Submission to the
Law Reform, Drugs and Crime Prevention Committee

Inquiry into the supply and use of methamphetamines, particularly ‘ice’, in Victoria

From
Youth Support + Advocacy Service (YSAS)

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Introduction

YSAS welcomes the opportunity to submit evidence and expert opinion to the parliamentary inquiry into the supply and use of methamphetamines, particularly ‘ice’, in Victoria by the Law Reform, Drugs and Crime Prevention Committee.

YSAS is Victoria’s only statewide, youth specific, alcohol and other drug treatment service. It is the largest and most comprehensive service of its kind in Australia.

Since it was established fifteen years ago, YSAS, in partnership with Commonwealth and Victorian Governments, has assisted over 20,000 young Victorians and their families to address problems associated with substance abuse or dependence. The primary substance of concern for many of these young people was and continues to be methamphetamine. YSAS has enabled over half of these young people to cease or significantly reduce their substance use through the delivery of integrated therapeutic interventions and treatment services.

The YSAS approach has proven to be effective in reducing harm and enabling young people to address substance problems. It is based on providing continuous care and recovery support for young people and families through assertive outreach, residential withdrawal and rehabilitation, supported accommodation and structured day programs.

YSAS will not respond to all aspects of the terms of reference set out for the inquiry. Rather YSAS will provide evidence and expert opinion that assists the ‘Law Reform, Drugs and Crime Prevention Committee’ to:

- Examine the nature, prevalence and culture of methamphetamine use in Victoria, particularly amongst young people, indigenous people and those who live in rural areas
- Examine the links between methamphetamine use and crime, in particular crimes against the person
- Examine the short and long term consequences of methamphetamine use
- Consider best practice strategies to address methamphetamine use and associated crime, including regulatory, law enforcement, education and treatment responses (particularly for groups outlined above).
The nature, prevalence and culture of methamphetamine use in Victoria, particularly amongst young people, indigenous people and those who live in rural areas

Over the past 15 years, YSAS has assisted over 20,000 young Victorians and their families to address problems associated with substance abuse or dependence. Since 2009, methamphetamine has increased five-fold as the primary drug of concern for these young people (see figure 1 below).

**Figure 1.** Primary drug of concern for episodes of care at YSAS—financial years 2006/7 to 2012/3, showing an increase in the use of amphetamine type stimulants.

![Graph showing the increase in the use of amphetamine type stimulants.](image)

The June 2013 census of 1,000 clients in youth AOD services in Victoria identified 255 clients (25.5%) whose primary drug of concern was meth/amphetamine (see figure 2). This also illustrates the continuing trend for methamphetamine users to be increasingly represented among the overall population of youth AOD treatment clients.

Methamphetamine use in the Victorian youth AOD client population is at high levels relative to the general population and when compared to other previous treatment populations of a similar age. Australia’s AOD National Minimum Data Set (NMDS) for 2011-12 (all age groups) shows Amphetamines use at 11%. The NMDS 2010-11 identified a more comparative sub-cohort aged 10 to 29 years old that shows Amphetamine users representing 9%. This suggests a sharp rise over the previous 2 years of young people seeking treatment for methamphetamine related problems.

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1On June 6, 2013 practitioners from specialist youth AOD services in Victoria completed an on-line survey on all current clients to determine the severity of their substance use issues and their level of psychosocial vulnerability. 1009 surveys were returned and 1000 were correctly completed. This represented 84% of clients in the youth AOD service system on the census date. The study was coordinated by YSAS with support from Turning Point. Collaborating organisations and practitioners were highly motivated to ensure that the needs of their clients would be accurately identified and represented in the upcoming youth AOD service system reform process. Mental Health, Drugs and Regions Divisions of Victoria’s Department of Health both endorsed and supported the census. The age range of clients was 8 to 27 years with an average age of 18.9 years. Young women represented 33.9% of valid surveys completed and Aboriginal and Torres Straight Islander clients 7.6%.
YSAS believes that because methamphetamine is most commonly smoked rather than injected, young people are more easily initiated into using it. The likelihood is increased when young people either associate with others for whom smoking methamphetamine is common or for those who believe it is common among other young people.

YSAS is also aware that methamphetamine use is an emerging problem for young trainees, apprentices and those in trades. Unfamiliar with accessing support services, this cohort is reluctant to seek help until they face crisis, making engagement and early intervention difficult. They are not currently significantly represented among clients in Victoria's AOD treatment services.

**Figure 2:** Primary substance of concern for Victorian youth AOD clients (Statewide client census, 2013)

![Methamphetamine Use in Victorian Youth AOD Clients](image)

While 25.5% of the 1,000 youth AOD clients represented in the Victorian census identified methamphetamine as their primary drug of concern, 35% had used amphetamine type stimulants in the previous 4 weeks. Over one third of these young people were using amphetamine type stimulants on a daily basis (see figure 3).

**Figure 3:** Frequency of substance use among for Victorian youth AOD clients (Statewide client census, 2013)

![Substance Use Frequency](image)
Comparison of clients with methamphetamine as a primary drug of concern and those and other clients in the census of Victorian youth AOD services

From the June 2013 census of clients in youth AOD services in Victoria, the 255 clients with methamphetamine as a primary drug of concern can be compared with the 745 other clients to shed more light on their needs and characteristics.

Demographics

Methamphetamine clients were older than other clients. Only 3% (vs. 13%) were aged 8 to 15 years, 24% aged 16-18 years (v. 35%), 50% aged 19-21 years (v. 38%), and 23% were over 22 years (v. 13%).

No differences were found for gay and lesbian clients or between male and female clients.

Also, no differences were found between clients of regional and metro agencies.

Treatment involvement

Interestingly, methamphetamine clients were more likely to be involved in treatment in more than one AOD agency (13% v. 6%) and were overrepresented in the group of clients who were in treatment for 1 to 4 weeks (36% v. 26%). This again suggests that the proportion of clients seeking treatment for methamphetamine related-problems is increasing.

Frequency of use

Methamphetamine clients were more likely to use 3 or more different drugs in the last 4 weeks (46% v. 23%). They were more likely to use prescription drugs (22% v. 11%) and ecstasy (8% v. 3%). They were also less likely to use alcohol (53% v. 67%) and cannabis (54% v. 68%) in the last 4 weeks and less likely to use cannabis daily (38% v. 51%).

No differences for daily use of alcohol, heroin, tobacco, prescription drugs, other opiates, inhalants, ecstasy, or "other" drugs, or to use any one drug (excluding tobacco) daily or almost daily.

Drug use severity, harms, dependence, injecting

The rate of substance dependence among methamphetamine clients was 56%, the same as for other clients for whom other drugs were the primary concern. Methamphetamine clients were more likely to be assessed with high or severe drug use severity (59% v. 36%).

When controlling for age group, this significant difference in drug use severity was prominent for the 16 to 18 year old group (57% v. 33%) and in the 22 years and older group (63% v. 28%).

Methamphetamine clients were more likely to have a history of drug injection (40% v. 16%) and more likely to have experienced drug use harms in the last 3 months (47% v. 36%).

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2Even so, in the previous 4 weeks over half the population of methamphetamine clients also used cannabis and over half the population of methamphetamine clients also used alcohol.
The links between methamphetamine use and crime, in particular crimes against the person

Victoria Police have made it clear that the use of methamphetamine is implicated in criminal activity and in particular crimes against the person.

The June 2013 census of 1,000 clients in youth AOD services in Victoria revealed extremely high levels of criminal activity and criminal justice system involvement (see figure 4). When the 255 clients (25.5%) whose primary drug of concern was meth/amphetamine are compared to other young people in the census the level of criminal activity and criminal justice system involvement is higher again.

Methamphetamine clients likely than other young people using youth AOD treatment services to:

- Have a current problem with criminal offending (49% v. 38%).
- Have been involved in criminal activity in the last 4 weeks (26% v. 16%).
- Be a Community Offenders Assessment and Treatment Service (COATS) client (41% v. 32%).

When current involvement in the Criminal Justice System (CJS) and current criminal activity were combined, methamphetamine clients were more likely to be involved in CJS or crime (54% v. 44%).

**Figure 4:** Criminal activity and criminal justice system involvement (n=1000 – all clients represented in the June census of Victorian youth AOD treatment services)
The short and long term consequences of methamphetamine use

In general, substance misuse and dependence is the most prevalent and potentially harmful of all complex issues faced by our most vulnerable and at risk young Victorians.

While there are immediate harms and potentially serious long-term consequences associated with methamphetamine use, it is important to realize that young people use it to feel alert, energetic, euphoric and excitable. These effects stem from methamphetamine stimulating neurotransmitters in the brain, specifically dopamine, noradrenaline and serotonin.

Young people who feel anxious in social situations find that amphetamines make them more confident and others use them for the feelings of invincibility that can be engendered. The short and long term consequences of methamphetamine use must be understood in the context of the gains young people seek from taking them.

Even so, YSAS has direct experience of the negative immediate effects of methamphetamine use and the long term consequences for young people and families.

The immediate effects include paranoia, hallucinations, anxiety, heart palpitations and aggression. Persistent methamphetamine use can result in mental health problems with the resultant lack of sleep or eating for long periods of time potentially causing cognitive impairment and drug-induced psychosis. Further, ongoing use of ice can also result in permanent diminution of dopamine, noradrenaline and serotonin. The association between persistent and intensive methamphetamine use and increased potential for violence can also be corroborated by YSAS practitioners.

Findings from the statewide census of clients in Victorian youth AOD services (June, 2013)

The June 2013 census of 1,000 clients in youth AOD services in Victoria revealed extremely high levels of psycho-social vulnerability (see figure 5). This indicates that substance use problems and in particular methamphetamine problems have a major impact on young people’s development, health and future prospects.

Figure 5: Level of psychosocial vulnerability (percentage of all clients (n=1000) represented in the June census of Victorian youth AOD treatment services meeting criteria for problems on 10 psychosocial indicators)
A more fine grained view of how vulnerable the 255 clients (25.5%) whose primary drug of concern was methamphetamine can be gained by comparing them with other clients in the Victorian census of youth AOD services (June 2013). Before reporting on the finding in a range of domains YSAS points out that there was significantly more vulnerability recorded in the 16 to 18 year old group, a period when many clients in the youth AOD services initiate methamphetamine use.

**Education & employment**

More methamphetamine clients had current problems with employment (63% v. 52%) and were more likely to have unmet service needs for employment problems (32% v. 19%). They were also less likely to be involved in education (21% v. 37%) or to have been suspended from school (28% v. 37%).

Also more methamphetamine clients were identified with an attention deficit disorder (10% v. 5%).

**Housing**

No differences between methamphetamine clients and other clients were noted with current housing problems (28% v. 24%), or acute housing problems (22% v. 19%) but they more likely to struggle to get the housing service they required (10% v. 5%). There were no differences in the type of usual accommodation, whether they lived with family, or whether their housing was unstable.

**Family / Relationships**

The degree of family conflict and disconnection was found to be extremely high for all clients (n=1000) represented in the June 2013 census of Victorian youth AOD treatment services, including the 255 methamphetamine clients.

**Figure 6:** Family relationship issues (All clients (n=1000) represented in the June 2013 census of Victorian youth AOD treatment services

![Bar chart showing family relationship issues](image)

**Psychological and physical health / quality of life.**

Measures on the psychological health, physical health and quality of life were completed for all clients (n=1000) represented in the June census of Victorian youth AOD treatment services, including the 255 methamphetamine clients. When scores were compared for those with 0 – 4 (poor) methamphetamine clients were more likely to have poor physical health (34% v. 25%), and poor quality of life (46% v. 36%).

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3Methamphetamine clients are an older group which accounts for some of this difference
Mental health

The degree of mental health problems experienced by all clients (n=1000) represented in the June census of Victorian youth AOD treatment services was extremely concerning. This includes the 255 methamphetamine clients. In particular, young women were at elevated levels on all indicators. Methamphetamine clients were more likely to have ever had a mental health diagnosis (46% v. 38%) but no difference in rates of current mental health diagnosis.

**Figure 7:** Mental health and gender (All clients (n=1000) represented in the June census of Victorian youth AOD treatment services

![Bar chart showing mental health and gender (All clients (n=1000) represented in the June census of Victorian youth AOD treatment services)](chart)

Psychosocial vulnerability combined with a severity of substance use problem

Figure 8 shows the percentage of clients represented in the June census of Victorian youth AOD treatment services that have an extremely level of psychosocial vulnerability combined with a severe substance use problem. For methamphetamine clients it is 68%.

**Figure 8:** Percentage of census clients with both extreme psychosocial vulnerability and a severe substance use problem

![Bar chart showing percentage of census clients with both extreme psychosocial vulnerability and a severe substance use problem](chart)
Best practice strategies to address methamphetamine use and associated crime, including regulatory, law enforcement, education and treatment responses (particularly for groups outlined above)

YSAS believes that the most effective way to address the increasing methamphetamine use and associated issues, including crime, is to develop an integrated statewide methamphetamine strategy.

A Victorian methamphetamine strategy would be informed by the findings of this inquiry and initiated by a high level ‘Methamphetamine Summit’ that could inform government and coordinate responses. YSAS recommends that such a strategy be explicit about how strategies targeting and seeking to limit the supply of methamphetamine be coordinated with strategies to reduce both the demand for methamphetamine and the harm that it causes individuals, families and communities.

It is particularly important that sufficient attention is dedicated to distinguishing between different groups of methamphetamine users and targeting strategies accordingly, in particular:

- Families in households already experiencing domestic violence where incidents of methamphetamine-related violent assaults have increased;
- Young trainees, trades people and apprentices early in their ice misuse is also a challenge as this cohort has not sought assistance from support agencies before; and
- Young people in most at risk of developing alcohol and other drug problems as a result of heightened psychosocial vulnerability.

Effective treatment responses and interventions

A spectrum of interventions, ranging from prevention to treatment, can be implemented to tackle harmful and problematic substance use, including methamphetamine use, in populations of young people. Evidence suggests that this is best achieved through the ‘concerted application of a combination of regulatory, early-intervention, and harm-reduction approaches’ (Toumbourou et al., 2007, p.1). In relation to treatment and direct care (which incorporates harm reduction approaches and the capacity for early intervention) it is almost universally agreed that adolescents with AOD and other psychosocial difficulties require services and programs that are designed specifically to meet the unique developmental needs (Brannigan et al., 2004; Henderson et al., 2008).

Colby et al (2004) found strong evidence that tailoring services to meet individual needs or subgroup characteristics not only positively influences treatment outcomes but it also the likelihood of treatment involvement and retention (Colby et al, 2004).

There are a number of other fundamental differences between youth specific AOD services and adult AOD services, as follows:

- Youth AOD services are able to create environments and programs that are attractive and accessible for young people thus promoting the potential for treatment engagement and retention.
- Youth AOD services and programs are designed to offer clients experiences that promote progress towards achieving developmental tasks such as exploring their social and vocational identity, developing life skills, practicing contingency planning learning to make mature judgements.
- Youth AOD practitioners are experienced in working with young people, have specific training pertaining adolescent development and can undertake developmentally targeted risk assessment and management.
- Youth AOD services are intimately aware of the unique statutory provisions applying to children and young people. This includes understanding provision special considerations around privacy, duty of care and consent (e.g. determining “mature minor” status).
Youth AOD services are embedded within youth specific service systems and networks and staff understand how different youth specific programs and services operate.

Youth AOD intake processes feature proactive collaboration with referring agencies and practitioners from the youth health and community services sector that involves relationship development and training.

The most effective Youth AOD service systems are multi-faceted, consisting of many different 'types' of interventions and programs.

Over the past decade, a great deal has been learned about how to engage and provide treatment services for clients with methamphetamine related problems (Pennay and Lee 2009). Even so, evidence suggests that methamphetamine users may experience barriers in accessing appropriate treatment and find existing treatment services unsuitable (Degenhardt et al. 2008; Pennay and Lee 2009). This perception has been validated by a range of clinical studies identifying that traditional alcohol and other drugs (AOD) treatment approaches (i.e. substitution therapies like methadone) tend to be geared to the requirements of opiate dependent clients and less effective for treatment of Amphetamine type stimulants such as methamphetamine. (Heinzerling et al. 2010). Further, Degenhardt et al. (2008) note that insufficient attention has been dedicated to distinguishing between different groups of methamphetamine users and to establishing suitable services in response to their specific needs.

Effective Youth AOD services work with young people and those involved in their care to:

- Reduce the immediate risk of harm associated with harmful methamphetamine use
- Establish viable alternatives to substance use as a way of meeting needs and responding to unresolved underlying issues that cause distress
- Decrease young people’s reliance on substance use so that rather than being a necessity it becomes one option for coping among a range of others.

‘A guide to assisting young people experiencing ATS related problems’, provided in Attachment A. This is a chapter written by YSAS for the recent Australian publication: ‘Understanding and Responding to Amphetamine Type Stimulants’ edited by Professor Steve Allsop and Dr Nicole Lee.

This guide demonstrates that AOD services can improve their accessibility and attractiveness to young people with methamphetamine problems by:

- Maximizing the possibility of engagement through providing an option for young people to “drop in”, and creating safe, supportive, welcoming environments that are not overly clinical and impersonal.
- Having the capacity to respond to crisis particularly when young people are agitated, confused and possibly paranoid
- Limiting complex intake processes
- Responding to the most pressing issue for the young person
- Having the flexibility for assertive follow up and to be able to take services to young people
- Having available a stable, drug free residential setting that is capable of supporting withdrawal from methamphetamines and other substances awhile addressing a range of psycho-social problems
- Being prepared to work among networks of young people who use methamphetamine
- Involve the family in treatment where possible
- Using evidence based approaches such as cognitive behavior therapy and the community reinforcement approach

The June 2013 census of 1,000 clients in youth AOD services in Victoria revealed the strong correlation between substance use severity and psychosocial vulnerability. The majority of current youth AOD clients experience both simultaneously. This is demonstrated by the current treatment involvement of clients lengthens as both substance use severity and psychosocial vulnerability increases (see figure 9).
High levels of past and current abuse and neglect among methamphetamine clients suggest that:

- Services should be trauma-informed
- Clients can require protective environments and relationships

It is worth noting that the majority of clients (73%) use youth residential withdrawal services in their first 4 weeks of current treatment involvement. This suggests these programs are providing a gateway into treatment.

YSAS believes that these stable environments can be enhanced by extending the potential length of stay from 14 days to 28 days. This would enable the young person to recover from sleep deprivation, re-establish normal cognitive functioning, stabilise mood and restore general health. Once the young person begins to recover, these structured environments can be used to promote connection with meaningful activity and facilitating constructive participation in the community. This is required to break the circuit of harmful methamphetamine dependence and to support ongoing relapse prevention.

**Figure 9:** length of current treatment involvement / substance use severity and psychosocial vulnerability

Youth AOD services require the capacity to provide sufficient continuity of care. This means providing coordination of services and interventions as well as effective aftercare where young people have used residential programs.

Unemployment is a major problem for youth AOD clients that are 19 plus and tenuous connections and disconnection from school is a major issue for younger clients. Assertive linkage to meaningful activity is critical to the success of any treatment program.

Finally, the best responses incorporate a capacity to intervene at the earliest possible time where young people are at risk of or are beginning to develop methamphetamine problems. This involves reaching young people early before their problems have developed to the extent that they need treatment. It is then critical to facilitate meaningful connections to activities and relationships that the young person values highly and that clash with a drug using lifestyle.

YSAS recommends the establishment of new area-based ‘Drug & Alcohol Response Teams’ (DARTs) that would enable early intervention and education support for clubs, local government, schools, police and community groups, including brief interventions and development of prevention and early intervention local drug action plans.
References


Attachment A

‘A guide to assisting young people experiencing ATS related problems’

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INTRODUCTION

In the early to mid 2000’s, researchers, policy makers, and service providers began to respond to a dramatic increase in the prevalence of crystal methamphetamine use in the community (McKetin and McLaren 2004). The Australian media touted such trends as indicative of an “epidemic” termed the “ice age” (Carney 2006), however, more recent data indicates that rates of use may have declined. For example, an annual survey of Australian regular ecstasy users in 2007 found that 71% of the sample had used any type of methamphetamine in the previous six months, compared to 54% in 2009 (Black et al. 2008; Sindicich and Burns 2010). Despite this drop, methamphetamine continues to be one of the most commonly used illicit drugs among young people in our community (Cassar et al. 2009; Sindicich and Burns 2010). In this chapter we investigate how service providers and practitioners can best respond to the particular needs of those young people whose use of amphetamine type stimulants (ATS), particularly methamphetamine, has become dependent and problematic.

Over the past decade, a great deal has been learned about how to engage and provide treatment services for clients with methamphetamine related problems (Pennay and Lee 2009). Even so, evidence suggests that methamphetamine users may experience barriers in accessing appropriate treatment and find existing treatment services unsuitable (Degenhardt et al. 2008; Pennay and Lee 2009). This perception has been validated by a range of clinical studies identifying that traditional alcohol and other drugs (AOD) treatment approaches (i.e. substitution therapies) tend to be geared to the requirements of opiate dependant clients and less effective for ATS treatment (Heinzerling et al. 2010). Further, Degenhardt et al. (2008) note that insufficient attention has been dedicated to distinguishing between different groups of methamphetamine users and to establishing suitable services in response to their specific needs.

Young methamphetamine users are themselves a heterogeneous population with diverse interests and needs. The usage patterns of different groups can reflect nuanced identities, expressing ethnicity and particular forms of masculinity, femininity or sexual preference (for example Slavin 2004). It is also critical to consider each young person’s development stage and level of maturity.

Research suggests that young drug users tend to be strongly invested in the notion that using is an active choice over which they are able to maintain control (Maycock 2002; MacLean et al. 2009). Duff (2003) recognises that contemporary youth culture has produced the well-adjusted, responsible adolescent, “…who...
uses drugs recreationally, very deliberately and very strategically" (p.435). The majority of young people who use illicit drugs remain integrated in a cultural mainstream (through education, employment, etc) without coming to the attention of AOD services (DoHA 2008). For other young people, the demarcation between recreational and problematic use is less clear. Research suggests that a range of socio-ecological and intrapersonal factors can influence vulnerability to experiencing drug related harm (Macdonald and Marsh 2002; Shildrick 2002; South 2004).

In this chapter, we examine the case of a client of the Youth Support and Advocacy Service (YSAS). YSAS is a youth-focused AOD service for young people aged 10-25 years. YSAS has 15 sites in inner city and greater metropolitan Melbourne and rural Victoria (Australia). Service modalities include outreach, day programs, residential withdrawal, long-term residential rehabilitation and a supported housing program, Sharni4 is a seventeen year-old young women who developed significant problems related to the use of methamphetamine. The second and third authors of this paper recounted Sharni’s case based on their experience working directly with Sharni and managing other YSAS staff involved in her care. Sharni’s case is analysed here because it typifies many aspects of YSAS’s approach to assisting young people with ATS-related issues, and demonstrates key aspects of practice across numerous stages of engagement.

In this chapter we reflect on the nature of Shani’s drug use, its meaning and purpose in the broader context of her life, and how she came to decide that it had become a problem that she wished to change. We discuss factors likely to either nurture or obstruct her efforts to change, and describe how Sharni was supported to resolve her methamphetamine related problems.

CASE STUDY: SHARNI

Initial contact with Sharni

At 11.30am on a Monday, Sharni presented at a primary health day program and recovery space operated by YSAS in an inner suburb of Melbourne. Leah, a young women of similar age, accompanied Sharni as she entered the service. Both young women and a young man had been observed in the direct vicinity of the entrance for the previous twenty minutes. All three had arrived in the young man’s car that was parked nearby. Sharni was observed pacing up and down, arguing with the others. The other two were clearly encouraging her to enter the service. The YSAS duty worker and a colleague monitored the unfolding scene.

Eventually Leah came into the service with Sharni, approaching the duty worker to request help for her friend. Leah seemed frustrated and exhausted but was quite coherent. Sharni kept her distance but appeared agitated and distressed. She was observed wringing her hands and scratching at her shoulders, arms, upper legs and abdomen in a repetitive manner.

The duty worker introduced both herself and her colleague Eric and learned the first names of both young women. On being asked, “How can we help?” Leah explained that they had been partying with friends all week-end and this morning Sharni started to “schiz” (a colloquial term derived from ‘schizophrenic’, and referring to uncontained emotions or behaviour). By gently asking Leah simple, closed questions, the worker learned that Sharni had become increasingly anxious over the past two hours and that both young women had been up all night. Sharni showed possible signs of methamphetamine intoxication. At this stage, the priority was to engage both young women and facilitate a move to a more private and suitable space where further assessment could be conducted and relevant drug related questions explored.

Taking care to use her name and allowing a generous amount of personal space (distance between them), Eric addressed Sharni directly. He offered her a cool drink and asked if she would like to move to a more comfortable place within the service. Sharni accepted his offer and accompanied Eric to a quiet, private room in close proximity of the waiting area. At this point Leah left the service in order to get a lift home with the young man waiting outside.

Eric addressed Sharni in a reassuring tone, “I think you’ve come to the right place and I’m sure we can help. I’m going to ask a question that that will help me to understand what is going on. You don’t need to answer but it will help if you do. Have you used any drugs in the past 24 hours?” after brief moment of hesitation Sharni started with, “we’ve been on meth, but my mum can’t find out.” As Eric began to assure her that the service is confidential, Sharni continued unabated. She raced over a number of topics including, “we should

4Names of young people and staff used in this chapter are pseudonyms, and “Sharni’s” story has been modified to protect her identity
Eric suggested that she take some deep breaths, have a sip of water and sit down on the couch. Sharni did so but remained tense and within minutes was standing again. Eric continued to give her space. He reiterated that the service was confidential and asked “when did you last use?” and “how much?” Sharni explained that she had a “couple of pipes” at around 8am in an attempt to stay awake and attend school. She was unsure of the exact amount. He learned Sharni hadn’t slept since Thursday night but was unsure how much methamphetamine she had taken as it was shared among a number of friends. She could also remember taking two ecstasy tablets on Saturday night.

What are the immediate issues to consider and what would constitute an effective response?

The most urgent consideration for Eric and the duty worker was to assess for methamphetamine overdose (toxicity), which is a medical emergency. Indications of this condition include high fever or overheating, severe headache, chest pain, muscle tremor, spasm or fierce jerky movements and seizures (Jenner and Lee, 2008, p.27). Sharni hadn’t presented with any of these symptoms but if detected an ambulance should be called immediately.

Sharni was clearly experiencing unwanted complications associated with methamphetamine intoxication which can make users prone to confusion, disorganised thinking, anxiety and panic. It also increases the possibility that people become angry or hostile but this did not emerge as an issue. Where it does, practitioners are advised not to confront or argue with a client in a highly intoxicated state but rather focus on what can be provided seizures (Jenner and Lee 2008).

Eric and the duty worker adopted a team approach. While Eric took the lead in engaging and following through with Sharni, the duty worker let other colleagues know what was occurring and continued to passively monitor the situation. Taking care to keep the waiting area clear and preparing a safe, comfortable space for Sharni in advance ensured that their service’s duty of care for other young people and staff members, as well as Sharni and Leah, was enacted.

Preparation is vital for services seeking to effectively engage, assess and respond to young people who are intoxicated and in need of assistance. Competent staff who relate well with young people are a valuable asset, particularly when they have some knowledge of ATS and an interest in youth culture. Services can improve their accessibility and attractiveness to young people in the following ways: limiting complex intake processes, responding to presenting issues as they arise, providing an option for young people to “drop in”, and creating safe, supportive, welcoming environments that are not overly clinical and impersonal (Armstrong et al. 2005; Ashton 2005).

Learning more about Sharni

By 1pm, Sharni was considerably calmer and thinking about leaving. As she became more composed, Eric sought out and capitalised on opportunities to learn more about Sharni and her circumstances.

Sharni considered herself to be a regular recreational user. She stated emphatically that she had never injected and never would. She had begun using methamphetamine after meeting Brett (her boyfriend, aged 22 years) and becoming part of his peer group around 12 months earlier. She explained that she attended nightclubs in the Melbourne CBD with Brett most weekends. It was typical for her to use methamphetamine (both crystalline and powder) interchangeably on Friday and Saturday evenings, smoked through a “crack pipe” (a glass implement designed for delivery of methamphetamine) or more occasionally via insufflation (snorted). She had difficulty describing the exact dosage taken in any one event as she and a small group of friends usually acquired an “8-Ball” (3.5 grams) that would be shared throughout the weekend. This had become a common practice for Sharni. She also used ecstasy occasionally.

Sharni lived with her mother (Jane) and younger sisters, Niki (13 years) and Grace (11 years); however, she stayed with Brett on weekends and some weeknights. Their relationship, and particularly the age difference between them, was a source of much tension between Sharni and her mother.

At age 15 years, Sharni had been very close to dropping out of school or being expelled. She attended classes rarely, did not compete her work, and had been suspended when she was caught smoking cannabis.
She left her highschool and began attending an alternative school in the local area that catered for young people with tenuous connections to education. This was where Sharni met Leah. YSAS Youth Outreach staff often deliver drug education sessions in these settings and aim to make students aware of what the service offers and provide a contact point. Leah had decided to contact YSAS because she had remembered a session conducted by Eric’s colleague at her school. The session had been organised by the school’s Welfare Co-ordinator, Kym with whom Eric had a close working relationship. It transpired that Sharni knew Kym very well.

What can be done to maximise the prospects for further engagement

Eric demonstrated an interest in Sharni’s viewpoint and had refrained from lecturing or judging. This contributed to her comfort in sharing information with him, however, Sharni left Eric with no doubt that she would continue using. She dismissed the morning’s events as an aberration. She was, however, motivated to avoid a repeat occurrence and expressed how embarrassed she felt. Eric worked through a range of context sensitive strategies for reducing the harms associated with her use. Sharni was not interested in taking any written material but did enter Eric’s number in her phone, even though she was adamant that she wouldn’t need to use YSAS services in the future.

Eric set out to position YSAS as a viable option for Sharni should further AOD related problems arise. He was mindful of the stigma Sharni might associate with receiving further help from YSAS. He confirmed that her privacy would always be respected and explained that he would be happy to see her again, even if she dropped in for “a chat.” While keeping the conversation informal he made sure that Sharni was aware of the types of assistance provided by YSAS and how it can be accessed.

Further, Eric sought a natural opportunity to follow up with Sharni and asked her permission to, “say hi” if he saw her at her school when visiting Kym, the student welfare co-ordinator. He expressed an interest in following up the next day with a phone call to make sure she was okay. Sharni agreed but didn’t take the call or reply and this ended the first engagement experience with YSAS.

Researchers demonstrate the importance of ensuring that young people do not feel humiliated or disempowered when they access services. Room (2005) explains that accessing an AOD treatment service can be humiliating evidence of failure in self-management. Values of independence and autonomy are important to many young people who are increasingly required be active managers of their own lives and identities and positioned as individually responsible for failed risk taking behaviour such as illicit drug use. This is perhaps one reason that young people are less likely than adults to view themselves as having an AOD ‘problem’ and to access treatment services (Muck et al. 2001; Chassin 2008) - even when AOD use is closely connected with highly problematic life experiences (Rosenthal et al. 2008).

Sociologists have recognised that maintaining control and autonomy over one’s life, particularly in relation to involvement in risk behaviour, is a part of being a successful citizen in contemporary society (Kelly 2006; Furlong and Cartmel 1997). Sharni strived to present a competent identity, differentiating herself from more stigmatised and ‘failed’ managers of risk – dependent drug users – and resisting the possibility that her methamphetamine use had become problematic.

Sharni’s request for further assistance

Three weeks after last seeing Sharni, Eric received an urgent call from Kym at her school. During the morning Sharni arrived at school carrying three bags, filled with her belongings. Sharni had been asked by her mother to leave home that morning.

During the previous night Sharni’s boyfriend Brett had broken up with her. Earlier in the evening they had used “meth” with friends. Still somewhat intoxicated, Sharni left Brett’s house at 3am and returned home to her mothers’ shortly afterward. Her mother awoke and an argument ensued where Sharni was accused of being a “druggie” and a “bad influence” on her younger sisters. Sharni reacted angrily and went to bed. In the morning they had agreed that living together was no longer tenable.

When Sharni met Kym at school in the morning, she explained the events of the previous night, also disclosing that she had used methamphetamine. Further discussion revealed that Sharni had previous contact with Eric at YSAS. The was the basis on which Kym contacted Eric, with Sharni’s permission, Kym explained the situation, and mentioned that while Sharni was extremely distressed, she did not seem intoxicated.
Responding to immediate concerns at critical moments

Jenner and Lee (2008) recommend responding promptly to the client’s request for help to resolve immediate concerns before offering targeted interventions for methamphetamine use. As a “Youth AOD Outreach” worker Eric had the flexibility to respond to Sharni’s urgent request and was able to arrange a time to meet her and Kym at the school in the early afternoon.

While methamphetamine use was a factor in Sharni’s predicament, her priority was to find somewhere to stay. This was Eric’s focus at this point. From the perspective of both Sharni and her mother (who Kym had contacted earlier), there was no chance of a return home. Brett’s house was also no longer an option. Further, Sharni felt too ashamed to seek accommodation with her network of friends (who were also Brett’s), and the same applied with her friend Leah’s parents.

For many young people like Sharni, the experience adversity can trigger or result in a continuation of negative chain effects (Johnson 2007). Masten (2001) demonstrates that well-timed interventions delivered at critical moments have the potential to limit the progression of snowballing problems and create conditions that foster positive chain effects. Positive adaptation in adverse circumstances is a demonstration of ‘resilience’ (Luthar et al. 2006). Resilience relies on a young person possessing the personal and social resources required for coping, together with sufficient opportunity and motivation to employ them effectively (Ungar 2005, Bruun 2008). Eric and Kym sought to maximise the potential for Sharni to be resilient and cope with the adversity that she was faced with. Their focus was on enabling Sharni to secure viable and secure accommodation that would mitigate immediate risks and create a necessary foundation to support any further efforts she might make to resolve the issues she faced.

Kym and Eric identified two options for Sharni. The first was a placement in an emergency youth refuge. The second was an emergency admission to a four-bed youth residential withdrawal unit. These services offer young people, up to the age of 21 years, age appropriate and drug free accommodation with inbuilt capacity to support and medically supervise drug withdrawal. Eric located a possible placement at a YSAS unit.

Upon meeting Sharni, at the school Eric greeted her warmly and confirmed the confidential nature of his service. He was careful to explain that this extended to Kym. At this time there was no need to review the sequence of distressing events that had culminated in her becoming homeless. It was important however for Eric to acknowledge how devastating the experience of losing control (of her situation) could be for Sharni and to recognise that, in turning to Kim, she had made an active choice to respond constructively. Eric shared his view that, “anyone in this situation would find it tough” and expressed his respect for Sharni’s, “decision to deal with it.” Both Eric and Kym confirmed their support for her in finding solutions, and sought to discuss with Sharni the ‘pros’ and ‘cons’ of the service options that they had investigated.

Sharni had previously resisted the notion that she would need to use an AOD service; however, she had also responded very apprehensively to the prospect of seeking accommodation in a refuge. Responding to these concerns, Eric explained that it was possible to use the unit for safe, short term accommodation and, once there, she could decide whether or not to focus on AOD use without pressure from staff. Sharni decided to “try” the YSAS withdrawal unit because it housed smaller numbers of other young people. Eric and Kym confirmed with Sharni that their support for her would be ongoing should change her mind.

At around 4pm Harmish transported Sharni to the unit. Kym agreed to let Sharni’s mother know that residential placement had been found. Sharni did not wish for any more details to be disclosed.

Incremental assessment and customised intervention

Up to this point, Eric had gradually accumulated information that enabled him to assist Sharni to deal with the urgent issues she faces. Making assessment in increments is commensurate with a “Stepped Care” approach (see Kay-Lambkin 2008) which has been demonstrated to improve client engagement and retention. However, his assessment was incomplete.

Sharni’s decision to access the youth residential withdrawal unit meant that further assessment would be required, including more detailed information regarding her use of ATS and other drugs. Eric had not pressured Sharni to discuss her ATS use in his dealings with her thus far. Regardless, she understood the reason why information was required and was prepared to share it with Eric and (subsequently) staff at the unit. Eric also prepared Sharni for the eventuality of a physical and mental health check (completion of pre-admission screening is routine for clients entering a residential program in the AOD field).
Pre-admission assessment
At the unit Sharni nominated Kym and Eric as her support persons and gave written consent for relevant information pertaining to her case to be shared with them. The pre-admission assessment revealed that, since becoming a regular ATS user, Sharni had used every weekend. While ATS boosted her mood, she also used around a gram of cannabis every weekend to moderate the effect of “coming down” after methamphetamine use, and occasionally during the week to “relax.” Sharni answered questions to determine whether she was dependent on ATS and if so, how severe (see Gossop et al. 2003). Her dependence was considered mild.

Mental health screening showed a cluster of symptoms including sleep disturbance, mood swings, decreased energy (tiredness for no reason), irritability, agitation and anxiety, poor concentration and memory. Together with cravings to use, these symptoms are common signs of ATS withdrawal but they might also be indicative of mood disturbance. The fact that Sharni also reported using ATS to help boost her mood suggested an underlying issue that would require investigation in the future.

Methamphetamine use, particularly in conjunction with other drugs, is associated with increased prevalence of mental health complaints, including development of psychotic symptoms (McKetin et al. 2010). Sharni’s use of both cannabis and methamphetamine suggested that she may be at increased risk. Screening and direct observation of Sharni at this time indicated no such effect. Further she did not present with physical health issues or show signs that suicidal ideation, self injury or aggressive behaviour would be a concern.

The unit staff spent time orienting Sharni to her new environment and she met other residents. Eric stayed with her until she had settled in. After eating, she went straight to bed and slept through until early in the afternoon the next day. Around an hour after Sharni awoke, Eric called the unit to find her relatively calm and well. He made a time with Sharni for the following day.

When Eric arrived at the unit, he was surprised to find Sharni quietly drawing in the unit’s art room. Unlike their previous encounters, where Sharni was in a heightened state of distress, she now seemed quite calm. Eric admired the drawing and asked how she was going. She said she was “doing fine” and trying to keep herself occupied. The unit, being an intentionally youth focussed environment offered opportunities for residents to participate in a range structured and unstructured activities. Eric learned that she slept well and besides being a bit flat had no negative “comedown” experiences. She was however experiencing some cravings for cannabis that she was successfully managing (or “on top of”).

Complete assessment
In this stable environment,  Eric had an opportunity to conduct a more thorough assessment with Sharni. Jenner and Lee (2008) identify that assessment with clients who are ATS users should include: exploration of current and past methamphetamine use, other drug use, dependence on each drug, physical and psychological health, previous methamphetamine withdrawal, social factors, trauma history, and readiness to change (p.5). Further, they note that youth specific assessment should include an exploration of leisure and social functioning, family relationships, peer interactions, hobbies and educational history (p.63).

Eric explained to Sharni that he would need to know more about her circumstances to help her further. Keeping the conversation natural, he summarised the information that he had already gathered and sought clarification from Sharni, who talked openly, without the fear and mistrust that had characterised their first encounter.

Sharni had moved to Melbourne from Brisbane three years earlier. Her mother and sisters left her father and extended family in Brisbane (including her maternal grandparents). She missed them and her old friends in Brisbane but showed animosity towards her father who she identified as “a drunk,” saying that, “he was the reason we moved.” He had been very hard on her mother, and violent at times. She said that because of this she, “can’t stand alcohol.” Her mother and sisters had no contact with her father.

Sharni recounted having difficulties related to making new friends, having trouble at school and being bored; however she had recently come to believe that it was an exciting city, “more fun than Brisbane.” In Brisbane she had been involved in organised sport (netball, softball, tennis, swimming) but these interests fell away after the move. She still saw herself as an “outdoor girl” and was interested in gardening. Sharni hoped one day to pursue a career in horticulture but could also see herself as a chef as she enjoyed cooking.

Sharni explained that in her first year in Melbourne she had been suspended from the local high school, which she rarely attended however, she was strongly connected to her current school. She liked the teachers, the school’s activities and Kym (the student welfare co-ordinator). Although she got on well with the other students Leah was the only one she saw out of school hours and regarded as her “best friend”. Sharni had
enjoyed being a part of her ex-boyfriend Brett’s broader friendship network but was unsure where she stood with them since breaking up with him.

The function and meaning of ATS for Sharni
Eric asked Sharni what it was that she liked about ATS. She described an “amazing feeling” of energy and confidence that rid her of social anxiety and helped her gain acceptance with Brett’s friends, who were older than her. As in the pre-admission assessment, Sharni mentioned that ATS helped lift her mood when she was down.

Eric took the opportunity to explore further what Sharni meant by being “down.” She explained that there were times when she didn’t feel like seeing people or going out. Some days she just wanted to stay in bed. Sharni’s earliest recollection of feeling that way was in Brisbane just before she moved. Her parents were fighting and she would lock herself away in her room. Sharni told Eric that she still finds it hard to cope if her mother gets upset and shouts at her. In her first year in Melbourne there were times when the feeling lasted for weeks but she didn’t talk with anyone about it. On asking if this was the first time that she talked about this feeling with anyone, Eric learned that Sharni had talked to Kym when she first went to her new school and found that it helped.

Over the past month she had been starting to feel down again and this was, “not just after a big weekend.” At times the feeling would last for days but would lift when she “partied” (used ATS). Sharni connected these periods of feeling down with an increase in the amount of ATS she was using. Eric asked Sharni if this increase might explain the state that she was in when they first met at the YSAS day program. Sharni then disclosed that something similar had happened twice more in recent times and believed this to be why Brett had ended their relationship. She also felt deeply embarrassed that Brett’s (and her) friends had seen her “so messed up.” Sharni also recognised that her ATS use and her relationship with Brett troubled her mother. Still, she felt resentful towards her for “judging.”

Eric suggested that Sharni use the time in the unit to reflect on her recent experiences and start thinking about her plans for the period immediately after her stay. He arranged a further meeting in three days time. Eric knew Sharni had connected well with staff in the unit and encouraged her to talk with them should she feel down or wished to talk more about what they had discussed.

Motivation and change
In the relatively short period of time that Eric had known Sharni, he noticed that her orientation towards ATS had changed. Initially, she was adamant that her use would continue and that it wasn’t associated with any problems. In their most recent session, Sharni had become more reflective, demonstrating a growing insight into the reasons why ATS had been attractive to her and giving consideration to the negative aspects of using.

Prochaska and DiClemente (1984) developed a model known as the “Stages of Change” for understanding the motivations of people engaged in behaviours such as ATS use, and gauging their “readiness to change.” Sharni was clearly in the “contemplation stage,” as evidenced by her recent ambivalence regarding both ATS use and the prospect of change.

Research suggests that applying “action-oriented” behavioural approaches with young people in contemplation or pre-contemplation stages is likely to elicit an uncooperative response from clients (Giozalosias and Davis 2005). Conversely, adopting a passive, non-action oriented approach with people who have committed to making changes can be counterproductive. Motivational interviewing is an effective method that practitioners can employ to guide young people through a process of exploration so as to make there own decision to either change or continue using (Miller and Rollnick 2002).

New plans for Sharni
On her fifth day in the unit, Eric visited Sharni for the third time. Sharni’s focus had initially been on her immediate circumstances; however, this had shifted to how she might manage after her stay in the unit. She had taken up Eric’s suggestion and continued discussions with unit staff. Sharni was also visited by Kym, who was collaborating with Eric.

Sharni had decided to have “a break” from ATS use. Eric was interested to learn more about her decision. Sharni explained that she preferred to live with her mother and sisters, however her ATS use and involvement with Brett had made this difficult. She had time to consider how Brett had treated her, particularly in recent times. She thought it best to “move on” and planned not to have contact with him,
particularly as she knew that she would probably use again if she saw him. Eric delved further, discovering that Sharni thought her ATS use had got “a bit out of control,” making particular mention of the associated “schitz” outs.

According to the “Stages of Change” model (Prochaska and DiClemente 1984), Sharni had moved from “contemplation” and was now preparing to change. It is crucial to understand a client’s reasons for deciding to change, but equally, one must consider the significance of what could be lost. This assists practitioners and clients to identify “high risk situations” that can trigger lapse and relapse, thus providing rich information for future relapse prevention efforts (Witkiewitz and Marlatt 2004). It also enables practitioners to identify desirable alternative or substitute behaviours that might address the antecedents of previous drug using behaviour.

Accordingly, Eric reminded Sharni of what she liked about ATS use and the function it had served when she felt down. The result of the ensuing discussion (incorporating a number of practical considerations) was the development of a set of short term goals that would guide their work together and work of others involved with Sharni such as Kym and the unit staff. Specifically, Sharni sought to: re-establish and improve her relationship with her mother and move home, attend school regularly, seek Leah’s support, see Kym on a regular basis to develop strategies that help dealing with being down, find an interest (preferably something outdoors) to occupy time on weekends, and avoid contact with Brett or his social network.

What interventions can to employed to best enable Sharni to change?

Where young people are actively pursuing change, research suggests that interventions should move beyond engagement and motivational enhancement to mobilising requisite resources and the development of skills and beliefs (cognitive schemas) that support their efforts. (Prochaska et al. 1992, Clark 2001). A number of evidence-based therapeutic interventions can be employed that simultaneously target psychological and emotional processes within the individual and their environment.

**Cognitive Behavioural Approaches**

Jenner and Lee (2008) point out that, “cognitive behavioural approaches are the most extensively evaluated of the counselling styles and are effective in helping people address problems with meth/amphetamine use” (p.58). There is strong evidence for the effectiveness cognitive behavioural therapy (CBT) in supporting people to deal with AOD related problems and to prevent relapse.

Activity scheduling procedures should also be helpful in ensuring that Sharni participates in enjoyable activities regularly. This could help in stabilising mood and providing reinforcement for her decision not to use methamphetamine.

Cognitive restructuring procedures could help Sharni develop more a realistic perspective on the meaning and implications of negative emotional expression from others and to feel less threatened by it. CBT-based communication and problem-solving skills training could help her work through conflict-driven exchanges more confidently and calmly. Such skills can also contribute to Sharni’s ability to develop a more emotionally supportive relationship with her mother. CBT-based assertiveness skills training could also help Sharni to resist offers of methamphetamine from Brett or other ATS users in her social network.

**Family Focused Interventions**

Jenner and Lee (2008) stipulate that family focused interventions are an essential ingredient in the care of young clients with ATS related problems. There is a growing evidence-base supporting the effectiveness of Multidimensional Family Therapy (MDFT) for adolescents with alcohol and other drug use problems, especially adolescents with multiple and complex needs (Liddle 2010; Rowe 2010), however, it may not be suitable for all cases (Hunt and Stevens 2005, p.18). MDFT is multidimensional in the sense that it targets multiple domains of adolescent development in which the risk and protective factors for alcohol and other drug use and related problems develop and operate. The consistent effectiveness of MDFT for this population underlines the importance of ensuring that family focused interventions are informed by, and articulated with, interventions targeting other systems important to adolescent development such as personal skills, education and recreation.

Family focused interventions can also be employed to support a Community Reinforcement Approach (CRA) by building the skills of parents, caregivers and other relatives to provide timely and appropriate encouragement and reinforcement (Dennis et al. 2004). In Sharni’s case, Eric believed that he could assist in achieving her goal to engage her mother in future plans by convening a purposeful, solution focused family meeting. “Single Session Family Work” could be applied for this purpose (Perkins 2006).
The Community Reinforcement Approach

The Community Reinforcement Approach is a form of contingency management (CM) in that the treatment goal is to, "systematically weaken the influence of reinforcement derived from alcohol and other drug use and its related lifestyle, and to increase the frequency and magnitude of reinforcement derived from healthier alternative activities" (Stranger and Budney 2010, p.548). CRA was designed to systematically facilitate changes in clients' daily environment that maximise naturally occurring opportunities for positive reinforcement (Thorpe and Olsen 1997). Further, the way environments are structured might be the reward. For example, if Sharni was successful in negotiating and sustaining a move back into the family home this would in itself provide positive reinforcement. The home then becomes a "context for action" where further constructive effort can be recognised and reinforced by her mother and others. CRA has proved very effective when specifically customised for adolescent clients (Godley et al. 2001; Garner et al. 2009).

In Sharni’s case, the application of CRA required the formulation of simple, obtainable, time-bound goals that minimise exposure to the antecedents of her ATS use promote the uptake of healthy alternatives. Co-opting significant persons in her life (her mother, Kym, Eric and Leah) to provide encouragement and reinforcement in line with her goals, and the development of personal skills (assertiveness, communication, etc) help to make the achievement of goals possible.

Sharni’s progress

Early Steps

When preparing to leave the residential withdrawal unit, Sharni confirmed her commitment to number of goals, including taking a break from using ATS. In order to make a successful transition back into the community a number of tasks needed to be completed – the most pressing of which centred on re-establishing her relationship with her mother and negotiating a move home. This was a significant step for Sharni and was the goal that she felt most uncertain about achieving.

Eric suggested to her that he convene a family meeting as soon as possible. Sharni agreed but felt too afraid and ashamed to call her mother, Jane. Eric was aware that Kym (Sharni’s student welfare co-ordinator) had established a helping relationship with both Sharni and Jane, and was trusted as an honest broker. He suggested that Kym be involved and would be the most appropriate person to invite Jane to the meeting. Kym was prepared to participate. She used the invitation as an opportunity to update Jane on Sharni’s current circumstances and respond to any concerns prior to the meeting. Though disturbed, Jane was comforted that Sharni was residing at an AOD withdrawal unit, and she agreed to participate.

The family meeting took place the next day at the residential withdrawal unit. Immediately after the ground rules for the meeting had been established, and the purpose of the meeting confirmed, Jane burst into tears and stated that she had “never imagined her daughter would get herself into this situation.”

Eric acknowledged Jane’s distress and asked Sharni how she felt about her mother saying this. Sharni initially became very withdrawn and commented almost sub-audibly, “this is typical, she has no idea…” Eric responded with, “tell us what you mean Sharni?” who continued more emphatically with, “she just judges me and it’s not fair.” Eric invited Jane (who was bristling at Sharni’s comments) to share her concerns about Sharni’s drug use. She expressed that she was concerned for Sharni’s safety, that “Brett treats you like shit,” explaining that she had been treated similarly by Sharni’s father and, “it hurts me to see the same thing happening.” Jane then said that she missed being close to Sharni, “like we used to be.”

Eric gave Sharni space to respond. Sharni was silent but her demeanour had changed; she seemed much less adversarial. Eric then asked if she was ready to let her mother and Kym know of her plans. With encouragement from Eric she did so. On hearing Sharni’s plans, Jane was greatly relieved. She was also impressed with the level of maturity shown by Sharni and pointed this out to the group.

They negotiated some conditions for her return home, including regular school attendance, abstaining from ATS use, and keeping Jane informed as to her whereabouts on weekends (even if she chose to stay out). Jane was aware that Sharni might continue to use cannabis. Sharni agreed not to use in the house and to avoid being obviously intoxicated in the presence of her younger sisters. Jane agreed to communicate more respectfully and calmly with Sharni. This entailed not raising her voice or using “blaming” language.

Eric referred back to Jane’s statement that that she missed the closeness that she and Sharni had once had. He acknowledged that recently their relationship had been conflicted and invited them to think of an enjoyable activity they might do together on a regular basis. They decided to create a garden in their backyard, an activity that could also involve Sharni’s sisters. This would have the additional benefit of
providing a constructive time use option for Sharni to prevent boredom. It was also crucial that Jane recognise Sharni’s friend Leah as an important source of support and did not associate her with a return to ATS use.

Finally, Eric explained to the group that while he believed that the plans made would come to fruition it was a responsible step to make contingency plans. Sharni agreed to contact Eric should she either start feeling like using again or if she lapsed. Kym made herself available to Jane should she have any concerns and confirmed her support for Sharni. In the event of problems, the assembled group agreed to meet before any decisions were made or actions taken. As a proactive measure, a tentative agreement was made for three further fortnightly meetings to be held at Sharni’s school.

After the meeting, Sharni seemed in a positive frame of mind. With Eric's support she explained to Kym that she had begun to feel down again in the weeks preceding her admission to the residential withdrawal unit and negotiated a weekly appointment with her to start talking again.

A final step before leaving the residential withdrawal unit was coopting Leah’s support. Sharni contacted Leah to let her know what had occurred and arranged to meet. Eric knew that if he supervised her Sharni could meet Leah in a local coffee shop. He cleared this with the unit manager and Kym agreed to pick up Leah and bring her to the meeting. When they met, Sharni explained that she was having a break from ATS use. Leah, who still used occasionally, was respectful of this decision and agreed to not discuss ATS use with her. They also talked about finding other options for spending time together.

**Back in the Community**

One month after leaving the residential withdrawal unit, Sharni was still living at home and attending school regularly. She had managed to avoid using ATS in that time. She found this particularly difficult on weekends however, the gardening project she started with her mother and sisters helped as it had really captured her interest. Spending time with Leah on Friday and Saturday nights also helped.

Sharni had continued to meet Eric once a week in Kym’s room at her school. She had arranged one extra time to visit him at his office when she learned that Brett had another girlfriend. It made her feel like getting “wasted” and in that week she had used more cannabis. This in turn created some tension at home but was raised and dealt with in one of the pre-arranged family meetings involving Eric and Kym. Sharni continued to see Kym for counselling once a week and let Eric know that it was “working out well”.

In her weekly sessions with Eric, Sharni reviewed her progress and re-committed to the goals that she had made. The incremental gains that she had made, and the recognition of significant others, had provided positive reinforcement for the path that she was on. This encouraged her to consider and set goals that would extend over a longer time frame including investigating horticulture courses and apprenticeships that she could take up after school. Conversations occurred about re-capturing her sense of exuberance and fun which felt that she had lost since moving from Brisbane. Sharni began to investigate joining local netball competitions and had signed up to a mentoring program that Kym had told her about. This program would expose Sharni to a number of recreational activities such as camping and rock climbing which might become substitutes for excitement associated with ATS use.

**CONCLUSION**

In this chapter we explored how young people who use methamphetamine might present to services, and how their needs can be addressed through a staged, multi-systemic, and integrated service response that is youth focused and tailored to their individual situation.

In particular, we have identified the significance of responding to the needs young client at “critical moments”, which are often times of crisis (Thomson et al. 2002). We acknowledge that, unlike YSAS, many health and community services experience significant resource constraints such that they are not able to respond immediately to such clients. However, we believe that the principles and practices outlined here may be useful if adapted according to professional training and specific organisational contexts. In particular, we note that our response incorporated a range of workers. A collaborative multi-service response is particularly relevant for many smaller services.

We conclude here by emphasising the importance of consideration of developmental factors when tailoring services to young people. We stress two guiding points that we draw from both our extensive practice experience in working with young people like Sharni, and our understanding of current research evidence.
First, maintaining authenticity and transparency with clients in all dealings is vital to successful outcomes. This is linked to a second point that can be used to guide both responses to ATS-related issues among young people and youth practice more generally. That is, young people commonly desire to feel that they are active agents in their own lives, and to present as capable and in control of their situation. Accordingly, we believe that positive outcomes are linked to achieving a balance between intentional and pro-active employment of evidence-based interventions, and flexible responsiveness to the directions set by the young person.

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