. T., & Baker, R. W. (1993). *The psychiatric mental status examination.* New York: Oxford University Press.

Ungar, M. (2005). A thicker description of resilience. *International Journal of Narrative Therapy and Community Work, 3 & 4,* 89-95.

Ungar, M. (2006). Resilience among children in child welfare, corrections, mental health and educational settings: Recommendations for service. *Child and Youth Care Forum, 34*(6), 445-464.

Ungar, M., Dumond, C., & MacDonald, W. (2005). Risk, resilience and outdoor programmes for at-risk children. *Journal of Social Work Practice, 5*, 319-338.

Vaughn, B. E., Bost, K. K., & Van Ijzendoorn, M. H. (2008). Attachment and Temperament. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of Attachment: Theory, Research and Clinical Applications* (pp192-216). New York: Guilford Press.

Victorian Department of Human Services (2001). *Promoting health and wellbeing through built, social, economic and natural environments: Municipal public health planning framework*. Melbourne, Victoria.

Vinson, T. (2009). *Social Inclusion: The origins, meaning, definition and economic implications of the concept social inclusion/exclusion.* Canberra: Australian Department of Education, Employment and Workplace Relations.

Werner, E. E., & Smith, R. S. (1992). *Vulnerable but not invincible: A longitudinal study of resilient children and youth.* New York: McGraw-Hill.

White, R., & Wyn, J. (2008). Youth & society: Exploring the social dynamics of youth experience

Williams, P., Pocock, B., & Bridge, K. (2009). Kids' lives in adult space and time: how home, community, school and adult work affect opportunity for teenagers in suburban Australia. [Paper in Social Determinants of Child Health and Well-being. Li, Jianhong; Mattes, Eugen; McMurray, Anne; Hertzman, Clyde and Stanley, Fiona (eds).]. *Health Sociology Review, 18*(1), 79-93.

Wright, M. O., Crawford, E., & Sebastian, K. (2007). Positive resolution of childhood sexual abuse experiences: The role of coping, benefit-finding, and meaning-making. *Journal of Family Violence,* 22, 597-608.

7. Practice framework implementation

7.1 Overview

This section briefly introduces several additional structures, processes and design features of service systems that need to be considered when thinking about how a practice framework will be implemented or operationalised.

Ensuring that practice is adequately informed by, and consistent with a well thought-out practice framework requires clarity around modes of delivery and decision processes. The information and ideas that are documented in a practice framework will remain just that if organisations do not actively enable and support practitioners to make use of it.

Clarity is needed around several aspects of service systems that are sometimes misunderstood as practice approaches or even as interventions in their own right, but are more accurately understood as structures for supporting practice or delivering interventions. These include 'modalities' of service delivery such as outreach, clinic-based services, day programs, acute residential (withdrawal), and long-term residential rehabilitation; as well as 'vehicles' of service delivery, including therapeutic relationships and environments.

Key processes needed to support sound decision making include systematic and clearly articulated approaches to: assessment; case formulation; care planning; case notes; supervision, and case review. These processes are increasingly recognised as components of clinical governance.

This section also introduces an innovative approach to describing and packaging the content and techniques of psychotherapeutic interventions, which holds considerable promise in overcoming some difficult barriers to the implementation of evidence-based practice.

These structures, processes and approaches to implementation are outlined briefly and will be described and considered in greater depth in a separate publication.

7.2 Service modalities

Service modalities are the structural or organisational platforms for the delivery of services and programs.

These modalities vary in the types of environments that are utilised or created and in the degree of structure that they provide for young people engaging with AOD services.

Some modalities are relatively loose and highly flexible encouraging young people to engage at times and in ways that suit them. Others are highly structured and encourage young people to make a commitment to fitting in with an organised environment and the needs of others who are sharing the space. Providing structured environments is a logical response to the evidence presented earlier about substance use problems being closely correlated with the loss of major social structures in young people's lives (Room, 2005).

Victorian youth AOD services and programs tend to rely upon six main modalities:

- Outreach
- Clinic based
- Day programs
- Acute residential services
- Long-term residential rehabilitation
- Specialist programs.

Several other modalities could potentially contribute to improving therapeutic outcomes for clients and to building the sector's capacity to deliver prevention and early intervention programs (e.g. delivery in education, vocational training and employment settings).

Therapeutic practice frameworks for youth AOD services should ideally:

- Include statements outlining the range of service modalities used; and
- Provide rationale and explanation of how the chosen modalities support other critical aspects of therapeutic practice such as psychosocial interventions, and the characteristics of effective services and programs.

It is important to recognise that services modalities are not therapeutic interventions in their own right. They are organisational structures that provide or use physical spaces or environments in particular ways to facilitate the delivery of therapeutic interventions.

Understanding the distinction and relationship between modalities and therapeutic interventions is important for policy makers and services planners working at the system level whose responsibility it is to design reforms and facilitate changes in the ways that services operate. The following four points serve to illustrate this.

- Modalities vary in the extent to which they enable and facilitate certain types of interventions. In order to provide the full range of interventions, a variety of modalities are required.
- Modalities vary in the extent to which they are accessible and appropriate to the diverse needs of young people and their carers. A range of modalities are necessary to maximise accessibility and capacity to respond to variable and changing needs.
- Interventions are highly flexible and amenable to adjustment. Modalities on the other hand are fixed structures and are relatively slow and costly to reorganise. Reforms aimed at enhancing flexibility and responsiveness to changing needs may be achieved more effectively by focusing on the types of interventions that are provided, and on the ways that services are enabled to support these interventions.
- Youth AOD policy and administrative procedures have historically focused on modalities, with little or no attention given to therapeutic interventions. There is need for a shift towards greater balance in policy and administrative attention.

Further research and analysis is required to assess evidence and practice wisdom relating to best practice in the use of different modalities, and to explore questions such as how the various modalities support, and could better support, delivery of effective therapeutic psychosocial interventions. This resource document addresses these issues only in relation to outreach and residential services (see Section 4).

7.2.1 Outreach

Youth outreach workers provide services in a diverse range of locations where young people live, congregate and feel comfortable. A key function of outreach is to enhance access and engagement of hard-to-reach adolescents who do not present to AOD services of their own volition.

Outreach is also a critical mechanism for linking and coordinating activities across different services and sectors. For example, outreach workers can connect with youth in custody to engage them in AOD services before release, or actually deliver AOD interventions within the physical spaces of other services, schools or community-based settings.

Box 7.1: Types of interventions provided via outreach

- Service promotion & case finding
- Assertive engagement
- Case work (including assessment & individualised care planning)
- Liaison & advocacy
- Health education & health promotion
- Foundational counselling
- Behavioural & other psychosocial interventions
- Family support
- Home-based withdrawal
- Secondary consultation to other services

7.2.2 Clinic based

Once youth AOD clients have reached a level of stability in their lives and have ceased or reduced substance use they are often at a stage of readiness to begin dealing with underlying psychological issues that have exacerbated, or been exacerbated by, harmful AOD use. This can involve a regular visit for counselling or psychotherapy in a clinic-based setting.

Sessional services are provided within youth AOD services as 1-2 hour appointments (e.g. counselling) or as brief consultations.

Sectors other than youth AOD have highly developed expertise in therapeutic interventions that are readily provided via sessional clinic-based services. However, apart from publicly funded mental health services, access to needed services is extremely limited.

Box 7.2: The types of specialist interventions that are potentially best provided in a clinic-based setting

- Pharmacotherapy
- Specialist mental health care for a range of serious mental health problems including: major depression, PTSD, other anxiety disorders, bipolar disorder, psychotic illnesses
- Family therapy
- Grief & loss counselling
- Sexual assault counselling
- Medical care

Key providers for such services include:

- Child & Youth Mental Health Services (CYMHS)
- Headspace
- Centres Against Sexual Assault (CASAs)
- Specialist family support
- Private psychiatrists
- Private psychologists
- Medical practitioners & nurses

7.2.3 Day programs

Day programs provide safe, stimulating and flexible environments that young people can access in their own time and to the extent that they desire. Day programs offer a wide range of resources that motivate, encourage and support young people to move away from problematic behaviours and contexts towards a more stable and healthy lifestyle.

Box 7.3: Types of interventions provided via day programs

- A safe place to spend time / respite
- Supervised or monitored recovery
- Primary health care
- Personal care facilities
- Health education
- Activity-based therapeutic programming
- Life skills programming
- Motivational Interviewing
- Foundational counselling
- Behavioural & other psychosocial interventions
- Peer support
- Supported referral & linkages
- Secondary consultation to other services

7.2.4 Acute residential services

This service modality provides up to two weeks of safe, AOD free, age appropriate accommodation in a unit that is continuously staffed. Previously called 'residential withdrawal', the range of intervention types provided has expanded well beyond medically supervised withdrawal. Many clients entering acute residential services are in physical and emotional crisis and a key function of treatment is to stabilise their mental and physical health. Subsequent interventions focus on engaging clients in longer-term treatment of AOD and mental health problems, and planning and initiating these interventions.

Box 7.4: Types of interventions provided via acute residential services

- Comprehensive health screening & assessment
- Integrated care planning (co-ordinated with other services)
- Medically supervised AOD withdrawal
- Comprehensive medical care
- Health education
- Pharmacotherapy
- Motivational Interviewing
- Foundational counselling
- Behavioural & other psychosocial interventions
- Peer support
- Supported referral
- Secondary consultation to other services

7.2.5 Long-term residential rehabilitation

Long-term residential rehabilitation includes:

- Traditional residential rehabilitation, in which shared dormitory accommodation is provided for up to six months, and
- Supported accommodation, in which young people are provided with a range of supports while living independently or semi-independently in rental accommodation in the community.

It provides a safe, stable, and structured environment within which young people can be assisted to secure and build the diverse range of resources and assets needed for resilience against life stressors and to live well without resorting to misuse of alcohol and other drugs. Supported accommodation provides a step down from residential rehabilitation into a less structured setting.

Box 7.5: Types of interventions provided via long-term supported accommodation and residential rehabilitation services

- Assessment & therapeutic care planning
- Medical care
- Health education
- Education & vocational transitions
- Life skills programming
- Activity-based therapeutic programming
- Motivational Interviewing
- Foundational counselling
- Behavioural & other psychosocial interventions
- Family focused interventions
- Peer support
- Supported referral & linkages
- Secondary consultation to other services

7.2.6 Specialist programs

Specialist programs are designed around particular groups of young people in order to meet needs that are specific and unique to those groups (e.g. young parents or Aboriginal youth), or as a means of delivering specialist interventions provided by practitioners with specific expertise not possessed by the mainstream workforce (e.g. medical care, specialist mental health nursing). They may be based within one or more of the other modalities (e.g. specialist housing support workers located in outreach teams) or they may use alternative modalities that are not provided routinely (e.g. outdoor adventure programs).

It is important to recognise specialist programs as a core modality because they are essential to ensuring equity in service provision for clients whose needs cannot be adequately met by other modalities. They also ensure cost-effective use of rare and expensive expertise.

Specialist programs provide important vehicles for concentrating scarce resources upon more complex problems and scaling up from innovative projects that have been evaluated and found effective.

Box 7.6: Examples of specialist programs in the youth AOD sector

- Young Parents Program
- Reconnect (focused on reducing youth homelessness by improving the connections young people have with their family, work, education & the community)
- Youth Outdoor Therapy (adventure activities)
- Koori Community AOD workers (outreach)
- Koori Youth Healing Service (long-term residential service)
- YSAS Line (telephone information & support)
- Primary health care
- Specialist Mental Health Nurse Program
- Home-based withdrawal

7.3 Therapeutic vehicles

Therapeutic vehicles are interpersonal, environmental and technological platforms for the delivery of therapeutic interventions. Victorian youth AOD services and programs tend to rely upon two main vehicles: therapeutic relationships and therapeutic environments.

Therapeutic relationships and environments enable youth AOD services to operationalise several characteristics of effective programs, including client-centred and relationship-based care and a behavioural/experiential/skill-focused approach. These vehicles are also central to the engagement and retention strategies of Victorian youth AOD services.

There are other therapeutic vehicles that have considerable potential in building the capacity of youth AOD services to reach more young people and enrich the therapeutic experience. Key among these is information and e-communication technology.

Further work is required to assess evidence and practice wisdom relating to the use of therapeutic vehicles within youth AOD services. Clearer conceptualisation of the nature of these vehicles is required, as is elaboration of their actual and potential contribution to effective delivery of psychosocial interventions.

7.3.1 Therapeutic relationships

The strength or quality of the relationship between the worker or a team of workers and the client – in terms of trust, openness, and the time they spend together engaged in conversation or varied activities – is the primary platform for the delivery of interventions. The actions involved in building a positive therapeutic connection including active listening, matching the client's language, and demonstrating understanding and empathy, which are critical to engaging a client in the therapeutic project.

Maintaining and strengthening the therapeutic relationship over time is instrumental to retaining the client in the therapeutic program and promoting their active participation in the work (Meier, Donmall, McElduff, Barrowclough, & Heller, 2006; Simpson, Joe, Rowan-Szal, & Greener, 1997). In turn, retention and participation are strong predictors of positive outcomes (Bell, Atkinson, William, Nelson, & Spence, 1996; Simpson, et al., 1997).

It is important to recognise that neither the therapeutic relationship nor retention in a treatment or support setting should be considered primarily as therapeutic interventions in their own right. Even though there is a view among some commentators that the therapeutic relationship confers psychological benefit to clients, viewing it mainly as an intervention does very little to assist the cause of improving the quality and effectiveness of practice.

Rather, it is important to understand what it is about the therapeutic relationship that confers benefit, what these relationships look like and how they can be promoted. Such analysis highlights a host of therapeutic practices – actions, behaviours, techniques – that are delivered through interaction with the client and practised in the relationship, but which can be recognised as distinct from it. The relationship can be understood as a vehicle for these therapeutic practices, but it is not a replacement for them.

In this resource we have included 'relationship-based' practice as one of ten characteristics of effective services and programs, along with features such as client-centred, developmentally appropriate, and family involvement (see Section 3). These characteristics refer to 'how' or 'the ways in which' services are delivered rather than the content or 'what' is delivered (see Section 4).

Relationship-based practice involves consistently placing strong emphasis on the use of the therapeutic relationship to deliver therapeutic interventions. Relationship-based practice is instrumental to achieving several other characteristics of effective services and programs, including client-centred care, engagement and retention strategies, building on strengths, and an experiential-behavioural approach.

With respect to *client-centred care,* for example, the therapeutic relationship serves as the foundation of a collaborative process whereby the client and the worker develop a shared understanding of the issues requiring attention and make decisions about how they will be addressed. The relationship does not privilege any particular disorder, illness, problem or therapeutic intervention. Instead, it creates a neutral space that can act as a vehicle or platform for identifying, accessing, containing and integrating a diversity of supports and intervention types. Practitioners adopt an egalitarian stance. Clients are respected as experts in their own lives, an approach that opens up the opportunity for such expertise to develop further, thereby *building on clients' strengths*.

The relationship also provides a setting or space in which clients gain emotionally corrective *experiences* such as being listened to, respected, understood and validated, as well as opportunities to practise new *behaviours* such as communication and other social skills. Commitment to a long-term working relationship also helps the practitioner to establish a developmental perspective and an orientation to continuous care that recognises that the frequency and severity of problems are constantly changing.

7.3.2 Therapeutic environments

Social environments such as acute residential settings, residential rehabilitation settings and day programs are designed to provide young people with a space and a range of opportunities for accessing needed resources such as rest/respite, emotional and practical support, social interaction, and trying out new activities and behaviours.

Providing services in the places where young people live, work and play via outreach can also be understood as involving use of environment for therapeutic purposes. Youth AOD services make use of such environments to help deliver particular kinds of interventions in ways that are consistent with the developmental needs of young people.

Characteristics of effective services and programs that are particularly well facilitated through the use of environments are 'behavioural, experiential and skill focused', and 'comprehensive, holistic, multisystemic and ecological' (see Section 2, Chapter 3).

Environments such residential settings and the real-world places where young people live, work and play offer much richer environments for the delivery of behavioural interventions than office-based counselling. Most essentially, it is widely recognised that residential settings provide a highly structured environment with clear routines, expectations and boundaries. This provides many young people with an experience of safety and security that has so often been lacking in their lives.

Both natural and structured interactive social environments provide many opportunities for practitioners to observe young people's behaviour in varied situations and contexts. Designing an individually tailored CBT-based skills training package for a client requires detailed behavioural assessment, including examination of specific environmental influences such as contingencies, reinforcers and stimulus pairings operating in the client's natural environment and the client's responsiveness to such events (Thorpe & Olson, 1997).

In clinic-based settings, this assessment is limited to verbal enquiry about the situations in which the problem behaviour occurs. In outreach and residential environments, verbal enquiry can be supplemented or largely replaced with direct observation. This is particularly helpful for adolescents who are not yet clear about which behaviours they want to change or who have limited insight into the environmental factors that affect behaviours they may want to change.

Natural and interactive environments help workers to promptly communicate observations to young people, to teach new skills in real-life contexts, and to provide timely reinforcement when young people demonstrate desired behaviours. Residential settings also provide opportunities for practitioners to set up supervised practice and graduated real-life practice of new or alternative behaviours in partially or fully naturalistic social contexts.

Groups can be readily constructed to provide dynamic social interactions for young people to act within. Outreach applied as aftercare following a residential stay can be particularly beneficial for real-life practice, enabling practice in a series of real-life situations that gradually become more challenging.

Multisystemic and ecological practice is exceedingly difficult to achieve without work also taking place in the natural environments where young people spend most of their time. For example, interventions aimed at building the capacity of natural social networks such as families, peers, and schools to support vulnerable young people are most effectively implemented in the settings where network members congregate and interact.

7.4 Therapeutic intentions

'Therapeutic intentionality' means being clear and explicit about the objectives the practitioner is trying to achieve in their therapeutic work with a client at any particular point in time. Intentionality is critical to realising and integrating the principles of client-centred or individualised care and evidence-based practice.

A large array of therapeutic interventions is available for use with adolescents experiencing emotional and behavioural difficulties. Some way must be found to select one or more interventions from this pool that are most appropriate to the client's needs at the time.

It is useful to think in terms of long-term or 'big-picture' intentions. Big-picture intentions focus on the client's goals in the long term, after the current difficulties are overcome (e.g. staying off drugs, getting and keeping a job, or forming a committed relationship). Big-picture intentions may also focus on living according to core values such as treating loved ones with respect.

'Here and now' intentions focus on short-term objectives that need to be reached on the way towards long-term goals (e.g. finding somewhere to live, resolving a fight with a parent, or learning how to manage anger). They help to keep the client on track towards achieving the things that are part of the big picture. Bruun and Hynan have referred to this distinction as "one eye on the present and one eye on the path" (Bruun & Hynan, 2006; p22).

The resources and assets that clients have at their disposal to work towards their goals vary, and the goals and objectives of a particular client tend to evolve and shift over time. Hence there is a need for an approach to case formulation based on a "flexible and idiosyncratic understanding of each [client's] individual problems" (Tarrier, 2006; p9-10). Therapeutic intentions link such case formulation to the selection of appropriate therapeutic interventions.

The particular set of intentions that are pursued over time and the patterns in which they arise and are pursued will be as unique as the client's individual problems, strengths and goals. But in working with young people experiencing behavioural challenges such as AOD problems, offending behaviour and mental health issues, certain types of intentions repeatedly present. This is particularly apparent in the clinical literature describing the therapeutic models that are well established or promising in terms of their effectiveness for use within youth AOD services.

Five types of intention arise repeatedly in the literature dealing with these therapeutic models, with most addressing at least two intentions and some addressing several. These five types of therapeutic intentions also have considerable face validity to the known mission statements, aims and objectives of Victorian youth AOD services, and they articulate well with the Resources and Assets described in Section 6.2 of this resource.

It is beyond the scope of this resource to go into full details about these therapeutic intentions. They are fleshed out a little here and their function within the wider practice framework is explained.

Further research is required to test the validity of these therapeutic intentions and to assess the extent to which they are appropriate and comprehensive with respect to the Victorian context. Qualitative research with Victorian practitioners and further literature review is needed to describe them in depth. Conceptual work is also required to clarify the relationship between these intentions and the five Domains of Need (see Section 6.3). Such work would contribute to the longer-term task of refining therapeutic outcome domains for the youth AOD sector.

7.4.1 Engagement and building the therapeutic relationship

Engaging the client in the therapeutic project and building a strong therapeutic relationship are highlighted as critical aims of most of the therapeutic models described in this resource. All psychotherapeutic models recognise that active participation of the client and a positive therapeutic relationship are fundamental to the success of behaviour change efforts. As such, the work of building these is understood as one of the

'common factors' shared by all effective therapeutic models (Hubble, Duncan, & Miller, 1999; Miller & Duncan, 2000). Some models give this factor more emphasis than others and the various models approach the work differently, or emphasise different aspects.

Engagement and building the therapeutic relationship have been recognised as particularly important and challenging when working with adolescents, because they are less likely than adults to recognise and actively seek assistance for psychological and behavioural issues (Chassin, 2008; Lennings, Kenny, & Nelson, 2006; Waldron, Kern-Jones, Turner, Peterson, & Ozechowski, 2007).

Engagement is the primary therapeutic intention of Motivational Interviewing (MI) alongside building motivation for change. MI contains numerous strategies that are designed to promote engagement. Key among these are careful orientation to the purpose and nature of the work, active listening and other person-centred communication strategies, rolling with resistance and avoiding argument, and evoking and working with the client's own view and experiences of change (Naar-King & Suarez, 2011).

Solution Focused Therapy (SFT) and Narrative Therapy (NT) also place strong emphasis on engagement. Key strategies include 'joining' (active listening and adapting the communication style to suit the client's language), collaborating with the client to ensure that the work is centred on the client's own goals, and an affirmative strengths-based orientation.

7.4.2 Enhancing motivation, instilling hope and building confidence

This therapeutic intention focuses upon building up the internal resources and assets relating to beliefs, including ideas about the self and the world that shape identity and meaning (see Section 6.2.4).

The essence of this area of intention is to motivate efforts by the client towards change, instil hope that a better future is possible, and build confidence in the ability of the client to make the changes they need to make to achieve that better future.

Enhancing motivation, instilling hope, and building confidence are tightly bound with engagement and building the therapeutic relationship. Many of the strategies designed for one also assist with the other. However, they are not identical and it is useful to separate the constructs to highlight the importance of each aspect.

All but one of the therapeutic models described in this resource incorporate several strategies designed to motivate the client to embark upon change or to build confidence that change is possible and will be rewarding. Motivating for change is the primary therapeutic intention of Motivational Interviewing (MI) alongside engagement. Key strategies from this model include exploring ambivalence about change and developing awareness of any discrepancies between current behaviour and goals for the future.

SFT and NT both place strong emphasis on building hope and confidence by helping the client to recognise existing strengths and past successes in solving problems. The motivational strategy of the Adolescent Community Reinforcement Approach (ACRA) is more towards building hope and confidence by rapidly organising an array of practical supports and reinforcers for change from as many sources as possible in the young person's environment.

For all four of these approaches, there is a strong focus on goals for the future and keeping the young person in touch with the rewards that will accrue from persistence in working towards them.

Motivational strategies that build hope and confidence are particularly vital when working with young people who have long histories of trauma, neglect, or disadvantage. These young people tend to have low self-efficacy, low expectations of themselves, and low levels of belief that the necessary supports will be available.

Alternatively, many young people may have an inflated sense of their own capacities and perceive no need to change their own attitudes or behaviour. Here motivational strategies might focus even more strongly on future goals and channelling strengths towards more effective problem-solving.

7.4.3 Modifying cognitions, building skills and increasing knowledge

This therapeutic intention seeks to shape some of the same beliefs targeted by motivational strategies. However, the scope shifts and expands to incorporate additional categories of internal resources and assets, specifically knowledge and skills that enable effective daily living, self-management and interpersonal relations (see Section 6.2.3).

The essence of this area of intention is to:

- Make changes to beliefs (cognitions) that are holding the client back from achieving their goals;
- Build the skills and shape the behaviours that are necessary to achieve the goals; and
- Provide knowledge that will enable the client to consciously drive their personal development now and in the future.

Modifying cognitions and building skills is the therapeutic domain dominated by Cognitive Behaviour Therapy (CBT). Newer, more comprehensive models that include a focus on building skills (e.g. The Adolescent Community Reinforcement Approach - ACRA and Multidimensional Family Therapy) have essentially incorporated the content and techniques developed within the tradition of CBT with little modification.

Dialectical Behaviour Therapy (DBT), which places strong emphasis on modifying cognitions as well as building skills, also draws heavily upon CBT, but has integrated this with content and techniques from Eastern spiritual traditions.

Increasing knowledge can be an important precursor to modifying cognitions and building skills. Knowledge also enables the client to actively choose to participate in the change process. Hence psychoeducation is an important element of CBT and the newer models that incorporate it. This involves providing clear and overt explanation to the client about the basic ideas behind CBT (e.g. the connection between thoughts, feelings and behaviours) and why they might be relevant to the client's issues.

Self-knowledge or self-awareness is a foundational element of any work aimed at modifying cognitions and building communication, social, and emotion regulation skills. CBT uses a lot of instructional explanation and feedback aimed at increasing knowledge and understanding. While valuable as a precursor to change, knowledge about how change is achieved is perhaps even more important if the client is to continue to learn and grow of their own volition into the future.

7.4.4 Strengthening relationships, enabling participation and modifying contingencies

In this area of intention we shift decisively to a concern with resources and assets in the external environment or the social ecology, specifically human resources and socio-cultural resources (see Section 6.2.2).

Because the social-environmental factors that shape our attitudes, beliefs, and behaviours are so powerful, any changes that a young person makes while involved with a youth service may not last long if supports and reinforcers in their natural ecology cannot be found and bolstered.

The essence of this intention is to:

- Increase the quantity and quality of support that the young person receives from family members, peers and significant others in their social networks (including existing and new networks); and
- Increase the young person's opportunities for meaningful participation in learning, employment, recreation, culture, spiritual pursuits or other aspects of the community.

A key assumption underlying this therapeutic intention is that support and participation provide substantial reward or reinforcement for positive behaviour changes that the young person achieves initially through their own efforts (by acquiring knowledge, modifying their thinking and building their skills). Access to new social networks and opportunities for meaningful participation also offers relationships and environments that enable ongoing learning, change and growth.

ACRA (Garner, et al., 2009; Godley, et al., 2001) is one of the only evidence-based therapeutic models that focuses strongly on this therapeutic intention. ACRA combines elements of contingency management from behaviour therapy with strategies highly consistent with social-ecological casework (Ungar, 2011) to identify human and socio-cultural resources in the community and help young people navigate to these resources.

7.4.5 Navigating to, and negotiating for, health and community services

The resources and assets in the natural social ecology are sometimes insufficient to provide young people with the reinforcement and support they need to achieve and maintain change and a positive developmental trajectory.

Additional supports may be needed from health and community services, sometimes for extended periods. Such services have been included as a category of resources and assets in their own right in the Framework for Resilience Based Intervention (see Section 6.2.2).

Health and community services provide assistance with material resources such as income, housing, transportation, safe physical environments and information technology. They also provide physical, mental and dental health care plus emergency services. Community services that provide support with accessing education, training and employment also fit into this category.

Young people with AOD problems combined with other issues, such as mental health problems and housing insecurity, frequently receive services from agencies in a variety of sectors. Some studies have found that they have higher rates of utilisation of services compared

with clients who have problems in a single domain (Ozechowski & Waldron, 2010).

However, there is ample evidence that rates of service use are frequently below what problem prevalence would indicate as needed (Busen & Engebretson, 2008; Chassin, 2008; De Rosa, et al., 1999; Dworsky & Courtney, 2009; Lennings, et al., 2006). It is well recognised that young people with multiple and complex needs are often inadequately engaged or have difficulty securing the right kind of assistance at the times they need it (Chassin, 2008; Gilvarry, 2000; Lennings, et al., 2006; Statham, 2004; Waldron, et al., 2007).

One approach that practitioners can use to help young people find and stay with a service long enough to get some benefit is targeted engagement strategies and building a strong therapeutic relationship. Another approach is to help health and community services respond better to the needs of young people, and to help young people navigate to the services and negotiate for what they need to be provided in appropriate ways.

Ungar's (2011) constructs of navigation and negotiation are useful here. He reminds us that we all exercise personal agency in our search for resources to sustain ourselves, and that people only willingly participate in interventions that are meaningful to them. Navigation is the process of searching for the resources we need. Negotiation is the process of making the resources meaningful or relevant to our unique individual requirements (Ungar, 2011).

If people are finding their way to services for help it is usually "because their environments oppress, marginalise or have failed to provide them with what they need" (Ungar, 2011; p8). Assistance with navigation may help young people uncover resources and assets that they did not know about previously, or to find their way to new environments with richer allocations of resources.

Negotiation can focus on the individual or the environment. Negotiating assistance for the individual may involve providing information, developing some basic assertiveness and other communication skills, challenging unhelpful attitudes, or deconstructing unproductive narratives (see Section 7.4.3). Negotiation assistance that targets the environment can involve a wide range of strategies including advocacy, liaison, coordination and collaborative care planning.

Ungar (2011) also underlines the importance of considering culture, because culture strongly influences the meaning that is attributed to resources. This highlights that the negotiation role for the youth-focused practitioner may also be understood as involving transcultural consultancy. This approach, which Ungar calls socio-ecological counselling, requires that clinical or psychotherapeutic practice is tightly interwoven with casework or case management. "In our very individualistic society we forget that we can't help people unless we also influence the context in which they live" (p10).

Advocacy and liaison targeting other providers are often not considered part of psychotherapeutic practice. However, if they are conducted openly and involve the young person as a collaborating team member they can provide powerful modelling and practice of effective negotiation skills. The demonstration of respect, affirmation and valuing of the young person's agency is also directly therapeutic.

7.5 A modular practice elements approach to evidence-based practice

At the end of Section 4 it was noted that individual youth AOD services can not be expected to implement all of the therapeutic models outlined, and that choices need to be made about where resources for implementation will be directed. It was also observed that services research has found substantial barriers to implementation of evidence-based practice based on highly structured or integral manual-based programs.

7.5.1 The practice elements approach

The practice elements approach is based on the idea that effective treatment models are comprised of numerous elements that can be identified, specified and employed in different ways. It rejects the assumption that these elements can only be organised and delivered in fixed arrangements specified in empirically supported treatment (EST) models.

Chorpita and colleagues define a 'practice element' as "a discrete clinical technique or strategy (e.g. 'time-out' or 'relaxation') used as part of a larger intervention plan" (Chorpita, Daleiden, & Weisz, 2005a; p11). Practice elements are defined by content and technique, not by duration, periodicity or location within a manual.

Garland et al. (2008) use the term 'core elements' to refer to the same basic concept and identify four different types: therapeutic content; treatment technique; aspects of the working alliance; and treatment parameters (Garland, Hawley, Brookman-Frazee, & Hurlburt, 2008). Practice elements are also consistent with the notion of the most essential 'active ingredients' (Moos, 2007) of otherwise elaborate therapeutic procedures.

Two or more different ESTs (or any psychotherapeutic interventions for that matter) may share varying numbers of practice elements with each other. Interventions that are very similar, such as CBT-based problem-solving skills training and CBT-based coping skills training, share most practice elements. Narrative Therapy would share few practice elements with these behavioural treatments but a few more with cognitive therapies that incorporate cognitive restructuring.

Given the fact that there are a very large number of EST programs or protocols on the market which that share many similarities, there may actually be fewer evidence-based practice elements, depending on how finely these are conceptualised. Chorpita and colleagues found that a set of 49 different EST protocols for emotional and behavioural disorders of childhood could be reduced to a set of approximately 20 practice elements (Chorpita, et al., 2005a).

7.5.2 The modular approach

Modularity is an approach to design that has long been applied in many fields including engineering, architecture, and computing. It is used to promote product qualities such as customisation, scalability, resilience against faults or damage, and to increase efficiencies in product development and innovation. Generally, modularity refers to breaking complex activities or structures into simpler parts that may function independently. Modules are self-contained functional units that can connect with other units, but do not necessarily rely on those other units for their own stable operations (Chorpita, Daleiden, & Weisz, 2005b).

The application of modularity to the design of therapeutic interventions has been elaborated by Chorpita, Daleiden and Weisz (2005b). They begin by contrasting 'modular' designs with 'integral' designs that combine parts into a single functional whole. Treatment protocols involving highly cumulative and sequenced sets of procedures that build steadily upon previous activities are integral designs. The industry standard for EST protocols tends towards a highly integral design.

In contrast to this, Chorpita et al. (2005b) define modularity as applied to therapeutic intervention in terms of four properties:

- **Partial decomposability** – A complex system may be at least partially divided into meaningful functional units with highly similar form (i.e. modules).
- **Proper functioning** – Modules must have a specified purpose or function and can be expected to produce the desired result; they are not simply subdivisions based on other considerations such as convenience (e.g. 50-minute sessions).
- **Standardised interface** – Modules within the overall design connect or communicate with one another in a structured fashion. Although independent, modules interact to produce a whole with better functioning than the sum of the parts, just as building blocks can make a house. The standardised interface allows modules to be easily rearranged to build differently shaped wholes (i.e. interchangeability); they do not need to be connected in fixed arrangements.
- **Information hiding or encapsulation** – Each module contains all the information that is needed for its own operation. In selecting and using a group of modules, the practitioner only needs to know that these modules exist and can be combined; they do not need to know the information that is 'hidden' or 'encapsulated' in the other modules. Keeping information self-contained in this manner allows great flexibility in the arrangement and interchange of modules.

7.5.3 Benefits of a modular practice elements approach

Chorpita, Daleiden and Weisz (2005b) make a clear distinction between practice elements and modules. Practice elements are defined purely in terms of the content and techniques of therapeutic interventions; the concept implies nothing about the overall design or structure of an intervention in terms of how practice elements are combined. They can be combined equally well within integral or modular designs.

However, modularity in treatment design is greatly assisted by the definition and use of practice elements. "[A] module is best thought of as a structured 'container' that can contain one or more practice elements" (Chorpita et al., 2005; p145). Because modules are distinguished by functionality, a module would contain practice elements that theory or practice wisdom suggests will add value to one other in achieving particular functions or therapeutic purposes.

For example, various elements that can be used to help build a therapeutic relationship such as 'reflective listening', 'collaborating with the client', 'providing affirmative statements' and 'rolling with resistance and avoiding argument' could be combined into a module called 'Getting to know you', 'Engagement' or 'Joining forces'. Combining these practice elements into a module might be useful for a variety of reasons, including:

- **Treatment planning or case review** – to set out a range of suitable evidence-based options for addressing particular challenges;
- **Practice** – if a client is difficult to engage, a combination of different engagement strategies may be required, and
- **Teaching** – because they contain similar or complementary therapeutic content and techniques, learning one or more related elements simultaneously may provide efficiencies and reinforce learning.

The modular practice elements approach to evidence-based practice (EBP) offers several major advantages to services such as those comprising Victoria's youth AOD service system which serve a client population with multiple and complex needs and are strongly committed to certain value-based practice orientations, compared with traditional approaches to EBP implementation.

Individual tailoring – By breaking interventions into small elements, practitioners and clients are better able to choose therapeutic content that addresses individual needs and therapeutic techniques best suited to the skills and style of the worker and the nature of the relationship. Content and techniques can be more readily selected and organised according to the developmental stage of a young person and their personal goals.

Readily integrated with existing practice – Rather than attempting to replace existing practice with whole new intervention models or integral programs, the modular practice elements approach provides a way of building on the strengths of existing practice through incremental enhancement.

Because they each involve only a small number of techniques and a discrete selection of content, practice elements (on their own or combined into modules) can be readily added to existing practice approaches or adjusted as the need arises.

Implementation researchers have argued that EBP might advance more quickly in community-based settings if service development incorporated elements into existing practice rather than adopting whole new programs (Chorpita, Becker, & Daleiden, 2007; Garland, et al., 2008).

Amenable to varied modalities – Most ESTs are designed for use in highly structured modalities, such as a series of one-on-one or group-work sessions. In contrast, the Victorian youth AOD system offers services using modalities including outreach, day programs, acute residential, and long-term residential rehabilitation.

Within these settings, opportunities for psychotherapeutic work are built into and interspersed with other activities and interaction, and the shape of these opportunities is highly variable. Furthermore, each young person connects with services for variable amounts of time. This diversity of modality presents significant barriers to the implementation of structured session-by-session manualised programs.

In contrast, the modular practice elements approach is amenable to diverse modalities. Because of their small size and interchangeability, one or several practice elements can be selected and used whenever opportunities arise. For example, elements comprising social skills training and emotion regulation skills training can be built into everyday domestic activities in a residential setting. Individualised problem-solving practice, personalised cognitive restructuring and graded exposure to challenging situations in the young person's usual environment can be readily incorporated into outreach contact.

Communication between staff – Much of the work being conducted within Victorian youth AOD services is consistent with evidence-based practice. However, many workers are not aware of this fact and lack the technical language to describe their work in ways that link with the discourse of clinical science.

Breaking intervention models (e.g. CBT, SFT) into their most basic elements and putting a consistent set of names to these elements would provide a common language for communication between workers about their practice and with other stakeholders.

Evaluation and quality assurance – Defining an agreed set of EBP elements essential to practice would provide a set of benchmarks, which could be used to explore the extent to which current practice is consistent with EBP.

The results could then be used to identify practice elements that need to be introduced, further developed or dropped. Informed revision of training and organisational support can be undertaken.

Sensitivity to context – Service units can select groups of practice elements (perhaps in the form of modules) that are particularly suited to the modalities of service offered and the needs of clients in those settings (Chorpita, Daleiden, & Burns, 2004; Chorpita, et al., 2005b). As contextual factors and needs shift, practice elements can be added, subtracted or enhanced.

Cost efficiencies in training and support – Rather than training and supervising staff in multiple elaborate ESTs, training can focus on practice elements that are missing from, or underdeveloped within, the skill set of workers employed within particular service settings.

Teaching new practice elements within modules can capitalise on any similarities that exist between practice elements that are new and those that are already part of practice. Emphasising the ready interchangeability of modules in training can give trainers the flexibility to facilitate creative discussion about ways in which new practice elements might be incorporated into existing practice.

Modularity also allows much more flexibility in the allocation of resources to training and support. Effective introduction of a new integral EST demands investment of large sums up-front. In contrast, introduction of new modules can be scaled and timed according to the availability of funds for capacity building, and the readiness of different teams and units to make the most of such opportunities.

Interagency collaboration – There is little guidance in the EBP literature to help decision-makers design a collaborative practice approach or infrastructure for supporting the delivery of ESTs across multiple service settings.

Because practice approaches are generally based on strongly held professional values, differences in philosophy or culture between services in different sectors are likely to be major barriers to design of integrated practice models – unless ways can be found to recognise and accommodate different contributions.

At the system level, a common language around practice elements could be used to build shared understanding of the interventions that are unique to a particular service or shared across multiple services. This will help clarify points in a client's journey at which referral versus collaborative care are indicated.

7.5.4 Future work

Implementation research conducted in other child and youth-focused service systems has found almost insurmountable barriers to the sustained implementation of integral manualised ESTs in real-world, community-based services (Kazak, et al., 2010; McHugh & Barlow, 2010; Weisz, Southam-Gerow, Gordis, & Connor-Smith, 2003). Greater success may be achieved with more flexible, modular interventions when funding support is sufficient (Godley, Garner, Smith, Meyers, & Godley, 2011).

Resource constraints within the Victorian youth AOD system suggest that comprehensive implementation (i.e. with high levels of fidelity) of multiple manualised ESTs across the service system is unlikely to be feasible. EBP could be implemented more cost-effectively by ensuring that capacity-building investments build on existing strengths as much as possible.

Defining a set of feasible practice elements drawn from empirically supported treatment models, identifying elements that are well used within services, and targeting professional development towards necessary elements that are not well developed is an affordable approach with considerable promise.

The review of seven therapeutic intervention models provided in Section 4 includes a preliminary analysis of the practice elements of each that may be most important to Victorian youth AOD services, given their structure. This analysis is preliminary and was designed primarily to illustrate the practice elements approach. This analysis is limited in the following ways:

- It is based on the assumption that Victorian youth AOD services endorse the therapeutic models reviewed;
- The literature used to scope and describe the therapeutic models may be too narrow or may fail to capture the breadth and depth of ways in which Victorian youth AOD services understand and practice these therapeutic models; and
- It is based on the assumption that Victorian youth AOD services endorse the characteristics of effective services and programs that helped guide the identification of key practice elements.

It is recommended that further work be conducted involving qualitative research and an additional literature review to identify, define and describe a set of practice elements drawn from an agreed set of therapeutic models to be supported by the Victorian youth AOD sector.

7.6 Processes to support clinical decision-making

There are at least six main processes that support clinical decision making in therapeutic interventions.

Making appropriate choices begins with **assessment** involving comprehensive data collection about a client and their social ecology, combined with **case formulation** involving theoretically informed analysis of those data and collaborative problem definition and goal setting.

Care planning in close collaboration with the client builds on assessment and case formulation to design a strategy for problem solving or change. A systematic approach to **recording case notes** enables the practitioner to critically reflect upon progress, review the strategy, and ensure that the care process is transparent and accountable.

Regular supervision and **case review** are necessary to realise accountability, monitor quality, ensure that practitioners are adequately supported, detect and address emerging risks, and provide ongoing professional development.

Sections 5.6.1 through 5.6.6 briefly discuss the role of these six processes in supporting implementation of the components of the practice framework described here. Analysis focuses on how they may need to be improved within youth AOD services to better serve this purpose.

7.6.1 Assessment

The purpose of assessment is to collect information that can assist in choosing and designing therapeutic interventions that will be most helpful for the client. Youth AOD services in Victoria lack a clear framework to guide collection of data for therapeutic purposes.

We propose that assessment procedures should be clearly linked to a therapeutic practice framework that considers, describes and justifies:

- The range of information that should be collected, and
- Why and how that information is important to case formulation and design of interventions.

This resource includes at least three dimensions that provide clear guidance on the range of information that should be considered for collection: domains of need, resources and assets, and stages of change. Sections 5 and 6 explain why and under what circumstances data relevant to these dimensions may be important.

Assessment procedures should also provide guidance for ensuring that:

- The right information is collected at the right time to inform case formulation and care planning;
- Neither too little nor too much information is collected; and
- Data collection does not compromise client engagement or the establishment of a therapeutic relationship.

The resources and assets dimension attempts to consider the full range of internal and external factors that could potentially have an impact on the young person's ability to be resilient, solve their problems and establish a positive growth path.

Within this broad pool of resources and assets, assessment needs to start where the client is at in order to address the most immediate needs. The five domains of need provide a useful starting point for framing the type of information likely to be most relevant at a particular point in time.

This dimension is often easy to discern as it tends to reflect the immediate presenting issues and problems that the client is directly aware of. If a client presents in a panic due to a sudden loss of housing or income, the domain of need is clearly protection from harm and capacity to respond to crisis. Now is not the time to start assessing assets such as interpersonal skills and meaning making.

In contrast, once safety and stability are established and the young person has shifted their concern to conflict with their mother, loneliness, or a desire to make new friends, the domain of need is clearly developmentally conducive connections. Now is the time to assess interpersonal skills and meaning making, as well as other factors that may be affecting the quality of relationships. These could include internal factors such as core self-schemas and sexual identity, and external factors such as access to transport, information technology and recreational venues where other young people gather.

Assessment is not a discrete process that precedes case formulation and care planning. It is an iterative process that is revisited repeatedly over time and should be tightly interwoven with case formulation. Hypotheses about underlying issues that are generated during case formulation can be used to guide the direction of assessment. Thus, if it is hypothesised that depression or social anxiety underpins loneliness and difficulties making new friends, assessment should concentrate on testing these hypotheses.

Stage of change also becomes relevant to assessment here. For example, if depression is confirmed and is suspected of affecting the domain of need and the particular presenting problem, then assessment of stage of change in dealing with depression may be necessary. Further detailed assessment focusing on depression will be shaped by the client's level of readiness to deal with that particular issue.

Assessment procedures need to provide models for working through such complex sets of contingencies so that the right data are collected at the right time, in ways that make sense to the client and that promote their engagement in the therapeutic relationship.

7.6.2 Case formulation

Case formulation transforms data from assessment into a description of the problem to be addressed, in a format that points to appropriate interventions.

The ultimate purpose of case formulation is to inform the selection of treatment or support interventions from the options available (Tarrier, 2006: p3). The medical model relies heavily upon diagnostic categories to select treatments and individual differences may have little influence on decision making.

In contrast, a functional behavioural-analytic approach is more appropriate to youth AOD services that assist young people with complex needs. This approach supports a flexible, idiosyncratic understanding of each client's individual problems and strengths, irrespective of any diagnostic classification (Tarrier, 2006; p10).

Two key features of this model that make it appropriate to this context are that it is individualised and collaborative.

To be consistent with a client-focused therapeutic approach, case formulation must be highly individualised and take account of a large array of unique characteristics (e.g. internal and external resources and assets).

Persons (1989; cited in Tarrier, 2006) usefully made the distinction between 'overt difficulties' that are readily discernible to key observers, and the 'underlying psychological mechanisms' that may underpin the client's overt difficulties (p4). This idea is similar to, and elaborated by, the distinction between macro and micro levels of analysis.

The client's initial subjective description and explanation of their problem will often correspond to overt difficulties that are apparent at a macro level of analysis (e.g. conflict with mother, difficulty making new friends, using too many drugs). The practitioner's role in case formulation is to develop a finer and more detailed analysis of factors that may have contributed to the development and maintenance of the overt difficulties (e.g. poor emotion regulation, depression, social anxiety, poor communication skills), as well as factors that may have prevented them getting worse and that could be part of the solution (e.g. intelligence, loving support from an older sister, strong interest in music).

The process of case formulation should be collaborative. In developing the analysis of underlying mechanisms, the client's own views, beliefs and understandings about the problem need to be thoroughly assessed and explored. The formulation needs to account for and accommodate these beliefs (Tarrier, 2006).

The functional behavioural-analytic approach to case formulation is also action oriented. The problem is defined in operational terms so that a feasible intervention can be specified, based on a problem-solving approach to decision-making.

Thus case formulation is a way of generating testable hypotheses about the nature of the problem and how it could be solved. Whether the formulation is functional depends on the results or outcomes. This is also known as the scientist-practitioner model (Tarrier, 2006; p8).

The process is cyclical and iterative, with hypotheses being refined over time based on feedback from results. "It is this refinement of testable hypotheses upon which treatment strategies are based that prevents [intervention] from becoming a mere cookbook of clinical techniques" (Tarrier, 2006; p4).

The problem-solving approach to decision-making comprises five steps:

- Problem orientation
- Problem definition and formulation
- The generation of alternative strategies
- Decision-making
- Solution implementation and verification.

These steps help to illustrate the connection between assessment, case formulation, care planning and the other three processes to support decision-making.

The domain of need dimension of the framework serves as a useful schema for initial problem orientation. This then guides assessment towards more precise problem definition. As relevant resources and assets are identified and the interconnections between them ascertained, hypotheses about the core underlying problems begin to surface and crystallise.

Consultation with the client and significant others (including other service providers) helps to clarify the most likely hypotheses and point towards alternative strategies for intervention. The client's stage of change will influence problem formulation, in that their readiness to address a particular issue will affect the types of strategies that are likely to be effective, and complicate closely related problems.

Case formulation procedures may be best illustrated and communicated using a set of case studies.

7.6.3 Care planning

Care planning operationalises the decision-making and solution implementation phases of the problem-solving approach. An effective care plan helps clients to identify and prioritise goals to work towards, and to narrow these goals down to clear, specific and practical plans (Day, Best, Bartholomew, Dansereau, & Simpson, 2008). Care planning reviews the hypotheses about underlying problems and the range of potential strategies developed during case formulation, then prioritises among these according to a set of goals developed collaboratively by the client and the practitioner.

The first phase of the care planning process focuses strongly on formulating goals. Often considerable time must be spent translating vague statements of intent into actionable objectives. Goals should be consistent with the SMART mnemonic: Specific, Measurable, Achievable, Realistic, and have a Time Frame (Dobson & Dobson, 2009; p61; Neenan & Dryden, 2004; p65-66; Scott, 2009; p31).

The client's stage of change for particular underlying issues will influence the prioritisation of different goals. There may be other considerations, too. For example, there may be benefits in beginning with a goal that is likely to lead to quick success or a reduction in distress (Dobson & Dobson, 2009). Early wins build confidence and assist progress towards more challenging goals.

Care planning is an important process for ensuring that clients' strengths are recognised and used. Strengths can be validated by choosing and designing intervention strategies that build upon known strengths. Elements from Solution Focused Therapy designed to describe solutions that clients have successfully used in the past are appropriate for the care planning process.

Care plans should include a section that identifies practitioners in other organisations that are providing relevant treatment or care for the client and describe ways in which the practitioner will liaise, coordinate or collaborate with these other providers.

7.6.4 Case notes

Case notes involve a regular, detailed description of the work that has been conducted with a client over a specified period of time. For appointment-based sessions, medical and mental health professionals write case notes following each appointment. For irregular, ongoing or continuous contacts such as in outreach and residential modalities, it may be appropriate for case notes to be written daily or weekly.

The functions of case notes are multiple.

- **Accountability, quality assurance and risk management**
  Thorough documentation enables supervisors to monitor interventions and take any action that is required to ensure that practice is consistent with legal requirements and minimum practice standards.
- **Reflection and ongoing care planning**
  Writing regular case notes provides time and space for the practitioner to reflect upon the progress that is being made, assess what is working well and what is not, revisit and refine the case formulation, and reconsider the strategy or care plan.
  Writing good case notes is essential to ensuring intentional practice.
- **Learning and practice development**
  The reflection prompted by case notes provides an opportunity to think deeply about any difficulties and problems that are arising in the course of working with a client. The problem-solving process should include consideration of new practice elements that may be beyond the current repertoire of the practitioner. If the case notes template is adequately integrated with information in care plans and case formulation on the one hand, and information about the range of relevant practice elements on the other, the process of making case notes will help the problem-solving and learning process.

7.6.5 Supervision

Regular clinical supervision has several functions ranging from primarily administrative through to highly developmental. Administratively, supervision ensures that organisational procedures and accountability mechanisms are being followed. Regular supervision is also important to quality assurance and risk management, ensuring that potential risks and other difficulties in client care are identified early and that appropriate action is taken promptly.

Developmentally, supervision provides vital learning for practitioners through guided reflection. It is the means by which the reflective benefits of case formulation, care planning and case notes are realised. Supervision guides practitioners to adopt a critical and questioning stance in their reflection upon practice and to continuously challenge themselves to grow in understanding and skill. This learning orientation is not natural to all professionals and needs to be encouraged and supported at an organisational level.

Continuous professional development including supervision is necessary for both new and experienced practitioners. For new staff who are unfamiliar with practice within the organisation, regular supervision is essential to learn policies and procedures and to become familiar with the therapeutic practice framework.

For experienced staff, the focus of supervision shifts to more advanced domains of practice, such as areas of specialist expertise and the role that the senior practitioner may have in guiding other staff. Regular supervision is even more important at times of change and growth, such as the development and implementation of new practice frameworks or interventions.

To ensure that supervision is more than administrative, services should consider describing the developmental domains that should be covered and providing supervisory staff with training in supervision.

7.6.6 Case review

Case review can take at least two different forms. One involves regular (e.g. bimonthly or quarterly) review of all cases currently open with a particular team or service unit. This would involve the key worker and supervisor sitting down together or with other key people (e.g. collaborating practitioners in other agencies and perhaps the client) to revisit the case formulation, case notes and care plan to evaluate progress and make any necessary changes.

Another approach to case review involves a fortnightly or monthly team meeting dedicated to presentation of a selection of cases. The purpose is twofold: (i) accountability and quality assurance, and (ii) professional development for the whole team. Key workers present a selection of pertinent information about a client, highlighting challenges, achievements and areas of uncertainty. Discussion focuses primarily on problem solving.

The latter approach is particularly valuable for fostering a coherent and consistent practice approach across all members of a team. This is important in service settings that rely on a team-based approach and where clients are involved with a variety of staff members.

References

Bruun, A., & Hynan, C. (2006). Where to from here? Guiding for mental health for young people with complex needs. *Youth Studies Australia, 25*(1), 19-27.

Chassin, L. (2008). Juvenile justice and substance use. *The Future of Children, 18*(2), 165-183.

Chorpita, B. F., Becker, K. D., & Daleiden, E. L. (2007). Understanding the common elements of evidence-based practice: misconceptions and clinical examples. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(5), 467-472.

Chorpita, B. F., Daleiden, E. L., & Burns, J. A. (2004). Designs for instruction, designs for change: distributing knowledge of evidence-based practice. *Clinical Psychology: Science and Practice, 11*(3), 332-335.

Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005a). Identifying and selecting the common elements of evidence based interventions: A distillation and matching model. *Mental Health Services Research, 7*(1), 5-20.

Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005b). Modularity in the design and application of therapeutic interventions. *Applied and Preventive Psychology, 11,* 141-156.

Day, E., Best, D., Bartholomew, N. G., Dansereau, D. F., & Simpson, D. D. (2008). *Care planning: Mapping achievable goals - A collaborative, mapping-based intervention for helping key workers and clients identify effective treatment goals.* Birmingham: The University of Birmingham.

Dobson, D., & Dobson, K. (2009). *Evidence-based practice of cognitive behavioral therapy.* New York: The Guilford Press.

Garland, A. F., Hawley, K. M., Brookman-Frazee, L., & Hurlburt, M. S. (2008). Identifying common elements of evidence-based psychosocial treatments for children's disruptive behavior problems. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*(5), 505-514.

Gilvarry, E. (2000). Substance abuse in young people. *Journal of Child Psychology and Psychiatry, 41*(1), 55-88.

Godley, S. H., Garner, B. R., Smith, J. E., Meyers, R. J., & Godley, M. D. (2011). A large scale dissemination and implementation model for evidence-based treatment and continuing care. *Clinical Psychology: Science and Practice, 18*(1), 68-84.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999). *The heart and soul of change: what works in therapy.* Washington, DC: American Psychological Association.

Kazak, A. E., Hoagwood, K., Weisz, J. R., Hood, K., Kratochwill, T. R., Vargas, L. A., et al. (2010). A meta-systems approach to evidence-based practice for children and adolescents. *American Psychologist, 65*(2), 85-97.

Lennings, C. J., Kenny, D. T., & Nelson, P. (2006). Substance use and treatment seeking in young offenders on community orders. *Journal of Substance Abuse Treatment, 31*, 425-432.

McHugh, K. R., & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments: a review of current efforts. *American Psychologist, 65*(2), 73-84.

Meier, P. S., Donmall, M. C., McElduff, P., Barrowclough, C., & Heller, R. F. (2006). The role of the early therapeutic alliance in predicting drug treatment dropout. *Drug and Alcohol Dependence, 83*(1), 57-64.

Miller, S. D., & Duncan, B. L. (2000). Paradise lost: from model-driven to client-directed, outcome-informed clinical work. *Journal of Systemic Therapies, 19*(1), 20-35.

Moos, R. H. (2007). Theory-based active ingredients of effective treatments for substance use disorders. *Drug and Alcohol Dependence, 88*, 109-121.

Naar-King, S., & Suarez, M. (2011). *Motivational interviewing with adolescents and young adults.* New York: The Guilford Press.

Neenan, M., & Dryden, W. (2004). *Cognitive therapy: 100 key points & techniques.* Hove: Routledge.

Ozechowski, T. J., & Waldron, H. B. (2010). Assertive outreach strategies for narrowing the adolescent substance abuse treatment gap: implications for research, practice and policy. *The Journal of Behavioral Health Services & Research, 37*(1), 40-63.

Scott, M. J. (2009). *Simply effective cognitive behaviour therapy: a practitioner's guide.* East Sussex: Routledge.

Simpson, D. D., Joe, G. W., Rowan-Szal, G. A., & Greener, J. M. (1997). Drug abuse treatment process components that improve retention. *Journal of Substance Abuse Treatment, 14*(6), 565-572.

Statham, J. (2004). Effective services to support children in special circumstances. *Child: Care, Health & Development, 30*(6), 589-598.

Tarrier, N. (2006). An introduction to case formulation and its challenges. In N. Tarrier (Ed.), *Case formulation in cognitive behaviour therapy (pp. 1-11)*. Hove: Routledge.

Thorpe, G. L., & Olson, S. L. (1997). *Behavior therapy: concepts, procedures and applications* (2nd ed.). Needham Heights, MA: Allyn and Bacon.

Ungar, M. (2011). *Counselling in challenging contexts: Working with individuals and families across clinical and community settings.* Belmont: Brooks/Cole.

Waldron, H. B., Kern-Jones, S., Turner, C. W., Peterson, T. R., & Ozechowski, T. J. (2007). Engaging resistant adolescents in drug abuse treatment. *Journal of Substance Abuse Treatment, 32*, 133-142.

Weisz, J. R., Southam-Gerow, M. A., Gordis, E. B., & Connor-Smith, J. (2003). Primary and secondary control enhancement training for youth depression. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 165-183). New York: The Guilford Press.

YSAS Pty Ltd
Level 1, 131 Johnston Street, Fitzroy VIC 3065
PO Box 2950, Fitzroy VIC 3065
Phone: (03) 9415 8881
Fax: (03) 9415 8882
Email: donations@ysas.org.au
www.ysas.org.au