PERSPECTIVES ON EFFECTIVE INTERVENTIONS WITH SUBSTANCE ABUSING ADOLESCENTS IN AOTEAROA/NEW ZEALAND.

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ABSTRACT

Specialised adolescent substance abuse interventions are still relatively new to Aotearoa/New Zealand. While over the years adolescents have often experimented with substances and some have had to get help with their use of substances, the interventions used with youth have often been adult focussed techniques and programmes, or have come from overseas experiences. This thesis brings together literature on adolescent substance abuse from around Aotearoa/New Zealand and overseas, qualitative knowledge from interviews with alcohol and drug workers working with adolescents in Aotearoa/New Zealand, and adolescents' own perspectives of adolescent substance abuse interventions. The main objective of this thesis has been to synthesise this knowledge in order to make some clear recommendations about what constitutes effective interventions with substance abusing adolescents in Aotearoa/New Zealand, so that they might be a practical guide for those working with, or intending to work with adolescents in this country.

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Chapter One

INTRODUCTION

Huxley (1954) wrote that human beings were likely to continue to use

> "artificial paradises" to assuage the "principal appetite of the soul."

Freud (1961) commented that;

> "Life, as we find it, is too hard for us; it brings us too many pains, disappointments and impossible tasks" (Freud, 1961: 22). "He [Freud] added that intoxicating substances can make us insensitive to our miseries" (Shaw, 1992 :125).

More recently Levin (1987) noted,

> " Drugs are ideal for increasing self-tolerance because they give the illusion of control, power, and comfort through their seemingly magical qualities" (Levin, 1987 :195).

Such quotes throughout this century, can enable us to see the place of substances in our societies, and give us a glimpse of the battle we may be up against if we are to encourage people to use these substances with caution.

Research Objectives and Definitions

Usually alcohol and other substances are used to promote sociability and occasionally to promote wonder and awe, however, they can lead to both physical and/or psychological dependence. Adolescence is a time of change, experimentation, identity creation and independence, and often the use of alcohol and drugs are also a part of this period. This research is focussed on interventions for those adolescents in Aotearoa/New Zealand, whose use of substances becomes abusive and/or dependent in nature.

This research is based on qualitative interviews with both adolescents who have experienced some form of substance abuse intervention, and alcohol and drug workers from around Aotearoa/New Zealand who specialise in working with adolescents. The primary objective of this research is to establish some recommendations for effective interventions when working with substance abusing adolescents, based on the key

findings from the interviews and the relevant literature. This research also aims to identify a lack of resources in this service area, and to note other areas of concern in regards to adolescent substance abuse. It is hoped that the recommendations from this research can be used as a guideline by those already providing and those intending to provide adolescent substance abuse treatment services throughout Aotearoa/New Zealand.

It is important at this point to outline definitions that are specific to the main terms that will be used throughout this paper. For the purposes of this research the period of adolescence is taken to mean *'from the ages 11 through 17'*, however any conclusions reached may also apply to years either side of this definition. The age of 11 has been chosen to represent the first stage of early adolescence, and the age of 17 was chosen because it is the cut off point in terms of adolescent funding within the health system, and because 18 is usually the age at which adolescents are able to participate in adult alcohol and drug intervention programmes in Aotearoa/New Zealand. For the purposes of this research the age group 11 through 17 represents what is seen as an identified gap in available alcohol and drug services.

For the purposes of this research the term substance which is synonymous with the term drug, refers to *"Any psychoactive matter excluding tobacco and caffeine, which when taken changes the state of consciousness for nonmedical purposes"*. (The NHS Health Advisory Service: 1996). Substance abuse is defined as, and is apparent when "*negative social, psychological or physiological symptoms result from the use of psychoactive substances*" (The NHS Health Advisory Service: 1996). More simply if the use of a substance or substances (excluding tobacco and caffeine), is causing problems in a persons life then this is considered to be substance abuse. This clearly recognises that the 'use' of substances is not enough in itself to be classified as substance abuse. It also acknowledges that a person does not necessarily have to be physically or psychologically dependent on a substance, for the use of that substance to cause difficulty in that person's life and warrant intervention.

Given this definition of substance abuse then, it is important to identify what constitutes an intervention for dealing with this. For the purposes of this study an intervention is

'Any activity whose primary goal is the provision of assistance to an identified adolescent substance abuser, in order to lessen or remove the social, psychological and/or physiological symptoms they present with.'

Rationale for undertaking the research

Effects of substance use and abuse

The effects that the use of substances can have on the human body are relatively well known. Physically alcohol and other substances interfere with the functioning of the all the main organs of the body, depending on the substance (Arria et al., 1991). How the use of substances affect the adolescent body however is less clear. Because the adolescent body is going through rapid physical changes, it is often difficult to attribute any difficulties in puberty to the use of substances, as opposed to what may have occurred without their use. There is also concern that there is inadequate detection of adolescent substance abuse problems by doctors and other primary health care professionals (Arria et al., 1991). This means there is limited data and evidence to confirm medical consequences of adolescent substance abuse, which can lead to an assumption that medical/physical problems are not prevalent. However a recent American study presents the first concrete evidence that "...protracted, heavy alcohol use can impair brain function in adolescents" (National Institute of Alcohol Abuse and Alcoholism (NIAAA), 2000:1). This study noted that "Adolescents who had drunk heavily over time, scored lower on verbal and nonverbal retention in the contexts of intact learning and recognition discriminability" (NIAAA, 2000: 2). From this study and other limited available information, it does appear that there is evidence to suggest that general drug use may increase the adolescent's risk for health problems later in life due to a decrease in physical hardiness during adolescence (Arria et al., 1991).

Difficulties appear to emerge in more obvious ways in the adolescents' social, emotional and cognitive development. During early adolescence one of the primary developmental tasks is socialisation, with both the same and opposite sex friends. If an adolescent is abusing substances during this period, they can find it difficult to achieve this task. If substance abuse continues, this task may be significantly delayed until later in life or not

achieved at all, often leading to uncomfortable social and emotional difficulties including uncertain emotions and lack of empathy, a lack or excess of boundaries, an inability to socialise and self-centredness (Nuckols et al., 1994). Cognitively adolescence requires the person to move from concrete 'all or nothing' 'black and white' thinking to abstract 'problem solving' or formalised thinking. If an adolescent fails to develop this abstract thinking because of the interference of substance abuse, they may have difficulty considering alternative viewpoints, decision making, problem solving, and living in a world full of contradiction and paradox (Nickols et al., 1994.). Failure to meet these types of developmental tasks, can impair the adolescents' social, emotional and/or cognitive well-being.

Other frequently identified concerns about and/or consequences of adolescent substance use are many and varied, but can include; an increase in early sexual activity with concomitant outcomes of teenage pregnancy and an increase in the likelihood of getting a sexually transmitted disease, reduced involvement at school, unemployment, an increase in the involvement of crime, an increase in suicidal ideation and other mental health disorders including depression, and an increase in the likelihood of injury and/or accident. (Arria et al., 1991; Bukstein, 1995; Fergusson & Horwood, 1997; The NHS Health Advisory Service, 1996.) The negative consequences of adolescent substance abuse, whether physical, social, emotional, and/or cognitive can be extremely difficult to cope with for both the individual and society in general. It is at these demanding times that adolescents find that they may require some degree of intervention or help in overcoming both their substance abuse and its consequences.

Personal experience

While Aotearoa/New Zealand has a reasonable number of alcohol and drug treatment options for adults, treatment available for young people under the age of 18 is limited. Many adult treatment facilities do not take in those under 18 years of age as the programmes they provide are not always appropriate for adolescents who are at a different level in their social, emotional and cognitive development. International research shows considerable support for the provision of separate treatment facilities foradolescents (Bukstein, 1995; Burglass, 1998; Cavaiola & Kane-Cavaiola,1989; Polcin, 1992; Spooner, Mattick & Howard, 1996; MacEwan, 1999).

In my work as an Assessment Caseworker at the Salvation Army Waikato Bridge Programme, I came to see first hand the number of adolescents who are presenting with substance dependence with physiological dependence according to DSM IV[1] criteria.

This criteria, while not written for adolescents, appears to be one of the most acceptable diagnosis criteria at present along with The Drug Use Screen Inventory (DUSI)[2], (MacEwan, 1998; Ministry of Health, 1998; Kaminer, 1994), as no single adolescent assessment tool is being used in Aotearoa/New Zealand at present (MacEwan, 1999). With this in mind however;

> "It is relatively easy to diagnose substance abuse in adults who show physical symptoms and have long histories of substance use. Adolescents on the other hand, are often short-term substance users in whom little physical damage is evident"

(Lawson,1992: 225).

Although adolescents may show evidence of other difficulties caused or compounded by their substance abuse, this too may appear less significant than the difficulties presented by long-term using adults.

While assessments are important as part of any type of intervention, they are not the primary concern of this research, and are only mentioned at this point to emphasise the degree of problem that I witnessed in this role.

After these assessments were complete, I discovered that because of the age of these adolescents, treatment options were severely limited and the choices for the client were very slim even though they were ready and willing to ask for help. In the Waikato area there is no specialised alcohol and drug treatment available for those under the age of 18. One option in the area is one on one counselling with agencies who specialise in working with adolescents, of which there are three in Hamilton City including the Adolescent Mental Health Service. The second option is one on one counselling with an adult

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[1] The Diagnostic Statistical Manual of Mental Disorders IV (DSM IV) is a manual developed by the American Psychiatric Association which incorporates classification and diagnosis criteria for mental health disorders, including substance abuse and dependence.

[2] A copy of the DUSI assessment tool can be found in Appendix G

alcohol and drug service. Specialists in both areas are difficult to find. Another option for adolescents requiring some form of intervention for their substance abuse in the Waikato area, is the GAIN programme. This programme provides short term, once a week group work around aspects of alcohol and drug use, communication and anger awareness, with the adolescent and their support people and/or family. Out of region treatment (paid for by the Health Funding Authority-Midland) is only available in Auckland, at Odyssey House Youth Residential Services. Throughout other areas of Aotearoa/New Zealand there is a similar lack of available services for adolescents. This Odyssey House facility is in fact at present one of only two residential treatment programmes for adolescents throughout the country. Queen Mary Hospital in Hanmer Springs also provides a residential adolescent service which began only recently in early 2000.

This signals a serious inadequacy in services, especially in the availability of community services, and those in the form of a day treatment or outpatient setting. Midland Health, which fund health services throughout the midland region including Hamilton, have identified that there are no dedicated adolescent alcohol and drug services in the Midland Health area and have made services for children and young people with serious mental illness and/or drug and alcohol problems a priority in their draft purchasing plan 1997-2003 (Midland Health, 1997.) A lack of adolescent alcohol and drug services in Aotearoa/New Zealand in general has also been identified by Burglass (1998); Rout & Lowe (1991); Bruner (1994); Moore (1997); Macdonald (1997); MacEwan (1998); National Centre for Treatment Development (1998), and Young (1998). This gap was identified by our previous governments (The 1996-1998 National/New Zealand First Coalition and the 1998-1999 National Government) which through the Health Funding Authority, allocated $3 million extra in 1999 to fund an extra 26 workers in the general alcohol and drug services field, target child and youth services, and fund extra places on the methadone programme (Boyd, 1999).

In 1996, 12-19 year olds made up approximately 12.42% of the Aotearoa/New Zealand population totaling approximately 433,376 people (Statistics New Zealand, 1998). The most recent statistics available (1992) for first time presentation to non-residential outpatient alcohol and drug treatment services by adolescents, indicated that 0 to 19

year olds made up 15% of all new clients (MacEwan, 1999). Adolescents are a significant proportion of the population, and a significant proportion of those presenting to alcohol and drug agencies for help. They are deserving of consideration in a number of areas, including the area of specialised alcohol and drug intervention services. My own experience of this area and these identified gaps have led to my interest in the area of adolescent substance abuse, and to my intention to pinpoint what interventions are being used effectively throughout Aotearoa/ New Zealand so that these gaps can be met with appropriate measures, when and if funding is provided in this area.

Thesis Outline

Chapter two of this text provides an historical look at the use and/or abuse of alcohol and drugs in Aotearoa/ New Zealand pre and post colonisation. It goes on to examine some previous studies of adolescent alcohol and drug use in Aotearoa/New Zealand from the seventies and eighties. It then outlines various contemporary studies that are currently in progress or have been undertaken in this area, and looks specifically at the prevalence of alcohol and drug use by adolescents in this country. The final part of this chapter outlines a number of known alcohol and drug initiatives and/or intervention programmes that are currently operating in parts of Aotearoa/ New Zealand. This list is not exhaustive, but rather an outline of the key programmes that can be found around the country.

Chapter three identifies a number of influential adolescent substance abuse theories and models, and reveals what each of these has to offer in terms of providing model interventions for Aotearoa/New Zealand youth. This chapter also explores theories of human development, looking specifically at the adolescence stage in this development. This exploration provides vital knowledge about the unique stage of adolescence, and how this may impact both on the individual and the interventions provided for the substance abusing adolescent.

Chapter four looks specifically at the role of Aotearoa/New Zealand social policy in the area of adolescent substance abuse. A number of policies and their political context are

identified that apply to this area, and a number of gaps in policy are also identified. Of particular importance in this chapter is the discussion about the recent lowering on the drinking age to 18 in the amendments to the Sale of Liquor Act. Following this, this chapter also takes a probing look in to the unique role that social work can play in the area of adolescent substance abuse, and social policy formation. Aotearoa/New Zealand has few qualified social workers employed in this area, compared to a number of other professions, yet social workers possess a variety of skills that could be well utilised in this field.

Chapter five is the methodological chapter, identifying the methodological considerations that were made before embarking on the research, and the final choice of approach. It gives details of how the research was carried out including ethics, selection criteria, access to participants, encountered problems and limitations of the study.

Chapter six details both the adolescent interview data and the data from the interviews with the alcohol and drug workers. The adolescent data, taken from interviews with four adolescents, includes the age of onset use for each adolescent, the type of treatment they undertook and their experience of this. The alcohol and drug worker data, taken from interviews with ten workers, includes information about the services they provide, what theories and models they use, and their idea of what constitutes the ideal intervention.

Chapter seven integrates the previous literature chapters with the findings from the analysis of the interview data and summarises some key finding from the synthesis of this data.

Chapter eight brings all of the previous chapters together, and summarises the overall findings throughout. General conclusions will be made, and specific recommendations as to how to work effectively with adolescent substance abusers in Aotearoa/New Zealand will be established.

Chapter Two

ADOLESCENT SUBSTANCE USE AND ABUSE

During the last couple of decades, growing concern about adolescent substance use has become apparent, both overseas, and in Aotearoa/New Zealand. According to the United Nations 'World Drug Report' (1997), illicit drug consumption has increased throughout the world. Western youth cultures are providing models for other nations to follow, and because drug use is very much a part of this Western youth culture, there is evidence that there is an increasing availability of drugs, that the age of first drug use is falling, and that there is an acceptability that using drugs is 'normal' behaviour for youth all around the world. Some United States statistics elaborate on the UN's concerns regarding earlier use of substances among adolescents, and the rate at which this use is increasing.

> "Adolescents now begin to drink 1 year younger than did their same age peers of the 1940s and 1950s. The number of children under 10 years of age who drink has doubled within the last 6 years." (Covert & Wangberg, 1992: 131)

> "In 1997, substance use among 12-17 year old children rose to 11.4% with illicit drug use among 12 and 13 year olds increasing from 2.2% to 3.8%, according to the 1997 National Household Survey on Drug Abuse..." (Center for Substance Abuse Treatment, 1999:2).

Of primary concern in the UN's document was the growing popularity of drugs such as ecstasy, methamphetamine and other synthetic stimulants (United Nations, 1997). In a document entitled "Guidelines for Safe Dance Parties: The Big Book" (1999). the Ministry of Health in Aotearoa/New Zealand also acknowledges the growing use of these types of drugs. This recognises the use of drugs such as ecstasy, LSD and amphetamines at dance parties around Aotearoa/New Zealand. These guidelines take a 'harm minimisation' approach, and provide several key recommendations as to how to provide a safer environment for these dance parties. Most pivotal throughout this

document, is the practical realisation that these drugs are being used especially among the age group 15-30 years (Ministry of Health, November 1999). While there is growing concern about these types of illicit drugs, the main drugs of abuse in Aotearoa/New Zealand are still alcohol, tobacco and cannabis (Field & Casswell, 1999). Internationally Aotearoa/New Zealand ranks 20th in alcohol consumption per capita at all ages, based on fifty countries from which data was collected (ALAC, 2000 b).

Historical Background

Aotearoa/New Zealand

Before colonisation Aotearoa was one of the few parts of the world that had never developed alcoholic beverages, and while it is suggested that there was some use of the tutu berry as a mild intoxicant, the evidence of its effects are contradictory, and its use was not widespread (Hutt, 1999). Alcohol first came to Aotearoa/New Zealand with European travellers and settlers in the nineteenth century, and while Maori appeared at first to abhor alcohol and its effects, it was soon being used in trade, and eventually came to be used on a regular basis. Just as it caused problems for the settlers it began too to cause problems for tangata whenua[3] (Hutt, 1999). As problems with the use of alcohol began to manifest around the country for both Maori and Pakeha the fight against the 'evils' of liquor by the New Zealand Temperance society also began.

As early as 1836 the forming of the New Zealand Temperance Society was recorded by the printing of an eight page pamphlet, which is thought to be the first 'book' to be printed in Aotearoa/New Zealand (Williams, 1930). The Temperance Society which promoted prohibition of all liquor, played a major role in establishing law to prohibit of the distillation of spirits, prohibit sales to Maori, and in 1851 helped establish the 'Licensing Amendment Ordinance' whereby local citizens could vote to reduce and eventually abolish liquor licenses in their districts (Lakeland, 1990).

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[3] Tangata whenua is a Maori term meaning 'local people' or 'indigenous people of the land'.

In 1881 the prohibition movement had its first victory with the Licensing Act 1881 which provided Sunday closing. Much later came the six o'clock closing of hotels and bars, which was initially a war measure intended to reduce alcohol consumption, but became known as the 'six o'clock swill' and lasted for 50 years (Lakeland, 1990).

While initially the Temperance Society made many gains, gradually over the years public attitude and liquor licensing has relaxed substantially. The first theatre was licensed for the sale of alcohol in 1969, the first airport in 1970 (Lakeland, 1990), and recently due to the Sale of Liquor Amendment Act 1999, there has been a return to Sunday trading, and the legal drinking age has been reduced to 18. This does not mean that the problems associated with the use of alcohol have disappeared, but merely that public attitudes have changed, and alcohol use has become much more acceptable, and indeed the 'norm' rather than the exception.

Adolescents in Aotearoa/New Zealand too, have a history alongside adults post colonisation, of using alcohol and other psychoactive substances to varying degrees (Stacey, 1981; Wyllie et al., 1996; Business Research Centre, 1997; Field & Casswell, 1999). The use of these substances is often seen as a rite of passage into the adult world (Business Research Centre, 1997). Previous to the relatively new evidence from the United Nations regarding the use of drugs worldwide, various people around Aotearoa/New Zealand were beginning to show concern in the area of adolescent alcohol use and abuse. With this growing interest over the years, a number of Aotearoa/New Zealand specific studies were undertaken to gain more insight into this area.

Historical prevalence of substance use in Aotearoa/New Zealand

A social survey carried out in Auckland High Schools by Casswell and Hood (1977), was the first significant study reported in Aotearoa/New Zealand about recreational drug use by youth. In this study 90% of participants described themselves as Pakeha. It is nevertheless interesting to note as it sets a benchmark for Aotearoa/New Zealand. This survey found that 79% of participants were currently using alcohol, and that 41% used it once a week or more. Over 90% of the participants had first tried alcohol at the age of 15 or younger. The research concluded that "Alcohol use, unlike tobacco smoking is

the norm for the vast majority of young New Zealanders, 15 years and older." (Casswell and Hood, 1977:318).

In 1978 an Alcoholic Liquor Advisory Council (ALAC)[4] initiated study undertaken by Mary Routledge (1979), was carried out to provide an assessment of the attitudes and behaviours of school children towards alcohol. The sample consisted of 1000 students from each of the forms 2, 4 and 6 (approximately ages 13, 15 and 17) throughout Aotearoa/New Zealand. From this survey it was found that 79% of the participants had drunk alcohol at least 'a few times a year.' This survey gave us an indication, among other things that;

> "The great majority of young people are initiated into drinking in the home, and that parents and relatives are a direct influence on the maintenance of alcohol use" (Stacey, 1981:10)

In 1978 ALAC also commissioned a national survey of 10,000 New Zealanders aged between 14 and 65. The 14-17 year olds in this sample have been studied by Elvy (1980), and Stacey and Elvy (1981).

> "At 14 and 15 the alcohol consumption of the sexes was highly similar; with four out of five youngsters drinking little or nothing (Gregson, Elvy & Stacey, 1981; Stacey & Absalom, 1980). For both sexes consumption rose rapidly during the later teens, more rapidly for males than females" (Stacey, 1981:13).

While all of these surveys rely on self reports from the young people, and therefore are likely to underestimate the prevalence because of the illegality of their use, what the results of these surveys do provide is valuable information for cross referencing with later studies. They also indicate when real concern about youth substance use may have begun to come to the fore.

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[4] ALAC was originally the Alcoholic Liquor Advisory Council established by the Alcoholic Liquor Advisory Council Act 1976, to promote moderation in the use of alcohol and develop and promote strategies that will reduce alcohol related problems. ALAC is governed by a council, whose members are appointed by the Governor General on the recommendations of the Minister of Health. It is now known as the Alcohol Advisory Council of New Zealand-Te Kaunihera Whakatupato O Aotearoa, and continues to be funded by a levy on all alcohol produced in New Zealand or imported here for sale.

In spite of these early pieces of Aotearoa/New Zealand research about behaviours and attitudes, Aotearoa/New Zealand appears to be along way behind other countries in the realm of intervention and/or research regarding interventions for problems that may arise because of these behaviours and attitudes. Up until 1966 treatment services for anybody with an alcohol or drug problem were operated as part of Justice services, and it was not until the early 1990s that ad-hoc funding often by religious organisations, was gathered together under a single purchaser (now the Health Funding Authority) (MacEwan, 1999). This background may account for the lack of interventions and research regarding interventions for adolescents with substance abuse problems. Primarily interventions around adolescent alcohol and drug abuse have been in the form of prevention and education initiatives. The history of adolescent substance abuse interventions in Aotearoa/New Zealand is still in the making.

Current Prevalence of Adolescent Substance in Aotearoa/New Zealand

A number of research studies have been completed recently in Aotearoa/New Zealand on the prevalence rates of adolescent substance use and abuse. These studies give a statistical indication of the prevalence of adolescent substance abuse in Aotearoa/New Zealand, and provide evidence of the problem.

In 1995 a national survey of drinking in Aotearoa/New Zealand, funded by ALAC and the Health Research Council of New Zealand, surveyed 4232 people aged between 14 and 65 years. Results from this survey found that at age 14 to 15 years, 69% of males and 56% of females were drinkers; that is they had consumed alcohol in the last 12 months, and by the time they were age 16 to 17 years, 89% of males and 90% of females were drinking (Wyllie et al., 1996: 12). This study not only looked at prevalence, but also asked about any negative effects their use was having on them. One in seven 16-24 year olds felt their drinking was having a medium to large harmful effect on their financial position (Wyllie et al., 1996: 27).

Similar smaller scale surveys looking at the prevalence of adolescent alcohol and drug use have also been conducted by: Project Adventure New Zealand at Dunstan High School in Alexandra (Project Adventure New Zealand, 1998); Injury Prevention Research Centre, University of Auckland in two coed secondary schools, one in Auckland and one in Northland (Injury Prevention Research Centre, 1997); and The Ashburton Community Alcohol and Drug Service at Ashburton College and Mt. Hutt College (Clark, 1997). While these surveys provide relevant statistics for alcohol and drug consumption, and other youth 'at risk' behaviours, they also provide evidence of difference in prevalence throughout the country. For example the Alexandra Survey found that 30% of the young people surveyed had tried marijuana compared to 34% in the Northland Survey and 14% in the 1995 national survey (Project Adventure New Zealand, 1998: 2).

The Alexandra survey also found that; "30% of all students surveyed were drinking large quantities of alcohol, compared to 16% in the Ashburton Survey and 28% in the national survey" (Project Adventure New Zealand,1998: 3). While the age group and methodology of these surveys differed they do provide base line evidence that young people are experimenting with alcohol and drugs to varying degrees, throughout the country. Given the nature of alcohol and other types of drugs it can be hypothesised that if these things are being experimented with, then problems are also arising for which young people may require some level of intervention.

Where specific youth substance use research is concerned the ALAC 'Youth and Alcohol Survey' undertaken in 1997 by the Business Research Centre, established some benchmark statistics about youth and their substance use. It is the first part of a research programme which in the long-run intends to evaluate and give future directions to ALAC's alcohol and youth strategies. This survey is soon to be followed by a time-series evaluation of ALAC's youth and alcohol strategies. This campaign has sprung from the basic assumption that young people see drinking to excess as a "rite of passage to adulthood" (Business Research Centre, 1997:11). This belief includes a rather uncomfortable acknowledgment that young people are not only drinking to excess but may also be indulging in dangerous behaviours like unsafe sex and drunk driving, therefore putting themselves in physical danger.

According to the 'Youth and Alcohol Survey' 1997, which surveyed 500 14-18 year olds:

> "About a third of young people are classified as heavy drinkers - they say they consumed five or more glasses of alcohol last time they drank. This group consumes four-fifths of all the alcohol young people drink". (Business Research Centre, 1997:2).

This report also states that, " More than a quarter of heavier drinkers use cannabis, compared to one in 50 non drinkers". (Business Research Centre, 1997:3).
This survey provides evidence that some young people are using alcohol to levels above and beyond recommended safe drinking limits. This use in turn could cause social, psychological and/or physiological harm.

The on going evaluations of ALAC's youth and alcohol strategies found some evidence in 1998 that the ALAC ad campaign "Where is that drink taking you?", is impacting positively on alcohol related attitudes beliefs and behaviours, however at this time it was too early to make any solid conclusions from this evidence (Edgar & Kalafatelis, 1998). The 1999 evaluation of ALAC's strategies found that attitudes of adolescents towards alcohol were beginning to change, but that behaviours such as heavy drinking had yet to show significant changes. It found that most teenagers knew how to keep themselves safe when drinking alcohol, and were keen to have open dialogue with their parents about their drinking. (Dowden, Kalafatelis, & Fryer, 1999).

The most recent monitor (May 2000) conducted as part of this research, however has found that teenage binge drinking has increased since the lowering of the legal drinking age, up from 40% in 1998 to 50% in 2000. It has also found that fewer teenagers are now non-drinkers, and that teenagers are experiencing serious consequences of heavy drinking including passing out, throwing up, memory loss, injury, guilt and driving drunk (Business Research Centre, May 2000).

The ALAC Youth and Alcohol survey has now widened its focus to include parents and has recently surveyed parents of teenagers on their views of adolescent alcohol use, and has begun an advertising campaign to support parents whose teenagers are using alcohol (Business Research Centre, May 2000; Business Research Centre, 2000).

Both the Christchurch Health and Development study and the Dunedin Multidisciplinary Health and Development Study, are also relevant to this research. The Christchurch study is a longitudinal study of a birth cohort of 1265 children born in the Christchurch urban region during mid 1977. It found among other things that at the age of 16, 8.3% of the sample were identified as prone to abusive or hazardous drinking (Fergusson et al.,1996). The Dunedin study followed the health and development of 1037 babies born in Dunedin between 1 April 1972, and 31 March 1973 to the age of 21. In this study alcohol was by far the most commonly used substance among members of the study at each age. At age 18, 85% reported experiencing at least some negative consequence from drinking sometime in the past, for example vomiting, and suffering from a hangover. Very few study members had smoked cannabis by age 13 years (1.3% of females and 0.8% of males), but by age 15 this number had increased to 15% for both male and female. In contrast inhalants were used more often by 15 year olds, than by 18 year olds, indicating that inhalants are generally only used by those under 18 years of age, and are a drug of choice for the early years of adolescence. Prevalence rates for other illicit drugs were much lower than for alcohol, cannabis and inhalants. They were at the highest prevalence of use at age 18, at 6%. This study also showed differences in gender, and age across adolescence.

> "Results of the study showed that at age 15 conduct problems were highly related to alcohol use and multiple drug use by females and males and to marijuana or inhalant use by females" (Moffitt & Harrington, 1996:190).

Both the Christchurch and Dunedin study provide us with prevalence rates of alcohol and drug use throughout the various stages of adolescence, and also correlate these findings against general conduct and juvenile offending. For example Fergusson et al reported

> "that individuals who engaged in frequent, heavy or abusive drinking had rates of officially recorded offending that were between 2.3 and 4.2 times higher than teenagers who did not engage in such drinking." (Fergusson et al, 1996:483).

This is further evidence that there are problems associated with adolescent substance abuse, and therefore indicates that some form of treatment intervention, not just prevention programmes need to be implemented.

When analysing the statistics from Field & Casswell (1999), 'Drug Use in New Zealand-Comparison surveys, 1990 & 1998', which compares random samples of approximately 5000 people aged 15-45 from greater Auckland and the Bay of Plenty in both of the years, some interesting trends can be noted. In the age group 15-17 years, for both males and females, there has been a decrease in the number of people who have tried alcohol, down to 70% in 1998 from 76% of the sample in 1990 for men, and down to 71% from 76.5% of the sample for women. There has also been a decrease in the number of people who reported using alcohol in the last 12 months preceding the survey. For males the figures are down to 70% from 74% of the sample, and for women they are down to 69% from 76% of the sample. The trend however appears to be that while this age group is moving away from using alcohol, they are using more of a variety of other substances. For both men and women in the 15-17 year age group, there was an increase in the number of those who had tried marijuana, hallucinogens, stimulants, solvents and opiates in 1998 compared to the survey conducted in 1990. The figures for those who had used these substances in the last 12 months prior to the survey, had also increased over the 1990 to 1998 period. These figures compared to the decrease in the use of alcohol seems to suggest that drug use is becoming a substitute for the use of alcohol, among some young people. (Field and Casswell, 1999). This would appear to support the United Nations concern about the increased use of ecstasy, methamphetamine, and other synthetic stimulants around the world.

Prevalence of substance abuse and mental health effects among Maori

There is limited ethnicity specific research on adolescent substance abuse in Aotearoa/New Zealand, however according to 'Trends in Maori Mental Health, 1984-1993', alcohol and drug abuse and psychosis are still the major reasons for Maori being admitted to psychiatric hospitals or wards for the first time (Ministry of Maori Development. Te Puni Kokiri,1996). According to this document they accounted for 32% of all Maori first admissions in 1993. This is increasingly significant especially for Maori women, whose first admission rates for alcohol and drug disorders has increased 49% over this ten year period. Drug psychosis admissions for both genders have also grown rapidly and in 1993 made up 21% of all Maori admissions for alcohol and drug disorders, compared with 5% for Pakeha. As far as figures for the youth population in regards to these Maori mental health trends is concerned, the most significant trend is

seen in the re-admission rates for Maori men aged between 15-19, which are significantly high relative to Maori women, Pakeha men and Pacific Islands men. There were no statistics stated for age and alcohol and drug related admissions, however it would appear from the above findings that young Maori admission rates for alcohol and drug related disorders would be significant (Ministry of Maori Development. Te Puni Korkiri, 1996).

Information collected from Maori respondents aged 15-45 who participated in a 1998 telephone survey of drug use in Aotearoa/New Zealand, has recently been published (Dacey & Barnes, 2000). This report is the first in a series that will examine trends in Maori drug use, to better inform drug policy in relation to the Maori population. The report found that 83% of the participants were drinkers (had consumed alcohol in the previous 12 months), 46% drank alcohol at least once a week, and 27% of these drank large amounts of alcohol (six or more drinks for men, or four or more drinks for women) at least once a week (Dacey & Barnes, 2000: 1). The most commonly reported problem associated with drinking was a negative effect on peoples' energy levels and vitality reported by 25% of drinkers (Dacey & Barnes, 2000: 1).

Sixty percent of participants in this study also reported having tried marijuana at some time in their lives, 25% stated they had used it sometime in the last 12 months, but only 18% regarded themselves as current users. Forty percent of those who had tried marijuana said that they tried it for the first time between ages 15 and 17. The younger participants reported trying it at a slightly earlier age than this (Dacey & Barnes, 2000: 2). The most commonly reported problem associated with marijuana use was an adverse effect on their energy levels and vitality reported by 28% of users (Dacey & Barnes, 2000: 3).

Fifteen percent of the participants' stated that they had tried hallucinogens, 7% had tried stimulants, 6.3% had tried kava, 3.1% had tried solvents, and 1.2% had administered drugs via a needle (Dacey & Barnes, 2000: 3-4).

It is important to point out that all of the studies mentioned here rely on self-reports of alcohol and drug use by the participants. There maybe an under-reporting of substance use throughout these, given that many substances are illegal, and that this may discourage people from being honest about their use (Field & Casswell, 1999). While these studies provide excellent much needed evidence of prevalence, their reliability and validity should be treated with caution because of the reliance on self reporting. There is some evidence to suggest that the prevalence of cannabis use among young New Zealanders may actually be higher than these studies suggest (Poultan et al., 1997)

Other Aotearoa/New Zealand Specific Research on Adolescent Substance Abuse in the 1990s

Effective Interventions

Flexibility

A recent study 'Towards an Inclusive Understanding of Alcohol and Drug problems in New Zealand' by Dr. Grant Paton-Simpson, (1999) analysed 150 in depth qualitative telephone interviews with former clients of a regional outpatient service in Aotearoa/New Zealand. While it is not youth specific, the themes which emerged from the research are vitally important to mention as they may also have some bearing on the needs of the adolescent.

The main point which emerged from the research is the diversity of the problems which alcohol and drug services must cater for. Alcohol and drug problems were seen to present in a variety of ways, last various lengths of time, be caused by and/or cause various other problems, and involve a variety of types and/or amounts of drugs and alcohol. In reference to this the author states;

> "..programmes need to be very flexible. No single treatment can fit all clients and services provided must be tailored to meet individual need. Care must be taken to allow for multiple treatment goals-including goals which are not directly related to alcohol or drug consumption." (Paton-Simpson, 1999: 2). MacEwan, (1999) agrees that there is growing advocacy to move away from generalised services to services that are tailored to individual need, and have full client participation in the decision making process.

MacEwan (1998) also states that the use of the multimodal approach (the use of a variety of different treatment models) is important in the success of any programme, as it provides for this diversity of need.

Family involvement

A number of recent Aotearoa/New Zealand studies have shown the importance of family involvement in substance abuse treatment. A paper presented at the Perspectives for Change Conference in Rotorua in 1994, by Houlahan and Middleham, emphasised the importance of families being involved with their substance abusing adolescents who maybe receiving some form of intervention. They identified that substance use by adolescents can often be a way of coping with difficulties in the family, and that the family can adopt unhelpful patterns, which can help to maintain the problem. They also believe it is important for all the family members to be heard, and for appropriate boundaries to be put in place.

An 18 month study of adolescents undertaken in the Hawkes Bay by Whaitiri (1995), between 1993 and 1995 to provide information about the attitudes of youth in regards to alcohol, drugs, and related issues also determined the importance of family. This qualitative study incorporated a number of interviews with individuals and small groups of youth aged 10 to 18, the researcher interviewed 1334 adolescents over the 18 month period. Of special note in the study was that the greatest factor of influence in the area of adolescent alcohol and drug use is the family/whanau. Family/whanau are both the primary role models of substance using and/or abusing behaviour, and of paramount importance when adolescents need support to overcome their substance abuse (Whaitiri, 1995).

Research undertaken by 'The Rock Trust' in Christchurch (Burglass, 1998) also established the importance of family and peer involvement in effective interventions. The Rock Trust's goal is to "provide troubled adolescents with a solid foundation on which to rebuild their lives". The goal of this particular study was to provide information that might lead to the establishment of a youth focussed alcohol and drug service in the Christchurch region, in the ongoing pursuit of The Rock's objective, and to compliment existing youth services. The report aimed to identify existing gaps in service provision,

and recommend changes to better co-ordinate existing services. The research, which surveyed young person's 'at risk' of substance abuse, adolescent alcohol and drug service providers, community, youth and front line workers, helping agencies and education professionals, was undertaken from October to November 1998 in an informal interview setting, with the use of standardised questionnaires. Different questionnaires were created for the youth, the agency workers, and the service providers (Burglass, 1998). It found, among other things, that more support from friends and family was recommended when intervening with substance abusing adolescents.

Day programmes

The Department of Public Health and General Practice, at the Christchurch School of Medicine, produced a report in August 1999, titled 'Effectiveness of early interventions for preventing mental illness in young people: A critical appraisal of the literature' (Nicholas and Broadstock, 1999). This publication looked primarily at preventative measures in the realm of alcohol and drug and other mental health issues, and had a number of inclusion criteria[5]. It is interesting to note that while most of the literature studied was inconclusive concerning problem marijuana use, however, there was some evidence to suggest that smaller, more interactive programmes were most effective for youth.

A study of the literature in the area of 'Adolescent day programmes and community-based programmes for serious mental illness and serious drug and alcohol problems' was recently undertaken by Dr. Robert Weir for New Zealand Health Technology Assessment (NZHTA) at the Christchurch School of Medicine in 1998 confirms the conclusions made by Nicholas and Broadstock (1999), about the overseas studies of youth alcohol and drug intervention programmes. Dr. Weir found little evidence in his study of the literature on adolescent therapeutic day programmes and community- based programmes for serious alcohol and drug problems, to demonstrate these to be effective,

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[5] The studies were selected for appraisal if they quantitatively evaluated the effectiveness of early interventions to affect the mental health outcomes for people aged 14-24 years, with some measure of outcome for a group of people to whom the intervention was offered.

as much of it was too flawed to provide any definite evidence. However one conclusion he was able to draw from his study was that there was some evidence to suggest that day programmes appeared to be effective in reducing substance abuse, and improving educational outcome. Only one article examined was Aotearoa/New Zealand based, therefore any conclusions drawn from this would need to be made with caution.

One-stop-shops

Another relevant publication is 'Under One Roof: A review of one stop shop health services for young people in New Zealand' produced by the Ministry of Youth Affairs in July 1998. This identifies a number of 'one stop shops', 'wraparound services' and 'first point of contact services' for adolescents throughout Aotearoa/New Zealand. These are all integrated health services for young people, and while each of these three types of service is different in many ways, they do provide similar integrated approaches that appear to have improved young people's access to health care, including alcohol and drug interventions. The review shows that the number of 'one-stop-shop' type services has increased since 1992 when the first service in Wanganui was established, and that there are now 8 services up and running and several more due to begin operation. This review concludes that little is known about the effectiveness of these services because they are relatively new, and have not yet been fully evaluated. However,

> "At a theoretical level, both international and New Zealand research supports developing and delivering comprehensive, integrated, primary health care services for young people"

(Ministry of Youth Affairs, 1998: 8). More research is needed in the area of the effectiveness of these integrated health services to ascertain whether alcohol and drug interventions may be better provided, accessed and utilised via these 'one-stop-shop' type services.

Assessment

There is little Aotearoa/New Zealand based research which supports any one type of adolescent alcohol and drug assessment, however MacEwan (1998) in his literature review of 64 papers articles and books entitled 'Alcohol, Drugs and Adolescence', points out that;

> "..the DUSI [Drug Use Screening Inventory] remains the most critically accepted screening inventory intended to identify medical and psychiatric disturbances and psychosocial maladjustment's, including problematic drug use, in adolescents" (MacEwan, 1998: 9).

Recommendations

From the study by Whaitiri (1995) a number of other recommendations directly from the youth were provided. These include; "find the right presenters who can relate"; "accept that cannabis is here to stay"; "stop talking down to us"; "do something about societies expectations-they're too high"; "look at the areas of anger and violence, jealousy, resentment, fear, guilt, and emotions"; "don't refer to the old days when you were young"; and "find presenters who can help us find ways to solve problems rather than just say 'Don't do it'".[6]

In terms of improvements to existing services, the report by Burglass (1998) for The Rock Trust had some general recommendations including more advertising of the services, and more sympathetic counsellors.

Youth experience of alcohol and drug treatment programmes

The only Aotearoa/New Zealand based research available that studies the youth experience of an adult alcohol and drug treatment comes from researchers at Queen Mary Hospital, Hanmer Springs. The study 'Under 18-year olds: Outcomes after treatment for addictions at Queen Mary Hospital' undertaken by Faisandier et al.(1998), studies the outcomes of 85% of the total number of clients aged under 18 that attended Queen Mary Hospital between 1994 and 1997. The respondents were clients under the age of 18 who attended this primarily adult treatment centre. While outcomes indicated overall improvements in a variety of areas including, less involvement with government agencies, living with parents as opposed to living on the streets, improved self-esteem, and improved physical health, the general feeling of the majority of the participants was that a programme especially for adolescents would have been of benefit to them. This is

[6] There is a substantial list of recommendations from youth in Whaitiri's study. Those mentioned are just some of those which a large proportion (45-90%) of the participants recommended.

an interesting study which does appear to give qualitative evidence that youth specific programmes are important. The main issue specified throughout the study, indicating the need for a youth programme was that participants found it difficult being the youngest in the groups because the adult clients did not have an understanding of their situation, and did not see the adolescents' problems as being as serious as their own. Respondents believed a more structured programme with plenty of activities, and with younger counsellors (in the 25-30 year old age range), may be more effective with adolescents (Faisandier et al., 1998).

Influences on adolescent substance use behaviour

There have been a number of Aotearoa/New Zealand based studies which look at the context of substance use, and what influences young people to begin and continue this use. Research undertaken by Connolly et al., (1992) looked at the drinking context and other influences on the drinking of 15 year old New Zealanders. They discovered that different situations where alcohol was drunk, and with whom it was drunk, did affect the amount of alcohol consumed. The study found that greater amounts of alcohol were consumed when the alcohol was obtained by peers and drunk with peers in the evening, away from home. These findings indicate that the situation in which drinking occurs is important, and suggests an area where families and others may be able to influence the drinking behaviour of adolescent. This seems to suggest supervised use of alcohol may be preferred by parents/caregivers, to either use without supervision or the completely prohibited use of alcohol, which could lead to an increase in the amount used when and if it is used without parental knowledge. This is important to bear in mind when looking at harm reduction interventions with adolescents.

Whaitiri's (1995) study provides some interesting information about protective factors, in regards to the harmful use of alcohol and drugs, and confirms the Connolly et al. (1992) study about the influence of parents/caregivers/whanau/family. Whaitiri identified five important factors which led to youth in her study being less likely to abuse alcohol and drugs. These were: strong support and consistent messages from a safe secure family/whanau; high self esteem and feelings of self worth; a strong sense of identity;

clear, accurate and well presented education on alcohol and drugs; and the right and freedom to make choices with knowledge of what those choices are.

This study also identified some of the important influences or risk factors in terms of adolescent substance use behaviour. Firstly, the study identified that there was an almost complete absence of reference to 'peer pressure', and it appeared that what is seen by older people to be peer pressure is not seen as peer pressure by the adolescents themselves. The first risk factor/influence mentioned was the widespread availability of alcohol, cannabis, and some other drugs throughout the Hawkes Bay, and that most of these are obtained relatively easily from family/whanau and/or family/whanau contacts (Whaitiri, 1995). This highlights the previously mentioned importance of family/whanau, as this study found that the greatest factor of influence in the area of adolescent alcohol and drug use is the family/whanau. Family/whanau are the primary role models in adolescent substance use behaviour as well as the main suppliers of alcohol and drugs. This study, although limited to the Hawkes Bay area, provides some very relevant youth experiences of importance to this research (Whaitiri, 1995).

The ALAC publication 'Alcohol, Drugs and Adolescence' (MacEwan, 1998), also supports among other things the importance of family/whanau influence on adolescent substance use. The literature review by MacEwan which incorporates findings from 64 papers, articles and books discovered nine 'Key Findings'. These are;

1. Gender differences are decreasing
2. Parental anti social behaviour may play a significant role in the development of alcohol problems in their children.
3. Parental drinking, especially that of the father, appears to be related to dysfunction of school age children, and/or conversely that adolescents with behavioural problems can lead to increased alcohol consumption in the adult guardian of that adolescent.
4. There has been a dramatic increase in the numbers of adolescents presenting with coexisting disorders, such as substance abuse with psychosis.
5. Antisocial personality disorder, impulsive behaviour, and conduct disorder-taken together can predict the development of alcohol abuse and/or dependence.
6. Researchers have documented an association between alcohol abuse and eating disorders.

7. Adolescents are only moderately successful in assessing how much they know about alcohol, and often are generally over-confident about how much they know.

8. There is no correlational data to support the association between drinking behaviour and frequency of unprotected sex, that is, there seems to be no direct impact from drinking on contraceptive use (MacEwan, 1998).

Needs in Aotearoa/New Zealand

The need for more and better services for adolescents with substance abuse problems is well documented in Aotearoa/New Zealand. The literature review by MacEwan (1998) concludes that there needs to be:

> " ...intensive residential treatment for the more seriously disturbed, a comprehensive drop-in support centre for the moderately disturbed, and support groups of the mildly affected."

(MacEwan, 1998: 12). MacEwan lists these in order of priority as "Intensive residential treatment, counselling, day care, and respite care." (MacEwan, 1998: 12).

The National Centre for Treatment Development (Alcohol, Drugs & Addiction) (NCTD) in New Zealand, produced a document entitled 'Guidelines for Clinical Process Self-Evaluations in Alcohol and Drug Treatment Agencies'(Deering et al., 1998). This document briefly identifies that there is a need for youth specific services in the alcohol and drug treatment field, and that:

> "While there is a lack of controlled treatment-outcome research on interventions for substance use problems in adolescents, evidence available suggests that efforts of treatment against no-treatment or wait -list control interventions is positive [Spooner et al. 1996]." (Deering et al., 1998:47).

This document outlines some implications for residential and non-residential service planning and delivery in this area from the reviews by MacEwan (1998), and Spooner et al. (1996), an Australian based document (Deering et al., 1998). It also lists implications in this area from the Ministry of Health's (1998) publication 'New Futures: A strategic framework for specialist mental health services for children and young people in New Zealand' which, while very light on specific information and recommendations for specialised adolescent alcohol and drug services, provides some recommendations under the heading of severe mental health problems. From these reviews this NCTD document

concludes that a number of things are necessary in the provision of alcohol and drug services for adolescents. These are;

> "...high quality staff, individualized comprehensive assessments and treatment with attention paid to existing physical and mental health and social problems, the availability of a range of interventions, co-ordination and continuity of care, and responsiveness to the cultural and other special needs of particular groups/populations." (NCTD, 1998:49).

It also states that specific attention needs to be paid to;

> "...co-existing educational, health and social problems, developmental stage, legislation, parental/caregiver involvement, the role of peers, and the importance of a muliti-systemic and collaborative inter-agency approach. (NCTD, 1998: 49).

Burglass (1998) identified gaps in the field which supported previous research and included: a lack of residential treatment programme, which was identified by 33% of the respondents; a youth drop in centre; specialised counsellors in this field; social detox centre; respite care service; alcohol and drug focussed day and after school programme; co-ordinated case management; specific programme for Maori and Pacific Island youth; and services for young women. The author of the research also identified that while interagency co-operation on the whole had improved, it still remained fragmented and inefficient. (Burglass, 1998).

Burglass concluded this study by recommending;

> "-Co-operative, interagency initiatives continue with the responsibility to drive and fund these initiatives remaining with the HFA,
>
> -That a unified national youth strategy be developed at a government level which binds Governmental agencies and Funding bodies to a common set of principles and objectives relating to the provision of services (including A&D) for young people." (Burglass, 1998:51).

Lack of relevant research

Due to the lack of available Aotearoa/New Zealand specific research in this area this literature review has been limited. The lack of research in this area is well documented. Nicholas and Broadstock (1999), when evaluating literature on early intervention and prevention of substance abuse and mental illness, found that;

> "Despite extensive consultation with researchers and programme providers, particularly with respect to Maori, we were unable to find any local studies that had completed outcome evaluations which met our inclusion criteria..." (Nicholas & Broadstock, 1999: iv).

They conclude that;

> "..there has been little good quality research done on programme effectiveness.", and that "The lack of research may reflect a focus on programmes intervening in middle childhood rather than in adolescence." (Nicholas & Broadstock, 1999: v).

This is relevant to this research as there is a similar lack of research in the area of adolescent alcohol and drug interventions also.

Findings from the evaluations done, which were all from American studies, found that there was insufficient evidence from the studies to assess the impact of parent and community involvement, and that results from almost all of the studies were inconclusive in a number of areas. They clearly stated that programmes for addicted youth were excluded from the appraisal of the literature, however some of the programmes studied were for young people who had been identified as using and or abusing alcohol and other drugs, and therefore this information is important to bear in mind.

The literature review by Weir (1998) supports the conclusions made by Nicholas and Broadstock (1999) about the overseas studies of youth alcohol and drug intervention programmes. Weir found little evidence in his study of the literature on adolescent therapeutic day programmes and community-based programmes for serious alcohol and drug problems to demonstrate these to be effective, as much of it was too flawed to provide any definite evidence.

While overseas countries like America and the United Kingdom have already established alcohol and drug treatment services for their adolescents and are now at the stage of evaluating their effectiveness and efficiency, (Doyle et al., 1994; Friedman & Glickman, 1986; Friedman et al., 1986; Marshall & Marshall, 1993) people in Aotearoa/New Zealand must be careful to recognise the limitations that these overseas programmes and research studies have for the Aotearoa/New Zealand experience.

> "Many programmes are introduced into New Zealand from overseas and often fail to take into account the different ethnic cultural needs in New Zealand as well as the youth culture. .....New Zealand young people are quite different to American young people..."

(Taylor, 1990:48).

General alcohol and drug services around Aotearoa/New Zealand are continuing to develop, while services for adolescents are still in the very early stages of evolution. The Core Services Committee released a report on 'Treatment of People with Alcohol and Drug Problems' in 1994 which stated that alcohol and drug services in New Zealand had developed in an

> "Uncoordinated and ad hoc fashion. Consequently services are unevenly distributed with much evidence of duplication on the one hand, and failure to respond to particular groups with special needs, especially Maori, on the other." (New Zealand Health and Hospital, May/June 1994:4).

This report also stated that alcohol and drug problems are the second most common mental health problem after depression and therefore, emphasised the need for such research and services to be of high quality.

What is now very clear is that interventions based on Aotearoa/New Zealand specific research need to be available. This is especially imperative now because of social policy changes including the recently passed Sale of Liquor Amendment Act 1999 which, among other things, lowered the drinking age to 18 on 1 December 1999, and has generally bought about a liberalisation of liquor sales and licensing.

Work in progress

Current work in progress, as found in the ALAC Research Database[7] is also important to note.

- Elaine Mossman is currently undertaking a Ph.D. at the University of Canterbury, researching the 'Adventure Development Counselling' programmes which run in Southland, Otago and Canterbury. These are six month long adolescent adventure based drug and alcohol programmes that run in these areas twice a year with approximately 10 clients per programme.

[7] Found online at ALAC's web site (http:/www.alcohol.org.nz)

- Researchers at the Business Research Centre are continuing to monitor ALAC's moderation in drinking campaign targeted at youth (13-18), and will be measuring changes in attitudes and behaviour among youth, in an ongoing study. They are also working on an ALAC initiated piece of research that aims to identify, what parents are looking for, in regards to dealing with their children and the issue of alcohol, and will continue to monitor the survey of parental concern. The ultimate aim is to consider what role ALAC can take in this area (ALAC Website, http:/www.alcohol.org.nz, 2000).

- Michael Webb is in the process of writing a book on 'Addiction and the Law: A Case-Study of the Alcoholism and Drug Addiction Act 1966', which is relevant because while this Act is legally applicable to adolescents, there is debate around how moral and ethical it would be to use the Act on adolescents (For more on The Alcoholism and Drug Addiction Act 1966 see Chapter Three).

- Kay Kristensen, in Hamilton is currently researching 'To identify barriers in communication based on differences between caregivers and adolescents in relation to how adolescents use/misuse alcohol.' (ALAC Website, http:/www.alcohol.org.nz, 2000).

- Sue Blyth in conjunction with ALAC, is currently working on an adapted form of 'Guided Self Change', a well researched motivational intervention for adults developed in Canada. This will be called 'Smashed or Stoned' and will be used with teenagers who have been involved in problematic alcohol or drug use. Accompanying this programme will be comprehensive training and a training manual for counsellors (ALAC, 2000b).

Key Aotearoa/New Zealand Initiatives & Programmes

There are a number of excellent local adolescent substance abuse initiatives operating around the country on an ad-hoc basis. This section does not attempt to cover all of

these initiatives, as do to so is outside the scope of this research. However, it does aim to describe some of the pivotal services operating for adolescents with substance abuse issues.

Residential programmes

Auckland Odyssey House Youth Residential Service and Queen Mary Hospital Youth Programme in Hanmer Springs are currently the only two operating residential alcohol and drug intervention programme for adolescents in Aotearoa/New Zealand. The Odyssey House Residential Service in Christchurch does take those people 16 years and older, so therefore does cater for the adolescent group to some degree. The Odyssey House services in both Auckland and Christchurch also provide youth day programmes.

Both Queen Mary and Odyssey House services cater for the more severely dependent client. The Odyssey House Youth Residential Service in Auckland is a long term residential treatment which has 16 beds and provides schooling, group therapy, counselling, family therapy, multi-family groups, a recreation programme, alcohol and drug education, psychiatric services, Te Reo[8], a Maori cultural programme, and a medical service, all in a residential 'therapeutic community' setting. (Odyssey House Website, http:/www.odyssey.org.nz, 1999). The youth day programme provides a similar programme on a daily basis, but without accommodation.

Queen Mary Hospital, Hanmer Springs has up to 15 adolescent residential beds on their youth programme and provide a ten to twelve week programme which incorporates; schooling, group therapy, counselling, family therapy, a recreation programme, a lecture programme (incorporating alcohol and drug addiction education and life skills), a medical service and daily support group meetings (Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Adult Children of Alcoholics (ACOA) and spiritual).

Most Health Funding Authorities do purchase a set number of 'bed nights' from Odyssey House Youth Residential Programme, which enables adolescents from most parts of Aotearoa/New Zealand to attend the programme if they meet the criteria. Given the Queen Mary Youth Programme is still relatively new at this stage only the Southern

[8] Maori language

HFA funds for beds on this programme. For anyone living outside of Auckland or the middle of the South Island these options mean having to leave their home, community and family/whanau support. Obviously given that these are the only programmes of their kind operating in Aotearoa/New Zealand, demand is high and waiting lists can be up to three months long.

Short term group interventions

The GAIN (Get Alternative Information Now) Factor early intervention programme, which has already been mentioned, provides a short term once a week group programme for adolescents and their whanau/family and is currently used throughout various centres around Aotearoa/New Zealand, including Wellington, Auckland, and the Manawatu. The programme was originally developed at the Family Service Agency, Little Rock, Arkansas, in the USA. The GAIN family of programmes has been altered to meet the needs of New Zealanders. The GAIN Factor programmes are primarily concerned with reducing the risk of the teenagers becoming involved in drug and alcohol abuse, by improving family communication and self esteem, by teaching problem solving, and conflict resolution skills. The sessions are not 'therapy' but rather educational learning sessions (Meredith, 1999; The GAIN Family of Programmes Pamphlet, 1998.) An evaluation of the GAIN programme was undertaken in 1998 by Winslade. The research showed;

> "..a clear picture of support for the GAIN programme in terms of its objectives...In outcome terms both parents and teenagers are overwhelmingly positive in their response to the programme...The impact of the programme on family relationships is noticeable. Less clear is the value of the programme in bringing about changes in attitudes towards drugs although there is some indication of this happening." (Winslade, 1998: Conclusions)

GAIN Whakaruruhou, a marae based programme, which has also been adapted from the original American programme is also gathering momentum, and is currently operating in Wellington, Porirua, Palmerston North, and Bay of Plenty. While this programme is not specially centred on alcohol and drug use, these issues are discussed along with other areas including communication and problem solving.

Community initiatives

Regional Alcohol and Drug Services (RADS) in Auckland provide an Auckland wide youth counselling service called 'Altered High'. Altered High specialises with at risk youth including those youth with a dual diagnosis, gay/lesbian, transgendered youth and/or youth with same sex attraction issues, and Pacific Islands youth.

Another important initiative to identify is The Alcohol and Public Health Research Unit's (APHRU), Alcohol and Youth Community Action Project. It involves six high priority communities including rural, urban and provincial Aotearoa/New Zealand. The community approach recognises the social context of substance use. Each region has a community development worker to plan and implement strategies.

The objectives of the project are to:

> "-Increase informed debate on drug issues and their impact on the community.
> -Promote, implement and support policies and safe behaviours on drug use.
> -Identify existing and/or developing 'best practice' programmes to address schools and student needs including youth/whanau in need of support.
> -Develop alliances between key community organisations and sectors
> -Develop local resources to raise awareness and facilitate and support youth voice and discussion on reducing drug-related harm. (APHRU Website, http:/www.aphru.ac.nz, 1999).

While this initiative is primarily preventative, some areas in this project have developed in-school interventions or Student Assistance Programmes when young people have been identified as having alcohol and/or drug problems, and before disciplinary action is required. Student Assistance Programmes aim to try and keep the young people in school, and often involves whanau. They are relatively new initiatives in Aotearoa/New Zealand, and involve schools providing programmes on topics including alcohol and drug abuse and other related issues in school, alongside academic subjects. Information about these Student Assistance Programmes was brought back to Aotearoa/New Zealand, from California by Fran Manahi in 1997. The key to Student Assistance Programmes is that schools, supported by community agencies, play a fundamental role in providing programmes that, while often seen as important, have never been provided by schools

before. The underlying philosophy of the Student Assistance Programmes is that all students have the right to education, not just the 'good' ones. From the American example there appear to be many advantages for both the pupil and the school when these programmes are implemented, because issues are dealt with rather than ignored, which provides a healthier environment from which to teach and learn. While proven in the USA, these programmes will need to be evaluated where they are implemented in Aotearoa/New Zealand (Manahi, 1998).

Adventure/outdoor programmes

Adventure Development counselling run by the Special Education Service is the most well known of the adventure/outdoor programmes. At present the programme runs throughout most of the South Island from Southland to Nelson, and has been running since 1993.

While this programme is not just for those with substance abuse issues, this is a major part of the focus of the programme. Primarily this is a 6 month to one year individualised intervention for those aged 13 to 19. It comprises four major elements including individual therapy, family therapy, integration with other services and wilderness therapy. The wilderness therapy part of the programme is a nine day group retreat to the wilderness, for example the Southern Alps or the Nelson Lakes, and puts the adolescents through a series of challenges in order to enhance problem solving and life skills, self-esteem and confidence (Goldthorpe, 2000).

Chapter Summary

The use of alcohol and other drugs among adolescents around the world is of growing concern. Prevalence rates of adolescent substance use in Aotearoa/New Zealand are increasing as is the variety of drugs used (Business Research Centre, 2000; Field & Casswell, 1999).

Interventions which are specifically aimed towards the needs of young people are important as adult focussed programmes do not adequately cater for the different

cognitive, emotional and developmental needs of adolescents (Bukstein, 1995; Burglass, 1998; Cavaiola & Kane-Cavaiola,1989; Polcin, 1992; Spooner, Mattick & Howard, 1996; MacEwan, 1999).

Aotearoa/New Zealand is currently somewhat behind other developed countries in terms of research and the provision of interventions for adolescents with substance abuse problems, however from the limited available research some conclusions can be drawn.

- Family/whanau and parents/guardians can be a big influence both positively and negatively on adolescent substance abuse.
- Peers and poor mental health also influence adolescent substance use behaviour.
- It is important to be able to provide flexible interventions to meet the diverse needs of clients.
- There is some evidence to suggest that smaller, more interactive programmes are most effective for youth.
- Counsellor attributes are important.
- There needs to be more advertising of the existing services.
- More research is needed in the area of the effectiveness of 'One -Stop-Shops', however in theory they appear to be beneficial.
- There is little Aotearoa/New Zealand based research which supports any one type of adolescent alcohol and drug assessment.

While currently there are a number of excellent local adolescent substance abuse initiatives operating around the country on an ad-hoc basis including residential and day services, short term group interventions, community initiatives, Student Assistance Programmes, and adventure/outdoor programmes, the need for more and better services in the realm of adolescent substance abuse interventions is well documented (Burglass, 1998; Rout & Lowe, 1991; Bruner, 1994; Moore, 1997; Macdonald, 1997; MacEwan, 1998; National Centre for Treatment Development, 1998, and Young, 1998). The lack of good quality Aotearoa/New Zealand based research also documented (Nicholas & Broadstock, 1999). More and better services for Aotearoa/New Zealand adolescents based on more and better research in this area is needed.

Chapter Three

THEORETICAL PERSPECTIVES ON ADOLESCENT SUBSTANCE ABUSE

This chapter will firstly explore the five main theories of adolescent alcohol and drug abuse, and identify their contribution to the objectives of this research. Secondly risk and protective factors that can either put an adolescent at risk of developing substance abuse problems, or help to protect them from it, will be identified and discussed. Thirdly a number of identified treatment models that have been developed as adolescent substance abuse interventions and as a result of these theories and factors, will be discussed. Finally the significance of the developmental stage of adolescence will be discussed in terms of adolescent substance abuse interventions. Both adolescent substance abuse and human development theory, alongside identified risk and protective factors, guide models of intervention with substance abusing adolescents, and therefore are of paramount importance to this research.

Theories of Adolescent Substance Abuse

> " Theory not only defines the language used to describe, predict, and explain substance abuse, but is also the source of intervention development" (DiClemente et al., 1996: 171).

There are a number of different theories as to the cause or causes of adolescent substance abuse. These are especially relevant to explore in the search for effective interventions, because theories of why substance abuse occurs, can help us to identify how and in what way to work with young people in order to control or alleviate their substance abuse. These theories will be considered alongside the empirical data gathered in this research to draw comparisons and make conclusions about their relevance to adolescent substance abuse interventions in Aotearoa/New Zealand.

According to Bukstein (1995), historically addiction of any sort has been seen as a moral failing or a disease. For over a century, alcoholism and drug addiction went back and forth from being considered a pathetic condition that the individual had no control over but one deserving of compassion, to a deviant nefarious behaviour which deserved contempt. Adolescent addiction was not really given much thought before the 60s, but when it was, the blame often fell on the parents of the adolescent, for not bringing them up correctly. In the 60s however researchers and clinicians overseas began to look more closely at adolescent substance abuse, and detailed theories began to be established, many of which still play a substantial role in theoretical perspectives today (Bukstein, 1995; Pagliaro & Pagliaro, 1996).

For the purposes of presenting a structured look at these theories, five main groups will be used as a guide throughout this part of this chapter. The five groups of theories are identified as the disease model, psychological theories, behavioural theories, sociological theories and biological theories. A substantial number of specific theories have been developed under each of these headings however it is not the intention or within the scope of this thesis to look at these in detail. These theories represent the five basic explanations of adolescent substance abuse that have helped guide interventions with substance abusing adolescents around the world. When discussed and reviewed in detail and examined alongside the data from this study, they will also serve as a guide to the final recommendations of this research.

The Disease Model

The disease concept of addiction has probably had the biggest influence on the alcohol and drug treatment world throughout history, and played a significant role in bringing addiction into the health system and away from the legal system (Bukstein, 1995). While no complete consensus or explanation of the 'disease model' exists, the core principle or belief of the 'disease model' is that addiction is a disease, just as is diabetes or cancer. It is not so much an explanation of addiction, as much as it is a statement about the nature of addiction (Bukstein, 1995). Those who believe in the 'disease model' consider that individuals are born with it, will have it for the rest of their lives, and once in remission from this disease, will never be able to use substances again or the disease will relapse.

The well known 12 steps of Alcoholics Anonymous (AA), and the very philosophy of AA are based on the disease concept of addiction.

Generally it is believed that this concept is less helpful for adolescents than adults (Kaminer, 1994). Adolescents are often short term substances abusers, and can 'grow out of' this abuse. As Lawson (1992) points out, many adults who would not be considered alcoholics or addicts today, during their adolescence had periods when they would have been labelled chemically dependent. The disease concept of addiction would have had these types of adolescents labelled as addicts or alcoholics, a stigma which can last a lifetime, while the dependence or abuse may not. The disease concept according to Lawson (1992), is also non-scientific, and there is little evidence that all of those people who have difficulty with substances have always had this problem, or always will.

Those who critique the 'disease model' believe other theories of adolescent substance abuse have more to offer in terms of explanations for the behaviour (Lawson, 1992; Kaminer, 1994). However the influence that the disease model of substance abuse has had on AA and many treatment programmes all over the world can not be overlooked. This model and its influence on treatment for alcohol and drug dependence appears to have helped many people in their struggle with addiction.

Psychological Theories

Psychological theories in this setting are those which pertain to the internal mental processes of the individual adolescent. Traditionally substance abuse was perceived by those who support this theory, as a self destructive or chronic suicidal behaviour (Kaminer, 1994). Psychological theories explain the abuse of substances by adolescents using concepts such as feelings, emotions and personality. Primarily psychological theories consider that feelings, emotions and personality cause substance abuse and other pathological behaviour (Bukstein, 1995).

Psychodynamic theory views substance abuse as a symptom of some other underlying emotional problem. The use of alcohol and/or drugs are seen to provide an escape from emotional problems and the negative feelings associated with these including guilt, anger,

and loneliness. Substances are thought to provide an alternative reality to the one that is causing the adolescent so much pain. Reasons for this emotional pain can be many and varied, including early sexual or physical abuse, and/or abandonment issues. This theory is also sometimes referred to as the 'self-medication hypothesis' (Bukstein, 1995).

The main critique of these types of theories is that they do not take into consideration the influence of the individuals environment, for example their family upbringing or the influence of their peers. These types of theories rely entirely on the internal processes and personality of the individual to explain adolescent substance abuse (Bukstein, 1995).

Behavioural Learning Theories

Behavioural theories seek to explain substance abuse by adolescents on the basis of the individuals' interactions with the environment and other people in that environment (Bukstein, 1995). An example of a behavioural learning theory is Social Learning Theory. The basic belief of Social Learning Theory is that behaviour is acquired in the most part, as a result of relationships between people and other environmental influences. The behaviour observed is 'modelled' by those in the individuals environment. This theory does not argue that people are powerless over their behaviours and environments, but it does hypothesise that people are not free agents to become whatever they choose, but that they are strongly influenced by those around them. The godfather of this theory, Bandura (1977), proposed that both people and their environments influence each other.

There are three basic constructs of Social Learning Theory, these are 'observational learning', 'reinforcement', and 'expectancies'. Observational learning is the process by which an individual imitates behaviour they have seen someone else do. Others provide the environment, and the observing individual sees what results this behaviour brings, that is whether it brings rewards or punishments. For example an adolescent may observe another person drinking or taking drugs and also observe that this other person appears to be having a lot of fun and appears to be confident. What is observed is the behaviour of drinking or drugging, attracting rewards for the person who does it. This encourages the observer to act in the same way. Reinforcement is the process by which this learned behaviour will be continued and repeated, or discontinued. If the observer

gets rewards from the behaviour that they enact, then this behaviour has given the observer positive reinforcement to continue the behaviour. If the observer now performing the behaviour has a difficult time and does not enjoy the behaviour, this is negative reinforcement, and means the person is less likely to try this behaviour again. Once the behaviour has been observed and/or reinforced , this is internalised to form a belief by the individual that is based on what is now expected from the behaviour. For example if the observed behaviour produced positive reinforcement for the adolescent, the adolescent would now hold the belief and expectation that drinking and drugging is good and produces rewards. The more positive the belief and expectancies about the use of substances are, the more likely the behaviour is to continue. (Howard, 1992)

Another behavioural learning theory about adolescent substance abuse is self-esteem motive theory. Low self esteem is often mentioned as a reason for the use of alcohol and drugs by adolescents. The major belief of the self-esteem motive theory, is that because of the infants initial reliance on adults to provide for them, the individual develops a need for human interaction, positive evaluations by others and an affirmative self image. The adolescent is believed to behave in ways to avoid rejection and gain favour, for example the adolescent may use drugs to maintain the acceptance of their peer group (Langer, 1996).

The main critique of these types of theories is that they do not pay enough consideration to individual choice and the self-determination of the individual (Bukstein, 1995). They do not explain adolescent drug and alcohol abuse by those who have not had this modelled, or conversely abstinence by those who have had this behaviour modelled. It also does little to explain the psychologically 'addictive' nature of substance use, where time and time again using behaviour brings about negative reinforcement, yet continues.

Sociological Theories

Beginning in the 1970s attention began to focus on the role of the family in adolescent substance abuse. These theories emphasise the idea that adolescent substance abuse serves a 'family function', that is, as a system families encourage adolescent substance abuse because it serves a role in maintaining some balance in the family. Substance use by the adolescent in the family keeps the adolescent helpless and dependent on the

family, which in turn unifies and sustains the family cohesion (Pagliaro & Pagliaro, 1996). How the members of the family relate to each other and how the household runs are also important variables in determining adolescent substance abuse. For example if the relationships between members are disengaged (very low level of relationship), or enmeshed (overly high level of relationship), problems such as adolescent substance abuse are thought to occur. If families are rigid and extreme in the running of their household, it is thought there is more likelihood of adolescent substance abuse compared to a more flexible and balanced household. However if the running of the household is too flexible it can become chaotic and this too is thought to influence adolescent substance abuse. In both examples a balance between the extremes in the relationships and the running of the household is thought to be the healthiest (Bukstein, 1995; Pagliaro & Pagliaro, 1996). The use of substances by parents and siblings is also thought to be important, again if the use or non-use is in the extreme, problems are thought to arise, however if alcohol use is modelled appropriately this is seen as positive (Bukstein, 1995).

Sociological theories also identify the importance of peer relationship and influence on adolescent substance abuse. In terms of sociological theory the role of peer influence has been seen as a prominent cause, if not the number one cause of adolescent substance use. Recent studies show however that while peer influence is still marked, the magnitude of the influence may have been over estimated (Bauman & Ennett, 1996; United Nations, 1997).

Sociological theories also identify important components of adolescent substance abuse on a broader scale, for example factors in society including unemployment and education costs, as these are seen to influence the future outlook of adolescents. Some sociological theories therefore pinpoint political and legislative influences in the area of adolescent substance abuse (Dorn, 1983). Some of these political and legislative influences will be further discussed in Chapter Three, 'Social Policy and Social Work in Relation to Adolescent Substance Abuse.'

Sociological theories also look at the influence that cultural factors, socio-economic status and gender have on adolescent substance abuse. Theories have been suggested

across cultures highlighting differences, and the importance of appropriate interventions for different cultures. Sociological theories also seek to explain the various types of adolescent substance abuse subcultures, for example cannabis users, intravenous drug users, and binge alcohol drinkers, who appear to have quite different subcultures. These subcultures are often identified with the use of sociological concepts such as values, norms and roles, which are often different depending on the subculture. For example it may be a norm for intravenous drug users to use crime to support their habit, however this may not be an acceptable norm for binge alcohol drinkers (Pagliaro & Pagliaro, 1996).

The main critique of sociological theories is similar to that of behavioural theories; that is that they do not pay enough homage to the individual self-determination in a given situation, despite surroundings, and relationships (Bukstein, 1995; Pagliaro & Pagliaro, 1996).

Biological Theories

Biological theories consider that underlying substance abuse is some sort of physical abnormality, either anatomical, biochemical, physiological, or genetic. Several genetic studies have been undertaken including adoption and twin studies (Cloninger et al., 1981; Goodwin et al., 1973; Cadoret, 1992) which do show a substantial genetic component independent of environmental influences. With this evidence of genetic predisposition researchers (Blum et al., 1990) have tried to locate biological markers, that may predispose the individual to the development of substance abuse problems. Researchers have proposed that there could be abnormalities in neurotransmitter function or differences in the metabolism of alcohol, as biological reasons for this predisposition to developing problems with substances. However:

> "The absence of overwhelming evidence for any of these biological markers makes a single factor biological cause or theory unlikely." (Bukstein, 1996: 16).

These types of biological theories are in direct conflict with ideas of behavioural theories, and provide us with the classic 'nature versus nurture' debate.

Eclectic Theories

While these five distinct groups provide different theories of adolescent substance abuse, none of them provide unequivocal explanations of adolescent substance abuse for every case. For example not all adolescents suffering from substance abuse will suffer from their problem for the rest of their lives, have family dysfunction and/or emotional/psychological problems, have had unhealthy role models, and/or addiction in their families. Often with adolescent substance abusers none of these explanations appear to make any sense, while at other times all of them appear to help explain some aspect of the problem. There is no absolute explanation of substance abuse as it is a very complex phenomenon which effects very complex individuals in a variety of ways, and for a variety of reasons. It is now widely believed that;

> "No single biological, psychological, or sociological factor has been found to account for the significant patterns of substance abuse observed among adolescents.....In this regard, it appears that a unique combination of biological, psychological, and sociological factors are required." (Pagliaro & Pagliaro, 1996: 138).

> "There is no single reason and no list or reasons for drug use that will apply to all adolescents. Drug use results from a complex interaction of genetic endowment, behaviour patterns, motives, and social and psychological determinants. Reasons for use may be extremely complex or a simple as availability" (Archambault, 1992: 12).

With this is mind then, the best explanations of adolescent substance abuse need to take into account each of these theories, and weigh up their importance depending on each individual. Theories which take into consideration an array of concepts from a variety of theories are known as eclectic theories.

In recent years there has been a move towards incorporating distinct factors from one theory with one or more factors from one or more other theories (Bukstein, 1995; Pagliaro & Pagliaro, 1996). For example, psychosocial, sociocultural and biopsychosocial theories of adolescent substance abuse are common place. Eclectic theories might take into account for example, not only biological, psychological and social learning theories for initially taking a particular drug, but also the attitudes and personality of the user, the social implications of the use, and the physical and social

setting in which the substance use takes place, to explain the continued use of the substance. Eclectic theories reconcile the classic 'nature/nurture' debate by giving theories of both nature and nurture equal significance in terms of explaining adolescent substance abuse.

In terms of how this influences interventions with substance abusing adolescents, it is clear that interventions must take into account a number of factors for each individual and work on these concomitantly. There is no typical substance abusing adolescent, there is no specific personality type, family history, socio-economic situation, or stressful experience that can predict the development of substance abuse, and therefore interventions must be flexible.

Given this reality however, it is important to comment on a number of specific factors that have been identified as either putting adolescents at greater risk of developing substance abuse problems (risk factors), or protecting them from abusing substances (protective factors).

Risk and Protective Factors

Risk factors are those factors which research has shown may cause adolescent substance abuse. Protective factors are those which may protect an adolescent from abusing substances or may mediate or moderate against the risk factors. Risk factors must be differentiated from factors that are caused by substance abuse, or those that are not causally related. For example, both the substance abuse and the related factor may be caused by something else (Spooner et al., 1996). This is sometimes difficult to determine because it is also thought that some risk factors may cause substance abuse as well as be a consequence of substance abuse. Risk factors are also very much dependent on the individual adolescent, for example some risk factors are more influential than others depending on where the adolescent is at in terms of their development. The developmental stage of adolescence is thought to be a risk factor in itself. Risk and protective factors are important to consider in developing effective substance abuse

interventions, so as to incorporate components to alleviate risk factors and promote protective factors.

Biology and genetics

According to Bukstein (1995) and Thomas & Schandler (1996), there is enough evidence to suggest that biology and genetics do play some part in putting some adolescents at higher risk of developing substance abuse problems than others. While the scientific evidence is unclear the 'nature versus nurture' debate continues. It is important to recognise however, that whether a child has been bought up in a substance abusing family or whether they have substance abusers in their biological family, they are at higher risk of developing a substance abuse problem, according to supporters of either biological or sociological theories. While biological vulnerability to substance abuse may depend to some degree on specific factors that have a genetic origin, other factors including attitude, personality and temperament also play and important role (Bukstein, 1995).

Attitude and personality

Attitudes and personality traits that reflect a lack of social bonding have been found to be predictive of adolescent substance use (Spooner et al., 1996; The NHS Health Advisory Service, 1996). These include:

> "Rebelliousness, non-comformity to traditional values, low sense of social responsibility, high tolerance of deviance, resistance to traditional authority, a strong need for independence, normlessness, 'contracultural' values: a complete disengagement from mainstream culture as indicated by numerous indicators such as low school commitment, unconventional dress, non-conformist values, and peer substance-using culture, alienation and health compromising behaviours, particularly smoking and alcohol misuse" (Spooner et al., 1996: 2-3).

Conversely, ties to society and tradition are thought to be associated with non-problematic use of substances, and may be considered protective factors. This would appear to indicate that involving adolescents at risk of substance abuse in community activities, and/or helping them to feel a sense of belonging to the community, would be advantageous as part of a substance abuse intervention. Another personality trait linked to substance abuse according to Spooner et al. (1996), is sensation seeking.

Interventions may be effective if this is channelled into healthier sensation providing activities, for example, rock climbing or kayaking. Models which incorporate these types of activities are called outdoor/adventure models and will be discussed further, later in the chapter under 'Treatment Models'

General anti-social behaviour and delinquency have been associated with substance abuse, however it is more likely that these problem behaviours have common causes rather than that anti-social behaviour and delinquency cause substance abuse (Spooner et al., 1996). These anti-social behaviours which are common amongst adolescent substance abusers need to be identified and worked on in any effective adolescent substance abuse intervention, for example, emphasis on mood management and impulse control may be important. At this point too it may be advantageous to work with the parents or caregivers of the adolescent to help them develop parenting skills and effective discipline techniques to minimise the these anti-social behaviours or the harm they may cause (Spooner et al., 1996; The NHS Health Advisory Service, 1996). Family therapy models of treatment for adolescent substance abuse take into consideration the needs of the parents and other members of the family and often incorporate parenting skills and discipline techniques as part of the intervention. Family therapy will be further discussed later in this chapter under 'Treatment Models'.

Family

Family factors can be both risk factors and protective factors. Family factors include the influence of the parents, siblings, aunts, uncles, cousins and all significant others, on the adolescent, as well as the conflicts that may exist within families. Some of these factors were mentioned earlier under sociological theories of adolescent substance abuse, and include closeness of relationships, management of the family, communication patterns, and parental substance use, and whether these elements are 'healthy' or not. Unhealthy family environments are risk factors, healthy environments can be protective factors (Barnes & Windle, 1987; Bukstein, 1995; Duncan et al., 1996; Spooner et al., 1996; The NHS Health Advisory Service, 1996; Thomas & Shandler, 1996). These findings emphasise the importance of family and/or positive parental figures being involved in effective interventions with substance abusing adolescents. Family experience plays a huge role in predicting the abuse or otherwise of substances by adolescents, and issues

arising from the family experience will need to be dealt with during treatment (Stephenson et al., 1996). Family therapy is common in adolescent substance abuse treatment because of the huge influence the family has on the life of the adolescent (Kaminer, 1994). This will be discussed further under 'Treatment Models'.

Physical and sexual abuse

According to Spooner et al. (1996), people who have experienced childhood physical and/or sexual abuse are also at high risk of developing substance abuse problems in adolescence. The use of substances is thought to alleviate feelings of fear, guilt and shame associated with this abuse. As childhood abuse is a risk factor, treatment interventions need to address these issues and help the adolescent deal with the unwanted feelings that this experience leaves them with. If this is not dealt with, substance use is likely to continue as it alleviates these feelings (Spooner et al., 1996).

Socio-economic status

Low socio-economic status and community or neighbourhood characteristics such as high population density, high crime, and high unemployment rates are risk factors for adolescents. It is recognised that these communities usually offer few resources for adolescents, and deviant alternatives to social norms such as criminal activity and substance use are often provided (Bukstein, 1995; Spooner et al., 1996). It is well recognised that substance abuse problems can infiltrate all socio-economic backgrounds, and often more money can be related to increased consumption, however research shows that socio-economic status does influence substance use behaviours, and that the highest prevalence of substance abuse exists in the areas with the lowest socio-economic status (Dryfoos, 1990; Smart et al., 1994).

Macro-economics

Macro-economic factors are those factors on a wider societal scale that influence adolescent substance abuse. These include alcohol labelling, pricing and advertising, legislation regarding the use of substances and how this legislation is enforced. These things do have a direct impact on the use of substances and on social values related to substance use (Spooner et al., 1996). Other societal factors which appear to directly impact upon adolescents include unemployment, homelessness, and education pressures.

Richard Eckersley, (1988) describes these types of factors as stressors on the child or young person, and paints a bleak picture of the affect these types of stressors can have on young people.

> "...growing numbers of young people feel there is no escape; they feel powerless and hopeless...Those who fail, or feel they never had a chance, are giving up, and resorting to crime, drug induced oblivion, and suicide" (Eckersley, 1988: 1)

These feelings of hopelessness need to be addressed in any form of adolescent substance abuse intervention. Hope for the future needs to be instilled in these young people throughout the course of their intervention programme (Spooner et al., 1996).

Coping skills

The way an adolescent is able to cope with the stressors mentioned above, and other types of stressors in their lives can be either risk or protective factors. If the adolescent has healthy coping mechanisms and has problem solving skills, self-control, self-assurance, and assertiveness, they are less likely to use substances as a way of coping with stress. If, however, they lack these skills they are more likely to use substances to cope (Thomas & Schandler, 1996). Also important in coping with stressors is the social support the adolescent has from family, peers and the community. If these social supports are lacking this is a risk factor for adolescent substance abuse, however when in place they act as protective factors (Spooner et al., 1996). It would therefore appear that coping skills education and the setting up of social supports would be important in any adolescent substance abuse intervention.

Mental health

Depression, schizophrenia, eating disorders and other mental health issues are thought to be risk factors for adolescent substance abuse (Smith & Hucker, 1994; Ziedonis & Fisher, 1994; Carey, 1996; Merikangas et al.,1996), although the picture is still unclear. Whether mental health is adversely affected by substance abuse, and a illness develops, or whether the mental illness is primary and the substance abuse is used as a type of self medication or exacerbates the problem, is often difficult to determine. There is however a tendency for adolescents who abuse substances to have higher rates of mental health or emotional problems (Spooner et al., 1996), and therefore mental health as a risk factor should be taken into account. Adolescent substance abuse interventions would do well

to screen for any mental health problems, however whether these problems should be treated concurrently in an alcohol and drug setting, or separately is still debatable, and depends on the severity of the mental health problem.

Peer group

At the stage of adolescence, the influence of peers in the adolescents life can become more important than the influence of the family, as the adolescent seeks to gain independence and identity. Peer influence can be both a risk factor or a protective factor, and depends on such things as the peers' substance use, and how this is perceived by the adolescent, peer attitudes about substance use, and the level of attachment to the peer group (Bukstein, 1995; Spooner et al., 1996; Thomas & Schandler, 1996). In an effective adolescent substance abuse intervention, social skills education reinforcing the choosing of positive peers could provide the adolescent with the skills to meet and make favourable friends which in turn can become a protective factor against relapse.

Education

> "Low commitment to education has been associated with substance misuse and delinquent behaviour. Substance users are more likely than non-substance users to be absent from school, skip classes and perform poorly, drop out of school early, dislike school, perceive course work as irrelevant, spend less time on homework and be suspended from school" (Spooner et al., 1996: 2-10)

It is difficult to know whether academic problems are a contributor to, or a consequence of substance abuse. The reality is that by the time the adolescent seeks help for their substance abuse their schooling and educational background has probably already been negatively affected (Magolis, 1995). This means that an assessment of their educational skills, and the provision of appropriate education for each individual would be important as part of a substance abuse intervention.

Age of onset and early labelling

The age at which the adolescent first begins to use substances is a risk factor. The earlier the age of onset of initiation into substance use the more the likely the adolescent is to abuse substances and be at increased risk through this abuse (Bukstein, 1995; Spooner et

al., 1996). There is also an increase in the probability that they will use more serious and illicit drugs (Bukstein, 1995; Spooner et al., 1996). The early labelling of the adolescent as an 'alcoholic' 'addict' or 'substance abuser', has also been proven to increase the likelihood that the adolescent will continue to act according to their label. This is thought to be because the label gives them identity, a social group and further alienates them from societal 'norms'. Interventions aimed at helping the adolescent substance abuser could be referred to as something other than 'substance abuse programmes', and the workers would do well to limit the labelling of their clients (Spooner et al., 1996).

These factors highlight the complexity of the nature of this problem, and offer some insight into how effective interventions may be provided for those adolescents who need it. Each of these risk or protective factors is unique to the individual, and their substance of choice. There is no single risk factor that is more important than another in predicting adolescent substance abuse, rather it is the number of risk and protective factors combined that is more likely to predict this. As with the different theories of adolescent substance abuse, where risk and protective factors are concerned there are also no absolutes. A combination of information about individual factors, the environment, and the substances being used is likely to give us the best understanding of the phenomenon that is adolescent substance abuse (Spooner et al., 1996).

Treatment Models

Based on these theories of adolescent substance abuse and the identified risk and protective factors, a number of treatment modalities have been developed. There are far too many adolescent treatment models, some based on research and others on clinical knowledge, for them all to be mentioned here. However this part of the chapter will identify some of the main treatment models being used in Aotearoa/New Zealand and around the world in the treatment of adolescent substance abuse, whether this be in an outpatient, day or residential setting. The importance of using a combination of these models will be discussed and seen alongside the empirical data from this research, when final recommendations about effective interventions are made.

The Minnesota 12-step Model

While this model was not specifically designed for use with adolescents it is still widely used with both adults and adolescents in a number of settings. This model of therapy offers a specific set of coping mechanisms, and is primarily group focussed. These mechanisms include 12 steps (based on the 12-steps of Alcoholics Anonymous), which the individual must take to 'recover' from their substance abuse (Bukstein, 1995). This model also strongly emphases a connection with peer groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). It is seen as a confrontational model, with the goal of abstinence. Above all the 'alcoholics' and 'addicts' are expected to face the fact that they must never drink or use drugs ever again. One of the basic beliefs of this model is 'once and alcoholic always an alcoholic'. The concept of 'God' or a 'higher power' is also important in the 12-step philosophy, and something that individuals must come to terms with in their own way if this model is to work for them, as recovery is seen as a spiritual awakening (Polcin, 1992). This model which fits best with the disease concept of addiction, is mostly used in day and residential settings, and will often incorporate education and individual and family therapy into its programme. Aftercare and follow up includes continuation long term with AA or NA meetings in the community.

There is much variety amongst programmes that have the 12 steps as their foundation, however those who criticise this model are quick to point out that there is a general lack of research to support the effectiveness of the any 12-step model for adolescent substance abuse (Washton, 1995; DiClemente et al., 1996; Lawson, 1992). Another criticism comes from the fact that adolescents in a 12-step programme, can be labelled as alcoholics or addicts when the degree of abuse may just be a phase of experimentation in adolescence. Early labelling of adolescents as 'alcoholics' or 'addicts' has been identified as a risk factor for continued adolescent substance abuse (Spooner et al., 1996).

> "The fact is that, during any 10-20 year period, approximately one third of alcoholics "mature out" into various forms of moderate drinking or abstinence. The rate of maturing out is even higher among heavy drinkers who are not diagnosed as alcoholics (Fillmore, 1998)" (Lawson, 1992: 225).

From this it would appear that labelling the individual as an 'alcoholic' or 'addict', which is a permanent life long label, as is part of the 12-step model, can be detrimental to the recovery of that person, especially an adolescent. Research has shown that generally adults over the age of 30 do better in programmes that use the 12-step model (Lawson, 1992).

Pharmacology

Using a variety of drugs is common with acute overdoses, and with people detoxing from substances to alleviate some of their withdrawal symptoms. Some forms of pharmacology are also used as treatment for substance abuse and dependence, however very rarely in isolation (Pagliaro & Pagliaro, 1996). Drugs such as disulfirum (Antabuse) are used to help the individual stay abstinent from alcohol. This drug works because even if a small amount of alcohol is taken while on this medication a severe reaction will occur including nausea, chest pain, blurred vision, and breathing difficulties. This reaction is supposed to put the individual off ever using alcohol again. A more recent drug called naltrexone is used to treat abusive and compulsive patterns of opiate use as it acts as an opiate antagonist. It also blocks the euphoric effect of the opiate. This is still a reasonably new drug especially in Aotearoa/New Zealand, and concerns have been raised overseas in regards to possible overdoses due to people taking larger amounts of opiates, as they are not getting the desired effect on regular doses (Pagliaro & Pagliaro, 1996).

Another form of pharmacology is in the form of substitution. Substitution is based on the principle of harm reduction. Substitution attempts to reduce the level of harm associated with the use of certain drugs. Methadone is widely used as a substitute for heroin, morphine and home bake use in Aotearoa/New Zealand, and is available in some parts of the country to adolescents. The idea of the methadone programme is to to ward off withdrawal, and stop illegal means of supporting an opiate habit. It exists to allow the individual to continue in their life as normally as possible (Bukstein, 1995; Pagliaro & Pagliaro, 1996).

Medication for clients with mental health problems as well as substance abuse problems ('dual diagnosis' or 'co-morbidity'), is now more common. Some adolescent

programmes still do not cater for those substance abusers who require psychiatric medication, however unless the primary diagnosis is psychosis, the trend is to try and treat the disorders side by side, and therefore allow clients with co-morbidity into substance abuse treatment. According to MacEwan (1999), pharmacological interventions should be available to adolescents to allow them to be sufficiently emotional stable to comply with treatment.

The major concern in this area is that adolescents may begin to abuse their prescribed medication, or that the use of medication may seem to promote a drug use philosophy. There is also concern that psychiatric disorders may be diagnosed and medication prescribed, when the symptoms that are presenting are as a result of alcohol and drug abuse and not due to a psychiatric disorder at all. Certainly medication for people with a dual diagnosis needs to be well monitored and supervised in the early days of treatment (Bukstein, 1995).

Social skills training

Social skills training is widely used in adolescent substance abuse interventions in a variety of settings. Social skills training (taught in detailed training sessions that deal with typical problems) bests fits under the behavioural theory heading of adolescent substance abuse. Social skills training as an intervention aims at giving adolescents the skills to deal with their families, peers, teachers, or employers with an emphasis on competence enhancement. Skills taught might include alcohol and drug refusal skills, communication skills, assertiveness training, conflict resolution, problem solving skills, anger awareness and management, relaxation, stress management and leisure time management (Smith & Miller, 1992; Bukstein, 1995; Pagliaro & Pagliaro, 1996). Evidence shows that these are areas that adolescent substance abusers often lack skills in (Smith & Miller, 1992). Often these skills are taught through role-modelling, role playing and peer feedback. The idea is to provide adolescents with the skills to deal with any relationships, negative feelings, or conflicts that may arise without relying on substances to cope with these. It is seen as beneficial, because instead of relying on reducing negative behaviours, it helps to develop positive behaviours. Usually these skills are best taught in a group setting, but many of them can be taught quite well in one on one counselling sessions:

> "...recent commentators have stated that 'controlled research to date clearly supports social-skills training as a helpful addition to alcoholism treatment' (p151) 18." (Spooner et al., 1996: 6-4).

Social skills training continues to be widely used, while some empirical evidence for social skills training as an intervention with substance abusing adolescents shows positive results initially (Spooner, et al., 1996; Jesen, 1998), "...few studies demonstrate long-term effects of acquired skills on reduction in alcohol and drug use (Jesen, Wells, Plotnick, Hawkins, & Catalano, 1993)." (Jesen, 1998: 23). Its main critique, as with most behavioural models, is that it does not pay enough attention to the psychology of the adolescent. That is, it does not seek to heal emotional or psychological damage from the past, which may also be necessary for the adolescent to give up or control their use of substances.

Family therapy

> "Because family issues are so pervasively interwoven in all areas , family therapy seems to be the therapy of choice for adolescent substance abuse" (Archambault,1992: 26).

Family therapy refers to a number of different kinds of interventions that may range from being behaviourally, psychologically, or functionally focussed, but have a common belief that behavioural problems are in some way related to dysfunction of the family system. Whatever the theory behind the family therapy, there are common goals (Bukstein, 1995). The first is to break through any parental denial about the existence of the adolescent's substance abuse, and to persuade them to try and take some level of control over the adolescent's behaviour. The next step is to help the parents re-establish their own structure to limit-set and monitor the adolescents behaviour and activities. The next step involves looking at parental or sibling substance use and/or abuse, their relationships, and the role that the abusing adolescent plays in the structure of the family. Lastly a healthier family system needs to be established through education, the development of coping skills, and communication (Bukstein, 1995).

Multiple Family Therapy may also be used as an intervention. This involves a number of families and their affected adolescents in one large group, and has been found to be both educational and supportive to the family members (Kaminer, 1994). Obviously there are a number of problems that can arise with any sort of family therapy, as families who had

not believed themselves to be dysfunctional have to take some responsibility for the behaviours of their children. Other problems arise when families refuse to be involved, whether because of denial of their own substance abuse or because they believe the adolescent must do it on their own.

Family therapy is thought to be especially important when working with adolescents because, they are less likely than adults to be independent from their families, and usually are still dealing with home structure and family function. Drug or alcohol abuse by parents or siblings is especially important to deal with if possible, because if the adolescent is returning home to this the results are often destructive (Margolis, 1995).

Evidence shows that, when done correctly by a qualified professional, family therapy does work with substance abusing adolescents (Spooner et al., 1996).

Psychotherapy and group psychotherapy

Psychotherapy emphasises a host of emotional problems that underlie substance abuse, and seeks to heal these. There are many types of psychotherapies, however cognitive therapy is probably the most commonly used form of psychotherapy in the treatment of adolescent substance abusers (Pagliaro & Pagliaro, 1996). Cognitive therapy is directed at correction or modification of irrational belief systems, deficient coping skills, and faulty thinking patterns, that can stem from past emotional issues and experiences. This therapy encourages the individual whether in a one-on-one session, or in a group to share their experiences, thoughts and feelings. Experiences are highlighted that may give some understanding to the situation the individual now finds themselves in. These experiences are seen as possible reasons for their behaviour, but not excuses. Over time there is emphasis put on making changes, now that there is an awareness and acceptance of past experiences and how these may have affected their lives. Thoughts and feelings are talked through and analysed and, gradually over time, substituted for more positive and rational thoughts and feelings. The development of certain interpersonal or social skills like communication and anger management, are also an important part of this therapy, so as to give the adolescents the skills they need to cope and deal with any problems they may encounter (Pagliaro & Pagliaro, 1996).

Group psychotherapy is also very common as part of adolescent substance abuse programmes. The group reduces the sense of isolation for the adolescent, and together the individuals can see what they have in common with others who are struggling with similar problems as them (Vannicelli, 1995). The goals are similar to that of individual psychotherapy, but the group process usually means there are dynamics between group members that can provide positive experiences and better understanding, that perhaps may not have been achieved in an individual session.

The main critique of this therapy is that sometimes there is not enough attention paid to the actual substance abuse and the consequences of this. Sometimes psychotherapy can become stuck in past emotional issues, while the individual continues to struggle with their substance abuse. It is very questionable as to how helpful psychotherapy is if the adolescent is still using, whether they are drunk or stoned at the time of the session, or not. These issues can be reduced however if the clinician is competent, and can remain focussed on the issue of substance abuse.

Therapeutic Communities

> "Therapeutic communities (TCs) are based on the assumption that substance use is primarily symptomatic of psychosocial maladaptation to society, often as a result of incompetence in dealing with stress or social privation and alienation" (Pagliaro & Pagliaro, 1996: 263).

DeLeon (1989) has stated the therapeutic community perspective views the drug abuse as;

> "a disorder of the whole person, reflecting problems in conduct, attitudes, values, moods and emotional management." (DeLeon, 1989: 179).

The Therapeutic Community model fits with sociological theories of adolescent substance abuse, but also incorporates some behavioural theory elements such as social skills training, and some psychological theory components including group therapy. Therapeutic communities are usually long term residential substance abuse programmes that give adolescents the opportunity to live with other adolescents who have similar problems in a highly structured community environment (Pagliaro & Pagliaro, 1996). At the centre of therapeutic community philosophy is the critical importance of involvement

with peers, and the peer group. The community environment is run by the individual clients in it who have the responsibility to see that community problems are minimised and that everything runs smoothly. Regular meetings are held throughout the day, some formal, some informal. Recreational activities, work duties, education, and group therapy are also part of a normal week in a therapeutic community. The aim of the programme is to get the adolescents off the substances (all TCs require total abstinence of mind altering substances), teach healthy ways of dealing with everyday problems, and return them to their communities as functioning and independent individuals. A global change in lifestyle is the goal of the treatment, not just abstinence from substances (Pagliaro & Pagliaro,1996).

Adolescent therapeutic communities tend to have clients whose drug involvement, criminal behaviour, and family situations are such that removal from the home is thought to be necessary (Stevens et al., 1996). It is therefore not a realistic option for all adolescent substance abusers, but more suited to those at the more severe end of the scale.

For those that finish the therapeutic community programmes there is a high success rate of more than 75% (Rosenthal, 1984: 55). However most clients, that is up to 75%, do not finish the entire course of the programme. (Cohen, 1982). Generally, positive outcomes are directly related to increased length of stay in the therapeutic community (Carroll & Berry, 1998).

Motivational interviewing

The development of motivational interviewing, which best fits with behavioural explanations of adolescent substance abuse, came about as an attempt to find an alternative strategy to enhance motivation to change (Rollnick & Morgan, 1995). Confrontational types of counselling with any substance abuser can create resistance and denial (Rollnick & Morgan, 1995). Motivational interviewing is a technique used to get around this resistance. It is primarily a directive, client-centred tool used in counselling with substance abusers, but can also be used in a group setting. This tool is often used alongside 'stage change models' (Prochaska et al., 1992) that are used to describe the different phases that individuals go through in order to make a change in their lives or

change a behaviour. The phases in stage change models range from pre contemplation, to contemplation, to preparation, to action and to maintenance and/or relapse (Prochaska et al., 1992). People can fluctuate through these phases, forwards and backwards at various times in their journey. Motivational interviewing works alongside this concept of stages of change to build motivation to move on to the next phase, and/or to strengthen the commitment to change (Rollnick & Morgan, 1995).

Motivational interviewing seeks to use the internal motivators of the individual as opposed to external motivators, that is, it seeks to use the individuals own personal reasons to want to change rather than other outside motivators like police or court pressure, to influence the change. The basic assumption of motivational interviewing is that each individual is able to access their own internal motivators if asked the right questions in the right ways. Developing discrepancies in what the individual is saying, and in their present reality compared to their future goals is one way of doing this. Rolling with resistance also allows the individual to come to their own conclusions about matters, again if the right questions are asked within this resistance. Overall there needs to be a high level of empathy, and support throughout the process from the counsellor, whether the individual moves through pre contemplation to contemplation or remains at pre contemplation. The idea is that persuading or confronting the clients with their problems is not as helpful as helping them to understand in their own way, and in their own words, how the problem is and the consequences it brings (Rollnick & Morgan, 1995).

This is a commonly used tool throughout Aotearoa/New Zealand with both adolescents and adults. Its main critique is that it does not take into consideration emotional or psychological issues that may present that need to be dealt with. However if the counsellor is well trained they will be able to deal with these issues by leaving motivational interviewing to the side and concentrating on the issues at hand. If these issues are being raised however it is suitable to assume that the person maybe moving from pre contemplation to contemplation, in terms of changing some of their behaviours.

Education

Usually education is used in preventative models of adolescent substance abuse. However it can also be used as an intervention. It is important to teach adolescents about the nature and affects of substances on their emotional, psychological, physical, mental and social well being so that if they choose to use substances they are aware of the possible consequences. While it might be that most of this is known to the adolescents, this type of honest information is necessary to dispel any myths and rumours that may abound in the adolescent substance abusers subculture.

Many adolescents who have substance abuse issues experience educational delays, and it is important as part of a substance abuse programme or intervention that some appropriate level of education is offered to address educational deficits. This also can address appropriate study skills, and the setting of both short and long term goals (Margolis, 1995).

Therefore while not enough of an intervention on its own, it would appear that education both general and specific in nature is an important component in any alcohol or drug treatment programme, and should be considered where possible in both residential and outpatient settings.

Alternative outdoor/adventure models

Outdoor/adventure models of intervention with substance abusing adolescents provide sometimes rigorous outdoor activities or adventures. The activities themselves are many and varied and range from absailing to kayaking. The activities are all 'holistic' activities that rely on the physical, mental, emotional and spiritual strengths to varying degrees. This is thought to be a helpful practice for when drawing on these strengths in everyday living. Theoretically there are many good reasons for these types of programmes, which can teach trust building, goal setting, dealing with a challenge/stress, dealing with 'peak' experiences, how to have fun and/or take risks and seek sensations without having to use substances, and problem solving (Schoel et al., 1988). These types of skills are commonly taught based on behavioural explanations of adolescent substance abuse.

While there is some evidence to suggest that these types of programmes are more effective in reducing re-offending rates of youth 'at risk', in comparison with institutionalised care (Kerslake, 1987), there is no evidence that these types of programmes specifically aimed at alcohol and drug abuse achieve their goals past the short term, or that the skills learnt in the outdoors are easily taken back to the adolescent's community or home life reality (Bukstein, 1995). It would therefore appear that while these types of models may make the intervention for substance abuse more interesting and exciting, and may provide skills in the short term, they need to be incorporated with other models to be most effective. Many residential adolescent substance abuse facilities have an adventure/outdoor component as well as a physical fitness component as part of the overall programme they offer. "Constructive use of leisure time, physical fitness, and nurturing interests in possible hobbies or other activities are all positive adjuncts to treatment" (MacEwan, 1999:83-84).

An eclectic approach

As has already been alluded to under the heading motivational interviewing, education and alternative outdoor/adventure models, sometimes a combination of one or more of the above models are best used together. While many of these models are derived from a number of different theories, they are not inherently incompatible (Bukstein, 1995). Just as a variety of theoretical explanations of adolescent substance abuse are more helpful than any one explanation on its own, a combination of models of intervention based on the variety of theoretical explanations can provide the most 'holistic' approach to intervening with substance abusing adolescents.

"Substance use disorders are multifaceted problems with physical, psychological, social, and spiritual components that vary widely across individuals" (Daley, 1987: 138). Each of the models mentioned above target important aspects of adolescent substance abuse, and where one model may neglect an area, another can cover that area in a different manner. Treatment needs to address the four basic areas of life equally, these are the physical, psychological, social and personal aspects of the individual (MacEwan, 1999). Also, where one counselling technique might suit one individual, it might not suit another. Using a combination of models also makes the intervention varied and perhaps more interesting for the client. Those treatment programmes which use a variety of

models in their approach to adolescent substance abuse do consistently better than those with few interventions (MacEwan, 1999).

There is little evidence to support one intervention over another, in terms of outcome, instead interventions should be applied selectively (MacEwan, 1999). Using a variety of models, or choosing what model or models might suit each individual can provide the most appropriate intervention possible (Bukstein, 1995).

Further Considerations

When investigating what makes an effective treatment or intervention with substance abusing adolescents there are a number of other considerations to take into account which have so far not been mentioned.

Abstinence versus harm reduction

As already mentioned the most popular approach since the turn of the century to drug use and its treatment came from the disease model theory of 'addiction'. Historically there has been much debate about abstinence from substances versus harm reduction of the use of substances, as a suitable goal for individuals with substance abuse problems (Marlatt, 1998, Erickson et al., 1997). While traditional 12-step models of treatment and therapeutic communities aim for abstinence and require that the client be substance free while in residence, a number of other out patient programmes take a harm reduction approach.

Harm reduction is an alternative to the abstinence based models, and may be incorporated into a number of the models mentioned above, for example motivational interviewing, psychotherapy or family therapy. Harm reduction still recognises that abstinence is the ideal, but accepts any alternative methods that reduce harm (Single, 1995; Marlatt, 1998). Programmes or agencies that take a harm reduction approach do not set limits involving abstinence as a condition of entry in to their agency or programme, and are therefore seen to be removing barriers and making it easier for those who need help to, 'get on board'. There is certainly potential for increased participation

in such treatment services. There is evidence to suggest that addiction rather than always being progressive and fatal is often intermittent and discontinuous, particularly among younger people. Harm reduction is seen as an effective way of dealing with this reality. (Marlatt, 1998)

Looking at this issue rationally, it is probably more reasonable to expect an adolescent to control their use of substances as opposed to give them up completely. They may still be at the stage of experimentation, it may be a part of the culture of their peer group, and the thought of having to go for the rest of their lives without their substance of choice may be too difficult to contemplate. However, there may be adolescents whose substance dependence is in fact very severe and where the only reasonable long term goal must be abstinence. This may be the case for someone with a psychiatric disorder who is on medication, for example. Where abstinence is a long term goal initially, unless the adolescent under goes detoxification, goals may also be harm reduction in nature.

Of most importance in this debate of abstinence versus harm reduction, has to be the individual, their needs, wants, and safety. It is better to work with the clients needs and wants in the first instance, so as not to alienate them or increase resistance, and so that if the safety of the client is compromised you have an established trusting relationship with the adolescent, and can therefore intervene if necessary.

Voluntary versus involuntary interventions

The next consideration is, should adolescents be made to go to alcohol and drug treatment involuntarily for example, as a form of punishment for example from Community Probation, or should all treatment be voluntary? According to Ivanoff et al. (1994), clients range along a continuum from voluntary to involuntary. Given the age of the adolescent client group, and the fact that many of them are still under the jurisdiction of parents or guardians, the majority of referrals to substance abuse counsellors or programmes are likely to come from people other than the adolescent themselves, thus the adolescent will fall at various stages along the voluntary-involuntary continuum. To varying degrees the adolescent client may be reluctant or resistant to any form of substance abuse intervention, which can make the intervention itself difficult for both the

client and the alcohol and drug worker. This is especially true as most counselling theories are based on the premise of the co-operative client (Ritchie, 1986).

While the Alcoholism and Drug Addiction Act 1966 can cater for under 18 year olds, the ethical and moral issues in regards to committal of an adolescent for alcohol and drug treatment are huge. For example, should a young person be made to take treatment for something they are not willing to give up? How helpful is this when it is against their will, and could potentially be just a period of experimentation? Aside from these issues the practical realities do not allow for the committal of an adolescent under the Alcoholism and Drug Addiction Act 1966 to a recognised alcohol and drug treatment facility because none of the four alcohol and drug services that provide for committed clients accept under 18 year olds. So while there are no age specifications in the Act, there are no actual services to provide for committed under 18 year olds. Rather treatment or counselling is often given to the adolescent as a 'no option alternative'. Rarely, if ever, has the Act been used to actually commit adolescents to this treatment.

Treatment or counselling may be detrimental if used as a punishment because the punishment can lead to a negative perception of counselling, which in turn can influence the client seeking help voluntarily in the future, if the need arises. Involuntary treatment can also be perceived as a waste of time and money for both the counsellor and agency as well as for the adolescent. However there is a chance that something that is said or talked about in the treatment may plant a seed of recovery in the adolescent, and that this involuntary treatment could be more valuable than anyone knows.

Historically it has been thought that 'nothing works' with involuntary clients, however more recently there has been evidence that involuntary clients can have more successful results than had earlier been thought (Rooney, 1992). While there is still little research in this area, due to involuntary clients not partaking in research and/or involuntary clients not being distinguished from voluntary clients in programme evaluations, it does appear that it is especially important with involuntary clients to establish the boundaries of confidentiality. Can the counsellor offer complete confidentiality to their client or do they have loyalties to their agency and/or the referrer? A trusting relationship is the most important foundation upon which to build a therapeutic relationship, and this can be

established even with involuntary clients, if boundaries and confidentiality issues are clear (Ritchie, 1986). Rooney (1992) agrees that the most important factor in providing interventions with involuntary clients is the client-practitioner interaction and the ability of the practitioner to enhance the motivation of the client.

Most treatment programmes and counsellors have their own views on the 'involuntary client', and again the outcome often comes down to the individual; that is, some may be more likely to learn from involuntary treatment than others. Clinicians should not expect the adolescent to be motivated towards treatment and should see themselves as motivators. It may take several attempts to engage the adolescent in the programme, but change is possible. (Howard, 1995).

Treatment matching

Treatment matching is the next consideration. The clinician needs to have a broad understanding of the options in the area, and in consultation with the adolescent, match the client with the intervention as best as possible (Windel et al.,1996; Spooner et al., 1996; MacEwan, 1999). In Aotearoa/New Zealand we do not have the number of agencies and options that other countries have, however clinicians can treatment match where possible. After a comprehensive assessment it should be more clear where the adolescent is at, and what type of intervention they may require. Consideration needs to be given to whether the adolescent requires a detoxification, and how this will be done (in hospital, in a social detoxification centre, or by their doctor). More severe cases may warrant a residential or day programme, while less severe cases may only require once a week counselling. Consideration should be given to whether the client may benefit more form a group setting or one on one sessions, from an abstinence or harm reduction approach. Other considerations include the gender, culture, mental health and family/whanau. Not all interventions are appropriate for all genders and cultures, and if family/whanau are important in the adolescent's life then moving them out of the community may not be as appropriate as finding an intervention within the community. Not all treatment centres will accept those with a dual diagnosis who are on medication, and not all interventions cater for these adolescents even if they do allow them on board. Unfortunately the lack of options in Aotearoa/New Zealand sometimes means having to put adolescents into treatment that is destined to fail.

Youth alcohol and drug workers

Another important factor to mention is the workers themselves. Workers must have the necessary attributes to work in this area. These include a natural ability and ease in relating to adolescents, the ability to be a positive role model, the ability to show empathy, a well organised approach to each case, the ability to make appropriate referrals, and several years of counselling experience (Archambault, 1992; Spooner et al., 1996). Evidence suggests that workers who use 'power tactics' and are confrontational are less likely to be effective with substance abusing adolescents. If the mix of worker attributes is not right the adolescent will pick up on this, to the detriment of their recovery (Spooner et al., 1996).

Medical considerations

It is important to have a medical team, or doctor as part of the process when intervening with a substance abusing adolescent. Whether the intervention is residential, day or on an outpatient basis a medical check up is important where possible to ensure there are no urgent medical problems to be dealt with before counselling beings.

> "The effects of drug abuse, HIV infection, neglectful self-care, lifestyle effects, sleep/waking regulation, indiscriminate sexual behaviour, risk taking behaviour, and junk food diet all commend that general health status be parts of the treatments available" (MacEwan, 1999: 82).

Follow- up

Often a well structured follow-up to any intervention upon completion is important in the transition back to every day living for the adolescent. This follow-up can range from home visits once a week to follow-up counselling once a month, for as long as it is thought necessary. There is little research about the importance of follow-up, however it is commonly recognised that the 'real work' begins for a client with the completion of a programme, and upon their return to the community (Spooner at al., 1996).

Barriers to effectiveness

There are a number of things to bear in mind that can become barriers to the effectiveness of the intervention. Firstly generalisations should not be made about the adolescent client population. Programmes and interventions need to be as flexible as

possible for these individuals. Interventions should grow to meet the adolescents needs the adolescent should not be moulded to fit the intervention (Howard, 1995). Secondly access to interventions may be limited to adolescents if they are out of their community, or financial capacity, are not culturally appropriate or adolescent friendly. Interventions may need to be taken in to smaller communities or, counsellors may need to be mobile. Every effort must be taken to make the intervention safe for the adolescent in terms of their culture, sexuality and /or religious beliefs (Howard, 1995). Thirdly as much as possible agencies and services who deal with adolescents should communicate, work together and co-ordinate their services for the sake of the adolescent (Howard, 1995).

Human Development

At this stage it is important to explore the realm of human development, and the impact the period of adolescence has on the individual. The transition between childhood and adulthood involves many physical, psychological and social challenges for young people.

The phase of adolescence can be roughly separated into three stages. Early adolescence covers approximately age 10 to 13, middle adolescence age 14 to 16 and late adolescence 17 to 20 (Petersen & Leffert, 1995). During this transition there are a number of developmental tasks which adolescents will encounter, and which must be completed for healthy development and to allow further growth. Firstly, early adolescents must adjust to the physical changes of puberty, including height, weight, changes in hormonal level, and onset of menstruation. The issue of sex and the variety of concerns that stem from this, also come up during this phase.

The next developmental task, which begins in adolescence is separation from the parents, and the gaining of a sense of independence and competency. This can occur at any of the stages of adolescence, but is usually underway by middle adolescence. At this stage issues of separation for both the adolescent and the parent must be dealt with appropriately and gradually. If there is an unhealthy relationship between the adolescent and the parent, for example if the relationship is enmeshed, then both parties may have

difficulties with separation and the task may not get accomplished, or the adolescent may rebel (Cavaiola & Kane-Cavaiola, 1989).

Adolescence also marks the beginnings of developing effective and appropriate relationships with same and opposite sex friends. The adolescent may start to identify with a peer group, and at this time start to experiment with sexual relations and recognise their sexual orientation. Values are often formed at this stage, and while it is common for these values to be different from parental values during adolescence, most adolescents take into adulthood the values they were taught in childhood (Cavaiola & Kane-Cavaiola, 1989).

The next task for the adolescent is to decide upon a vocation, and then go about acquiring the education and skills to achieve this vocation. Educational and career choices are vital for future economic independence. It is typical however for the adolescent to be confused about what they want to do with their life, especially before late adolescence (Cavaiola & Kane-Cavaiola,1989).

Finally and most importantly is the task of developing a sense of identity, and having an understanding of where they fit in relation to other people and the environment. If this sense of identity is not established in adolescence there can be role and identify confusion about their place in the world. This task begins in early adolescence and continues through the years into late adolescence by which time a sense of identity has usually been established (Cavaiola & Kane-Cavaiola,1989).

All of these tasks require the adolescent to change and develop a number of things including their emotional maturity and cognitive ability, therefore it is no wonder adolescence has been described as a time of 'stress and storm' (Hall, 1904). At any stage during adolescence problems can arise because of these challenges and tasks, especially when adolescents no longer agree with, or abide by the rules of their parents and assume the rights of an adult. For example the adolescent may have a different time frame for wanting to achieve their independence and sense of identity, than do their parents.

Confusion about relationships with partners, love, sex and philosophy are often topics of discussion or thought among adolescents, and for the first time they may begin to realise there are no answers to all their questions and that life is not fair. Adolescence is also well known to be the stage at which people begin to experiment with substances. While most adolescents will mature out of any abuse problems they may have with substances (Lawson, 1992), a small minority of adolescents will require assistance with their substance abuse or dependence issues.

The effects of adolescent substance abuse on the adolescent are many and varied. Adolescents who use substances are more likely to exit adolescent roles early and enter adulthood unprepared in many ways (Krohn, et al., 1997). Alcohol and drug use during early adolescence has been proven to have an adverse affect on the quality of academic performance and the completion of school, and relationships within the family (Krohn, et al., 1997). Adolescent drug use also disrupts age appropriate transitions to marriage and parenthood. Drug use in early adult years is proven to delay these while drug use in early adolescent years is related to earlier onset of these things (Krohn, et al., 1997). Psychosocial dysfunction including escapism, egocentrism, external locus of control, self-depreciation, and alienation and estrangement have also been found to be results of substance abuse in adolescence (Baumrind & Moselle, 1985). At the very least these adolescents may suffer from developmental lag, where the normal course through adolescence is not guaranteed and results in difficult and disturbing times (Baumrind & Moselle, 1985).

A sound knowledge of the human developmental stage theories of adolescence is needed in order to provide appropriate stage related interventions with the substance abusing adolescents. Alongside this, a good understanding of the effects substance abuse can have on the development of the adolescent is required. These issues must be taken into consideration alongside theories of adolescent substance abuse and the factors of risk and protection in order to see adolescent substance abuse in context.

Chapter Summary

Research into what is effective with substance abusing adolescents, is limited. However we do know;

> "The available research indicates that adolescents can benefit from treatment and that treatment, at least in general, is effective for many adolescents. Many types of treatment are effective in producing some level of change in youth." (Windle et al., 1996: 153)

This chapter has gathered data from the available resources and has described theories of adolescent substance abuse, risk and protective factors, treatment models, and the adolescent stage of human development.

There are five main theories behind explanations of adolescent substance abuse, however evidence has shown (Bukstein, 1995; Pagliaro & Pagliaro, 1996) that the most helpful explanations of adolescent substance abuse are those that take into consideration biopsychosocial, behavioural factors and the disease concept of addiction. No one theory provides a thorough understanding of adolescent substance abuse as it is very complex in nature. As well as the importance of the eclectic approach in the understanding of adolescent substance abuse, there are a number of risk and protective factors that have been identified that should also be taken into consideration. While some of these factors are likely to be part of one or some of the theories already outlined, others are quite unique and separate, but still must be taken into account, when designing effective interventions with substance abusing adolescents. Those things that put adolescents at risk should be alleviated, while those things that protect the adolescent should be enhanced.

The theories, risk and protective factors discussed are used to varying degrees to establish treatment models for adolescent substance abusers. Some of the models mentioned in this chapter are based on one or more of the theories outlined, however given that it has already been established that the eclectic approach is the most appropriate in the understanding of this phenomenon, then a combination of the models represented in this chapter is the most promising way to provide an effective intervention with substance abusing adolescents. That is, while biopschosocial, behavioural and

disease concept theories are used to understand the problem, interventions which consider these aspects of the adolescent are likely to be most effective.

Other considerations in terms of developing effective interventions with substance abusing adolescents include abstinence versus harm reduction, voluntary versus involuntary treatment, the importance of the counsellor/therapist and treatment matching, and the importance of a medical assessment and follow-up.

Research shows that:

- Harm reduction models are effective with substance abusing adolescents, but that abstinence may be a long term goal for some (Marlatt, 1998).
- Some good can be gained from involuntary treatment of substance abusing adolescents (Rooney, 1992).
- Counsellors need to be appropriate to work with young people (Archambault, 1992; Spooner et al., 1996).
- Adolescents should be 'matched' to the treatment (Windel et al.,1996; Spooner et al., 1996; MacEwan, 1999).
- All interventions should have a medical assessment where possible (MacEwan, 1999).
- Follow-up after the intervention is highly encouraged (Spooner et al., 1996)

With this these things in mind, eclectic understandings and a combination of models, need to also take into consideration the human developmental stage of adolescence, and how this can also impact on the adolescent and therefore on the intervention. It is important that the intervention is aimed appropriately not just to the age of the adolescent, but to their developmental stage. Adolescence is a time of physical, psychological, cognitive and emotional change, and if interventions are aimed at a similar level for the different age ranges that adolescence encompasses, then some one is destined to miss out. It may be necessary to provide variations of an intervention for the different and specific stages of adolescence.

The evidence provided about the importance of using an eclectic understanding with a combination of models of treatment, alongside an understanding of the adolescence

stages of human development, leads to the assumption that interventions need to be very flexible depending on the needs of the individual. What this chapter has highlighted is that there are no absolute answers to the problem of adolescent substance abuse, and that each intervention needs to be tailored to the individual.

There is a definite need for more research to be conducted in this area, especially in Aotearoa/New Zealand, with specific populations in regards to such things as age, ethnicity, gender, and mental health. Where interventions are currently operating, quantitative and representative evaluations of their effectiveness should continue, so that information such as that given in this chapter is proven to be effective by more than one or two studies.

The next chapter looks at social policy in relation to adolescent substance abuse, and evaluates the potential role of social work in this area.

Chapter Four

SOCIAL POLICY AND SOCIAL WORK IN RELATION TO ADOLESCENT SUBSTANCE ABUSE

This chapter identifies and discusses the main social policies in Aotearoa/New Zealand which impact upon adolescent substance abuse, and its treatment. These include youth specific social policies, legislation regarding the controlled use or illegality of substances, and the Alcoholism and Drug Addiction Act 1966. Due consideration will also be given to certain topical political issues in regards to these social policies, including the legal drinking age, and the 'legalise/decriminalise cannabis' debate.

Against this comprehensive background the second part of this chapter discusses the professional role of social work within Aotearoa/New Zealand, and its relevance to work in the area of adolescent substance abuse intervention. A lack of understanding about what 'social work' is, coupled with little knowledge of how this fits within a variety of social service settings has resulted in some professionally qualified social workers performing low grade welfare roles. Social workers are well trained in a broad range of areas including macroeconomics, social policy, family work, group work, community development, law and human development among other things, and as a profession they have a lot to offer the alcohol and drug field. These skills will be identified and highlighted in terms of their importance in the area of interventions with substance abusing adolescents.

Aotearoa/New Zealand Social Policy

All societies function through systems of formal and informal control (United Nations, 1997). Informal controls include shared values, norms and moral standards, as well as concern for one another and the community as a whole, in the interest of living peacefully. Formal controls include laws that individuals are expected to abide by and, in

democratic countries, these usually arise from consensus (the people of the country elect a government who in turn create the laws), and are designed to reconcile the goals of individual freedom with the interests of collective welfare (United Nations, 1997).

Definitions of social policy can vary to include actions that occur in the market place and in voluntary associations (Cheyne et al., 1997), however, for the purposes of this study social policy is defined as legislation and policy (implemented by the state) that aim to enhance the well-being of people. Policy is a statement about what is thought to be desirable and attainable, a statement of will, goals and the social map to get us there (Garbarino, 1993). New Zealand social policy according to The Royal Commission on Social Policy (1988)

> " is about quality of life. Its about opportunity and security for all: all cultures, women and men, the young and older people. Social policy is about how we look after ourselves and each other and how we work together yet respect each others differences. It is about employment, housing, transport, our system of justice, environmental and land issues. It is about health and access to health services. It is about the education of children and the chances they have in life. It is about opportunities for those who want and need further education and training" (Royal Commission on Social Policy, 1988: 1).

The goal of social policy according to the 1988 Royal Commission on Social Policy is 'social well-being'.

> "Social well-being exists when all members of the community have a reasonable expectation of achieving those things which are generally accepted as necessary for a healthy and happy life (Royal Commission on Social Policy, 1988:6).

These explanations of social policy and its goals, while idealistic in nature, do highlight the importance of social policy to the realm of adolescent substance abuse.

The state, according to the Royal Commission on Social Policy (1988), is the ultimate expression of collective responsibility and the state alone can provide the desirable and attainable standard of living and opportunities for all (Royal Commission on Social Policy, 1988). This understanding of the role of the state from the 1980s, is in direct

contrast to more recent 'market driven' influences over the role of the state in the welfare of New Zealanders. Since the 1990s Aotearoa/New Zealand has seen a series of centre-right administrations which have moved towards a neo-liberal philosophy for many areas including health and education, and minimisation of the role of the state in welfare issues, and in other areas including industry and business (Boston et al., 1999). The 'free market' approach bounded by libertarianism for the most part, has at its core a belief that "..socially optimal outcomes will be achieved by using economic incentives and allowing individuals to engage in voluntary contracting via relatively free, competitive markets" (Boston et al., 1999: 23). Neo-liberals argue therefore, for the minimising of state paternalism in all areas and this ideology has meant many changes for social policy in recent times. These changes include benefit cuts, asset testing for superannuation, an overhaul of the health system, market rental for state housing, and means tested student allowances, all with a 'free market' approach at the core (Boston et al., 1999).

At the end of 1999, Aotearoa/New Zealand voters voted in a Labour/Alliance coalition government with a more generous approach to welfare, and with a different perception of a 'just society' which more closely resembles governments pre 1990s. Before the election Labour promised the implementation of a Youth Health Strategy which would have as a priority the reducing of youth drug and alcohol abuse (New Zealand Labour Party, 1999). The influence this change in government, and change in ideological reasoning, will have in the area of social policies remains to be seen, while at present we are left with social policies which have emerged primarily through the centre-right administrations prior to the 1999 election.

For the purposes of this thesis there will be three main areas of social policy that will be explored. These are youth specific social policies, substance use/control policies and the Alcoholism and Drug Addiction Act 1966.

Youth Social Policy

According to The New Zealand Labour Party (1999b), the lack of a coherent New Zealand Youth Policy is a glaring omission. Before the 1999 general election the Labour Party (now in government with coalition partners Alliance), made some promises to invest in youth and develop a comprehensive 'New Zealand Youth Policy'. While evidence of this remains to be seen, a pioneering Youth Research Project has been launched to enable young people to have their say in terms of youth policy (New Zealand Government, 2000a). Part of this research is to provide 'Youth Tribunals' that will be held around the country to generate information about the needs and issues of the young people. Comments can also be made via the Internet (New Zealand Government, 2000a). It would therefore appear that some steps are being taken towards a New Zealand Youth Policy as promised by the Labour Party before the election.

Currently however, according to The Ministry of Youth Affairs (1996), youth-related policies in Aotearoa/New Zealand can be separated into five broad themes. These are family, learning, working, well-being, and citizenship. Many of the policies under each of these headings has a direct impact on the everyday life of adolescents in Aotearoa/New Zealand.

Family

Under the theme of family the most important and influential policy, is the Children, Young Persons and their Families Act 1989. This Act provides for intervention from the Children Young Persons and their Families Agency, now renamed The Department of Child, Youth and Family Services (CYF-the government agency that enforces the Children, Young Persons and their Families Act), to ensure the safety and protection of the child or young person (Ministry of Youth Affairs, 1996). The Act has provisions for both youth justice and care and protection. CYF social workers will intervene if children or young people are unsafe in their living situations or are committing crimes and are not in a responsible living environment. One of the underlying principles of the CYPF Act is that there should be as much family/whanau, victim and community involvement with the decision making as possible. This approach is sought under the Family Group

Conference (FGC), where family/whanau, support people and the victims family/whanau and police (in Youth Justice cases) meet together, convened by a CYF social worker to discuss the issues and possible outcomes (Bertrand, 1997). If the child or young person is uplifted from their home, the priority is to place them with other family members (Ministry of Youth Affairs, 1996).

Where a young person is having substance abuse problems, and these are interfering with their life to a substantial degree, CYF may become involved, either in the form of youth justice or care and protection, to get the appropriate help for the adolescent. According to Manning (1999) the largest proportion of the CYF workload arises from children disturbed due to alcohol and drug addictions or violence problems.

Since its implementation the Children, Young Persons and their Families Act and CYF has been criticised in many areas, with concern about the training, funding and resourcing of CYF and its social workers, mandatory reporting of abuse, the lack of secure units for young offenders, abuse of children in CYF care and children having access to alcohol and drugs in CYF care (Royal Commission on Social Policy, 1992; Manning, 1999; New Zealand Labour Party, 1999b). While this Act puts in place legislation for the care and protection of children and young people, there have certainly been teething problems with its implementation (Royal Commission on Social Policy, 1992; Manning, 1999; New Zealand Labour Party, 1999b). Given that this Act can be used to intervene when an adolescent is having substance abuse problems, and that CYF provide services to adolescents and their families around these issues, these teething problems are of concern, especially in the case of adolescents having access to alcohol and drugs in CYF care. The lack of available services for adolescents with substance abuse issues, means that CYF may be the first and only point of contact if help is required. The services provided need to be professional and appropriate.

Other relevant policies in this area, include the Independent Youth Benefit which is paid to young people aged 16 and 17 who are independent from their family group, the Guardianship Act 1968, the Adoption Act 1955 and the Domestic Violence Act 1995. All of these policies can impact upon the lives of adolescents to varying degrees. In terms of the impact upon substance abuse, the Independent Youth Benefit gives

adolescents independence from their family, and can provide them with money for which to purchase alcohol or drugs. On the opposite side of the equation however, this benefit can also give the adolescent the freedom to get away from a family situation which is adding to the substance abuse problem (for example heavy substance abuse by parents). The Guardianship Act 1968 can provide options for a change of guardianship for the youth if their family life is difficult and the Adoption Act 1955 can impact hugely upon the adolescent in terms of providing a home and permanent family and/or helping the adolescent meet up with their biological family when they are old enough, which in turn can help resolve issues around identity. As already mentioned in previous chapters, family plays a huge role in the lives of adolescents and does impact upon their use of substances. These acts and the provisions they offer have the potential to limit stress for the adolescent if their family life is unsatisfactory.

Learning

The key legislation under the theme of learning for adolescents, are the Education Act 1989, and the Industry Training Act 1992. (Ministry of Youth Affairs, 1996). As has already be identified in previous chapters, education, social and coping skills are important in the lives of adolescents and can be protective factors against substance abuse (Spooner et al., 1996). The government provides funding to ensure the provision of schooling for all children; this is supported by a legislative framework which requires that the young person attends school until age 16. Part of this framework also provides funding aimed at reducing truancy, which is recognised to be something common among adolescent substance abusers (Spooner et al., 1996). There is also the provision of free access to career information and counselling to students at school and additional assistance for students with special needs. If students leave school at the age of 16, the government provides extra training for these young people to increase their skill base and so they are more likely to gain employment.

Policies around education and learning are of paramount importance to adolescents as schools are where their basic learning needs are met. If the education system does not cater appropriately for a number of different learning needs and cultures, this may leave the adolescent disenchanted about themselves, and with a negative attitude to schooling

and society in general; this is a recognised risk factor for adolescent substance abuse (Spooner et al., 1996).

Education too has been subject to the influence of the 'market driven' ideology, and since the late 1980s has begun to be seen increasingly as a private good and more than a public good (Gordon, 1999). Changes contained in policy known as 'Tomorrow's Schools' (1988) included bulk funding, private fee paying overseas students at state schools, sponsorship of schools by private companies, increased state funding to private schools, the Targeted Individual Entitlement (TIE) scheme, which pays for 'poor' children to go to private schools, and the devolution of funds including special education funding (Gordon, 1999). According to Sullivan (1998) the overall effect of these reforms

> "has been to change the focus of New Zealand education from a concern for equity, social justice and a good education for everybody to a focus on choice, efficiency, quality, accountability and a free market approach in all areas" (p143).

However Clark (1992), argues that education and the teaching profession cannot be measured in the commercial sense, and Marginson (1997) states that "The economics of education is simply mainstream neo-classical economics applied to research and policy making in education, whether it fits or not" (p3). Marginson (1997) suggests it does not fit.

According to Gordon (1999), these policies have led to three particular effects at the school level. The first being the assumption that some schools are better than others, the second that schools take less responsibility for their pupils, because the image of the school is seen as more important than the individual child, and finally the hiring of a "new breed of jingoistic principal, focused more on self and school promotion than nation-building" (Gordon,1999: 251). In this example of the effect of these policies, the image of the school is seen as more important than the individual pupil. This can lead to situations whereby pupils are suspended for such things as substance use in the school in order to protect the schools reputation, rather than helped by the school to get education and support.

In direct contrast to this view, Harrison (1998), in a paper given at the New Zealand Independent Schools Conference, does not believe that the education system has been deregulated enough. He states that accountability to consumers in the education market through the political process is weak, because "a central bureaucracy finds it difficult to promote consumer satisfaction or respond to diverse needs" (p200). He argues further that there is a conflict of interest where the government provides the education, regulates and finances competitors while also protecting consumer interests. According to Harrison (1998) the education system in Aotearoa/New Zealand is still closer to a centralised public system than a market system, and he believes a more market driven system would provide consumers with more freedom and choice in order to obtain the best education possible.

Currently caught in this middle ground between market driven deregulation and a centralised public system the Aotearoa/New Zealand schooling system, according to Hood (1998), does not cater for diversity very well. He states "Our schools have become essentially middle class institutions, our systems geared towards educating only some children" (Hood, 1998: 14). Hood (1998) also critiques the schooling system for valuing some subjects above others, and having expectations of student progress based on gender, race and class. Those children who may already be at high risk of developing substance abuse problems are likely to be the same children for whom the education system is failing. For example a young women who comes from a 'working class' family, who has grown up around heavy drinking and cannabis use, unemployment and poverty is not expected to do well at school, and therefore does not. That is, the education system is not set up to deal with these sorts of problems that children may face in their home life.

Hood (1998) suggests that rather than providing a system where all students have to fit in and learn, or fail, students should be assessed in terms of how they learn, and a suitable teaching methods should be used to enhance this. Whether it is possible to teach such a young women as given in the above example is perhaps arguable, but Hood (1998) argues that at least we ought to try and not give up before we begin, merely because of her background. Wylie (1988) agrees, and states that there is no natural basis for the different educational achievement levels between various groups. She believes

that when these differences occur, it indicates that the education system, and its relation to the wider society, needs to be critically evaluated because it is failing. Coxon et al. (1994) also support this view and state that when the content and the processes within the education system are assessed, the structures underlying them are revealed to be very much socially constructed, and often serve the interests of the most dominant groups in society.

One of the promises by the Labour party before the 1999 election was to close these gaps in the education system, by the abolition of bulk funding, staffing changes, incentives for the secondment of teachers to 'hard to staff' schools, and the continued development of specific programmes for Maori and Pacific Islands' children (New Zealand Labour Party, 1999a). It would appear that there is certainly room for improvement within the schooling system in Aotearoa/New Zealand, so that the diversity of need is addressed. This, in turn, can provide positive schooling experiences for adolescents, which has been recognised as a protective factor against substance abuse (Spooner et al., 1996).

Working and income

Gaining employment, and ensuring financial independence is recognised as a step that adolescents must take on their journey to adulthood, as well as being important for a sense of well-being (Ministry of Youth Affairs, 1996). The governments' student allowance policy which has people up to the age of 25 means tested against their parents income before being allocated a student allowance, is in direct contrast to this and is inconsistent with all other laws which pertain to independence.

Some of the most important pieces of legislation in the area of 'working' include the Employment Relations Act 2000, Equal Pay Act 1972 and the Minimum Wage Act 1983. Other legislation provides for youth development and training, by the Conservation Corps and the Youth Services Corps which provide education, recreation, community service and personal development.

Strategies have also been developed specifically for both Maori and Pacific Islands people, to assist them to gain employment, as there are high rates of unemployment for

youth of these cultures. According to the 1996 census, 30.4% of Maori and 32.4% of Pacific Islands young people, aged between 15 and 19 are unemployed. (Statistics New Zealand: 2000). Before the election Labour promised to get the Training Opportunities Programme (TOPs) back on track, and to provide further assistance and training for youth, including the re-establishment of an apprenticeship scheme (New Zealand Labour Party, 1999). Now that Labour is in government the changes promised, if enacted, may provide more assistance for youth to gain training and employment, if there are jobs to be had.

The Labour/Alliance Coalition government has already made some steps towards keeping these promises. When they came into government in late 1999 one of the first things they did was to increase the minimum wage for adults from $7 to $7.55 an hour (New Zealand Government, 1999). According to Laila Harre, the Minister of Youth Affairs, the minimum wage for youth is also currently under review, with the aim being to redress the inequity between the minimum wage for youth and adults (New Zealand Government, 2000b). According to Harre "No one should be paid less for doing exactly the same work as someone working alongside them...." (New Zealand Government, 1999).

The Government also announced in March 2000 that they will bring in a modern apprenticeship scheme to replace the apprenticeships of old that will target those aged 16-21. This programme aims to provide training for three thousand modern apprenticeships by 2002 (New Zealand Government, 2000).

The Employment Relations Act, which came into force on 2 October 2000, promises to be fair to both employers and employees through the principle of 'good faith bargaining'. Prior to its implementation the government promised that "Young people, in particular, will benefit when the Employment Contracts Act is replaced with modern and fair employment relations legislation" (New Zealand Labour Party, 1999c: 10). Evidence shows that gainful employment is a protective factor against adolescent substance abuse, even though it provides the adolescent with money to purchase substances (Eckersley, 1988; Spooner et al., 1996). Conversely unemployment is a risk factor (Eckersley, 1988;

Spooner et al., 1996). It is essential then that legislation pertaining to youth and working is effective.

Well-being

Well-being, according to Ministry of Youth Affairs (1996), pertains to good physical, social, cultural and mental health. Some of the key pieces of legislation under this heading include the Children, Young Persons and their Families Act 1989, Misuse of Drugs Act 1975, Sale of Liquor Act 1989 and the Sale of Liquor Amendment Act 1999 and the Sport, Fitness and Leisure Act 1987.

According to The Ministry of Youth Affairs (1996) some of the top priorities in terms of legislating for the well-being of youth have been improving road safety, as motor vehicle crashes are the most common cause of death for people aged 15-24 years. Other priorities include improving youth mental health, and suicide prevention as Aotearoa/New Zealand has one of the highest rates of youth suicide in the OECD (Ministry of Youth Affairs, 1996; Ministry of Health, 1997a; Ministry of Health, 1997b; Ministry of Health 1998a; Mental Health Commission, 1998). The New Zealand Youth Suicide Prevention Strategy (Ministry of Health, 1998d) outlines New Zealand's strategy to prevent youth suicide, and the Ministerial Committee on Youth Suicide Prevention (MCYSP) and the Inter-Agency Committee on Youth Suicide Prevention (IACYSP) assist with the implementation of this strategy. Since this strategy was introduced in March 1998, key initiatives including the provision of information to assist individuals, families, communities and professionals to identify youth at risk and to ensure appropriate responses, have commenced. (Ministry of Health Website, http:/www.moh.govt.nz, 2000).

In 1998 the Ministry of Health produced the document 'New Futures', which provides a strategic framework for specialist mental health services, including alcohol and drug, for children and young people in Aotearoa/New Zealand. Also in 1998 the Mental Health Commission recommended a major change in how many mental health professionals are needed to provide appropriate services in the mental health area for children and young people. According to Mr. Creech (New Zealand Government, 1999b) the Minister of Health at the time, the Health Funding Authority (HFA) aims to fund for the training of

300 additional mental health professionals to specialise in child and youth mental health by 2002 (New Zealand Government, 1999b). Mr. Creech went on to say that "Funding is planned to almost double, increasing from $26 million in 1996/7 to over $50 million in 2001/2002." (New Zealand Government, 1999b:1). These budget initiatives include additional drug and alcohol services for children and young people (New Zealand Government, 1999b). Other initiatives include mental health services for young people in CYF care, early intervention strategies based in schools and in the community, and improved links between CYF and mental health services (New Zealand Government, 1999b).

Over the last few years then, there has been frequent focus on social policy, legislation and service implementation in the area of youth 'well-being' (Ministry of Youth Affairs, 1996; Ministry of Health, 1997a; Midland Health, 1997; Ministry of Health, 1998a, Mental Health Commission, 1998; Mental Health Commission, 1997; New Zealand Labour Party, 1999c). A new government certainly means these initiatives may be reviewed, however seen in conjunction with the 'promises' of the Labour Party prior to the 1999 election, it is hopeful that these initiatives will be undertaken.

In terms of substance use/control legislation policies are also in place to control the supply of tobacco, drugs and alcohol. It is against the law to sell tobacco or alcohol to anyone under the age of 18. Only recently has the legal age of drinking been lowered to 18 years of age, with the Sale of Liquor Amendment Act 1999. Controversy about this, and the impact of this policy on adolescents will be discussed later in this chapter under 'Substance Use/Control Policies'. The supply of drugs is restricted through the Misuse of Drugs Act 1975, which will also be further discussed under 'Substance Use/Control Policies'.

In terms of physical well-being the school curriculum provides for health and sexual health education, alcohol and drug education as well as physical fitness. The Hillary Commission for Sport, Fitness and Leisure is an independent statutory body that initiates and supports programmes aimed at raising the quality and quantity of participation in sports and fitness in all age groups (Ministry of Youth Affairs, 1996).

While it appears there are a number of strategies aimed at the well-being of youth and adolescents, to what degree these initiatives are working is arguable. We still have a very high suicide rate among youth compared to other countries, and it continues to be the second leading cause of death in the 15 to 24 year age group, following motor vehicle crashes (Ministry of Health, 2000). Problems of substance abuse appear not to adequately addressed by alcohol and drug education in schools, as figures on youth alcohol and drug use remain high (Business Research Centre, 1997).

The well-being of youth is paramount as a protective factor against substance abuse and, where current policy is failing, new initiatives may need to be found. Changes to youth policy which have been promised by the current Labour/Alliance Government under a comprehensive 'New Zealand Youth Policy' (New Zealand Labour Party, 1999c), including a 'Youth Health Strategy' with priority given to youth alcohol and drug abuse (New Zealand Labour Party, 1999), may provide improvements to legislation, funding and services available to adolescents with substance abuse problems. The June 2000 Budget which allocated extra funding to the alcohol and drug treatment field generally (an extra twenty four and a half million over four years), and promised additional funding for youth treatment services was the first step towards meeting some of these promises (Jackman, 2000). Following this the Health Funding Authority (HFA) discussion document 'National Alcohol and Drug Services Funding Strategy' has also pinpointed children and youth for special focus with this increased funding (HFA, 2000).

Citizenship

All New Zealanders have both rights and obligations as citizens "as well as the opportunity to participate in the social, economic and culture development of their country" (Ministry of Youth Affairs, 1996: 45). Some of the current key polices in this area are the Status of Children Act 1964, Treaty of Waitangi Act 1975 and the Child Support Act 1991. These acts provide laws for when young people can be charged with criminal offences, when they can leave school, vote, leave home, have sex, get married, and join the armed forces. These laws are designed to establish a series of steps that increase people's participation in society from adolescence to adulthood (Ministry of Youth Affairs, 1996). "The Government reflects society's values in relation to the

appropriate responsibilities young people should face" (Ministry of Youth Affairs, 1996).

The Ministry of Youth Affairs was established in 1989 to facilitate the direct participation of young people in aspects of life in Aotearoa/New Zealand. The Ministry of Youth Affairs provides youth focussed policy advice for the government. According to the Ministry of Youth Affairs (1996), the key government initiative in terms of citizenship has been to achieve higher levels of participation by younger people in decision making at local and national levels. This is in concurrence with the current Labour/Alliance governments initiative to hold Youth Tribunals around the country to get an understanding about youth issues and needs, to help form a comprehensive 'New Zealand Youth Policy' (The New Zealand Labour Party, 1999c).

All of these five broad areas of youth policy relate not only to the youth (and their substance use/abuse) in Aotearoa/New Zealand, their families, education and job prospects, health and welfare, rights and responsibilities, but to the future of Aotearoa/New Zealand as a whole. Legislation influences so many areas of people's lives and therefore provides an important foundation from which to build the future of Aotearoa/New Zealand. Recent social policy legislation which has come from 'market driven' ideology appears to have created further poverty and inequality in this country, and has certainly done little to address it. A recent Northland study found that 1400 children in Northland were living in overcrowded housing, and that the region had high rates of Third World diseases such as meningitis and tuberculosis (Saville-Smith & Amey, 1999). According to Stephens et al. (2000) more than one-third of Aotearoa/New Zealand children live in poverty, and high housing costs are the key contributing factor. A Statistics New Zealand document identified that during the past 15 years the rich have got a lot richer and the poor have stayed poor or got poorer. The average income for the bottom 20% of households fell 4% from 1982 to 1996, while the income for the top 10% of households rose by 32% (Statistics New Zealand, 1999). Poverty and inequality are recognised as risk factors for many 'social problems' including adolescent substance abuse (see Chapter Two). The Labour/Alliance Coalition Government has made many promises in regards to youth social policy, which if fulfilled

vow to address this inequality and in turn the 'social problems' it creates. How this will happen, and what the future holds remains to be seen.

Substance Use/Control Policies

The main pieces of legislation that pertain to this section of this chapter are the Sale of Liquor Act 1989 and its subsequent amendments in 1999, the Misuse of Drugs Act 1975, and the National Drug Policy 1998-2003 (Ministry of Health, 1998b). The Sale of Liquor Amendments Act 1999 sets out the controlled use of alcoholic liquor, while the Misuse of Drugs Act 1975 sets out the controlled use of some substances and the illegality of others. The National Drug Policy brings together policy on Tobacco and Alcohol (Part 1) and Illicit and Other Drugs (Part 2), and establishes a strategic direction for drug policy from 1998-2003 to minimise drug-related harm (Ministry of Health, 1998b).

The Sale of Liquor Act 1989, and Amendments 1999

The proposed amendments to the Sale of Liquor Act 1989 were separated into 11 parts, and in mid 1999, MPs took a conscience vote on each (Ryall, 1999). There was much debate in respect to these recent changes, especially with regard to the changing of the drinking age from 20 to 18, the possible introduction of the sale of liquor on Sundays, and the sale of beer and spirits in supermarkets (ALAC, 1996; Hill & Stewart, 1996; Ministry of Justice, 1996; Hill & Stewart, 1998). The Sale of Liquor Act 1989, decreed that unless accompanied by an 'of age' guardian or spouse, or having a meal, all people had to be 20 to buy and consume alcohol. The 1999 Amendments lowered the drinking age to 18 years of age with only one exception, that is, that liquor can be supplied by a parent or legal guardian. Alongside this change there was an introduction of 'evidence of age document'. The law now allows only for the use of four types of identification of age; these are a New Zealand photo drivers licence, a New Zealand or overseas passport and an ' Hospitality Association of New Zealand (HANZ) 18+ card' (ALAC Website, www.alcohol.org.nz, 1999).

The concern regarding the lowering of the drinking age came primarily from evidence that the age at which minors begin to drink alcohol lowers in conjunction with the legal drinking age, and a lowering of the drinking age leads to an increase in road crashes involving young people (ALAC, 1996). The growing trend around the world has been to increase the drinking age to counteract these problems, for example from 14 to 16 in Germany, from 18 to 19 in Canada, and from 15 to 18 in Ireland (ALAC, 1996). According to MacKay (1999) the Chairperson of the New Zealand Medical Association "Evidence from many states in Australia and the United States showed that public health suffered when the drinking age was lowered" (MacKay, 1999:1). Organisations which opposed the changes to the Sale of Liquor Act because of such evidence included The Salvation Army, the Christian Heritage Party, the New Zealand Medical Association, the Automobile Association (AA), the Children's Commissioner and ALAC (Scoop Media Website, http:/www.scoop.co.nz, 2000). There were also 2000 submissions to the select committee hearing on the liquor law amendments with the majority of them against the proposed changes, as well as a TVNZ public opinion poll which found that 62 % of people were against the lowering of the drinking age (Magna Carta Society, 1999: 1).

In opposition to these arguments were calls from the liquor industry, HANZ, the Aotearoa Legalise Cannabis Party (ALCP), university students associations and individual politicians who based their argument on 'harm reduction' theory of teen alcohol use. This argument is that it is better for 18 year olds to be drinking in a supervised area in pubs and clubs, than out drinking on the streets. ALCP argued that prohibition has a negative effect on youth risk taking behaviours, while Laila Harre, the now Minister of Youth Affairs argued that "whether its sex, drugs or booze, young people will do it anyway in spite of sanctimonious attitudes" (ALCP, 1999).

Since the Sale of Liquor Amendments came into force on 1st December 1999, there has been a mixed response around the country to the lowering of the drinking age:

- From The New Zealand Herald (07-02-2000) an article describing how the new lower drinking age is being blamed for a spate of incidents in which drunken teenagers caused mayhem across the city (Hendery, 2000).
- From The Timaru Herald (28-02-2000) an article concerning unruly, drunk teens under the age of 18, possibly being supplied liquor by 18 year olds (Mutch, 2000).

- An article from The Dominion (18-02-2000) reports that the lowering of the drinking age has made enforcement of the law easier and has led to better co-operation between bar owners and police. This has been helped by their being no exceptions to the rule that a person must be 18 to be allowed to drink alcohol on a licensed premise, and by the fact that people must carry photo ID or will be refused entry (NZPA, 2000).
- The latest findings from ALAC's Youth Drinking Monitor suggests that teenage binge drinking has increased as a consequence of lowering the drinking age to 18 years, and that 20% of 16-17 year olds personally buy their own alcohol from licensed sellers, and only one third of teenagers buying alcohol are always asked for ID (Business Research Centre, 2000).

Long term outcomes from this legislative change may mean a more mature approach to drinking by young New Zealanders in years to come because of the 'harm reduction' focus. However, initially those 18 and 19 year olds for whom it is suddenly legal to drink alcohol in clubs and bars may cause concern, due to the fact that up until now they may not having been drinking at all or may be used to unsupervised drinking. The long term outcomes of the reduction in the legal drinking age to 18 remain to be seen, and while there is some evidence to suggest that adolescents who drink when supervised drink less than if unsupervised (Connolly et al., 1992), positive outcomes rely strongly on those who supply liquor to strictly comply with the law, and evidence suggests was not done very well when the drinking age was 20 (ALAC, 1996; Ryall, 1999b).

Other amendments to the law were the introduction of Sunday sales (except good Friday, Easter Sunday or Christmas day), now available from all on-licence and off licence premises, and the sale of beer in supermarkets (spirits were excluded) (ALAC Website, http:/www.alcohol.org.nz, 1999). There appears to have been less debate about Sunday sales in general, however The Christian Heritage Party strongly opposed this change, not only for religious reasons but because according to their research they believed Sunday sales would mean an increase in the demand for emergency services, and increased fatalities, and injuries from alcohol related crashes (Christian Heritage Party, 1999). On the opposite end of the debate Libertarianz Party, stated that it was about time we gave up the laws we have as a result of the dark ages of religious rule

(Libertarianz Party, 1999). Sunday Sales signal a further liberalisation of the Sale of Liquor Act, and mean that adolescents too can get access to alcohol even on a Sunday.

The Libertarianz Party along with The Distilled Spirits Association, which represents New Zealand's leading producers and marketers of spirits, also believe that spirits should have been included with beer and wine for sale at supermarkets. The Chief Executive of the Association Thomas Chin said " Illogical restrictions on consumers freedom of choice and the protecting of vested interests is not good law" (Distilled Spirits Association, 1999:1). Arguments still abound about this law, and given the number of stakeholders there is no chance that this law reform will please everyone, but how does affect young people? There may be easier access to alcohol by under 18 year olds if the amendments to the law are as poorly enforced as the original law (Ryall, 1999b). This concern however has been addressed to some degree by the 'evidence of age' document clause in the Act which allows for only four types of photographic identification, and by an increase in the fines for licensees, managers, bar staff and consumers (Sale of Liquor Amendments, 1999). Whether concerns raised by groups like ALAC, in regards to the lowering of the defacto drinking age, alongside the legal drinking age are vindicated remains to be seen.

The age at which the adolescent first begins to use substances is a risk factor (see Chapter Two). The earlier the age of onset of initiation into substance use the more likely the adolescent is to abuse substances and be at increased risk through this abuse (Bukstein, 1995; Spooner et al., 1996). There is also an increase in the probability that they will use more serious and illicit drugs (Bukstein, 1995; Spooner et al., 1996). Therefore, given this evidence there must be concern that earlier use of alcohol may lead to more alcohol abuse by adolescents and that this may also increase the likelihood that they will try other substances. While this evidence is clear, those behind this law reform argue that young people are going to drink anyway, whether it is legal or not (ALCP, 1999).

It is still to early to tell whether Aotearoa/New Zealand will have an increase in road crashes among young people and whether public health will suffer, as in overseas countries (ALAC, 1996; MacKay, 1999). If it does then the outcomes of the

amendments will be considered very negative. There are, however, some probable positive outcomes of these liquor amendments also. These include the fact the 18 year olds may now drink in a supervised area such a pub or club, where they may learn to drink in moderation instead of drinking at unsupervised parties or out on the street where they may get 'wasted'. This can be seen as a form of harm reduction. Unfortunately, however early evidence since the law reform, indicates that there has been an increase in binge drinking among adolescents (Business Research Centre, May 2000).

Another possible positive outcome of this law change, is that the area of service need that this research is about, that of adolescent substance abuse intervention, may be highlighted as an area of need now that the public have been made aware of these issues. Already the Education Minister and the Youth Affairs Minister have met to work on education policy in regards to this new law (Liewellyn, 1999). The bottom line is nobody knows the long term outcome of this law reform, however the overseas evidence does not look promising (ALAC, 1996) and this, coupled with the belief that public opinion appears to have been ignored by the politicians when they took their conscience votes, means that it has been a relatively risky move (Magna Carta Society, 1999).

The Misuse of Drugs Act 1975

> "The Misuse of Drugs Act provides for offences which extend from the very common to the very serious. It also creates powers of detention, search and seizure and methods of collection of evidence which are the most extensive known to law" (Mathias, 1987).

This law covers possession, supply, importing, exporting, producing, manufacturing, administering, consuming, cultivation, offering and permitting the use of premises for a range of substances. Under the Act substances are scheduled as either Class A, Class B or Class C controlled drugs. Class A controlled drugs include heroin, LSD, mescaline (cactus), and magic mushrooms. Class B controlled drugs include substances with a high abuse potential such as morphine, opium, cocaine, cannabis oil and resin, amphetamines, methadone and pethidine. Class C controlled drugs include cannabis leaf (fresh, dried or otherwise), codeine as well as 'designer drugs' such as ecstasy (Ministry of Health, 1998b). By labelling these substances 'controlled drugs', a clear message is sent to the public that these drugs are against the public interest and are therefore illegal (Ministry of Health 1996). Depending on the type of drug and the type of offence, the fine, or prison

sentence differs. For example someone 'supplying' LSD (Class A) is likely to receive a more severe punishment than someone in 'possession' of a small amount of cannabis leaf (Class C). Some restricted drugs like Ketamine and Amyl Nitrate fall under the Medicines Act 1981, and it is not illegal to possess these types of drugs (New Zealand Government, 1981).

This law was introduced in 1975 to enable prosecution of those involved with drugs in order to decrease the use and availability of certain illicit drugs in Aotearoa/New Zealand (Mathias,1987). Of recent times arguments about whether prohibition of drugs is the most appropriate and best way to deal with the problem of drug abuse and dependence has been debated (ALCP, 1999b & 2000; Drug Policy Forum Trust (DPFT), 1997; Abel & Casswell, 1998; Health Select Committee, 1998). Most frequently debated is the illegality of cannabis. With the liberalising of the liquor laws recently calls have come from ALCP to also liberalise cannabis laws. According to ALCP (1999b) the current cannabis prohibition laws are not working and the statistics for those people who have tried it or are using it are up to 70 % of the population. ALCP call for cannabis law reform to parallel the liquor law reform, that is for cannabis laws to be liberalised (ALCP, 1999b:1). They also argue that the moralistic tradition that 'good', legal drugs are OK, while 'bad', illegal drugs are bad is a double standard and that education would be better directed at distinguishing between good and bad relationships with drugs (ALCP, 1999b). ALCP also believe that;

> "Prohibition costs too much, misinforms our youth, inadvertently maximises uptake, prejudices mental health, corrupts law enforcement, perpetuates a criminal underworld unnecessarily, denies the economy a versatile environmentally friendly resource, and hurts far too many otherwise law abiding individuals" (ALCP, 1999b: 8).

Undeniably many people in Aotearoa/New Zealand are using cannabis, and some of these people are developing problem use of cannabis (Field & Casswell, 1999), therefore it would appear that the law is not working as intended, that is, to decrease use and availability of substances, in this case cannabis. Therefore what are the alternative systems of control? ALCP has come up with the idea of a Class D schedule for the Act, which would move cannabis away from having a Class C criminal status, and would mean that cannabis use, cultivation and possession in small quantities would not be

illegal, but cultivating, and supplying larger quantities would be (ALCP, 2000). This idea is more commonly known as decriminalisation or partial prohibition (DPFT, 1997).

The Drug Policy Forum Trust, is a group of scientists and professionals dedicated to elevating the level of debate concerning illicit drug policy in Aotearoa/New Zealand. According to this Trust the principal goals in Aotearoa/New Zealand national cannabis policy should be "1. To minimise the harmful use of cannabis and 2. To promote public health" (DPFT, 1997: 1). Other than decriminalisation or partial prohibition, other systems of control that they note are;

- Total prohibition with an expediency principle: this is the system that the Netherlands has in place, which allows the sale and purchase of small quantities of cannabis through a system of regulated coffee shops. This is still illegal, but is tolerated by the judicial system;
- Prohibition with civil penalties: in this system possession and use of cannabis would not be subject to criminal penalties, but to fines, like for speeding violations;
- Regulation: this would be like the system we now have for sale and use of tobacco and alcohol (DPFT, 1997; Abel & Casswell, 1998).

There are existing examples of all these types of systems, except for the system of regulation which is not operating anywhere in the world. They each have their potential advantages over total prohibition in terms of helping to eliminate the black market, and associated harms, saving money spent on criminal justice, and offering young people protection from the world of harder drugs (DPFT, 1997). However the concerns raised by those who support prohibition (former Education Minister Nick Smith, New Zealand First M.P. Ron Mark, The Christian Heritage Party and The Salvation Army), include fears that the number of people using cannabis will increase, as will the length and intensity of their using careers, and the prevalence of cannabis dependence (Salvation Army, 1999; Christian Heritage Party, 1999; The Christchurch Press, 2000). The concern is, for example, that young people will have an increased access to cannabis, and may start at a younger age, thus affecting their physical and emotional development, and hence effecting their long term quality of life. According to the DPFT (1997) research evidence of this happening in the Netherlands and elsewhere is hard to find, and they conclude that the international literature does not support the claim that the repeal of

cannabis prohibition will substantially increase cannabis use in Aotearoa/New Zealand, or among young people. According to DPFT

> "What ever damage is produced by these agents, both to user and society, is inevitably magnified by prohibtion...We know of no scholarly body to have endorsed cannabis prohibition as the preferred model of cannabis control" (DPFT, 1991: iii).

Calls from a variety of people (DPFT, 1997; Abel & Casswell, 1998; Health Select Committee, 1998; ALCP, 2000) for serious debate about alternative policy options for cannabis, appear to be warranted. It would appear from the available evidence that the prohibition laws are not helping deter young people away from cannabis use, and alternative solutions may mean youth can keep a clean criminal record, not be associated with 'the underworld' or the black market, and may be less excited by the idea of trying a legal drug. Obviously health effects and damage are still of concern, however the evidence suggests that cannabis is widely available to youth anyway and that those who want to use it are already doing so, and that alternative systems of control will have more positive harm reduction effects than prohibition (DPFT, 1997, Abel & Casswell, 1998). Recently the new Labour/Alliance Coalition Government has stated that they will review the legal status of cannabis (The Christchurch Press, 2000).

National Drug Policy 1998-2003

The goal of the National Drug Policy 1998-2003 is;

> "as far as possible within available resources, is to minimise harm caused by tobacco, alcohol, illicit and other drug use to both individuals and the community. (Ministry of Health, 1998b).

The policy is an attempt to pull together strategies to minimise drug related harm into one comprehensive framework, and sets a single direction that everyone can move towards and a means of ensuring that they do (Ministry of Health, 1998b). One of the primary objectives of the policy is to get government ministries, organisations and community organisations to work intersectorally and to form partnerships (Ministry of Health, 1998b). The National Drug Policy aims to reduce the effects of harmful substance abuse through a number of strategies. These include supply control measures, for example enforcing laws regarding illicit drugs, and preventing the sale of liquor to

minors; demand reduction measures for example drug education programmes in schools; and other different approaches depending on the issue or target group, for example drug treatment services and needle exchange programmes for intra venous drug users (Ministry of Health, 1998b). This policy identifies young people, among others, as a target group to prioritise.

This policy however does not mean more money for drug-related work, it allows only for the Ministerial Committee on Drug Policy (MCDP) which has been set up under the policy, to decide on new policy initiatives that should be recommended to the government. The Minister of Health from the previous National Government did however indicate that there would be a review of alcohol and drug treatment funding levels in the next budget round, and that they are committed to developing and providing more and better alcohol and drug treatment services (Ministry of Health, 1997b). In the meantime however it was announced that in order to meet the objectives of the Government's National Drug Policy, 1998:

> "The Health Funding Authority has this year allocated almost $3 million extra, which will fund an extra 26 workers, target child and youth services and fund an extra 300 places on the methadone treatment programme....It anticipates, for example, funding an extra 325 full-time equivalent positions in child and youth mental health services by July 2002. Better treatment services for children and young people should lessen the likelihood of addiction in later life, Dr. Boyd said" (Ministry of Health, 1999).

This showed some recognition of, and commitment to the alcohol and drug field, especially in the area of adolescent substance abuse interventions. Whether this obligation will still be met remains to be seen. Labour and Alliance policies do appear however, to be more favourable to the alcohol and drug treatment sector than previous governments, therefore the commitment is expected to be fulfilled. Already an extra twenty four million (over the next four years) has been allocated to alcohol and drug services in the June 2000 Budget (Jackman, 2000).

Alongside reform and increased funding is the historical, but not well documented, debate about where alcohol and drug services for both adults and adolescents should be placed out on their own or under the umbrella of physical health or mental health, and funded using the physical or mental health budget (MacEwan, 2000; NCTD: unpublished

survey results) Commonly HFAs tend to categorise alcohol and drug services separately, but alongside mental health in terms of policy and budget, for example Midland Health (1997). This publication is titled "Proposed Mental Health Services", but is in fact a publication of proposed mental health and alcohol and drug services. According to MacEwan (2000), some two thirds of those with alcohol and drug problems do not have a mental illness, and therefore it may be more appropriate for alcohol and drug services to be placed under public or personal health.

Whether youth alcohol and drug treatment should be met by alcohol and drug services or by child and youth mental health services is also a contentious issue. Lately treatment services for young people have been described by HFAs under the Child Youth and Mental Health specifications because policy documents encourage youth services to be considered together, not solely as an appendage on to adult services. However currently, HFA funded youth alcohol and drug services are located both within alcohol and drug services and Child, Youth and Mental Health services depending on the local situation and locality contracting (Cosgriff, 1999).

Whether adolescents under the age of 16 need parental consent to undertake substance abuse treatment or counselling is another contentious issue. Currently the Guardianship Act 1968 does not explicitly permit children under the age of 16 to consent to their own health care, however this is inconsistent with common law developments and the Code of Health and Disability Services Consumer's Rights 1996 (Ministry of Health, 1998c). While not currently tested in law, a publication by the Ministry of Health (1998c) provides advice to practitioners that if they consider the adolescent to have the intellectual capacity and maturity to make important decisions about their health then parental consent is not needed. Some clarification is needed in this area.

Alcoholism and Drug Addiction Act 1966

The Alcoholism and Drug Addiction Act 1966 (ADA Act) is a piece of legislation that allows for the committal voluntarily or involuntarily, of an 'alcoholic' or 'drug addict'. A person can commit themselves voluntarily to alcohol and drug treatment for a period of up to two years (ADA Act, 1966 s 8). In the case of an involuntary committal, a District Court Judge on application from a relative, a member of the Police force or any

other reputable person, can order detention and alcohol and drug treatment for an alleged 'alcoholic' or 'drug addict' of up to two years (ADA Act, 1966 s 9). If the committal is involuntary there must be evidence from two medical practitioners that they believe the person to be an 'alcoholic' or 'drug addict', or evidence that the alleged 'alcoholic' or 'drug addict' has refused medical examination, or failed to turn up for a medical examination (ADA Act, 1966 s 9). If the person has not had a medical examination, a warrant can be made for their arrest, and a medical examination undertaken after the arrest (ADA Act, 1966 s 9 (5)).

With the committal application there must be a named institution who is prepared to take the person in for treatment under the Act. Currently in Aotearoa/New Zealand there are 14 institutions certified to accept people committed under the Alcoholism and Drug Addiction Act. However only four of these are alcohol and drug programmes; the others are hospitals (Ministry of Health, 1999c). There is often a waiting list for places in these treatment programmes, as no special beds are reserved especially for the committed client.

The Alcoholism and Drug Addiction Act 1966 does not specify an age range for committal. However none of the treatment programmes who take in people under the Act, accept under 18 year olds into their programmes therefore, in essence this Act does not apply to under 18 year olds (except where they may be committed to a hospital). Whether, even if it did, this would be morally and ethically acceptable is another arguable point. Whether anybody should be forced against their will to undertake treatment, even if this is seen to be beneficial for them by others, is contentious, and questions abound as to who decides it is beneficial and for whom is it beneficial? Currently there is no policy or legislation that applies directly to intervening with substance abusing adolescents either on a voluntary or involuntary basis and this appears to be quite a gap.

The Alcoholism and Drug Addiction Act is currently under review. Over recent years the Ministry of Health has become aware of a number of practical and legal problems with this Act (Ministry of Health, 1999c). It is recognised that there is an inability to match treatment with the client, a lack of certified institutions to accept people under the Act, and that institutions are becoming unable or unwilling to accept clients who are

committed under the Act (Ministry of Health, 1999c). It is also recognised that the Act is inconsistent with the New Zealand Bill of Rights Act 1990. The review will look into whether there is still a place in our society to intervene to enforce people to have detoxification and treatment, and if so how this should continue to be done (Ministry of Health, 1999c). There may still be a place for the Alcoholism and Drug Addiction Act in Aotearoa/New Zealand, and even a place for it to apply to those under the age of 18. If the addiction the person is experiencing may significantly harm themselves or someone else, and/or where the addiction has taken over the person's ability to make an informed decision for themselves, the Act may still be relevant (as for people with mental illness under the Mental Health (Compulsory Assessment and Treatment) Act 1992). Most importantly appropriate treatment facilities and beds would need to be available to back up the legislation if the review finds it is still needed..

Social Policy Summary

As has been identified, there are several gaps in the area of youth policy in general (New Zealand Labour Party, 1999c). Implementation of a comprehensive New Zealand Youth Policy is needed, to cover a wide variety of social areas which concern youth. Youth should not always be dealt with legislatively as adults, nor should youth policy be an add on to general policy. According to New Zealand Labour Party (1999c), youth issues require a lot of thought and input needs to come from the youth themselves.

There has been a lot of recent interest and research work completed in the area of child and youth mental health, including alcohol and drug services. It is now well recognised that this area has been neglected for a long time, not only in terms of legislation, but in terms of resources (Ministry of Health, 1998a, Mental Health Commission, 1998; Mental Health Commission, 1998b; New Zealand Labour Party, 1999c). There was a pledge by the previous government to fund child and youth mental health services appropriately, and this pledge appears to also be part of the promises made by the Labour Party before they came into office in 1999 (New Zealand Labour Party, 1999). The need is certainly there, now the work needs to be done.

From the available literature it would appear that there does need to be more discussion into the legal status of cannabis, (DPFT, 1997; Abel & Casswell, 1998; Health Select Committee, 1998; ALCP, 2000) and more specifically its impact on adolescent substance abuse. Most research suggests that prohibition does not work, whether this also relates to other type of drugs is something that may become more relevant in years to come. With the liberalising of the liquor laws recently, it would appear that the move may soon come to liberalise our illicit drug laws also. The long-term outcome of liberalising our liquor laws, including the lowering of the legal drinking age, and whether the concerns raised from various parties actually transpire remains to be seen. Early indications suggest that there has been an increase in teenage binge drinking behaviour since lowering the legal drinking age (Business Research Centre, May 2000).

In terms specifically of adolescent substance abuse, not only is there a need for more and better services and for these services to co-ordinate and communicate, but also for policy in regards to when, how and who should treat or intervene when a problem develops. At the moment services in this area for adolescents, are limited, ad-hoc, either an add on to adult services or within child and youth mental health services, have no standard assessment tool, and are separate from other youth agencies like CYF. Assessment, and intervention with adolescents should ideally be covered by legislation that outlines when and how the adolescent can be treated, and whether or not this can happen involuntarily, as in the case of the Alcoholism and Drug Addiction Act. There also need to be clearer guidelines in terms of working with adolescents under the age of 16, that is, whether their parents or guardians need to be informed or this or not. Currently the Guardianship Act does not explicitly permit children under the age of 16 to consent to their own health care, however this is inconsistent with common law developments and the Code of Health and Disability Services Consumer's Rights 1996.

Where adolescents with substance abuse problems are best catered for also needs to be identified, whether this be at alcohol and drug services, mental health services, or youth one stop shops. In the following chapter which analyses the interview data from the adolescents and workers, some patterns emerge about where adolescents with substance abuse problems are best served.

Most of these policy and resource gaps may be met if the new Labour/Alliance Coalition Government fulfills its pre election promises for the establishment of a comprehensive youth policy. If more resources are allocated the policy needs to be in place to make sure it is spent and allocated appropriately and that the limited resources are put where they are most needed. Aside from this specific need an overall comprehensive youth policy incorporating more concisely the five areas of family, working, learning, well being and citizenship should also be of great benefit.

The Role of Social Work In The Alcohol and Drug Treatment Field

In the overseas literature from the United States and the United Kingdom, it is clear that social work has a role in the alcohol and drug treatment field (Barber, 1995; Burke & Clapp, 1997; Rhodes & Johnson, 1996). "The social work profession has a unique role in preventing and treating alcohol and other drug (AOD) problems" (Burke & Clapp, 1997: 552). There is little Aotearoa/New Zealand based literature on the role that social work can play in this area, however Aotearoa/New Zealand can easily take overseas literature and apply it to our own alcohol and drug treatment settings, because many aspects of the definitions of social work are universal.

The special hallmark of the social work profession, is its dual focus on the person and the environment (Barber, 1995; Rhodes & Johnson, 1996; Mumm et al., 1998). Traditional social work values are grounded in an holistic, ecological and systems based approach to problems (Burke & Clapp, 1997). Other core values in social work include high priority on concerns for equality, client strengths, the right to self-determination, social justice, cultural and social context, and public welfare (Barber, 1995; Burke & Clapp, 1997; Nash, 1998). While occupational definitions of social work have changed and adapted throughout history (Nash, 1998)[9] these professional values and traditions of social work are fundamental and appear to have stood the test of time. Given the evidence which has been gathered so far throughout this thesis about adolescent substance abuse, it would

[9] An in-depth discussion about definitions of social work and the changing role of social work can be found in Nash (1998).

appear that these fundamental components of social work 'fit' very well with ideas about how to intervene appropriately with adolescent substance abusers. We have seen evidence in Chapter Two of the importance of taking in to account not only the person (their personality, behaviour, genetics, and biology), but also their environment (their family background, socio-cultural background, education, housing and peers) when intervening with a substance abusing adolescent, and this person-in-environment focus is also a fundamental principle of social work (Burke & Clapp 1997). "An ecological model of causation which seeks to understand transactions between the person and the environment, offers a more robust model for describing addictive process and its effects" (Rhodes & Johnson, 1996: 183).

Social work is also primarily client focussed, which aligns with evidence that interventions with substance abusing adolescents should be client matched (Windel et al.,1996; Spooner et al., 1996; MacEwan, 1999) where possible and should begin with where the client is at, in terms of their own recognised needs and goals, for example whether this be controlled use or abstinence (Marlatt, 1998).

Definitions of social work have changed over the years and continue to change, with some disparity between how the social work profession defines itself and what front line social workers in agencies are actually doing (Nash, 1998).

> "Social workers have been deployed to work in multidisciplinary teams where there may be scant understanding of the orthodox social work role. In these ways, one can see the erosion of social work identity.....many of these positions only involve aspects of the social work task, thus losing the wholistic approach" (Nash, 1998: 408).

This erosion of the traditional definition of social work and its values, appears to have influenced social workers working in the realm of alcohol and drug treatment where they are often working in multidisciplinary teams. Overseas research suggests that rarely do social workers get to work as holistically as they would like with their clients in the alcohol and drug treatment field (Burke & Clapp, 1997). This appears to be due to the fact that many alcohol and drug programmes and interventions are based on one or only a few approaches to addiction and therefore do not allow for the holistic approach which takes into consideration a variety of approaches. From my own personal knowledge this

appears to be true also for the Aotearoa/New Zealand social work experience, especially in day programme and residential settings.

The medical model has been the major influence on treatment both in Aotearoa/New Zealand and overseas (Rhodes & Johnson, 1996), and this model does not account adequately for the many complex features identified with addiction, and those which the social work perspective recognises as significant.

> "By moving back to the disease/abstinance perspective, social workers risk losing their focus on a client-centred viewpoint: beginning where the client is, encouraging mutuality between worker and client, and building on client strengths" (Burke & Clapp, 1997: 554).

It does appear that there is a marked difference between what is being taught to professional social workers in the education setting and the actual role of the social worker at a local setting, and in this case in the alcohol and drug treatment field. Social workers are having to constantly resolve the conflict between the academic and the practice worlds (Rhodes & Johnson, 1996).

In a four year Bachelor of Social Work degree through Massey University, Palmerston North, the student is taught human development, Maori language and culture, psychology, sociology, economics, social policy, Treaty of Waitangi, social research, law & government, welfare development, community development, psychological, sociological and behavioural theories and models of practice, management, alongside an area they may wish to specialise in (for example education or rehabilitation), and has one hundred and twenty days of practical field work practice (Massey University, 1996). As this indicates this is a very wholistic programme and not one that focusses on solely welfare issues, or child care and protection issues, as many may imagine.

According to Burke & Clapp;

> " social workers have diagnostic and assessment skills, familiarity and comfort with positive therapeutic approaches, and a commitment to practice evaluation that can improve the quality of care in substance abuse settings" (Burke & Clapp, 1997: 554).

Social workers are specifically and intensively trained in many aspects of clinical work,

and it is likely that a higher quality of service could be provided by increased use of social workers in alcohol and drug treatment programmes (Magura, 1994). Unfortunately from personal experience it appears that these multitude of skills are not being utilised.

Can a person, even if they are professionally trained as such, call themselves a social worker if they are not prepared to work holistically, take into consideration social injustice, social policy, the person and the environment and critique the medical/disease concept of 'addiction'? Barber (1995) makes the point that perhaps relapse rates among alcohol and drug abusers are so high because generally these wider societal issues are not well identified or worked on as part of alcohol and drug interventions. Social workers must take some responsibility for advocating for the social work role, the person-in-environment approach and the significance of social and cultural contexts, and not merely blend in to the alcohol and drug field with a multitude of other 'caring' professions.

If social work is to reclaim the addictions field as an area of intervention then change needs to occur not only at the alcohol and drug treatment level, but also within social work education (Rhodes & Johnson, 1996). While social work does have a lot to offer this field, it is true to say that very little is taught about alcohol and drug abuse and addictions in social work training institutions around Aotearoa/New Zealand (Hannifin & Gruys, 1996). There is however support from several areas for social workers to be more involved with alcohol and drug issues (Hannifin & Gruys, 1996; Barber; 1995; Leckie, 1990), and agreement that social workers need to be adequately prepared for this via their education (Hannifin & Gruys, 1996). The reality is that many generalist front line social workers are dealing with alcohol and drug problems anyway (Hannifin & Gruys, 1996; Leckie, 1990).

It appears that there is good reason to not only have an alcohol and drug component as part of professional social work education and training for social workers, but also for more social workers to use their skills to specialise in the field of alcohol and drug abuse and the addictions. At the moment the lack of social workers in this field is significant given the problems of the client population and the programme functions that need to be

performed (Magura, 1994). If educators find room for an alcohol and drug component then some of the problems that are talked about here maybe able to be addressed. Social workers may even be inspired to specialise in this area and be more able to take on and critique traditional alcohol and drug programmes based on disease concepts of addiction.

Given the findings and recommendations in this thesis about what constitutes effective interventions with substance abusing adolescents, it appears imperative that social workers take a more active role in this area. Our professional training, values and unique perspective have much to offer this area.

Chapter Five

THE RESEARCH PROCESS

Given that the need for more and better adolescent alcohol and drug interventions has already been established (Burglass, 1998; Rout & Lowe, 1991; Bruner, 1994; Moore, 1997; Macdonald, 1997; MacEwan, 1998; Deering et al., 1998, and Young, 1998), the primary objective of this research was to develop a set of recommendations about how to work effectively with substance abusing adolescents. These recommendations were developed by qualitative interviewing of both adolescents who had some experience of treatment, and specialist adolescent alcohol and drug workers from around Aotearoa/New Zealand.

This chapter presents the research process in three parts. Firstly the theoretical perspective and methodology of the research will be outlined, followed by an outline and explanation of the research design and finally the ethical considerations inherent in the research.

Theoretical Perspective and Methodology

This research was approached from an interpretivist theoretical perspective, which views reality as internally experienced and socially constructed, presents reality in a descriptive form, and recognises that science is value laden (Sarantakos, 1994). The interpretivist perspective is appropriate for the objectives of this research because it recognises the individual's experiences of substance abuse treatment as their reality, and allows for the analysis of this qualitative and descriptive data. It recognises the importance of each individual's viewpoint, as well as the influence the researcher may have on the study. The viewpoints of both the workers working in this area and the adolescents themselves, are the main data source for this research. The interpretivist perspective recognises the significance of this, and allows this data to form the basis for the concluding recommendations, without relying on quantitative statistics and the like.

My choice of approach towards this research was primarily formative evaluation using inductive and qualitative methods. Formative evaluations serve the purpose of improving a specific programme, intervention or product (Patton, 1990). This research provides a set of recommendations in order to improve interventions offered to substance abusing adolescents, and is therefore formative and inductive. Inductive research refers to research which involves the development of generalisations from specific observations (Babbie, 1992) In this case I have developed a set of recommendations or generalisations about what constitutes effective interventions with substance abusing adolescents, from the information I have acquired from the participants in the research.

Qualitative analysis is " The non-numerical examination and interpretation of observations, for the purpose of discovering underlying meanings and patterns of relationships" (Babbie, 1992: G6). Qualitative research is based on the theoretical perspective that believes that reality is a social construction, and therefore information about a phenomenon is best obtained from the individuals experiencing it (Sarantakos, 1994). The implications of this perspective and using this type of methodology however, are that with so many different 'realities', including the adolescents', the workers' and the researchers, the research is less able to be generalised across a broad spectrum of people.

I chose this type of research because of the nature of adolescent substance abuse, its duration, and its complex affect on the person. I wanted to hear from both adolescents and alcohol and drug workers in their own words as much as possible, so as to get a quality understanding of their construction of experiences of adolescent substance abuse intervention.

> "Qualitative methods permit the evaluation researcher to study selected issues in depth and detail; the fact that data collection is not constrained by predetermined categories of analysis contributes to the depth and detail of qualitative data" (Patton, 1990: 165).

Qualitative methodology enables the researcher to research people in their natural settings, achieve a deeper understanding of the participant's world, allows a degree of flexibility within the research and presents a more realistic view of their construction of the world. (Sarantakos, 1994). Qualitative methodology fits well with formative

evaluation, as it allows for this descriptive data about previous experiences of substance abuse interventions to contribute to making improvements to those interventions.

While qualitative methodology and techniques have many advantages for this type of social research, there are also other limitations which need to be taken in to consideration, so as to see the research in context. When a qualitative method of research is undertaken, the researcher is often trading off between breadth and depth in their study. While qualitative research gives a more in-depth look at the phenomenon being studied, usually because of time and financial constraints, this method is not able to study as much of the phenomenon as the quantitative method might. Quantitative methods require the use of a standardised approach and respondents must answer questions according to pre determined response categories. This allows the researcher to have a larger sample size and more easily generalise about their findings. Quantitative data provides less depth but much more breadth in the study of the phenomenon. This is the trade off that choosing qualitative data involves (Patton, 1990). In this case I have chosen, because of the nature of the phenomenon I am studying, to go for depth in the research instead of breadth. While this has allowed me to gain a better understanding of the experiences of the participants, my sample size is smaller and not randomly selected, and therefore any generalisations from the research may be less scientifically valid. While quantitative methodology usually requires a random sample, this research has based its sample on purposeful sampling (this is further described in 'Research Design'). Purposeful sampling is appropriate if you have a good knowledge of the population, in order to get a wide variety of respondents (Babbie, 1992). In this case the alcohol and drug workers were sampled purposefully based on the geographical area they worked in. Purposeful sampling means that the sample chosen may have problems of generalisability and representativeness compared to research using random sampling, which is a quantitative technique.

Another criticism of the qualitative approach is that too much of the researchers' own subjectivity can influence the way the interview is undertaken, how the answers are interpreted and the final analysis (Babbie, 1992). However this concern can be alleviated if the researcher bias and/or philosophical position is explained and the probable

influence of this on the final research is identified. This will be discussed further, and identified in this chapter under 'Influence of the Researcher'.

Research Design

The overall design framework of the research was based on data triangulation. Data triangulation gives strength to the research because information and perspectives from two different sources are collected which allows the research to more accurately generalise about any patterns or themes that may emerge from the analysis of the data. (Patton, 1990). Given the limitations of the small sample size and the lack of random sampling, semi-structured interviews were used with both the adolescents and the alcohol and drug workers in order to be able to better generalise any findings.

Given the need for qualitative information, semi-structured interviews were used so I could ask the questions I wanted but also give the respondents some flexibility in their answers. Semi-stuctured interviews are usually an in-depth, open-ended and intensive way of gathering qualitative data (Patton, 1990). This method allowed me to listen to what the participants were saying and ask them further questions so as to get them to clarify a point, or elaborate on something not initially expected to be in the interview.

Recruitment of Participants

Access to adolescent participants

Initially information about the research, publicity flyers and an invitation to participate were sent out to the school counsellors of high schools in Hamilton and Cambridge, the only youth focussed 'one stop shop' in Hamilton -The Youth Resource Centre, and to the three main alcohol and drug treatment agencies in Hamilton: The Waikato Bridge Programme, National Society for Alcohol and Drug Dependency (NASD), and the Hospital Health Service (HHS) based Community Alcohol and Drug Service. The letters asked the school counsellors and agencies to advertise the research with the flyers which were enclosed, by putting them up in their waiting room. Adolescent participants had to have taken part in, and completed some form of substance abuse intervention, and be

between the ages of 11 and 17. The information that was displayed invited adolescents meeting these criteria to contact me for more information and to arrange an interview time.

After waiting initially for two weeks with only two replies to the flyers I decided to contact the alcohol and drug agencies directly to establish if they had an adolescent client base. After speaking to the counsellors directly, I discovered that one of the agencies was currently running an alcohol and drug programme with identified drug users at a local high school. I asked if the information and flyers could be made available to this group of young people. Another of these agencies was able to give me the name of a counsellor who worked for an education agency in Hamilton, but who specialised in alcohol and drug counselling. After speaking to this counsellor, she took the relevant information to her clients. From these exercises another two participants volunteered to take part in the research. Throughout the research process those interested in participating in the research contacted me to arrange an interview time.

In all I managed to get four adolescent participants for my research, however, these four where not selected by sampling but rather by convenience. Herein lay the first problem I encountered while undertaking the research. There was a general lack of respondents to advertisements about the research. I had hoped to get up to five adolescent participants from the initial advertising, however I only heard from two. I had to personally approach the alcohol and drug agencies, and then also widen the area I was hoping to select participants from, to include a counsellor who worked outside of a youth specific agency, school or alcohol and drug agency, to gain more participants. At this stage I felt I had exhausted my options for gaining adolescent participants in the Hamilton area and was happy with the participants who had chosen to participate. Convenience sampling is the least desirable form of sampling, and means the sample is not purposeful nor strategic (Patton, 1990), but given the type of participant needed it is not surprising that very few adolescents chose to participate. Even though the sampling was convenient, of those who chose to participate there were two males, two females, two Maori, two Pakeha and a reasonable mix of types of interventions experienced. Therefore even though the sample was convenient it was also purposeful, and would have been the kind of sample sought, so as to get a wide variety of respondents.

One important point to make at this stage is that it is likely that all those who chose to participate are likely to be those who now have their use of substances under control, or have stopped. Those still experiencing problems with their substance use would be less likely to want to participate in research about substance abuse interventions, as they may feel they are ineligible to provide quality information because they are still using. This means it is likely that the adolescent participants involved in this research, view the intervention they experienced more favourably than those who may still be living with active substance abuse.

Access to alcohol and drug worker participants

To gain alcohol and drug worker participants for the telephone interviews, I initially wrote to all the alcohol and drug agencies who were listed as providing services for adolescents according to the ' Directory of Alcohol and Other Treatment Services in New Zealand: All Regions, 1997' (Canterbury Community Council on Alcohol and Other Drugs (CCCAD), 1997). Access to the worker participants was much easier and I was really pleased with the number of respondents who wanted to participate. I received fifteen returned consent forms, from workers who agreed to participate, and four of the letters were 'returned to sender'. Of the 15 I decided to choose 10 by sampling the group using maximum variation sampling so that there was geographical variation among the workers who were to be interviewed. Using this form of sampling I had 10 participants from as many different places around Aotearoa/New Zealand as was possible.

> "Any common patterns that emerge from great variation are of particular interest and value in capturing the core experience and central, shared aspects or impacts of a program" (Patton, 1990: 172).

Once the sample was chosen, I wrote a letter of thanks to those who had applied but were not in the sample.

The Adolescent Interviews

When I was initially contacted by the adolescent, those who were under sixteen years of age, of which there were two, were told that their parents or caregivers would have to give their permission for me to interview them. At this stage I sent out the information sheet and parental consent form to the parents/caregivers, and it was brought back by the

participant at the time of the interview. They were also told over the phone that I would like to audio tape the interviews and they were asked if this was all right with them. If they did not agree to this over the phone I did not take the recording device with me, however those who had agreed also knew they were able to stop the tape at any time. When I arrived to interview them (I interviewed them wherever they felt comfortable), I again explained the research, got them to read the information sheet, answered any of their questions and asked them to sign the consent form, and state whether or not they agreed to having the interview audio-taped. (Please see Appendix A for a copy of the information sheet and consent form).

These interviews were undertaken from 4 October to 28 October 1999, and took between thirty minutes and one and a half hours to complete. The adolescents were asked questions in a number of key areas. These areas were;

- The history and nature of their substance abuse.
- Their experience of asking for and receiving help.
- Their current and future intentions regarding substance use.
- Their opinions of what an ideal intervention or programme would consist of.

(Please see Appendix B For adolescent interview guide.)

The interviews went well with only one adolescent participant not wanting to be audio-taped (written notes were taken in this instance). I felt that before beginning the interviews a reasonably good rapport had been established. Although the questions that the adolescents were asked were all the same, there was a big difference in the amount of information received from each individual. Two of the participants had a lot to say, while the other two were much quieter and had to be prompted more often. My observation of this is that the two participants who were less talkative were the two youngest participants and the two Maori participants. Whether the observed differences were due to their age or their cultural identity and their being awkward with me as a Pakeha researcher could both be relevant explanations for the way they expressed themselves. While they did not give me the same quantity of information as the older Pakeha participants, they were able to give me some quality knowledge relative to perhaps both their age and culture. This indicates the need for future samples to be large enough in each of these groups to detect age or cultural differences.

The worker interviews

These interviews were telephone interviews and were conducted from 2 December to 20 December 1999, and took between one to two hours to complete. These interviews were not audio-taped, but notes were made throughout the interview, which were later written up. The workers were asked questions in a number of key areas. These were:

- Their academic qualifications and experience relevant to the topic
- The 'why, how and what' of their work with substance abusing adolescents.
- Their opinions on the specific needs of adolescents growing up in Aotearoa/New Zealand.
- Their opinions on the benefits and frustrations of working in this area.
- Their opinions of what an ideal intervention or programme would consist of.

(Please see Appendix D for alcohol and drug worker interview guide).

Data processing and analysis

The transcription of the three taped interviews with the adolescents was carried out by myself. This meant that I could familiarise myself with the interviews and begin to notice patterns and themes emerging from them. As soon as each telephone interview with an alcohol and drug worker had finished I wrote up the notes I had taken from the interview. This meant that little content of the interviews was lost as my notes were well organised and systematic, and my memory was fresh from the interview. All participants in the research had the opportunity to look at the draft copies of their interview and make changes if necessary, where what they were saying was misheard or misinterpreted. Four of the worker participants made slight changes to the way they said things, but no substantial changes were made to the content of what they had said. Two of the adolescent participants told me at the time of their interview that they did not wish to see the draft copy of their interview or be further involved in the research after the interview. None of the other adolescent participants made any changes to their drafts.

Analysis of the data began with the adolescent interviews, noting themes which emerged from the four interviews. These themes were then separated out into sub-themes. This was done by actually cutting up the parts of each transcript that related to each theme, and compiling them (Patton, 1990). This gave a visual picture of the weight that each of these themes or sub themes held, in terms of how much of each interview supported the

theme. This helped me to organise my ideas around the key themes and identify the importance or otherwise of them. I also did this with the alcohol and drug workers' interviews, and noted the main themes and patterns which emerged from these. Then I compared across the interviews, comparing the main themes of the adolescents' interviews with the main themes of the workers interviews to note both similarities and differences. The key themes and sub-themes from each set of participants, as well as the comparison of the two, will be discussed and highlighted in the following chapter.

One of the general criteria of qualitative methodology according to Sarantakos, (1994) is that "It employs research procedures that produce descriptive data, presenting in the respondents' own words their views and experiences" (Sarantakos, 1994: 45.) This description of qualitative methodology analysis guided the way I chose to analyse the content of the interview. It was important that the content was described verbally in detail, not in the form of numbers or formulas. The research patterns and themes that emerged are therefore discussed using quotes from the actual interviews.

Ethical Issues

All of the procedures for this research were approved by the Massey University Human Ethics Committee. The fact that four of the participants were adolescents, and the research was about substance abuse, meant that there were a number of ethical issues to take into consideration. The fact that I wanted to interview adolescents, some being under the age of 16, and those who had experienced some form of alcohol and drug intervention, meant that there were several concerns around access to participants, confidentiality and informed consent. I have already detailed the process of gaining access to the participants, but here I will elaborate on the ethical considerations relevant to access to the adolescent participants. The access to alcohol and drug workers was not an ethical issue once Massey University Human Ethics Committee had approved the study.

Ethical considerations relating to access to adolescent participants

The first consideration was to ensure that no undue pressure was put on the adolescents to take part in the research. This meant no pressure from me, their counsellor, parents, or teachers. This was made clear to all those people who advertised the research. They were to inform the adolescents by displaying the information and answering any questions, but the adolescent had to contact me of their own free will and was not to be pressured into taking part. There was also concern that the adolescents may feel they 'owe it to' their counsellor to take part in the research, or that if they did it they would have to speak favourably of their counsellor or of the intervention they experienced. To allay any fears about this the participants were told very clearly that their identity would be protected and that their counsellor would not know what they had said. This was also spelled out in the information sheet and consent form. For those under the age of 16, parental consent was also needed for the adolescent to be a participant. A parent/caregiver information sheet along with a parental consent form was sent to the parents and returned by the adolescent at the time of their interview. (Please see Appendix E for copies of the parental information sheet and consent form). I would not have interviewed these adolescents without their parental or guardian consent.

The time and place of the interview was also something to take into consideration. I wanted to make sure that the adolescents were not forced to come to me, or be anywhere they felt uncomfortable. The adolescents chose where they wanted to have their interview and were made aware that they could be accompanied by a support person if they wanted to be. This was important as I not did want this research to in any way interfere with on going counselling, the relationship between the adolescent and their counsellor, and/or to be a pressure or inconvenience to the adolescent.

Informed consent

Both groups of participants were given an information sheet about the research (please see Appendix A and C for copies of the information sheets and consent forms). After reading the information sheet and asking any necessary questions, both types of participants were then asked to sign a consent form indicating that they agreed to let me use the information from the interviews in the final report. Written informed consent was obtained from the workers, prior to making an appointment time for the telephone

interviews. Adolescents also had to state on their consent forms, whether they agreed or not to being audio-taped, and knew that at any time they could have this switched off. Informed consent was also obtained where necessary from the parents of the adolescents.

Anonymity and confidentiality

All participants were offered confidentiality, and their names have not been mentioned in the research except with their explicit consent for this to happen. When writing up the transcripts a code was used to link the interview material to the participants, and while only I knew the code, this link meant that anonymity could not be offered. Names and anything that may identify the person, for example place or agency names, have been changed to protect the identity of the participants. All audio tapes and notes taken during the interview were initially locked in a filing cabinet, and upon completion of this research will be destroyed.

Potential harm to participants

To limit the harm as much as possible for the participants throughout the research, they were aware that they could refuse to answer any particular question, or withdraw from the research altogether at any time. Confidentiality of the participants was also ensured to minimise potential harm. I also provided a list of recommended alcohol and drug, and youth agencies in Hamilton so that if during the process of the interview, or afterwards the adolescent participants wished to see a counsellor to discuss any issues and/or debrief, they would have a number of options. My role as a researcher and not as an alcohol and drug worker had to be made clear throughout the interview, and therefore I needed to provide other avenues of help for the adolescents if necessary.

All of the interviews were undertaken by me, in a respectful and competent manner to ensure to the best of my ability that the participants did not feel used, taken for granted or looked down upon. While this form of qualitative methodology is excellent for the researcher to gain real insight into the lives of the participants, it can be very invasive, however, I felt that I minimised this to the best of my ability.

Influence of the researcher

Throughout the interview process I tried to remain as objective as possible when the participants answered their questions, however no researcher can ever be completely objective because they are influenced by their own values and judgments (Babbie,1992). Often times it is the researcher's passion for a subject that leads them to undertaking the research in the first place. This is certainly the case with this piece of research. While I did not want to influence the answers of the participants, I clearly came from the position that there was a lack of appropriate adolescent substance abuse interventions, (this is supported by Burglass, 1998; Rout & Lowe, 1991; Bruner, 1994; Moore, 1997; Macdonald, 1997; MacEwan, 1998; Deering et al., 1998, and Young, 1998), and that we needed to find some examples of effective interventions from which to write a set of recommendations. This would have come through quite clearly on the information sheet that both the adolescents and the workers had, and in the sorts of questions I asked in the semi-structured interview. This could have influenced the research in a number of ways.

Firstly those who did not agree with my convictions may have been less likely to apply to be participants in the research, either because they were not passionate enough about the subject or because they disagreed with the rationale on which the research was based. This may mean that the information I gain from the interviews, and the themes and patterns that emerge from it, may be more likely to support my view as the researcher. While this is important to note it does not mean the study is incompatible with good academic research, as the research still portrays the view of a number of people who have experienced alcohol and drug interventions and/or specialise in working in this area. There is also the possibility that that those who did oppose the rationale behind the research may have wanted to participate to put their views across to challenge my own. Secondly, although it would be a sub-concious action, I may have heard and/ or analysed the responses by the participants to reflect my own views of the subject. This is solved somewhat by having the participants check the transcripts of their own interview to make sure they agree with what has been attributed to them, however this does not solve any researcher bias I may have when analysing the transcripts. It is always important to bear in mind the influence of the researcher upon the research in order to see the study in context.

The next chapter outlines the actual data collected from both the workers and the adolescents and organises this data into themes and patterns, which emerged in the analysis.

Chapter six

THE INTERVIEW DATA

Introduction

This chapter looks in detail at the interviews with the adolescents. The focus of the study was to get both alcohol and drug workers' and adolescents' views on effective adolescent specific substance abuse interventions for Aotearoa/New Zealand. Alongside this primary aim, other questions were also asked in order to get a clearer understanding of the background of the both the adolescents and the workers.

The Adolescent Data

For the adolescents my specific areas of interest included;

- Their age of onset use of substances.
- What if anything influenced them to start using substances.
- What if anything influenced them to get help for their problem.
- Their experience of treatment.
- What they found to be most helpful, and most difficult.
- Their view of what would be an 'ideal' intervention.

These issues were covered in order to gauge any differences or similarities between the adolescent participants that may provide insight into the opinions on effective interventions. The adolescent sample consisted of a Pakeha male aged 16 who had been to Odyssey House Youth Residential Services, a Maori male aged 15 who had experienced a alcohol and drug intervention programme at his school, a Maori female aged 14 who had experienced one-on-one counselling with an adult alcohol and drug service, and a Pakeha female aged 18 who had experienced one-on-one counselling at her training institute (she had been 17 when she had undertaken the counselling). The questions asked were guided by a semi-structured interview format (see Appendix B),

and the replies were consolidated into the following subheadings. The answers have been condensed into table form.[10]

I have named the primary substance which caused the most reason for the adolescent to get treatment as the 'substance of concern'. This is different from drug of choice, as a person's drug of choice is not always the substance which causes them the most concern in terms of negative consequences.

Onset use

Onset of use refers to the age at which the participants first tried their substance of concern. Three of the four participants started using their substance of concern at the age of 12, the other at age 14. From this age the use of their substance of concern was regular.

Table 1

Age of onset use	Number of participants
Age 12	3
Age 13	0
Age 14	1

Other substances were also used and tried at various other ages, for example this from one participant whose substance of concern was cannabis;

> "I was about 12 years old when I first tried marijuana....I was about 5 when I started on alcohol."

Of the four participants, three mentioned that they were with friends when they first started using substances. However of these three, two specifically stated that they did not believe that they were pressured into trying substances, as in 'peer pressure'. Table 2 lists other influences on the adolescents first use of substances.

Table 2

Influence on first use of substances	Number of participants
Friends (but specifically not peer pressure)	2
Friends	1
Boredom	2
School	1
School holidays	1
Wanted to find a 'new buzz'	1

[10]Some adolescents gave more than one answer to each question.

Substance of concern

Substance of concern is the primary drug which caused the most reason for the adolescent to get treatment. Other substances may also be used in conjunction with the substance of concern. The use of more than one substance is called poly-substance use. Table 3 tabulates the substance of concern for the participants.

Table 3

Substance of concern	Number of participants
Alcohol and cannabis	1
Alcohol	1
Cannabis	2

While these were their substances of concern, and the primary reason they attended treatment, all participants used other substances prior to their having treatment as set out in table 4. The participant whose substance of concern was both alcohol and cannabis equally, had also used LSD and cannabis oil. The participant whose substance of concern was alcohol also used cannabis. One of the participants whose drug of concern was cannabis also used alcohol, LSD and Magic mushrooms and

> "pretty much everything really, to a certain extent",

although he never injected any substance. The other participant whose drug of concern was cannabis, also used alcohol. All participants therefore could be considered poly-substance users although all but one participant received treatment because of one primary substance.

Table 4

Other substances used excluding substance of concern	Number of participants
LSD	2
Cannabis Oil	1
Cannabis	1
Magic Mushrooms	1
Alcohol	2

Seeking help

This questioning was in order to get an understanding of how the adolescents found the experience of asking for help and also to give an indication of whether they were voluntary or involuntary clients. Of the four participants, one went to treatment completely involuntarily (that is, he reports he did not want to go but had little choice),

two undertook treatment voluntarily but with external pressure (from school and the police), and one went completely voluntarily.

Problematic use was recognised by all the participants, however one of the participants (Pakeha male aged 16 who attended residential treatment involuntarily) only realised in hindsight that there was a problem and did not see one at the time of treatment. Things that were mentioned throughout the interviews without prompting, that were indicative of problematic use are seen in table 5.

Table 5

Problematic use indicated by	Number of participants
Trouble with police	3
No motivation	2
Negative sexual experiences	2
Problems with parents	2
Problems at school	2
Sleeping in late	1
Losing friends	1
Being taken advantage of	1

Of these factors all four participants mentioned getting in trouble with authority figures as the major contributing factor to them seeking or receiving help for their substance abuse. Three of the four had been in trouble with the police, and one had been caught with drugs at school. Other major contributing factors are tabulated in table 6.

Table 6

Major contributing factor	Number of participants
Trouble with authority figures (other than parents)	4
Negative experiences when using	3
Trouble with parents	1
Not wanting to end up like other family members	1

One participant elaborates;

> "Well I just knew I was doing too much alcohol and drugs, it was out of hand, and I started getting into trouble with the police, just a bit, and doing stupid things, and sleeping with guys. I thought that I needed to get it under control, but not to stop altogether, just calm it down. And I didn't want to be like some of my family".

Three of the four participants knew where to go for help because of information given to them or provided by their education provider (school or training course). The remaining participant who went to treatment involuntarily had it all organised by his parents.

One of the participants who was voluntary described the experience of asking for help as hard.

> "Yeah it was [hard], cos I thought she might judge me, I mean she doesn't know me, and to go to someone and sit and talk about that sort of stuff, you don't know what's going through their head."

One described asking for help as "fine" and two did not have to ask for help, but were instead offered help.

Experience of the intervention

Getting an understanding from the adolescents about their experience of receiving help was of utmost importance to the research. With a variety of types of intervention experienced, there was a variety of feedback from the participants. Two of the four participants received one-on-one counselling; of these two, one went for the duration of six weeks and the other could not remember the duration. One received residential inpatient treatment for a period of six and a half to seven months but did not graduate from the programme, and one was involved in an eight week school based programme.

Three of the four participants described their overall impression of treatment as "good", "really good", and "pretty good", the remaining participant who had attended residential treatment on an involuntary basis said their experience was "...crap. Shocking place". This participant however went on to say some positive things about specific aspects of his experience of treatment.

> "Oh yeah it was good....all the staff members there. I had this cool as 'staff buddy', you know one on one person, she was cool as....We went on camps and that to Whangaparoa, way up north about 4-5 hours out of Auckland. Went there for about two weeks or something. And um learnt how to abseil, and all that stuff-went walking in the bush, abseiled down Bridal Veil Falls."

Other elements mentioned as helpful by this participant were the 'probe-in, probe-out'[11] activity, and being able to go outside of the residence for one-on-one meetings with his counsellor, for example, to a hamburger bar. Other elements that were mentioned as 'most helpful' by the participants are tabulated in table 7.

Table 7

'Most helpful'	Number of participants
Harm reduction strategies (such as tips on safer drinking levels)	3
Self-esteem/confidence building	2
Being listened to	1
Goal setting	1
Health education	1
Learning to forgive themselves	1

For example;

> "Well just talking to someone that didn't say I was a whore or anything like that. And setting goals for a good future was important instead of just waiting to see what happens...confidence and self-esteem building stuff. I think I learnt to forgive myself for those things I've done and realise it was the alcohol that made me do them. I learnt about only drinking for being sociable and not to get wasted, and the health problems of all types of drugs and alcohol."

Two of the participants said that there was nothing that they found particularly difficult about their experience of alcohol and drug treatment. The participant who had experienced residential treatment when asked what he had found difficult stated;

> "..you weren't allowed outside, weren't allowed to go out, weren't allowed money, weren't allowed to smoke cigarettes. It was shocking!"

The remaining participant mentioned;

> "telling her all the embarrassing things I've done, that made me feel sick...",

as the most difficult thing about her counselling.

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[11] A therapeutic technique involving the client telling their life story, as a means to assess appropriateness for continuation on the Odyssey Programme (Arnold, 2000).

Three of the four participants had no family involved in their intervention what so ever. One had her course tutor involved and while her family knew she was getting counselling they were not a part of it. Of the remaining two who had no family involvement, one participant said they thought having their family involved would have been beneficial, and one indicated they would not want their family involved at all. The participant who had experienced residential treatment did have their family involved but believes that;

> "It's something you've got to do for yourself really, cos ya family don't do shit really, to be honest. They're there ya know, its good to have them along but if you're gonna do anything ya have to realise it yourself, that's what I reckon anyway."

Three of the four participants agreed that having counsellors working with them who were in recovery themselves was important. The remaining participant agreed but also stated

> "...but you don't have to have been through these problems to be a nice person, as long as you are nice and people can trust you."

Two of the participants also mentioned that they did not believe the age of counsellors was important.

> "[Age] Doesn't matter, just as long as they can speak and tell them..tell us what they've....whats happened to them."

> "You just relate to some people and you don't to others."

To these adolescents the attributes of the worker, and their relationship with them is obviously important.

Three of the four participants believed that their treatment did work, however the remaining participant who had attended residential treatment while believing he had his problem under control did not attribute this to his treatment. He went on to explain how he finally decided to change.

> "Nah, I gave up....just thought ah this is taking me to jail, and I don't wanna go to jail, so I gave up and then....I don't know if I had my job then or not, oh well then I got my job and then just didn't have any time for it..other things to do, things to save my money for."

The ideal intervention

The adolescent participants were asked what they believed would be the ideal way to help people like themselves who had substance abuse problems. There was no consensus from the four participants about what would constitute the ideal intervention for them. Several things were mentioned individually as important. These are tabulated in table 8.

Table 8

The ideal intervention	Number of participants
Have people in 'recovery' working there	1
Peer support	1
Anger management	1
Challenges	1
Education about consequences for family and others	1
Outdoor/Bush or island setting	1
Life skills	1
Trust	1
Someone to listen	1

Residential and day programmes

Part of the study was to elicit the adolescents views on day programmes or residential treatment to see which if any they would personally prefer. Two of the three participants that did not have residential treatment indicated that they would go to a residential treatment setting if that was what was needed.

> "Yeah I would if it was to the point where I could not stop drinking, like always like a proper alcoholic, how you know they're always out buying alcohol and they drink and drink, and drink themselves silly. Yeah if I was to that point, where I couldn't control it anymore, and not know how to say no then yep I would. It would drive me mad but it would be something I'd make myself do."

The other participant also indicated that they would also attend a day programme if necessary. The remaining participant said she would not attend a residential programme, but that a day programme would be OK.

> "As long as it wasn't like a rehab or something that tries to make you give up altogether. And as long as you don't have to live there. I would probably go."

The participant who had been to residential treatment, however, did not believe that a day programme would have suited him because he would still have to come home at the

end of the day and have to deal with the same friends and acquaintances, who were using substances.

> "Nah, not in Hamilton. I could have if I'd gone to Auckland staying with the cousins or parents family, and then gone to it, cos I don't know no one so...know what I mean? Cos who the hell do I know in Auckland, absolutely no one, but here I still come home and talk to the same friends."

Family history of substance abuse

Having a family history of addiction or substance abuse problems is a risk factor for substance abuse, but is not always present, thus participants were asked about this. Two of the participants indicated that they had some history of substance abuse in their families.

> "My biological dad, he's an ex-alcoholic....My granddad was an alcoholic, and his dad was an alcoholic, so its like a gene thing."

Two of the participants had no known substance abuse history in their families.

Current use

All four participants were still using substances at the time of the interview. Three of the four participants said that while they still used substances they now believed they had the problem under control.

> "I don't drink at all that often, its probably once every now and again I will pick up a drink. Yeah now I just don't get to that point where I can't walk or I can't crawl."

> "I would still say I get drunk, but not to forgetting things or being sick. And I don't do it very often that's the main difference."

The participant who had been to residential treatment claimed,

> "...[I use] nothing like I used to, its controllable."

This participant did however, indicate some abuse of a substance (alcohol) other than his substance of concern and continued use of LSD.

"Nah, just when I'm on the piss and some's handed round. Drunk as don't know what your doing, feels good so...I had a trip a while ago and that was about it"

The remaining participant still used alcohol and cannabis irregularly, but indicated that he would like to give up altogether.

Two of the participants specifically mentioned that they did not believe they were 'alcoholics' or 'drug addicts'. For example;

"No, cos I don't consider myself as an alcoholic. I consider myself that I have a little problem, that is...that you can learn to handle."

All of the participants stated that they felt good and/or positive about their future and said they felt more confident now that they believed that they had their substance abuse under better control.

Most important thing learnt

There was no consensus about what was the most important thing learnt from their experience of having a substance abuse problem and getting help for it. Those elements mentioned as the most important things learnt from their experience of treatment are as follows;

Table 9

Most important thing learnt	Number of participants
Not to push family and friends away	1
Who their real friends are	1
Harm reduction	1
That its up to the individual to change	1
The need to respect yourself	1

"Most important thing....It's up to the individual, it's up to you, that's what I reckon, if you wanna do it you do it...You'll finally click like I did or you won't."

Adolescent data summary

The nature of the phenomenon, namely adolescent substance abuse, meant that it was very difficult to get adolescents to participate in this study. In this age range the use of alcohol and drugs is very common and for an adolescent to give up substances altogether would be extremely difficult, especially with the lack of community support. The reality

is that many of those that have been through treatment or had counselling may still be using. These adolescents may be less likely to want to partake in research like this for fear that they have failed and would not be very good examples for the study to use. The stigma that surrounds adolescents who have had substance abuse problems and also the illegality of some of the substances used, also added to the difficulty of finding participants for this study.

Because of the small sample size, the findings from the interviews with the adolescents cannot be generalised as safely as results based on rigorous sampling and standardised questions, or a much bigger sample size (Babbie,1992). While the sample was varied in terms of gender, culture, age and type of intervention experienced this also meant that the results are less able to be generalised for any one gender, culture, age or experience and may explain the array of different answers to the same questions. However, because of the qualitative nature of the interviews, what the adolescents have to say is very real for them and therefore very valid. What we can take from these interviews is a helpful starting point for establishing the views of adolescents in regards to interventions for substance abuse and this has some bearing on the development of guidelines for interventions. Following are some of the main points from this chapter (a fuller discussion linking the data with the earlier chapters follows in chapter seven).

The average age of onset use of the substance of concern was 12, and when first trying substances three of the four participants were with friends. Substances of concern were either alcohol, cannabis or both, however other drugs tried included LSD, magic mushrooms and cannabis oil.

Problematic use of substances was recognised primarily because of trouble with authority figures (police, parents or school) by all the participants. Having no motivation and negative sexual experiences were the other two main indicators of problematic use. Both the females mentioned negative sexual experiences.

The majority of the participants (three of the four) felt their treatment was good, and believed that it had worked. The remaining participant who had had residential treatment described his experience as 'crap', and did not believe his treatment had

anything to do with his current controlled use of his substance of concern. All four participants were still currently using, however three of the four all felt that they now had their problem under control. This 'controlled use' is acceptable because harm reduction strategies were seen by three of the four participants as the most helpful thing that they had learnt. This supports the harm reduction philosophy outlined in chapter two, for use with adolescents. Three of the four participants had no family involvement with their treatment however two of the four participants had family histories of substance abuse. Three of the four believed having a counsellor working with them who was in recovery would be beneficial. There was no consensus about what constituted an ideal intervention for them, or what the most valuable thing was that they had learnt.

The most telling pattern from this data is that although some had experienced some very negative consequences from substance abuse, they were all still continuing to use in a controlled manner, following their intervention. The second most telling pattern is the inconsistent responses from the various participants, which supports the reality that everyone is different, has different needs, views, expectations and beliefs about similar experiences. This should be noted as these results support the eclectic theory of adolescent substance abuse that endorses that each individual should be treated as an individual and flexible treatment arranged to cater to their needs.

It is clear that further qualitative study in this area with a larger sample of adolescents is needed, to make better generalisations about their views on substance abuse. Following this, studies could also be done looking specifically at the needs and views of different genders, cultures and ages.

The Alcohol and Drug Worker Data

Introduction

Ten workers were interviewed from around the country. Specific areas of interest in the interviews included;

- Their qualifications and experience.
- Their referral sources.

- What services they provide.
- What theories and models they use.
- Their opinions on what special needs Aotearoa/New Zealand adolescents have.
- What they believe would constitute an ideal intervention.
- The benefits and frustrations of working in this area.

The interviews took place over the phone, and the questions were guided by a semi-structured interview format (see Appendix D). The replies were recorded manually by written notes, and later checked for accuracy by the participants. The replies were consolidated into the following headings. Often the workers gave more than one answer to each question.

The agencies

There were ten interviews with workers each from a different agency. Table 10 tabulates where the agencies were geographically situated, whether they were Non-Government Organisations (NGOs), or Crown Health Enterprise (CHE)[12] based and what service they specialised in.

Table 10

Worker	Located in North Island	Located in South Island	NGO	CHE	Adult A&D	Youth A&D	Youth Mental Health	Generic Youth Service	Maori social Service Provider	Generic social service provider
Jo*		+		+		+				
Nancy*		+		+			+			
Paul	+			+	+					
Debbie		+	+					+		
Jan	+		+						+	
Robyn	+			+	+					
Mary*		+		+	+					
Bob*	+		+		+					
Jae	+		+							+
Simone	+			+		+				

* Indicates pseudonyms to protect confidentiality of the participant where requested.

A variety of services for adolescent substance abusers was provided by the ten agencies. The services provided are listed in table 11.

[12]Since these interviews were undertaken the term CHE has been replaced with Hospital Health Service (HHS).

Table 11

Type of service provided	Number of agencies that provided this
Alcohol and drug assessments	10
One on one counselling	10
Interventions in schools	6
Liaison with other services	6
Education	5
Outreach	5
Alcohol and drug treatment groups	4
Family therapy groups	4
Training and education for other service providers	3
Self-esteem groups	2
Stress management groups	2
Life skills groups	2
Parent groups	2
A user friendly atmosphere	2
Advocacy	2
Sexual health/safer sex education	1
A drop in service	1
Decision making groups	1
Finishing groups	1
Outdoor activity programme	1
Harm reduction groups	1
Grief groups	1
Anger management groups	1
A pressure group for adolescent issues	1
YMCA group	1
Anxiety disorder work	1
Eating disorder work	1

When the worker participants were asked if there were any areas that they believed their agency did not cover well or could improve upon, there was again a variety of answers. One of the worker participants stated;

> "There's so much that could be done in this area, and I feel sometimes we don't do it justice"

Four of the participants believed that their agency should do more work in schools. For example:

> "I'd like to increase the work done in schools, because in some areas cannabis is the way people are making a living and you have to get to youth on a community level"

Four believed that they needed to provide a day programme, and four believed that they needed to provide a residential in-patient treatment service.

"There should be an intensive youth day programme in the area, and a residential programme"

These and other elements mentioned by the workers are in table 12.

Table 12

How could the service provided be improved?	Number of participants
More work in schools	4
Provide a day programme	4
Provide a residential service	4
More group work	2
Shorten waiting lists	1
More outdoor programmes	1
More outreach work	1
More staff	1
More community awareness	1
More active lobbying	1
More resources for under 12 year olds	1
More one-stop-shops	1
More resources in general	1
More specialist training	1
More younger workers	1

The workers

There was a huge variety of type and 'field' of qualification, and experience amongst the ten workers interviewed. Workers had qualifications in the following areas: counselling, nursing, health sciences, alcohol and drug counselling, teaching, social and child psychology, criminology, psychology, and human behavioural science.

Table 13

Type of highest qualification	Number of participants
Certificate	4
Diploma	1
Registered nurse	1
Undergraduate Degree	2
Post Graduate Diploma	1
Two Masters Degrees	1

Four of the workers were currently involved in ongoing study. Further information about the workers experience is included in table 14.

Table 14

Type of previous experience	Number of participants
Alcohol and drug	7
Nursing	2
General social services	2
Women's health and welfare	1
Mental health	1
Youth work	1
Youth alcohol and drug	0

The length of generalist alcohol and drug experience ranged from 15 years to 2 years experience with an average of 3.5 years. The length of current youth alcohol and drug experience ranged from 5 years to 6 months experience with an average of 2.9 years. None of the workers had had any specialist youth alcohol and drug experience prior to their current role. The type of position held by each participant also varied.

Table 15

Position held	Number of participants
Managers/Co-ordinators	4
Alcohol and drug counsellors	2
0.5 Youth worker/0.5 alcohol and drug counsellor	2
Team Leader	1
Youth Worker	1

Five of the participants specialised in working with youth, three did not specialise and two specialised part time.

Participants were asked why they work with adolescents and some gave more than one reason. Five of the participants said that they specialised in working with youth because there was a need, and four mentioned that it was more fun/easier to work with adolescents:

> "Working with adolescents is more fun than working with adults, I have a ball, plus its sheer laziness because young people haven't been using for as long as adults and its easier to stand with them while they make changes."

These and other reasons given for working with youth are in table 16.

Table 16

Reasons for working with youth	Number of partcipants
Because of the need	5
Fun/easier to work with youth	4
Because of own life experiences	2
Because have good ability to work with youth	2
Because interested in the area	2
Because passionate about the area	2
Because adolescence is a difficult time	1

Referrals

There were a number of referral sources mentioned by the ten participant workers. These are as follows:

Table 17

Referral sources	Number of participants
Schools	9
Justice and Community Probation (including Youth Justice, Youth Aid, the Police and the courts)	8
Child, Youth and Family	8
Community agencies	7
Parents and/or family/whanau	6
Specific local community agencies	4
General Practitioners	3
Maori service providers and local Iwi	3
Hospital	2
Truancy officers	1
Public Health Nurses	1
The workplace	1

Only one of the ten agencies did not take self-referrals, as they dealt only with severe substance dependence and mental health problems. Of the nine workers from agencies which accepted self-referrals seven said that their self-referrals were a very small percentage (less than 15%) of their overall referrals.

> "About 0.1%, really its very low, and even those that are self referrals have usually come for some other reason, and not necessarily off their own bat."

One said self-referrals were a medium percentage (approximately 15%) of the overall number of referrals and one said they were the main source of the overall referrals (more than 50%)

> "They [self-referrals] would be the main referral source, higher than anything else. We have a very open friendly service and they seem to like to come in here"

Three of the ten participants said that they worked primarily with Maori adolescents, and six said they worked with New Zealand European/Pakeha in the majority, while one participant said he worked equally with both Maori and Pakeha adolescents.

Specific needs of adolescent substance abusers

There was a lot of variety in the answers given to the question "What specific needs do you believe adolescents have?" The answers were as follows:

Table 18

Specific needs	Number of participants
To feel trust/respect/love	5
Better and more education	4
Accessible services	4
To feel like they are being heard	3
Liaison and co-ordination with all parties involved	3
More family involvement	3
More resources	3
Realistic expectations by others	2
Better role-modelling from family and others	2
Developmentally specific interventions	2
Confidentiality	2
A friendly atmosphere	2
A separate methadone programme	1
One-stop-shops	1
More school involvement	1
Life skills	1
Shorter sessions	1
Visual stimulation	1
Groups and activities	1
To be spoken directly	1
Motivation	1
Someone specialised in their area	1

The most commonly mentioned specific need of adolescents was their need to feel trust respect and/or love.

> "The main one is just to have someone listen to them. They are always being told what to do and what not to do, and its important just to listen. It's important to build a trusting relationship, believe in them, affirm them and get on side with them. They need lots of love....."

This was closely followed by the need for more and better education services and the need for accessible health services. Other answers to this question include:

> "There are a whole array really, and needs vary depending on the young person. Many of them are dependent on other systems, financially, and family and sometimes school is involved, which is different than for adults....."

> "With the younger ones I think they need shorter sessions, like 1/2 to 3/4 of an hour, as opposed to a full hour. Generally they need lots of visual stimulation, to generate some energy. It's good to put them in groups and do lots of activities....."

Philosophy, theories and models of adolescent substance abuse

There was no consistent use of one or any assessment tool by the workers. Four of the workers used adult assessments,

> "No, we don't have a specific adolescent assessment, and we really need one";

three used DSM IV criteria, although all acknowledged it was not entirely applicable for youth.

> "...we do use DSM IV criteria to diagnose, but its not for adolescents so I'm careful to use this in relation to other parts of the assessment, like their living situation, any abuse issues, peer relationships and that sort of thing."

Four of the workers had adapted their own assessments to be more youth specific. Two did not comment on the type of assessment they used. Other types of assessment tools used are listed in table 19.

Table 19

Type of assessment tool used[13]	Number of participants
Own adapted adult assessment	4
DSM IV	3
The alcohol Use Disorders Identification Test (AUDIT)	2
The Drug Abuse Screening Test (DAST)	2
The Cannabis Abuse Syndrome Screening Test (CASST)	2
The HEADSS (home, education, activities, drug and alcohol, sex and sexuality, suicidal ideation) Assessment	1
The Four L's (livelihood, liver, lover ,law)	1
The CAGE Questionnaire	1
The Short Alcohol Dependence Data Questionnaire (SADD) Assessment	1
An adapted Parazzoli Model (not an alcohol and drug assessment tool)	1

Three of the participants said they believed that adolescent assessments need to be shorter than adult assessments, and three mentioned that they did not like labelling their adolescent clients.

> "It's not helpful for adolescents because they may still be experimenting, and will be given a label they may grow out of."

Three of the worker participants named harm reduction as their basic philosophy for working with adolescents. Seven said that they would use both abstinence and harm reduction philosophies, depending of the individual circumstances and goals.

> "Philosophically we are about meeting the person's needs, rather than have them fit into our structure. Whether we are harm minimisation or abstinence focussed, depends on the individual. If we have someone with a family history of substance dependence, or if they have other behavioural problems we might aim for abstinence. If there is none of that and the young person is going through an experimental stage, we might look at sensible ways of drinking or using drugs."

A variety of theories and models were used by each worker and around the country. Table 20 shows the variety.

[13]Please see Appendix G for copies of these alcohol and drug assessments and screening tools, where they are not explained here.

Table 20

Types of theories and models used	Number of participants
Cognitive/behavioural	7
Motivational Interviewing	5
Harm reduction	3
Transactional Analysis	3
Drawing therapy	3
Systems/Family therapy	3
Behavioural therapy	2
Reality therapy	2
Guided Self Change	2
Narrative therapy	2
Client centred model	2
Cognitive therapy	1
Rational Recovery Model	1
Interpersonal Therapy	1
Education model	1
Nuero-Lingusitic Programming (NLP)	1
Goal setting	1
Relapse Prevention	1
Milieu therapy	1
Psychodrama	1
Chair work (Gestalt)	1
Human development model	1

Eight out of the ten participants mentioned that which model or theory they used depended on the individual and on the situation.

> "There is not one particular thing that works for everybody"

> "Basically I work very eclectically, using different tools at different times"

> "The biggest one is-whatever works at the time do it! I have a good knowledge and background in NLP, Transactional Analysis, Motivational Enhancement, and cognitive/behavioural therapy, but no one [therapy] will work across the board with all adolescents."

Difference between age groups

One of the questions asked in the interview was about the differing age ranges within adolescence, and how the workers might work differently with adolescents of differing

ages and maturity. The answers were very varied. The most common answers included that different ages have different circumstances, for example:

> "In early adolescence the family unit is very important and we work with this. In middle adolescence it depends on what's going on for them, whether they're still at school and living at home or working and living with a boyfriend or girlfriend, but wherever they are we still use those support people. Late adolescents are more individual, and probably have less contact with family, although family is still important, they don't usually have the same dependence on the family unit.".

This and the other differences between the ages are in table 21.

Table 21

Differences between the ages	Number of participants
Different circumstances	4
Patterns of abuse are more ingrained in 16-18 year olds	3
Developmental changes are more obvious in younger adolescents (e.g. puberty)	3
Older adolescents are more sexually active	2
Younger adolescents need more education	2
Younger adolescents have more family involved	1

While there were some differences in the way the different age groups were worked with there were also some similarities.

> "Well they bring different experiences, different attitudes, beliefs and values, so I do work differently with them, but I still get them to look to the future, whether they are 13 or 17, and ask them do they still want to be doing what they're doing in four years time."

Two of the worker participants also mentioned that they work differently depending on the gender,

> "...there are huge gender differences too, especially with puberty, and relationship issues are vastly different too. We would take a whole different approach.",

while another worker mentioned that they have a separate group for opiate users.

" The only ones we separate out are the opiate dependent patients as they are different again, more street wise"

Seeing under-sixteen-year-olds

Throughout the interviews it became apparent that there was some difficulty due to the law and the counsellors ablity to see under-16-year-old clients without parental consent. Four of the ten participants specifically mentioned that the law made it difficult to see under-16 year-olds. The workers handled the situation differently. Of the nine workers who accepted self-referrals, two of the participants did not comment on this situation; two workers said that they did not have the need to see underage clients without their parents consent, two workers said they would see an under-16 year-old but would be clear about the situation in which confidentiality could be broken, one said they would see an under-16-year-old without the parents' consent, but would encourage the adolescent to tell their parents and also carefully explain the situations in which confidentiality could be broken, one worker saw under-16-year-olds without parental consent because after looking more closely at the law she believed that;

"if the young people are old enough to access their own health care then the parents don't have to know ".

She also covered herself by letting parents know that she provided a confidential counselling service, via the school newsletter, and was open to parents contacting her. Only one worker said she would not see an under-16-year-old without parental or CYF consent.

"I don't see under 16s unless I have parental or CYPFA [CYF] consent. If a client is referred I write to them and tell them that I need to have the written consent of their parents before I can see them. I won't see them without this otherwise I'm setting myself up."

Effective interventions/approaches

From answers to the question "What do you find that is particularly effective when working with adolescents?" and other statements throughout the interviews, a number of interventions were identified which the workers agreed were effective when working with adolescents.

Six of the ten participants mentioned that it was important to have accessible and/or mobile services for adolescents.

> "As I've already said, getting out and about, and getting into their world"

This meant anything from being available in rural areas, to providing transport to the office, or being able to go for a walk along the beach with the client.

> "We might get out of the centre and take a walk along the beach, we want to make it comfortable for them. We also provide transport to get them to the centre, we can pick them up and drop them off, we might even buy them lunch if they haven't got any."

It also included outreach work in schools, and working from different buildings.

> "I think they need to be met on their own ground, for example at school-they need outreach workers at their schools."

> "It's important to be able to work from different places, I will go to different buildings around town, to the schools, or do home visits, you must cater for their needs...."

Five of the ten participants mentioned having a respectful and trusting relationship with the adolescent as being effective.

> "Primarily you have to work on building the relationship with them otherwise nothing is going to work."

One participant believed from research that he had read that the relationship with the counsellor/therapist is more important than anything else.

> "A study done by the Rand Corporation , I think found that it didn't matter what models were used they all had about the same outcome, and what they found was that it come down to the ability of each individual therapist, and how they make a connection with the client that was most important."

These and other effective approaches are listed in table 22.

Table 22

Effective interventions/approaches	Number of participants
Accessible/mobile service	6
Respectful and trusting relationship	5
Education	5
Using the adolescents' own language (e.g. teen jargon)	4
'One-stop-shops' "From an agency perspective I think places like 198 Youth Health in Christchurch are great, one-stop-shops, run by youth for youth"	4
Motivational Interviewing	3
Family involvement	3
Shorter term and shorter length counselling sessions "Shorter interventions, in terms of the session time and the number of weeks that the young person is seen. I may contract to see them six times in four weeks, so I see them more often in a shorter period of time. Their concept of time is totally different to ours [adults]."	3
Cognitive/Behavioural Therapies	3
Praise/Postive consequences	2
Peer involvement	2
Listening	2
Being direct and honest	2
Clear confidentiality	2
Visual elements	2
Narrative Therapy	2
Working in schools	2
Role-modelling	2
Advocacy	1
Involvement in training courses/school/employment	1
The concept of power and control	1
'Here and now' interventions	1
Clear boundaries	1
Karakia	1
Asking them to try giving up	1
View withdrawal symptoms as positive	1
Look at the future	1
Ask them what activities they have given up for substances	1
Asking them to think about how other users they know behave	1
Life skills	1
Self expression/communication	1
Anger management	1
Self-esteem building	1
Videos	1
Group work	1
Flexibility	1
Don't label	1
Address developmental needs	1

What's so special about Aotearoa/New Zealand?

This research is Aotearoa/New Zealand specific and is so because of the belief of the researcher that some Aotearoa/New Zealand specific information is needed and we cannot rely solely on overseas research which may not be relevant to the Aotearoa/New Zealand experience. The worker participants were therefore asked what they believe is unique about Aotearoa/New Zealand, and how this impacts on the area of adolescent substance abuse interventions.

Five of the participants mentioned that they thought Aotearoa/New Zealand had a 'cannabis culture' , meaning that we have a high number of cannabis users in this country and that it is fairly 'normalised'. This is substantial and different from other countries like the USA and Great Britain. Four mentioned the importance of our tangata whenua, in making Aotearoa/New Zealand unique, and believed that more and better services are needed for Maori.

> " Well we have Maori kids, who have had a whole different upbringing, and a different way of looking at life, so they have to be treated differently, and must have access to Kaupapa Maori services[14]"

Three participants mentioned Pacific Islands people as being something unique to the make-up of Aotearoa/New Zealand.

> "We are very geographically isolated, and have a small country, which has a variety of ethnicities"

Three participants mentioned that Aotearoa/New Zealand is very isolated from the rest of the world, three mentioned that New Zealanders have less exposure to certain types of drugs, for example cocaine and crack. Two participants mentioned our 'alcohol culture', meaning that we have a tendency as a nation to be heavy and/or binge drinkers. Two participants mentioned the state of Aotearoa/New Zealand politics as something which singles us out from other countries.

> "And then there's the state of the government, I think there is a lot of politicking that keeps this country stuck."

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[14]Programme or project specific to Maori and with Maori culture as its base.

Two participants mentioned that they do not believe our education system adequately educates our children about alcohol and drugs, one of these participants also believes our education system does not cater well for a variety of ways of learning.

> " The education system here doesn't seem to cater well for different needs, there is one system and if you don't fit in to that, it's a very bad start."

Two participants believed however that our experience does mirror the overseas experience, especially because of technology like satellite and the Internet which means New Zealanders have access to information and trends world wide.

These explanations and others of what makes Aotearoa/New Zealand special are tabulated in table 23.

Table 23

What makes Aotearoa/New Zealand special	Number of participants
'Cannabis Culture'	5
Tangata whenua/Maori	4
Pacific Islands people	3
Isolation from the rest of the world	3
Less exposure to certain drugs (e.g. Cocaine	3
'Alcohol Culture'	2
Politics	2
Inadequate education system	2
Does mirror overseas experiences	2
Rural base	1
More of a morphine and home bake problem	1
Very small country	1
Adults have unhealthy attitudes to substance abuse	1
High separation and divorce rate	1
Depressed economy and depressed people	1
More racist than others	1
Addiction is seen as shameful	1

> "New Zealanders are much less likely to introduce themselves as in recovery, and its almost shameful that they needed help with their problem, whereas in the US people will tell you if they've been to the Betty Ford Clinic, and how long they've been in recovery, even if they're going for a job."

Frustration and benefits of working in this area

The most common frustration of working in the adolescent alcohol and drug treatment field was lack of funding and resourcing which was mentioned by eight of the ten participants.

> "The overall frustration is the lack of funding and lack of acknowledgment of this area from government. A & D gets 1% of the mental health budget in this country, compared to about 25% (I think) in Australia."

Also mentioned as a frustration was the debate about who should provide adolescent alcohol and drug treatment. That is, whether it should be provided by adolescent mental health services or alcohol and drug services. Four participants mentioned this as a frustration and did not believe adolescents were being catered for appropriately by mental health services.

> "The main frustration is the political frustrations of having to come under the mental health umbrella again, and being totally under funded, under resourced, under staffed and under paid."

> "Adolescents being seen under youth mental health is not working. They will only see the hard or most dependent 3% of cases."

These and other frustrations mentioned are listed in table 24.

Table 24

Frustrations	Number of participants
Lack of funding and resourcing	8
Adolescent mental health versus alcohol and drug services debate	4
Lack of acknowledgment	3
Parents and caregivers of young people who also have substance abuse problems	3
Being under staffed	3
Lack of school involvement in early intervention	3
Politics (e.g. agencies in competition for funding)	3
Negative views of adolescents by media and society	2
The youth themselves	2
Schools not managing the problem	2
Hard to deal with seeing poverty and abuse	2
Having to send clients out of the area for treatment	1
Lack of specific adolescent detox beds	1
Involuntary clients	1
Boundaries	1
The law	1
Lack of available training	1
Too few healthy role models	1
Mixed messages from teachers	1
'Cannabis Culture'	1

The benefits of working in this area were certainly not as diverse or extensive as the list of frustrations. However 5 participants mentioned that it was fulfilling to help people make positive changes.

> "I think there are a lot of benefits, the biggest one is being someone that can enable youth to feel respected and valued, make changes at home and in the schools, and stand up for them."

Other benefits of working in this area are in table 25.

Table 25

Benefits	Number of participants
Helping people make positive changes	5
Gives a buzz/have a real passion for it	3
Interesting	3
Positive feelings	2
Positive feedback	2
Ever changing and broad	2
It's good to be meeting a gap	1
Energising and creative	1
Has helped with relationships with own children	1
Good feeling when client brings friends and/or family to see me	1
Challenge	1

Ideal intervention

One of the priorities of the study was to get an idea from the participants, about what they believe an ideal intervention with substance abusing adolescents would consist of. Seven of the ten worker participants agreed that they would want to have a variety of interventions, as no one intervention will suit everyone.

> "I wouldn't want to risk just one approach, there would need to be several approaches, and I believe community/out patient services are most effective...."

> "I don't know there are so many different things that suit different cultures and parts of society."

Ideal interventions that were mentioned among this need for variety are listed in table 26.

Table 26

Ideal intervention	Number of participants
Day programme	5
One-stop-shop	4
Local initiatives	3
Outpatient clinics	2
A family programme	2
A life skills programme	2
A drop in centre	2
Detox beds	1
Physical activity	1
An outdoor programme on an island	1
A spiritually focussed programme	1

> "I would have a residential unit, a day programme, an outpatient service, a family programme, and a detox, all with no waiting lists."

Also mentioned at this time was the importance of having no waiting lists, lots of staff including teachers, and more access to better employment and training.

Nine of the ten participants said they would definitely support a day programme in their area, and one said they would support one depending on how it was run and by whom.

> "Depends who was running it and what they were doing. The people would need the right abilities, and the programme would have to be right, and then if that was OK then yes. I don't think it would work that well in Taranaki though, because we have so many rural areas and people couldn't get to the city."

One participant who lived in an area where a day programme was running said she would not refer to this programme.

> "No its a personal thing I don't like the way they operate, with behaviour modification-there's something missing, the spiritual aspect, not everything's about behaviours."

Worker Data Summary

The sample of workers was much easier to obtain and therefore larger than that of the adolescent sample. Because of the qualitative nature of the research the answers from

this sample are valid, because qualitative research allows for and justifies the importance of the views of each of the individuals.

The workers interviewed came from a variety of geographical locations around Aotearoa/New Zealand, from a mix of both Crown Health Enterprises and non-government organisations, and from a diverse range of agencies providing a variety of services. Only three of the ten workers however came from agencies which specialised only in adolescent alcohol and drug treatment. Other workers came from agencies whose core business ranged from Maori social services, to adult alcohol and drug services. This under representation by adolescent alcohol and drug service providers is indicative of the lack of them in this country, and of the as yet undecided debate about who adolescent alcohol and drug services are better provided by.

The workers themselves came from a variety of professional fields ranging from counselling to nursing, and had a variety of qualifications ranging from certificates to Masters degrees. The worker participants ranged from managers/co-ordinators to youth caseworkers. While seven of the participants had had alcohol and drug treatment experience prior to their current roles, none had specific adolescent alcohol and drug treatment experience prior to their current position.

Referrals to their services came from a variety of places, the most common being from schools, closely followed by justice and Community Probation services, Child, Youth and Family, parents and/or family/whanau, and other community agencies. These statutory referral agencies can be seen alongside the low percentages of self-referrals. Self-referrals were seen as being a very small percentage of the overall referrals by seven of the nine agencies which accepted self-referrals. Only one agency said that self-referrals were their main referral source, and this was the Maori social service provider.

All of the workers provided assessments, however there was no one assessment tool used, no clear understanding of what an adolescent assessment should incorporate, and four of the ten workers used adult assessments. All of the workers also did one on one counselling, however other than this there was a mixture of services provided including; interventions in schools, liaison with other services, education, outreach, alcohol and

drug treatment groups, and family therapy were the next most commonly provided services.

The most common reasons mentioned for working with youth were that there was a need, and because it was more fun/easier to work with youth. Only three of the ten workers provided services for Maori adolescents primarily, while six worked with Pakeha/European, and one worked with both ethnicities equally.

The workers were able to highlight some significant areas where they thought they could improve their services. Most common here was that they believed that they should do more work in schools, should provide a day programme and a residential in-patient facility. There was however no real consensus about what the special needs of adolescents are, however the most commonly mentioned answer was the need for them to feel love and respect.

A theme throughout the data was the importance of the needs of the individual, but also that a variety of subgroups within adolescence also had specific needs. There was some recognition that the differing age ranges that adolescence incorporates are different in terms of how they present and how they might best be helped. There was also some recognition by two of the workers that there are different needs depending on gender and one worker said they provided a different type of service for opiate dependent adolescents.

There was a mixture of ideas from the worker participants about what were effective interventions with substance abusing adolescents. However, the most frequently mentioned was the importance of having an accessible and mobile service. Also important was the relationship between the adolescent and the worker which must be respectful and trusting. These two points were the most commonly mentioned things needed in order to provide effective interventions with adolescents. Also popular as ideal interventions were a focus on education, one-stop-shops, and being able to speak to adolescents in their own language. Other suggestions were many and varied and reflect the ad-hoc nature of the services provided to adolescents with substance abuse problems.

The most common basic philosophies used by the workers were a mixture of both abstinence and harm-reduction strategies depending on the individual and their circumstances. The workers used a variety of theories and models, the most popular being cognitive behavioural theories and models, and motivational interviewing techniques. Eight of the ten worker participants however, mentioned that what model or theory they used depended on the individual and the situation. This thinking underpins beliefs about treatment matching and eclectic theories of adolescent substance abuse treatment discussed in previous chapters. The relationship between the data and the theories outlined in Chapter Two, will be further discussed in the next chapter.

There is obviously some confusion about whether or not it is legal to see adolescents under the age of 16 without parental consent. The way that workers handled this was different, however four of the workers said they would see under 16 year olds without parental consent if necessary. According to one of these participants the law in this area is grey, and she believed that if adolescents are old enough to access their own health care then she could legally see them. According to the Ministry of Health (1998), if practitioners believe that the adolescent under the age of 16 has the intellectual capacity and maturity to make their own decisions about their health care, then the practitioner does not need parental consent to see them. While the law has never been tested in this area, this is consistent with common law developments and the Code of Health and Disability Services Consumer's Rights 1996. The Ministry of Health document does stress however, that the adolescents should be encouraged, but not coerced, to let their parents know that they are undertaking any form of counselling or treatment. It would appear there is a need for workers working with adolescents to be more aware of the law and its inconclusiveness in this area.

Given that this research was Aotearoa/New Zealand specific it was important to gauge how the workers believed Aotearoa/New Zealand is different from other countries around the world. The most common answer to this was that Aotearoa/New Zealand has a 'cannabis culture' unique to this country. Also mentioned as unique to Aotearoa/New Zealand was our ethnic makeup and our indigenous people. It was understood by the workers that Aotearoa/New Zealand is unique and therefore

interventions have to take this uniqueness into consideration, however two participants believed our experiences do mirror overseas experiences and that we can learn from their research also.

There was some consensus about the frustrations of working in the adolescent substance abuse area. By far the most common frustration was the lack of funding and resourcing, this was followed by the frustration of the debate about who should provide adolescent alcohol and drug treatment, that is adolescent mental health or alcohol and drug services. There was some concern from four of the workers that adolescent mental health could not cater appropriately for adolescent alcohol and drug problems. The frustrations involved in working in this area appeared to outweigh the benefits, however the most positive benefit mentioned was the fulfilment gained from helping people make positive changes.

When asked what would constitute the ideal intervention with adolescents, again there were a variety of answers, however seven of the workers agreed that they would want to be able to offer a variety of interventions to provide for the diversity of the client population. Aside from this, high on the list of ideal interventions were day programmes, and one-stop-shops. Nine of the participants said they would support a day programme in their area.

One of the most telling patterns from this data was the ad-hoc nature of assessments and services provided, which is indicative of the fledgling state of adolescent substance abuse treatment in Aotearoa/New Zealand. It is in its early beginnings on a national scale, and appears to be going through a stage of trial and error. The second important pattern to note is that of the workers being flexible in their use of treatment, models, theories, and beliefs about adolescent substance abuse. This once again supports eclectic approaches to adolescent substance abuse, which appear to be founded not only in theory, but also in practice.

The next chapter analyses the findings from the two sets of research data alongside chapters one and two, to identify emerging patterns about adolescent substance abuse interventions. Conclusions and recommendations about policy, practice and further

research will be made in the following chapter, which also highlights the methodological limitations of the study.

Chapter Seven

SYNTHESIS AND INTERPRETATION OF FINDINGS

Introduction

This research was designed to identify what constitutes an effective intervention with substance abusing adolescents in Aotearoa/New Zealand. Adolescents and workers were asked a variety of questions about their experiences of the alcohol and drug treatment field, about what they found helpful, unhelpful, difficult and what they would consider to be an ideal intervention. In this chapter these views will be considered alongside research findings and literature from chapters one and two. The main topics from the synthesis of this data are: age of onset use, influence on first use of substances, substance of concern and other substance use, reasons for seeking help and referral sources, the importance of schools and education providers being involved, services provided, the most helpful elements in adolescent substance abuse intervention, family involvement, worker attributes, frustrations, and the ideal intervention.

Age of onset use

The average age of onset use of the adolescents' drug of concern was 12. This supports the UNs concerns and the research findings from the United States, that adolescents are first using substances at an earlier age than they were in previous years (United Nations, 1997; Covert & Wangberg, 1992), and that substance use among 12 to 13 year olds is increasing (Center for Substance Abuse Treatment, 1999). This also supports the New Zealand data from the ALAC Youth and Alcohol Survey (1997) which found that over 50% of respondents had had their first full glass of alcohol by the age of 14. Field and Casswell's (1999) national comparison survey also supports this finding with onset use of marijuana. In 1990, 40% of those who had tried marijuana had done so by age 16, but in 1998 this had increased to 52% (Field & Casswell, 1999).

At present we have no way of knowing the amounts, frequency, and consequences of substance use by young people in this age group (age 12). Unfortunately Aotearoa/New Zealand based research has shied away from studying this age group in terms of substance use, and most of the research begins at age 14. This is important to bear in mind for future research as we know that earlier use of substance use by young people is a risk factor for on going substance abuse problems (Bukstein, 1995; Spooner et al., 1996).

Influence on first use of substances

Friends (but not peer pressure) and boredom were the two main influences on the first use of substances by the adolescents interviewed. The influence of the peer group in the using of substances is supported by Connolly et al., (1992), who found that greater amounts of alcohol were consumed when obtained by peers and drunk with peers in the evening. It is well recognised that peer influence can be both a risk factor or a protective factor, and depends on such things as the peers' substance use, and how this is perceived by the adolescent, peer attitudes about substance use, and the level of attachment to the peer group (Bukstein, 1995; Spooner et al., 1996; Thomas et al., 1996).

Whaitiri's (1995) study of adolescents, found an almost complete absence of reference to 'peer pressure', and it appeared that what is seen by older people to be peer pressure is not seen as peer pressure by the adolescents themselves. Two of the adolescent participants mentioned that they did not feel a 'pressure' from their friends to use, only that they were friends at the time of use. This consistent with Whaitiri's findings.

Although adolescent participants mentioned boredom as a factor in first use, there is little reference to boredom specifically in either the national or international literature, however boredom can be associated with low socio-economic status and community or neighborhood characteristics such as high population density, high crime, and high unemployment rates, as it is recognised that these communities usually offer few resources for adolescents (Bukstein, 1995; Spooner et al., 1996). These elements are

also considered to be risk factors for adolescent substance abuse (Bukstein, 1995; Spooner et al., 1996). Boredom may also be associated with a lack of coping/life skills that would otherwise enable the adolescent to find activities or hobbies to better utilise their time. A lack of coping/life skills is another recognised risk factor for adolescent substance abuse (Thomas et al.,1996).

While peers and boredom were mentioned by the adolescents in this study as an influence to start using substances, and these influences are supported as risk factors by the literature, the workers mentioned very little about these things. While three of the ten worker participants mentioned the need for more resources for adolescents, only two of the ten mentioned the importance of peer involvement in their treatment as a special need, and only one mentioned the importance of keeping them in school, or training as important.

It appears then that if peers are not involved in the intervention in a positive way they may be a negative influence on the adolescent, or could be a risk factor. If young people are not kept busy with school and training and/or hobbies and activities, the risk is they will get bored and could get into trouble. From the adolescents' interview data and from the literature it is evident that interventions with youth may need to better focus on these two areas.

Substance of Concern and other Substance Use

The substances of concern among the adolescent participants were alcohol, cannabis or both. This supports the comparison research by Field and Casswell (1999) that alcohol and cannabis, along with tobacco, are still the most commonly used substances in Aotearoa/New Zealand. This is also supported by the workers, five of whom mentioned Aotearoa/New Zealand's 'cannabis culture' and two of whom mentioned the 'alcohol culture' in Aotearoa/New Zealand, as unique to this country.

While the adolescents' substances of concern were alcohol, cannabis or both, they had also used other drugs including LSD, magic mushrooms and cannabis oil. This is in line

with Field and Casswell's (1999) findings that the use of other types of drugs is increasing in the 15 to 17 year old age group.

Reasons for seeking help and referral sources

Most help seeking in this sample of adolescents was not voluntary and was strongly associated with problems at school, with the justice system and/or parents. Of the four adolescent participants only one went completely voluntarily to seek help. Two of them were voluntary but were pressured by either school or the police, and one went completely involuntarily, that is, he did not want to go but was 'made to go' by his parents. All four of the participants had had trouble with authorities because of their substance use, before seeking help. This information is supported by evidence from the worker participants whose main source of referrals were from schools and from the justice system (including police, the courts, Community Probation and Youth Aid) and is further supported by the literature which concludes that anti-social and rebellious behaviour are risk factors for adolescent substance abuse.

The number of self-referrals for adolescent substance abuse interventions were minimal. Only one worker said that her self-referrals were the largest referral source; this was the Maori social service provider. This minimal percentage of self-referrals is supported by the literature (Ivanoff, et al.,1994) which suggests that because of the age group of the adolescents, many of them are still under the jurisdiction of parents or guardians and therefore the majority of referrals to substance abuse counsellors or programmes are likely to come from people other than the adolescent themselves. From this it would appear that the majority of clients referred to adolescent substance abuse interventions will be involuntary or semi-voluntary, and therefore the intervention must reflect this, by using well recognised strategies for resistance such as motivational interviewing. The only exception to this may be that Maori adolescents are perhaps more likely to seek help voluntarily and may therefore be more motivated to change.

The importance of schools and education providers being involved

All of the adolescents who went to treatment voluntarily or semi-voluntarily received the information they needed to seek help from their school or education provider. This shows the importance of the education provider having the knowledge and skills to either work with the young person to provide help, or to know where to send them for further assistance. Similarly, from the worker's interview data, the largest number of referrals to the workers came from schools, with six out of ten workers providing services in schools, and four of the worker participants wanting to have more involvement in schools. Three of the worker participants also said that schools' lack of involvement with early interventions for alcohol and drug issues was frustrating, and two said that New Zealand's education system as a whole is inadequate.

The literature recognises that low commitment to education has been associated with substance misuse (Spooner et al., 1996). Other Aotearoa/New Zealand based literature recognises the importance of interventions for substance abuse in schools (Manahi, 1998). The Student Assistance Programme, which was developed in America, but is now being used here, is an example of this. This programme aims to try and keep young people in school and involves schools providing programmes on topics including alcohol and drug abuse and other related issues alongside academic subjects. The key to Student Assistance Programmes, is that schools, supported by community agencies, play a fundamental role in providing programmes that, while often seen as important, have never been provided by schools before (Manahi, 1998). Given the research findings, it would appear that programmes such as the Students Assistance Programme have an integral role to play in providing substance abuse interventions where they are most needed.

Services Provided

All of the workers interviewed in this study provided one-on-one counselling and some type of alcohol and drug assessment, however there was no one assessment tool used,

and no clear understanding of what an adolescent substance abuse assessment should consist of. According to the little available literature, the DUSI (Drug Use Screening Inventory)[15] remains the most widely accepted inventory for alcohol and drug assessments with adolescents (MacEwan, 1998). This assessment tool was not mentioned by any of the worker participants. It is evident that a standardised adolescent substance abuse assessment needs to be developed for use in Aotearoa/New Zealand.

None of the workers provided residential treatment, day treatment, a drop-in service, a special programme for young women or detoxification facilities. This supports the findings from MacEwan (1998) that there is a lack of intensive residential, day treatment and respite care in Aotearoa/New Zealand, and Burglass's (1998) findings, that there is a lack of youth drop in centres, programmes for young women and social detox in Aotearoa/New Zealand. The workers' data clarified that while these things are not provided and are recognised as lacking in the research, they are also recognised as lacking by the workers themselves. Four of the ten participants mentioned that their services could be improved by having a residential treatment, and four mentioned that having a day programme would improve their services thus providing further evidence of the need for more of these services.

The Most Helpful Elements in Adolescent Substance Abuse Intervention

The adolescents found the harm reduction strategies, such as learning how to control consumption, and the self-esteem/confidence building skills the most helpful elements of their intervention. In terms of harm reduction, all of the adolescent participants were still currently using their drug of concern. Three of them believed they had their substance use under control, and only one had the ideal of giving up altogether.

All of the workers interviewed used harm reduction techniques to some extent. Seven out of ten said they use a mix of harm reduction and abstinence philosophies depending

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[15] A copy of the DUSI assessment tool can be found in Appendix G.

on the individual and three said they used harm reduction philosophies only. It would appear therefore that in this case the workers were providing what is seen by the adolescents as one of the most helpful elements in an intervention. This use of harm reduction strategies is also supported in the literature as there is evidence to suggest that addiction, rather than always being progressive and fatal, is often intermittent and discontinuous, particularly among younger people, and harm reduction is seen as an effective way of dealing with this reality (Marlatt, 1998).

Two of the adolescent participants specifically stated that they did not consider themselves to be 'alcoholics' or 'addicts'. This indicates again the use of harm reduction in their intervention, and the importance of not labelling adolescents as 'alcoholics' or 'addicts', which can leave them stigmatised for life, even though their substance abuse may not last for the rest of their lives. It may have been that because of their understanding of harm reduction, these adolescents were able to use in a controlled manner without feeling that they had failed, or relapsed, which could in itself put more pressure on them to use.

In terms of self-esteem/confidence building which was also recognised by two of the four adolescent participants as most helpful, only two of the ten workers provided self-esteem groups and none mentioned they work on this specifically with the adolescents one-on-one. Only one of the worker participants mentioned it as being effective with young people. In the literature, low self-esteem is often mentioned as a reason for the use of alcohol and drugs by adolescents, and can be dealt with using psychodynamic theories and models which view substance abuse as a symptom of some other underlying emotional problem (Bukstein, 1995), or by behavioural theories and models where the adolescent is believed to behave in ways to avoid rejection and gain favour; for example the adolescent may use drugs to maintain the acceptance of their peer group (Langer, 1996). Either way it appears that some self-esteem/confidence building is an important part of any adolescent substance abuse intervention, and that at present more work could be done with adolescents in this area.

Family involvement

The importance of having the adolescent's family involved in the adolescent's substance abuse intervention is well documented in the Aotearoa/New Zealand literature (Houlahan & Middleham, 1994; Whaitiri, 1995; Burglass, 1998). Family therapy is also seen as an important part of adolescent substance abuse interventions internationally (Margolis, 1995; Archambault,1992). However only one of the four adolescent participants had their family involved in their treatment. Two of the four adolescent participants had some indication of addiction issues in their families. Because both biology and genetics are seen as risk factors to adolescent substance abuse (Bukstein,1995; Thomas et al.1996), it is important to at least be aware of the family background of adolescent clients, if not to have them involved.

Only three of the ten workers mentioned using family and/or systems theories in their work, while four of the ten provided family therapy groups and three out of ten said having family involved was effective. Given the literature, and the lack of family involvement with the adolescent participants it would appear there is more work to be done in the area of getting more family involved and working with families whose adolescents have substance abuse problems.

Worker Attributes

Adolescent participants, worker participants and the literature were all in agreement over the importance of worker attributes to the field of adolescent substance abuse. Three of the four adolescent participants said that having staff working with them who were in recovery themselves was important, because they would have a better understanding of their problems. The remaining participant agreed but also stated that whether or not they are in recovery is not as important as if they can be trusted. Two of the participants did not believe the age of the counsellor was important, as long as they could relate to young people. One of the participants also mentioned that its easier to relate to some counsellors than others. This is the same participant who when asked what he had liked

about the residential treatment said he had a "cool-as staff-buddy". Obviously then to the adolescents the counsellor attributes are important.

One of the workers also brought up the fact that the relationship with the counsellor is the most effective thing when working with adolescents. Other things mentioned by the worker participants that would align with the importance of the counsellor/client relationship were the effectiveness of a respectful and trusting relationship, which was mentioned by five of the ten workers, and the need for adolescents to feel love, trust and respect, which was also mentioned by five of the ten workers. Thus adolescents and workers are in agreement with the importance of this factor.

These findings are supported by literature which shows that the counsellor attributes are essential and should include a natural ability and ease in relating to adolescents, the ability to be a positive role model, the ability to show empathy, a well organised approach to each case, the ability to make appropriate referrals, and several years of counselling experience (Archambault, 1992; Spooner et al., 1996).

Frustrations

The main frustrations of working in the area of adolescent substance abuse mentioned by the workers included lack of funding and resourcing, closely followed by the debate over who should provide services to adolescents with substance abuse problems. While little is documented in the literature in regards to this debate, there is literature which backs up the very real frustrations of lack of funding and resources in this area. The need for more and better adolescent alcohol and drug interventions in Aotearoa/New Zealand is well documented (Burglass, 1998; Rout & Lowe, 1991; Bruner, 1994; Moore, 1997; Macdonald, 1997; MacEwan, 1998; Deering et al., 1998, and Young, 1998), in Chapter One of this study, and is further supported by the drug and alcohol workers in this research.

The Ideal Intervention

From the adolescents' perspective there was no consensus about what constitutes the ideal intervention, or what the most important thing was that they had learnt. There was also a wide variety of answers to the question of what constitutes the ideal intervention from the workers. Table 27 lists the effective/ideal interventions that were mentioned by both the workers and the adolescent.

Table 27

Effective/Ideal interventions	Number of adolescents	Number of workers
Outdoor programme	1	1
Life skills	1	2
Peer involvement	1	2
Anger Management	1	1
Education	1	5
Listening	1	2

As can be seen there is little agreement about what was ideal and effective when working with substance abusing adolescents. This inconsistency is however supported by the literature which also has no real answer to the 'ideal' intervention because of individual differences that need to be catered for. Because of this, a combination of approaches and the use of eclectic theories is indicated as effective (Bukstein, 1995; MacEwan, 1999). This view about the importance of using a variety of models and theories to suit the individual was mentioned by eight out of the ten worker participants, while seven out of the ten worker participants mentioned that the ideal intervention would have a variety of components to meet the diverse needs of the diverse range of clients.

The need for a variety of options encompassing components from a combination of models in any ideal intervention is further highlighted by the adolescents' answers to questions about residential and day programmes. Two of them who did not attend residential said they would have if there was that great a need, however one said they would not go to a residential. Two out of four said they would go to a day programme, however the participant who had attended residential treatment believed that a day programme would not have worked for him. It is clear then, that options that can provide a combination of approaches from eclectic theories and models are important

when working with substance abusing adolescents, in order to meet individual needs and requirements.

Chapter Summary

The main points that have been identified from synthesising the two lots of interview data with literature chapters one and two are:

- The age of onset use of substances is getting younger (approximately age 12).
- Peer influence, but not peer pressure, and boredom, can attribute to adolescents beginning to use substances.
- Cannabis and alcohol are still the most widely used substances (other than tobacco), however the use of other types of substances is growing.
- The main referral sources for adolescents who need substance abuse treatment tend to come from someone other than themselves, for example, the Police/the Courts/Youth Aid/Community Probation, and schools. The majority of adolescents in substance abuse treatment will be involuntary or semi-involuntary.
- Schools and training providers have a large role to play in providing referral information as well as services for adolescents with substance abuse problems like the Student Assistance Programmes.
- A standardised assessment tool for adolescent substance abuse needs to be developed for Aotearoa/New Zealand.
- Further services that provide residential and day programmes are needed.
- More general resources and funding is required in the realm of adolescent substance abuse interventions.
- Harm reduction philosophies and self-esteem/confidence building techniques are important in effective interventions with substance abusing adolescents.
- The attributes of the worker working with the substance abusing adolescent are of utmost importance.
- There is no single 'ideal intervention' in the realm of adolescent substance abuse. There should be a variety of types of intervention to chose from, and a variety of

theories and models used within each intervention to provide a effective service based on the diverse needs of the individual.

The final chapter will consider these findings in relation to the aims of the research, and the limitations of the study, in order to make recommendations for workers in the realm of adolescent substance abuse treatment, social policy and further research.

Chapter Eight

CONCLUSIONS

Introduction

The broad aim of this thesis was to get an understanding of what constitutes effective interventions with substance abusing adolescents in Aotearoa/New Zealand. The research into this was done by undertaking a literature review of relevant Aotearoa/New Zealand research, publications, and social policies as well as a review of existing philosophies, theories and models of adolescent substance abuse. These literature reviews were seen alongside semi-structured interview data with both adolescents who had experienced some form of substance abuse intervention, and alcohol and drug workers who work with adolescents. The questions in the semi- structured interviews were designed to elicit from the participants their experiences of adolescent substance abuse interventions, and what they found to be helpful, difficult and/or important to mention. From these sources this chapter makes some recommendations about what constitutes effective interventions for substance abusing adolescents. It also makes some recommendations for social policy, outlines other key findings including findings regarding the potential role of the social worker in this realm, describes the limitations of the study, and suggests areas for further research.

The Research in Context

Around the country there are a variety of services being offered to adolescents with substance abuse issues, in an ad-hoc way. Gathering information about some of these services was an important part of this research. This research recognises the need for unique services to meet the unique needs of young people growing up in Aotearoa/New Zealand. It also recognises the significance and importance of the views of the young people themselves, and workers working in this area. Because the programmes (not just for substance abusing youth) introduced into Aotearoa/New Zealand are often based on overseas models and theories one cannot assume that they will apply here. Aotearoa/New Zealand specific research is therefore of the utmost importance.

The lack of available services and resources for adolescents requiring substance abuse interventions is well documented (Burglass, 1998; Rout & Lowe, 1991; Bruner, 1994; Moore, 1997; Macdonald, 1997; MacEwan, 1998; Deering et al., 1998, and Young, 1998). This research came about not only because of this recognition of a lack of services, but also because of the concern that the use of alcohol and other drugs by adolescents around the world and in Aotearoa/New Zealand is increasing, as is the variety of types of drugs used, while the age of onset use is decreasing (United Nations, 1997; Business Research Centre, 2000a; Field & Casswell, 1999).

In 1996, 12-19 year olds made up approximately 12.42% of the Aotearoa/New Zealand population totaling approximately 433,376 people. (Statistics New Zealand, 1998). The most recent statistics available (1992) for first time presentation to non-residential outpatient alcohol and drug treatment services by adolescents, indicated that 0 to 19 year olds made up 15% of all new clients (MacEwan, 1999). Adolescents are a significant proportion of the population, and a significant proportion of those presenting to alcohol and drug agencies for help. Interventions that are specifically aimed at adolescents are important, as adult focussed programmes do not adequately cater for the differing cognitive, emotional and developmental needs of adolescents (Bukstein, 1995; Burglass, 1998; Cavaiola & Kane-Cavaiola, 1989; Polcin, 1992; Spooner et al., 1996; MacEwan, 1999). Adolescents are deserving of consideration in a number of areas, including the area of specialised alcohol and drug intervention services. It was with these things in mind that the research was undertaken.

These realities have now been officially recognised and in the June 2000 budget the new Labour/Alliance Coalition Government announced that substance abuse services specifically for youth are a priority. While, as yet, specific details about extra funding in this area have not been announced, this proclamation is of vital importance if this area of treatment services for youth is going to be developed to a level deserving of these young people.

The following recommendations come from an integration of the array of literature researched, including social policy as well as from the interview data. These

recommendations are based on those findings that come directly from the research data and which are backed up by the literature review.

Recommendations for Effective Interventions with Substance Abusing Adolescents in Aotearoa/New Zealand

These recommendations cover theory, assessment, intervention components, and the role of the provider.

Theory

Theories into adolescent substance abuse are many and varied. This research concludes that the complex nature of adolescent substance abuse should be viewed from an eclectic approach, considering biopsychosocial, behavioural and disease concepts. For this to be possible alcohol and drug workers should also be aware of human developmental theories and how these relate to where each of their clients is at. Both groups of respondents concurred with the literature indicating that an harm reduction approach should be taken when ever possible and when appropriate. It is recommended therefore that these findings form the basis for continuing developments in practice.

Assessment

Assessment of adolescent substance abuse is an essential pre-adjunct to working effectively with substance abusing adolescents. This research concludes that the components of a standard comprehensive adolescent alcohol and drug assessment need to be developed for use around the country. In addition adolescents' mental health status should be assessed before during and after the intervention where possible to gauge the influence that any poor mental health may be having on the well-being of the adolescent and relevant referrals should be made if necessary.

Components

Interventions with adolescents are often complex, multi-factorial, and shaped specifically for each individual. With this in mind this research concludes that there are some

components that are essential to any intervention. Interventions should be developmentally appropriate, not just age appropriate. Self esteem/confidence building techniques should be a part of any effective intervention with substance abusing adolescents, whether on an outpatient, day or residential basis. Family/whanau should be involved as much as possible in the intervention with the substance abusing adolescent, unless this is deemed to be a negative influence on the well-being of the adolescent. Peers should be involved as much as possible in the intervention with the adolescent, unless this is deemed to be detrimental to the adolescents well-being.

Providers

Providers of adolescent substance abuse interventions play a pivotal role in ensuring an effective intervention. This research concludes that schools and other training providers would do well to be more involved in both providing interventions (not just prevention and education programmes) for substance abusing adolescents, as well as having a sound knowledge of services that they can refer to. Alcohol and drug workers who work in the realm of adolescent substance abuse should be chosen carefully, as the attributes of the workers are of utmost importance and have a huge influence on the treatment of the adolescent. Alcohol and drug workers working in the realm of adolescent substance abuse should recognise the majority of their clients may be involuntary or semi-voluntray at first, and that they may need to motivators first and foremost. These workers should be able to recognise the variety of risk and protective factors that the adolescent has in their lives and they will need to have good networks and communication to and from their main referral sources. Individual alcohol and drug workers in any setting should have a sound knowledge of a variety of philosophies, theories and models of adolescent substance abuse, so as to be able to be flexible with the approach they take with each of their clients. If the alcohol and drug worker works within a team, each member of the team should be able to provide a different approach, and clients should matched to these skills appropriately. This flexibility will allow for the diverse range of needs of each individual client.

Social Policy Recommendations

Social policies not only influence resources for adolescents and their substance abuse interventions, but provide legislation about everything pertaining to being a young person. This is why social policy can have such an influence over the who, where, why and how of adolescent substance abuse interventions and the funding thereof. At present there still appear to be some gaps in this area. A comprehensive 'Youth Policy', in Aotearoa/New Zealand needs to continue to be developed, so that policy around youth issues are not merely add-ons to policies for adults. Adolescents should have their input into the development of this comprehensive 'Youth Policy'. When further funding is provided in the area of adolescent substance abuse treatment services, policy guidelines should be in place to make sure this funding is allocated appropriately, and this should be monitored and evaluated continually. The law around when and where adolescents under the age of 16 can be seen and by whom without parental consent, needs to be clarified as at present this is unclear. Debate about the legal status of cannabis in Aoteroa/New Zealand should continue so that some answers are found to reduce the harm associated with the prohibition of cannabis. These recommendations, if implemented would help to provide guidance and priorities for the provision of programmes and services for adolescents.

Other Key Findings

Other key findings that came directly from the research data or from the literature review are mentioned below. These are research data findings which I was unable to find literature on or literature review findings that were not collaborated by this research. These findings may warrant further research in order to be collaborated or dismissed. These findings look at adolescents, those who work with them, interventions they use, the Aotearoa/New Zealand context, both cultural and political, and end with consideration of the place of social work in this field of practice.

Adolescents

The nature of substance abuse means it is difficult to get adolescents who have experienced some form of substance abuse intervention to take part in these types of studies. From the information that has been acquired it appears that adolescents are beginning to use substances at an earlier age, and are using more of a variety of different substances. Family/whanau and parents/guardians can be a huge influence both positively and negatively on adolescent substance abuse, as can peers, however this is not necessarily in the form of 'peer pressure'. Poor mental health is associated with adolescent substance abuse and other risk and protective factors of adolescent substance abuse include; biology and genetics, attitude and personality, family, physical and/or sexual abuse, socioeconomic status, macroeconomics, coping skills, peer group, education, age of onset use, and early labeling.

Providers

At present workers in the adolescent alcohol and drug treatment field have a variety of qualifications from a variety of professions. Workers would like to provide an accessible mobile service, do more work in schools, see more 'one-stop-shops', and provide day programmes and residential services. A respectful and trusting relationship is deemed important by workers, and having workers who are themselves in recovery appears to be important to some adolescents. As much as possible agencies and services who deal with adolescents should communicate, work together and co-ordinate their services for the sake of the adolescent.

Interventions

Around Aotearoa/New Zealand there are a variety of different types of services being offered to adolescents with substance abuse problems, and more advertising should be done of these existing services. A medical assessment should be part of any intervention where possible. There is some evidence to suggest that smaller more interactive programmes are most effective for youth, and follow up after completion of an intervention is highly recommended.

Aotearoa/New Zealand

Cannabis and alcohol are still the most widely used substances in Aotearoa/New Zealand (other than tobacco), and Aotearoa/New Zealand is seen as having a 'cannabis culture'. Aotearoa/New Zealand is seen as unique because of our tangata whenua and ethnic make up.

Social Policy

It is probable that prohibition of cannabis at present is contributing to the problems associated with it. More funding is needed in the area of adolescent substance abuse treatment.

Social Work

Social work has a role in the alcohol and drug treatment field, as the fundamental components of social work 'fit' well with ideas about how to work appropriately with adolescent substance abusers (holistic approach). Therefore more social workers should be hired and/or apply for positions in this arena and should take responsibility for and advocate the social work perspective in the adolescent substance abuse arena. To enable this, more alcohol and drug education should be added as a part of social work training.

Limitations of the study

This study has come for the most part, from a Pakeha perspective. Most of the theories, models and perspectives outlined in this research have been those dominated by the European and American influence. Only one Maori social service provider was involved in the research, and while two of the adolescents were Maori and many of the workers worked with Maori adolescents the majority of this research is better suited to those adolescents who are Pakeha. This research also focussed toward more 'mainstream' adolescents, and does not take into account to any real degree specialised interventions for adolescents with sexuality issues, dual diagnosis, or severe criminal offending.

The semi-structured interviews with both adolescents and workers outlined some key areas in order to identify what constitutes an effective intervention with substance

abusing adolescents in Aotearoa/New Zealand. However, the methodological limitations of the study were that the results are not generalisable because of the small sample sizes used, and the way the sample of the youth (convenience sampling), and the sample of workers (purposeful sampling) was obtained. Purposeful and convenience sampling (which is the least desirable of all sampling techniques) means that the sample chosen have problems of generalisability and representativeness compared to research using random sampling, which is a quantitative technique.

A criticism of the qualitative approach is that too much of the researcher's own subjectivity can influence the way the interview is undertaken, how the answers are interpreted and the final analysis (Babbie, 1992). Throughout the interview process I tried to remain as objective as possible when the participants answered their questions, however no researcher can ever be completely objective because they are influenced by their own values and judgments (Babbie,1992). While I did not want to influence the answers of the participants, I clearly came from the position that there were a lack of appropriate adolescent substance abuse interventions, (this is supported by Burglass, 1998; Rout & Lowe, 1991; Bruner, 1994; Moore, 1997; Macdonald, 1997; MacEwan, 1998; Deering et al., 1998, and Young, 1998), and that we needed to find some examples of effective interventions from which to write a set of recommendations. This would have come through quite clearly throughout the research, and may have influenced those who chose to participate and to some degree the interpretation of their data. This may mean that the information I gained from the interviews, and the themes and patterns that emerge from it, may be more likely to support my view as the researcher. While this is important to note, it does not mean the study is incompatible with good academic research, as the research still portrays the view of a number of people who have experienced alcohol and drug interventions and/or specialise in working in this area.

Where the adolescent sample was concerned, those who offered to participate were likely to be those who now have their use of substances under control, or have stopped. Those still experiencing problems with their substance use would be less likely to want to participate in research about substance abuse interventions, as they may feel they are ineligible to provide quality information because they are still abusing. This means it is

likely that the adolescent participants involved in this research, view the intervention they experienced more favourably than those who may still be living with active substance abuse, and are probably those more likely to have a lesser dependence on substances.

These realties mean that both sets of samples were influenced by the very nature of the research itself and how it was undertaken. Those who chose to participate may not have been typical alcohol and drug workers or typical adolescent substance abusers, and how the information they gave was analysed could not be completely objective or value free.

This research certainly has its limitations however the recommendations in this thesis are still very valid, especially where the interview data supports other research and literature on the topic. Where new findings have emerged from the data, further research should be undertaken to substantiate or refute them.

Suggestions for further research

Further research in this area which is Aotearoa/New Zealand specific is of vital importance. While the samples of adolescents who have had some sort of substance abuse interventions are very difficult to obtain, if possible a much larger study should be done based on random sampling. Researchers would also do well to research specific age and developmental stages, as well as different genders, ethnicities, and sexualities specially to be better able to generalise by any age, gender, ethnicity and sexuality. Given the importance of tangata whenua, some Maori specific research in this area would be of utmost importance.

Although theory appears to suggest they can be beneficial, the effectiveness of 'One-Stop-Shops' in the realm of adolescent substance abuse needs to be researched, because this may help to solve the debate about where substance abusing adolescents are best served. Whether they are best served at mental health, alcohol and drug services or some other service such as a One-Stop-Shop needs to be resolved.

Research needs to be undertaken to look into what components should be in a standard comprehensive adolescent alcohol and drug assessment for use around the country.

More research is continually needed to evaluate existing interventions and programmes including the two residential programmes currently operating, all day programmes and other individual services to ensure the interventions being used are appropriate. More research which starts at age 12 is needed in the area of adolescent substance abuse, as this age appears to be about the time many young people who develop on going problems are beginning their use, but is often neglected by researchers. Finally continuing research is needed into the effects of recently lowering the drinking age to 18. This may continue to be monitored by the ALAC 'Alcohol and Youth' Research.

This thesis research could be used for further study. Further research could be done in areas where interview data is unsupported by the literature and where information from the workers and adolescents differ. For example the workers indicated the importance of having a mobile service, but this was not mentioned by the adolescents. However had the adolescents been asked about the importance of this specifically they may or may not have supported this view.

Adolescents need and deserve quality interventions based on research and professional practice. Further research in this area can only further highlight the need for specialised adolescent substance abuse interventions, and provide some direction for alcohol and drug workers in the field to follow.

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Appendix A

CONSENT FORM

(Number 1-For adolescents)

Effective Alcohol and Drug Interventions with Substance Abusing Adolescents in Aotearoa/New Zealand.

- I have read the information sheet for this study, and have had the details of the study explained to me.
- My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.
- I agree/do not agree to the interview being audio taped.
  (delete one)
- I understand that if I agree to have the interview audio taped that I may have the tape turned off at any time.
- I understand that I am free to withdraw from the study at any time, or to decline to answer any particular questions in the interview.
- I agree to provide information to the researcher on the understanding that it is completely confidential.
- I wish to participate in this study under the conditions outlined on the information sheet.
- I am over the age of 16, or have my parents consent to be part of this study.

Signed:.....

Name:.....

Date:.....

If under the age of 16 parental consent is also required

Signed:.....
(parent/guardian)

Name:.....

Date:.....

Appendix A

Effective Alcohol and Drug Interventions with Substance Abusing Adolescents in Aotearoa/New Zealand

Information Sheet

(Number 1b For Adolescents)

Who is the researcher?

My Name is Anna Nelson. I am a masterate student at Massey University, studying a Masters of Social Work Degree. I am currently employed by Waikeria Prison, where I work in alcohol and drug focussed groups with inmates. My interest in alcohol and drug interventions for adolescents has come about, because I became aware of the limited services to those adolescents who need alcohol and drug treatment in New Zealand. I believe that there needs to be more New Zealand research in this area to help us understand what is needed and what might help young people, so as we might at least attempt treatment that provides what we know works.

I am acting independently from my employer. My supervisors for this research are Dr.. Mary Nash, and Ann Flintift, both of whom are available at Massey University on (06) 356 9909. For Dr. Nash ask for the Social Work Department, and for Ann Flintoft, Health Sciences.

What is the study about?

The study is centred on identifying what is helpful and not helpful when adolescents have alcohol or drug problems. Adolescence is a very difficult time, and treatment used with adults is not always appropriate with adolescents. This study intends to look at research and studies already done, as well as interviewing alcohol and drug workers who specialise in the treatment of adolescents, and adolescents themselves. This will enable the research to get local ideas and knowledge that can add to our understanding.

What will participants be invited to do?

There are two main groups of participants. The adolescents, who have themselves experienced alcohol and drug treatment in some form, and also alcohol and drug workers who specialise in working with adolescents.

You will be asked questions about your alcohol and drug use and your experience of the help that you received. It is not a counselling session and will have no affect on your past or present use of alcohol and/or drugs.

If you agree to take part in this research you will be asked to sign a written consent form indicating that you agree to participate in the research and to attend an interview with me to talk about your experience of alcohol and drug treatment. If you are under 16 your parent/guardian/caregiver must give their permission for you to participate. They will also be provided with an information sheet explaining the research. With your informed consent the interviews will be audio-taped. You have the right at any time to request that the tape be turned off, for all or part of the interview.

During the interview you will have the opportunity to ask any questions about the research and may terminate the interview at any time.

A draft copy of the final document will be available for you to view before it is sent to be marked, so as you can be aware of how the information is being used. If you disagree with something printed that has been attributed to you, then you will have the opportunity to change it at this time.

What can the participants expect from the researcher?

If you decide to take part in the study, you can expect that any information that you provide will be treated with the utmost respect and confidentiality. The information you give is essential to the research and the wisdom that you provide will be considered expert knowledge, because you are the expert in this area. Your identity and privacy are protected as none of your details will be used in the research document and all information will be destroyed once used in the final document. If however you want your contribution to be directly attributed to them, you will be directly acknowledged throughout the final document where appropriate.

It is hoped that this research will go on to be used in the setting up of treatment programmes in this community for adolescents with alcohol and drug misuse problems, and also in the gaining of funds to do this.

Appendix B

Questions for Adolescents

1. Can you please explain the history of your alcohol and/or drug use?

2. What influenced you to first try substances?

3. What influenced you to get some help for your problem? How did you know where to go for this help? What was it like asking for help?

4. Where did you get help and how long was it for? How did it go?

5. What impact did this treatment/counselling have on you?

6. What did you find especially helpful?

7. What was most difficult?

8. What types of things did you learn?

9. Were your family or support people involved?

10. If you could develop the ideal way to help people like yourself with alcohol and drug problems, what would it be?

11. Do you think a day programme is a good idea? If one had been available in your area would you have gone to it?

12. What is your current use of substances?

13. What are your plans for the future, does it look bright?

14. What is the most important thing you have learnt from your experience of using alcohol and drugs and receiving help for it?

Appendix C

CONSENT FORM

(Number 2-For alcohol and drug workers)

Effective Alcohol and Drug Interventions with Substance Abusing Adolescents in Aotearoa/New Zealand.

- I have read the information sheet for this study, and have had the details of the study explained to me.
- My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.
- I understand that I am free to withdraw from the study at any time, or to decline to answer any particular questions in the interview.
- I agree to provide information to the researcher on the understanding that it is completely confidential.
- I wish to participate in this study under the conditions outlined on the information sheet.

Signed:.....

Name:..... Agency:.....

Date:.....

Appendix C

Effective Alcohol and Drug Interventions with Substance Abusing Adolescents in Aotearoa/New Zealand.

Information Sheet

No.2 (For alcohol and drug workers)

Who is the researcher?

My name is Anna Nelson. I am a masterate student at Massey University, studying a Masters of Social Work Degree. My interest in alcohol and drug treatment for adolescents has come about throughout my previous work, both with The Salvation Army Waikato Bridge Programme, as a Dual Diagnosis Social Worker and Assessment Caseworker, and at Waikeria Prison as an Alcohol and Drug Counsellor/Therapist. In these roles I became aware of the limited services available to those adolescents who may need alcohol and drug treatment in New Zealand. I believe that there needs to be more New Zealand initiated research in this area to help us understand what is needed and what might work with young people, so as we might at least attempt treatment that provides adequate services in the future.

My supervisors for this research are Dr.. Mary Nash, and Ann Flintoft both of whom are available at Massey University on (06) 356 9909. For Dr. Mary Nash ask for the Social Work Department, and for Ann Flintoft, Health Sciences.

What is the study about?

The study is centred around identifying what is important when treating adolescents with alcohol or drug problems. Adolescence is a very complex time, and because of this treatment used with adults is not always appropriate with adolescents. This study intends to look at research and theories already well documented in this area, as well as interviewing alcohol and drug workers who specialise in the treatment of adolescents, and the adolescents themselves. This will enable the research to locate local knowledge and ideas which can add to our understanding.

What will participants be invited to do?

There will be two main groups of participants. The adolescents, who have themselves experienced some sort of alcohol and drug abuse intervention, and also the alcohol and drug workers who specialise in working with adolescents.

If you agree to take part in this study you will be asked to sign a written consent form indicating that you agree to participate in the research, and to be involved in a telephone interview with me to talk about your experience of alcohol and drug treatment with adolescents. You are giving your consent for the information you provide in the telephone interview to be used in the research.

During the interview you will have the opportunity to ask any questions about the research, and may terminate the interview at any time.

What can the participants expect from the researcher?

If you decide to take part in the research, you can expect that any information you provide will be treated with respect and confidentiality. The information you give is essential to this research, and the wisdom that you provide will be considered expert knowledge, because you are an expert in this area. Your identity and privacy will be protected, as none of your details will be used in the research document and all information will be destroyed once used in the final document. If however you want your contribution to be directly attributed to you, you will be directly acknowledged throughout the document where appropriate.

A draft copy of the parts of the final document that contain your information, will be available for you to view before it is sent to be marked, so as you can be aware of how your information is being used. If you disagree with something printed that has been attributed to you, then you have the opportunity to change it at this time.

Appendix D

QUESTIONS FOR A & D WORKERS

1. What are your academic qualifications? What work experience have you had? If you are currently working what is your role?

2. Do you specialise in working with adolescents? If so why? Does your agency specialise in working with adolescents?

3. How do your clients usually come to you? What referral agencies do you work with? What is the percentage of self referrals?

4. What ethnicity do you work with in the majority?

5. What specific needs do you believe adolescents have? How do you and your agency meet these needs? Do you think there is any area your agency does not cover well?

6. What is your philosophical base, and what theories and models do you use when working with adolescents?

7. Do you work differently with the different age ranges that adolescence incorporates? Can you tell me what the differences are?

8. What have you found to be effective when working with adolescents? How do you know it is effective?

9. Do you think New Zealand adolescents have specific needs different from other adolescents around the world, for example in Britain or America were the majority of the research in this area is done? If so what are they?

10. Are there any particular frustrations of working in this area? Are they related to social or agency policy and/or funding? What are the benefits of working in this area?
11. What do you think would be the ideal treatment or intervention with adolescents? Would you refer to a day programme if one was running in your area?

Appendix E

CONSENT FORM

(Number 1-For adolescents & parents/caregivers)

Effective Alcohol and Drug Interventions with Substance Abusing Adolescents in Aotearoa/New Zealand.

- I have read the information sheet for this study, and have had the details of the study explained to me.
- My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.
- I agree/do not agree to the interview being audio taped.
  (delete one)
- I understand that if I agree to have the interview audio taped that I may have the tape turned off at any time.
- I understand that I am free to withdraw from the study at any time, or to decline to answer any particular questions in the interview.
- I agree to provide information to the researcher on the understanding that it is completely confidential.
- I wish to participate in this study under the conditions outlined on the information sheet.
- I am over the age of 16, or have my parents consent to be part of this study.

Signed:.....

Name:.....

Date:.....

If under the age of 16 parental consent is also required

Signed:.....
(parent/guardian)

Name:.....

Date:.....

Appendix E

Effective Alcohol and Drug Interventions with Substance Abusing Adolescents in Aotearoa/New Zealand

Information Sheet

(Number 1a -For Parents/Caregivers)

Who is the researcher?

My Name is Anna Nelson. I am a masterate student at Massey University, studying a Masters of Social Work Degree. I am currently employed by Waikeria Prison, where I work in alcohol and drug focussed groups with inmates. My interest in alcohol and drug interventions for adolescents has come about, because I became aware of the limited services to those adolescents who need alcohol and drug treatment in New Zealand. I believe that there needs to be more New Zealand research in this area to help us understand what is needed and what might help young people, so as we might at least attempt treatment that provides what we know works.

I am acting independently from my employer. My supervisors for this research are Dr. Mary Nash, and Ann Flintift, both of whom are available at Massey University on (06) 356 9909. For Dr.. Nash ask for the Social Work Department, and for Ann Flintoft, Health Sciences.

What is the study about?

The study is centred on identifying what is helpful and not helpful when adolescents have alcohol or drug problems. Adolescence is a very difficult time, and treatment used with adults is not always appropriate with adolescents. This study intends to look at research and studies already done, as well as interviewing alcohol and drug workers who specialise in the treatment of adolescents, and adolescents themselves. This will enable the research to get local ideas and knowledge that can add to our understanding.

What will participants be invited to do?

There are two main groups of participants. The adolescents, who have themselves experienced alcohol and drug treatment in some form, and also alcohol and drug workers who specialise in working with adolescents.

If you allow your child to participate in this study, they will be asked questions about their alcohol and drug use, and their experience of the help that they received for this. It is not a counselling session, and will have no affect on their past or present use of alcohol or drugs, or the service from which they received help.

If you agree to let your child take part you will be asked to sign a written consent form indicating that you agree to let them take part, and attend an interview with me to talk about their experience of alcohol and drug treatment. You are giving your consent for the information that they give in the interview to be used in the research. With you and your child's informed consent the interviews will be audio-taped. Your child will have the right at any time to request that the tape be turned off, for all or part of the interview.

During the interview your child will have the opportunity to ask any questions about the research and may terminate the interview at any time.

A draft copy of the final document will be available for you and your child to view before it is sent to be marked, so as you can be aware of how the information is being used. If your child disagrees with something printed that has been attributed to them, they will have the opportunity to change it at this time.

What can the participants expect from the researcher?

If you decide to let your child take part in the study, you can expect that any information that your child provides will be treated with the utmost respect and confidentiality. The information your child gives is essential to the research and the wisdom that they provide will be considered expert knowledge, because they are the expert in this area. Their identity and privacy are protected as none of their details will be used in the research document and all information will be destroyed once used in the final document. If however you and your child want their contribution to be directly attributed to them, they will be directly acknowledged throughout the final document where appropriate.

It is hoped that this research will go on to be used in the setting up of treatment programmes in this community for adolescents with alcohol and drug misuse problems, and also in the gaining of funds to do this.

Appendix F

MAORI TO ENGLISH TRANSLATION

Tangata whenua - Local people, or indigenous people of the land.

Te reo - Maori language.

Kaupapa Maori - Programme or project specific to maori and with maori culture as its base.

Whanau - Extended family.

Appendix G

Following are copies of alcohol and drug assessments and screening tools taken from ALAC, (July 1996). Guidelines for Alcohol and Drug Assessments: Review of Alcohol and Drug Screening, Diagnostic and Evaluation Instruments. Wellington, ALAC.

DUSI - Adolescent Substance Abuse
Table 1 : Personal History Form

1. Name: .....
(last) *First* *Initial*

2. How old are you? ..... 3. Birthdate: .....
Month *Day* *Year*

4. Sex ..... Male
..... Female

5. Marital Status: Single .....
Never Married .....
Divorced .....
Separated .....
Cohabitation .....

5. Which of the following best describes you?

..... Black
..... White
..... Puerto Rica/Hispanic
..... American Indian
..... Asian
..... Other

7. The religion I was raised in is:

..... Protestant
..... Catholic
..... Jewish
..... None
..... Other

8. Are you presently living with:

..... Both real parents
..... Mother only
..... Father only
..... Mother and Stepfather
..... Father and Stepmother
..... Other Relatives
..... Foster Parents
..... Friends
..... Spouse
..... Other
..... No One

9. Prior to coming here, what type of place did you live in?

..... No regular place
..... Rooming or Boarding House
..... Hotel
..... Apartment
..... Single Family House
..... Jail
..... Institution or Hospital
..... Residential Facility/Therapeutic Community

10. School class you are presently in .....

11. How many classes are you failing at the present time .....

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

DUSI - Adolescent Substance Abuse - Cont

12. Type of school programme (check one)

..... Academic
..... Vocational
..... Commercial/Business

13. General or overall grade score (circle one) A B C D Fail

14. How many times have you been to a doctor in the **last three (3) months**?

..... Never
..... Once
..... Twice
..... 3-5 times
..... More often than 5 times

15. Are you under a doctor's care now?

..... Yes
..... No

16. Were you kept overnight in a hospital in the last 6 months?

..... Yes
..... No

17. Are you presently taking any prescribed medications?

..... Yes
..... No

If *yes*, what medications are you taking .....

.....

18. Who should be contacted in case of emergency?

Name:.....

Address: .....

Telephone: .....

19. Which best describes your father's job?

..... Professional
..... Business/Sales
..... Office Worker
..... Skilled Trade
..... Unskilled Labour
..... Farming
..... Mostly Unemployed
..... Armed Services
..... Retired
..... Office Worker
..... In Jail
..... Don't Know
..... Other Type of Job

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

DUSI - Adolescent Substance Abuse - Cont

20. Which best describes your mother's job?

..... Professional
..... Business/Sales
..... Office Worker
..... Skilled Trade
..... Unskilled Labour
..... Farming
..... Mostly Unemployed
..... Armed Services
..... Retired
..... Office Worker
..... In Jail
..... Don't Know
..... Other Type of Job

21. List your brothers and sisters:

Brothers		Sisters	
Name:	Age	Name:	Age .....
Name:	Age	Name:	Age .....
Name:	Age	Name:	Age .....
Name:	Age	Name:	Age .....

Put an "x" next to the ones who are half brothers and sisters if any.

22. Are any children, including yourself adopted? (Circle the ones who are adopted)

..... Yes
..... No

23 Are you presently in school?

..... Yes
..... No

24. Are you presently in trouble with the law?

..... Yes
..... No

25. Are you presently seeing a psychiatrist, psychologist or counsellor?

..... Yes
..... No

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

DUSI - Adolescent Substance Abuse

Table 2 : Drug Use Screening Inventory

Domain I : Substance Use

A. Drug Preference

1. How many times have you used each of the drugs listed below in the last month?
Put an "x" in each box that applies to you.

	0 Times	1-2 Times	3-9 Times	10-20 Times	More Than 20 Times
Alcohol					
Cocaine/Crack					
Marijuana					
Stimulants/Uppers					
LSC/Mescaline					
Tranquillisers					
Pain Killers					
Heroin/Opiates					
PCP					
Gases or Fumes					
Other					

2. Circle the names of the drugs listed above that you prefer the most.

3. Shade in the circles for the drugs that you think you may have a problem with.

Instructions

Answer **ALL** of the following questions. If a question does not apply exactly, answer according to whether it is **mostly yes or mostly no**. Answer the questions as if they apply to you within the past year and leading up to the present time. Put a check mark (✓) in the "yes" or "no" space.

B. Drug Involvement	**Yes**	**No**
1. Have you ever had a craving or a very strong desire for alcohol or drugs?	☐	☐
2. Have you ever had to use more and more drugs or alcohol to get the effect you want?	☐	☐
3. Have you ever felt that you could not control your alcohol or drug use?	☐	☐
4. Have you ever felt that you were "hooked" on alcohol or drugs?	☐	☐
5. Have you ever missed out on activities because you spent too much money on drugs or alcohol?	☐	☐
6. Did you ever break rules or break the law because you were high on alcohol or drugs?	☐	☐
7. Do you change rapidly from very happy to very sad or from very sad to very happy because of drugs?	☐	☐
8. Have you ever had a car accident after using alcohol or drugs?	☐	☐

DUSI - Adolescent Substance Abuse - Cont

9.	Have you ever accidentally hurt yourself or someone else after using alcohol or drugs?	☐	☐
10.	Have you ever had a serious argument or fight with a friend or a family member because of your drinking or drug use?	☐	☐
11.	Have you ever had trouble getting along with any of your friends because of your drinking or drug use?	☐	☐
12.	Have you ever experienced any withdrawal symptoms following use of alcohol or drugs (eg headaches, nausea, vomiting, shaking)?	☐	☐
13.	Have you ever had a problem remembering what you had done while you were under the effects of drugs or alcohol?	☐	☐
14.	Do you like to play drinking games when you go to parties?	☐	☐
15.	Do you have trouble resisting using alcohol or drugs?	☐	☐

Domain II : Behaviour Patterns		**Yes**	**No**
1.	Do you argue a lot?	☐	☐
2.	Do you brag a lot?	☐	☐
3.	Do you tease or do harmful things to animals?	☐	☐
4.	Do you yell a lot?	☐	☐
5.	Are you stubborn?	☐	☐
6.	Are you suspicious of other people?	☐	☐
7.	Do you swear or use dirty language a lot?	☐	☐
8.	Do you tease others a lot?	☐	☐
9.	Do you have a bad temper?	☐	☐
10.	Are you very shy?	☐	☐
11.	Do you threaten to hurt people?	☐	☐
12.	Do you talk louder than other kids?	☐	☐
13.	Are you easily upset?	☐	☐
14.	Do you do things a lot without first thinking about the consequences?	☐	☐
15.	Do you do risky or dangerous things a lot?	☐	☐
16.	Do you take advantage of people if you can?	☐	☐

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

DUSI - Adolescent Substance Abuse

17. Do you generally feel angry? ☐ ☐

18. Do you spend most of your free time by yourself? ☐ ☐

19. Are you a loner? ☐ ☐

20. Are you very sensitive to criticism? ☐ ☐

Domain III : Health Status

1. Have you had a physical exam or been under a doctor's care in the last year? ☐ ☐

2. Have you had any accidents or injuries that still bother you? ☐ ☐

3. Do you sleep either too much or too little? ☐ ☐

4. Have you recently either lost or gained more than 10 pounds? ☐ ☐

5. Do you have less energy than you think you should have? ☐ ☐

6. Do you have trouble with your breathing or with coughing? ☐ ☐

7. Do you have any concerns about sex or your sex organs? ☐ ☐

8. Have you ever had sex with someone who shot up drugs? ☐ ☐

9. Have you had trouble with abdominal pain or nausea in the past year? ☐ ☐

10. Have your eyewhites ever turned yellow? ☐ ☐

Domain IV : Psychiatric Disorder

1. Have you ever intentionally damaged someone else's property? ☐ ☐

2. Have you stolen things on several occasions? ☐ ☐

3. Have you gotten into more fights than most kids? ☐ ☐

4. Are you a fidgety person? ☐ ☐

5. Are you restless and can't sit still? ☐ ☐

6. Do you get frustrated easily? ☐ ☐

7. Do you have trouble concentrating? ☐ ☐

8. Do you feel sad a lot? ☐ ☐

9. Do you bite your fingernails? ☐ ☐

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

DUSI - Adolescent Substance Abuse Cont.		Yes	No
10.	Do you have trouble sleeping?	☐	☐
11.	Are you nervous?	☐	☐
12.	Do you get easily frightened?	☐	☐
13.	Do you worry a lot?	☐	☐
14.	Do you have trouble getting your mind off things?	☐	☐
15.	Do people stare at you?	☐	☐
16.	Do you hear things that no one else around you hears?	☐	☐
17.	Do you have special powers no body else has?	☐	☐
18.	Are you afraid to be around people?	☐	☐
19.	Do you often feel like you want to cry?	☐	☐
20.	Do you have so much energy that you don't know what to do with yourself?	☐	☐

Domain V : Social Competency		Yes	No
1.	Do kids your own age dislike you?	☐	☐
2.	Are you usually unhappy with how well you do in activities with your friends?	☐	☐
3.	Is it difficult to make friends in a new group?	☐	☐
4.	Do people take advantage of you?	☐	☐
5.	Are you afraid to stand up for your rights?	☐	☐
6.	Is it hard for you to ask for help from others?	☐	☐
7.	Are you easily influenced by other kids?	☐	☐
8.	Do you prefer doing things with kids much older than you?	☐	☐
9.	Do you worry about how your actions will affect others?	☐	☐
10.	Do you have difficulty standing up for your opinions?	☐	☐
11.	Do you have trouble saying "no" to people?	☐	☐
12.	Do you feel uncomfortable if someone gives you a compliment?	☐	☐
13.	Do people see you as not being a friendly person?	☐	☐
14.	Do you avoid eye contact when talking to people?	☐	☐

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

DUSI - Adolescent Substance Abuse Cont.

Domain VI : Family System

		Yes	No
1.	Has a member of your family (mother, father, brother or sister) ever used marijuana or cocaine?	☐	☐
2.	Has member of your family used alcohol to the point of causing problems at home, at work or with friends?	☐	☐
3.	Has a member of your family every been arrested?	☐	☐
4.	Do you have frequent arguments with your parents or guardians which involve yelling and screaming?	☐	☐
5.	Does your family hardly ever do things together?	☐	☐
6.	Are your parents or guardians unaware of your likes and dislikes?	☐	☐
7.	Are there no clear rules about what you can and cannot do?	☐	☐
8.	Are your parents or guardian unaware of what you really think or feel about things that are important to you?	☐	☐
9.	Do your parents or guardians argue a lot with each other?	☐	☐
10.	Are your parents or guardians often unaware of where you are and what you are doing?	☐	☐
11.	Are your parents or guardians away from home most of the time?	☐	☐
12.	Do you feel that either of your parents or guardians don't care about you?	☐	☐
13.	Are you unhappy about your living arrangements?	☐	☐
14.	Do you feel in danger at home?	☐	☐

Domain VII : School Performance/Adjustment

1.	Do you dislike school?	☐	☐
2.	Do you have trouble concentrating in school or when studying?	☐	☐
3.	Are your grades below average?	☐	☐
4.	Do you cut school more than two days a month?	☐	☐
5.	Are you absent from school a lot?	☐	☐
6.	Have you thought seriously about quitting school?	☐	☐
7.	Do you often not do your school assignments?	☐	☐

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

DUSI - Adolescent Substance Abuse Cont

		Yes	No
8.	Do you often feel sleepy in class?	☐	☐
9.	Do you have different friends at school this year than you did last year?	☐	☐
11.	Do you feel irritable and upset when in school?	☐	☐
12.	Are you bored in school?	☐	☐
13.	Are your marks in school worse than they used to be?	☐	☐
14.	Do you feel in danger at school?	☐	☐
15.	Have you ever failed in a grade in school?	☐	☐
16.	Do you feel unwelcome in school clubs or extracurricular activities?	☐	☐
17.	Have you ever missed or been late to school because of alcohol or drugs?	☐	☐
18.	Have you ever been in trouble at school because of alcohol or drugs?	☐	☐
19.	Have alcohol or drugs ever interfered with your homework or school assignments?	☐	☐
20.	Have you ever been suspended?	☐	☐

Domain VIII : Work Adjustment		**Yes**	**No**
1.	Have you have had a *paying* job that you were fired from?	☐	☐
2.	Have you ever stopped working at a job because you didn't care?	☐	☐
3.	Do you need help from others to go about finding a job?	☐	☐
4.	Have you been frequently absent or late for work?	☐	☐
5.	Do you find it difficult to complete work tasks?	☐	☐
6.	Have you ever made money doing something that is against the law?	☐	☐
7.	Have you ever used alcohol or drugs while working on a job?	☐	☐
8.	Have you ever been fired from a job because of drugs?	☐	☐
9.	Do you have trouble getting along with bosses?	☐	☐
10.	Do you mostly work so that you can get money to buy drugs?	☐	☐

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

DUSI - Adolescent Substance Abuse - Cont

Domain IX : Peer Relationships

		Yes	No
1.	Do any of your friends regularly use alcohol or drugs?	☐	☐
2.	Do any of your friends sell or give drugs to other kids?	☐	☐
3.	Do any of your friends cheat on school tests.?	☐	☐
4.	Do your parents or guardians dislike your friends?	☐	☐
5.	Have any of your friends ever been in trouble with the law?	☐	☐
6.	Are most of your friends older than you?	☐	☐
7.	Do your friends cut school a lot?	☐	☐
8.	Do your friends get bored at parties when there is no alcohol served?	☐	☐
9.	Have your friends brought drugs or alcohol to parties in the past year?	☐	☐
10.	Have your friends stolen anything from a store or damaged school property on purpose during the past year?	☐	☐
11.	Do you belong to a gang?	☐	☐
12.	Are you bothered now by problems you are having with friends?	☐	☐
13.	Is there no friend you can confide in?	☐	☐
14.	Compared to most kids, do you have a few friends?	☐	☐

Domain C : Recreation

		Yes	No
1.	Compared to most kids, do you do less sports?	☐	☐
2.	Do you usually go out for fun on school nights without permission?	☐	☐
3.	On a typical day, do you watch more than two hours of TV?	☐	☐
4.	Are the parents absent at most of the parties you have gone to recently?	☐	☐
5.	Do you exercise less than most kids you know?	☐	☐
6.	Is your free time spent just hanging out with friends?	☐	☐
7.	Are you bored most of the time?	☐	☐
8.	Do you do most of your recreation or leisure activities alone?	☐	☐
9.	Do you use alcohol or drugs for recreational reasons?	☐	☐

DUSI - Adolescent Substance Abuse - Cont

10. Compared to most kids, are you less involved in hobbies or outside interests? ..... ☐ ☐

11. Are you dissatisfied with how you spend your free time? ..... ☐ ☐

12. Do you get tired very quickly when you exert yourself? ..... ☐ ☐

Instructions : go back over the answers and make sure that every question has either "yes" or "no" line filled in with a check mark.

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

DUSI - Adolescent Substance Abuse

Table 3 : Drug Use Screening Inventory

Summary

	Domain	Total Score	Raw Score	Absolute Problem Density	Relative Problem Density
I.	Substance User Behaviour	15	_____	_____	_____
II.	Behaviour Patterns	20	_____	_____	_____
III	Health Status	10	_____	_____	_____
iV	Psychiatric Disorder	20	_____	_____	_____
V	Social Skill	15	_____	_____	_____
VI	Family System	14	_____	_____	_____
VII	School	20	_____	_____	_____
VIII	Work	10	_____	_____	_____
IX	Peer Relationship	14	_____	_____	_____
X	Leisure and Recreation	12	_____	_____	_____
	Total	150			100

Overall problem density = $\frac{\text{total raw score}}{150} \times 100 =$ _____

Scoring instructions:

1. Problem density in Each Domain. Count the number of "yes" endorsements in each domain. Enter the score in the space adjacent to the domain under the title designate as Raw Score on the DUSI Summary Form. The index is obtained by dividing the number of item endorsements by the total number of items in the domain. Multiply the dividend by 100 to obtain the index describing the density of problems in that domain. In the designated space under Absolute Problem Density and adjacent to the domain title, record the index.
2. Relative Problem Density. This index describes the density of problems in each domain relative to the overall number of problems endorsed by the adolescent. The indices thus provide a measure of relative problem severity across the 10 domains assessed. First, the total raw score summed across the 10 domains is obtained. Place the score in the space designated. Next, divide this score into the total number of "yes" (raw score) endorsements in each domain and multiply the dividend by 100. Place this score in the Relative Problem Density space adjacent to the domain heading.
3. Summary Problem Index. The third describes overall severity from the universe of problems covered by the DUSI. The total raw score is divided by 160 and the resulting score multiplied by 100. This index documents the absolute severity of problems without reference to particular problem areas.

Profile Description. Since the raw scores are converted to percentages, yielding indices of problem severity within and among domains, the data are readily amenable to interpretation. Two graphical profiles can be constructed. The first profile documents absolute problem density and the second profile describes relative problem density among the 10 domains. Upon inspection of these graphs the domains requiring comprehensive diagnostic assessment are thus readily evident.

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

AUDIT - Alcohol Use Disorders Identification Test

1. How often do you have a drink containing alcohol?

(0) Never | (1) Monthly or less | (2) Two to four times a month | (3) Two to three times a week | (4) Four or more times per week

2. *How many drinks containing alcohol do you have on a typical day when you are drinking? [Code number of standard drinks]**

(0) One to two | (1) 3 or 4 | (2) 5 or 6 | (3) 7 to 9 | (4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never | (1) Less than monthly | (2) Monthly | (3) Weekly | (4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never | (1) Less than monthly | (2) Monthly | (3) Weekly | (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never | (1) Less than monthly | (2) Monthly | (3) Weekly | (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

(0) Never | (1) Less than monthly | (2) Monthly | (3) Weekly | (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never | (1) Less than monthly | (2) Monthly | (3) Weekly | (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never | (1) Less than monthly | (2) Monthly | (3) Weekly | (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

10. Has a relative, friend, doctor, or other health worker been concerned about your drinking or suggested that you should cut down?

(0) No (2) Yes, but not in the last year (4) Yes, during the last year

* Numbers in parentheses are scoring weights. See manual for scoring procedures and interpretation (Babor et al, AUDIT: *The alcohol use disorders identification test. Guidelines for use in Primary Health Care*, World Health Organisation, Geneva, 1989.

** In determining the response categories, it has been assumed that one "drink" contains 10 g alcohol. In countries where the alcohol level of a standard drink differs by more than 25% from 10 g, the response category should be modified accordingly.

Table 2 Clinical Screen Procedure*

Trauma History

Have you injured your head since your 18th birthday? [ ] - (3) Yes (0) No

Have you broken any bones since your 18th birthday? [ ] - (3) Yes (0) No

Clinical Examination

Code as follows:

(0) Not present
(1) Mild
(2) Moderate
(3) Severe

Conjunctival injection [ ]
Abnormal skin vascularisation [ ]
Tongue tremor [ ]
GGT values [ ]
(0) Lower normal (0-30)
(1) Upper normal (30-50)
(3) Abnormal (50- or higher)

Hepatomegaly [ ]
Hand tremor [ ]

*Numbers in parentheses are scoring weights. See manual for scoring procedures and interpretation. (Babor et al, AUDIT: *The alcohol use disorders identification test. Guide-lines for use in Primary Health Care*. World Health Organisation, Geneva, 1989.)

Scoring: Each item is scored between 1 and 4. Add to obtain the total AUDIT score. A score of 8 or more for the whole questionnaire suggests your patient has a harmful pattern of drinking. Additional information can be obtained by looking at the answers to each question.
Section A. (questions 1,2,3) enquires about "at risk" alcohol consumption. A score of 4 (or more) for women, or 5 (or more) for men suggests a level of drinking that places the person at risk of harm.
Section B. (questions 4,5,6) enquires about symptoms of dependence. A score of 4 (or more) indicates that person may be psychologically or physically dependent on alcohol.
Section C. (questions 7,8,9,10) enquires about problems relating to drinking. A score of 4 (or more) indicates significant problems already.

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

CAGE QUESTIONNAIRE

1. Have you ever felt you should **CUT** down on your drinking?

2. Have people **ANNOYED** you by criticising your drinking?

3. Have you felt bad or **GUILTY** about your drinking?

4. Have you **EVER** had a drink first thing in the morning to steady your nerves or get rid of a hangover (**eyeopener**?)

Two or more positive responses raised the possibility of alcohol abuse or alcohol dependence. Further assessment is needed to confirm this.

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

CANNABIS ABUSE SYNDROME SCREENING TEST

To be administered following an assessment of the individual's historical and present day cannabis use.

1. Have people close to you complained about your cannabis use?
2. Do you have problems with short term memory?
3. Have you experienced "paranoid" episodes following cannabis use?
4. Do you find it difficult to get through a day without a "joint"?
5. Do you lack the energy to get things done in the way you used to?
6. Do you ever worry about the effects of your cannabis use?
7. Do you have more difficulty in understanding new information? (difficulty in studying)
8. Have you ever unsuccessfully attempted to cut down or stop your cannabis use?
9. Do you like to get "stoned" in the morning?
10. Are you spending more and more time "stoned"?
11. Do you experience cravings, headaches, irritability or difficulty in concentration when you cut down or cease cannabis use?

An answer YES to three or more questions would suggest a diagnosis cannabism.

In administering this questionnaire, the cognitive deficits stemming from heave cannabis abuse should be taken into account. Questions can be paraphrased and concrete examples used.

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

SELF ADMINISTERED QUESTIONNAIRE ON ALCOHOL (SCAST)

Name: ..... **Patient No.:**.....

Sex: ..... **Age:**..... **Ward:**.....

Affix label here or fill in

		Tick: Yes	No
Q1	Have you been admitted to hospital more than once because of accidents? (by accidents, we mean all types)	☐	☐
Q2	Have any close family members such as a parent, brother, spouse, or sister had drinking problems?	☐	☐
	Thinking over THE LAST THREE MONTHS:		
Q3	Do you drink before lunch fairly often?	☐	☐
Q4	After the first glass or two of alcohol do you ever feel a craving for more?	☐	☐
Q5	Do you find you are thinking a lot about alcohol?	☐	☐
Q6	Do you sometimes drink alcohol against your doctor's advice?	☐	☐
Q7	When you drink a lot of alcohol, do you tend to eat less?	☐	☐
Q8	In the morning do you sometimes feel that you might be sick (vomit)?	☐	☐
Q9	Have you found that your hands have been trembling a lot?	☐	☐
Q10	Have you ever used alcohol to get rid of trembling or the feeling that you might be sick?	☐	☐
Q11	Have you ever been criticised at work because of your drinking?	☐	☐
Q12	Do you prefer to drink alone?	☐	☐
Q13	Do you think you're in worse shape because of your drinking?	☐	☐
Q14	Do you ever have a guilty conscience about drinking?	☐	☐
Q15	In order to cut down your drinking, have you ever felt it necessary to limit it to certain occasions or to certain times of the day?	☐	☐
Q16	Do you ever feel you should drink less?	☐	☐
Q17	Do you think that without alcohol you would have fewer problems?	☐	☐
Q18	When you're upset do you drink alcohol to calm down?	☐	☐
Q19	Are there times when you'd like to stop drinking?	☐	☐
Q20	Would you get along better with your spouse/partner/the people you're closest to if you didn't drink?	☐	☐
Q21	Have you ever deliberately tried to do without any alcohol at all?	☐	☐
Q22	Have you often been told that your breath smells of alcohol?	☐	☐

Q23 On the average, write in the number you would normally drink in a week:

Beer	**No.**	**Spirits**	**No.**	**Sherry**	**No.**
Glass/Can	☐	Nip	☐	Glass	☐
Large Can	☐	Bottle (sm)	☐	Bottle	☐
Handle	☐	Bottle (lge)	☐	**Cocktails**	
Bottle	☐	**Wine**		Glass	☐
Jugs	☐	Glass	☐		
Flagon	☐	Bottle	☐		

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

SCAST SCORE OVERLAY

1. Align score card with boxes and edges.

1	2	3	1	2	3	1	2	3	
1 x	=		1 x	=		1 x	=		A
2 x	=		16 x	=		14 x	=		
2 x	=		30 x	=					
4 x	=					2 x	=		
6 x	=		1 x	=			B		C
8 x	=		8 x	=				Total Score	D

2. Write in the number of "YES'S" for Questions 1-22 in A.

3. Multiply columns 1 and columns 2 together, write answers in column 3.

4. Add all the numbers in columns 3 and write the total in B.

5. If B equals 36 or more for males, 16 or more for females, write 1 in C, otherwise write 0.

6. Add A and C together and write the total in D.

CLINICIANS ASSESSMENT (if available)

Check for the presence of a palpable liver, Dupuytren's , elevated GGT and elevated AST. If any one or more of these are present, add one point to D.

TEST INTERPRETATION

The SCAST is a screening test designed specifically for hospitalised persons over the age of 15 years. It is not intended to be a fully diagnostic instrument. The following scoring system is suggested: 0-2 for non-problem drinking and 3 or more to indicate alcohol problems severe enough to warrant a fully clinical assessment. If 1 point is added from the Clinician's assessment, raise the cut-off score to 4 or more.

SOURCE

Elvy, GA and Wells, JE for the Alcohol Research Committee of the North Canterbury Hospital Board's Working Party on Alcohol and Drug Dependence, PO Box 1876, Christchurch. Copies of the SCAST and its overlay can be obtained from the Alcoholic Liquor Advisory Council, PO Box 5023, Wellington, New Zealand.

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

Table 1 : Dependence Criteria for DSM-III-R, DSM-IV and ICD-10[a]

DSM-IV Dependence	DSM-III-R Dependence	ICD-10-Dependence
A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following occurring at any time in the same 12 month period:	(a) At least three of the following; *and* (b) some symptoms of the disturbance have persisted for at least 1 month, or have occurred repeatedly over a longer period of time.	A diagnosis of dependence should be made if three or more of the following have been experience or exhibited at some time during the previous year.
1. Tolerance: (a) need for markedly increased amounts of the substance to achieve intoxication or desired affect or (b) markedly diminished effect with continued use of the same amount of the substance	7. Marked tolerance: Need for markedly increased amounts of the substance in order to achieve the same effect, or markedly diminished effect with continued use of the same amount.	(d) Evidence of tolerance such that increased doses of the substance are required in order to achieve effects originally produced by lower does.
2. Withdrawal: (a) characteristic withdrawal syndrome for the substance; or (b) the same substance takes to relieve or avoid withdrawal symptoms.	8. Characteristic withdrawal symptoms. 9. Substance often taken to relieve or avoid withdrawal symptoms.	(c) A physiological withdrawal state when substance use has ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving of avoiding withdrawal symptoms.
3. Substance is often taken in larger amounts or over a longer period than was intended.	1. Substance often taken in larger amounts or over a longer period than the person intended.	(a) a strong desire or sense of compulsion to take drugs or alcohol.
4. Any unsuccessful effort or a persistent desire to cut down or control substance use.	2. Persistent desire or one or more unsuccessful efforts to cut down or control substance use.	(b) difficulties in controlling substance-taking behaviour in terms of its onset, termination or levels of use.
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.	3. A great deal of time spent in activities necessary to get the substance, taking the substance or recovering from its effects.	(e) progressive neglect of alternative pleasure of interests in favour of substance use.
6. Important social, occupational or recreational activities given up or reduced because of substance use.	5. Important social, occupational or recreational activities given up or greatly reduced because of substance use.	(f) persisting with drug or alcohol use despite clear evidence overtly harmful consequences.
7. Continue substance use despite knowledge of having had a persistent tor recurrent physical or psychological problem that is likely to be caused or exacerbated by the substance	6. Continued substance use despite knowledge of having a persistent or recurrent social, psychological or physical problem that is caused or exacerbated by the use of the same. 4. Amount frequent intoxication or withdrawal when expected to fulfil major role obligations at work, school or home, or when substance use is physically hazardous	

* *Unique diagnostic criteria in each system are shown in italics.*

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

Table 2 : Abuse/Harmful Use Criteria in DSM-IV, DSM-III-R and ICD-10[a]

DMS-IV Abuse	DSM-III-R Abuse	ICD-10 Harmful Use
A. Amaladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by one or more of the following:	A. A maladaptive pattern of psychoactive substance use indicated by at least one of the following:	The diagnosis requires that actual damage should have been caused to the mental or physical health of the user.
1. Recurrent substance use resulting in a failure to fulfil major role obligations at work, school or home.		Harmful patterns of use are often criticised by others and are often associated with adverse social consequences of various kinds.
2. Recurrent substance use in situations in which it is physically hazardous.	2. Recurrent use in situations in which use is physically hazardous.	
3. Recurrent substance-related legal problems.		
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.	1. Continues use despite knowledge of having a persistent or recurrent social, occupational, psychological or physical problem that is caused or exacerbated by use of the psychoactive substance.	
	B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.	
B. Never meets the criteria for Substance Dependence for this substance.	C. Never met the criteria for Psychoactive Substance Dependence for this substance	Harmful use should not be diagnosed if the dependence syndrome, a psychotic disorder or other specific forms of drug or alcohol-related disorders are present.

* *Unique diagnostic criteria in each system are shown in italics*

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

DAST

Please read carefully:

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months.

Carefully read each question and decide if your answer is "Yes" or "No". Then circle the appropriate response beside the question.

In the questions "drug abuse" refers to:

1. The use of prescribed or over the counter drugs in excess of the directions and;

2. Any non-medical use of drugs.

The various classes of drugs may include:

- Cannabis (eg marijuana, hashish)
- Solvents
- Tranquillisers (eg Valium)
- Barbiturates
- Cocaine
- Stimulants (eg Amphetamines)
- Hallucinogens (eg LSD)
- Narcotics (eg heroin)

Remember that the questions do not include alcoholic beverages

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

DAST
THESE QUESTIONS REFER TO THE PAST 12 MONTHS

		Circle Your Response	
1.	Have you ever used drugs other than those required for medical reasons	Yes	No
2.	Have you abused prescription drugs?	Yes	No
3.	Do you abuse more than one drug at a time?	Yes	No
4.	Can you get through the week without using drugs?	Yes	No
5.	Are you always abie to stop using drugs when you want to?	Yes	No
6.	Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
7.	Do you feel badly or guilty about your drug use?	Yes	No
8.	Does your spouse (or parents) complain about your involvement with drugs?	Yes	No
9.	Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10.	Have you lost friends because of your use of drugs?	Yes	No
11.	Have you neglected your family because of your use of drugs?	Yes	No
12.	Have you been in trouble at work because of drug abuse?	Yes	No
13.	Have you lost a job because of drug abuse?	Yes	No
14.	Have you been in fights when under the influence of drugs?	Yes	No
15.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16.	Have you been arrested for possession of illegal drugs?	Yes	No
17.	Have you experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18.	Have you had medical problems as a result of your drug use? (eg memory loss, hepatitis, convulsions, bleeding etc)	Yes	No
19.	Have you seen anyone for help with a drug problem?	Yes	No
20.	Have you been involved in a treatment programme specifically related to drug use.	Yes	No

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

SCORING SCHEME FOR DAST

Item	Answer	Score	Item	Answer	Score
1	Yes	1	11	Yes	1
	No	0		No	0
2	Yes	1	12	Yes	1
	No	0		No	0
3	Yes	1	13	Yes	1
	No	0		No	0
4*	Yes	0	14	Yes	1
	No	1		No	0
5*	Yes	0	15	Yes	1
	No	1		No	0
6	Yes	1	16	Yes	1
	No	0		No	0
7	Yes	1	17	Yes	1
	No	0		No	0
8	Yes	1	18	Yes	1
	No	0		No	0
9	Yes	1	19	Yes	1
	No	0		No	0
10	Yes	1	20	Yes	1
	No	0		No	0

** Note reversal of scoring in these two items*

Dast Score	Degree of Problems Related to Drug Use
0	None reported
1-4	Low level, non-dependent
5-6	Suggestive of dependence
7 or more	Dependent

LEEDS SUBSTANCE DEPENDENCE QUESTIONNAIRE - LSDQ

In answering this questionnaire:

- think about the last week
- think about your main substance
- tick the answer that's most appropriate to you

		Never	Some Times	Often	Nearly Always
1.	Do you find yourself thinking about when you will next be able to have another drink or take more drugs?	☐	☐	☐	☐
	Pre-occupation				
2.	Is drinking or taking drugs more important than anything that anything else you might do during the day?	☐	☐	☐	☐
	Salience of Substance Use				
3.	Do you feel that your need for drink or drugs is too strong to control?	☐	☐	☐	☐
	Compulsion to Start				
4.	Do you plan your days around getting and taking drink or drugs?	☐	☐	☐	☐
	Planning Around Substance Use				
5.	Do you drink or take drugs in a particular way in order to increase the effect it gives you?	☐	☐	☐	☐
	Maximise Effect				
6.	Do you take drink or drugs morning, afternoon and evening?	☐	☐	☐	☐
	Narrowing of Using Repertoire				
7.	Do you feel you have to carry on drinking or taking drugs once you have started?	☐	☐	☐	☐
	Compulsion to Continue				
8.	Is getting the effect you want more important than the particular drink or drug you use?	☐	☐	☐	☐
	Primacy of Effect				
9.	Do you want to take more drink or drugs when the effect starts to wear off?	☐	☐	☐	☐
	Constant State				
10.	Do you find it difficult to cope with life without drink or drugs?	☐	☐	☐	☐
	Cognitive Set				

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.

The SADD Questionnaire

The following questions cover a wide range of topics to do with drinking. Please read each question carefully but do not think too much about its exact meaning. Think about your *Most recent* drinking habits and answer each question by placing a tick under the *Most appropriate* heading. If you have any difficulties ask for help

		Never	Sometimes	Often	Nearly Always
1.	Do you find it difficult to get the thought of drink out of your mind?	[ ]	[ ]	[ ]	[ ]
2.	Is getting drunk more important than your next meal?	[ ]	[ ]	[ ]	[ ]
3.	Do you plan your day around when and where you can drink?	[ ]	[ ]	[ ]	[ ]
4.	Do you drink in the morning, afternoon and evening?	[ ]	[ ]	[ ]	[ ]
5.	Do you drink for the effect of alcohol without caring what the drink is?	[ ]	[ ]	[ ]	[ ]
6.	Do you drink as much as you want irrespective of what you are doing the next day?	[ ]	[ ]	[ ]	[ ]
7.	Given that many problems might be caused by alcohol do you still drink too much?	[ ]	[ ]	[ ]	[ ]
8.	Do you know that you won't be able to stop drinking once you start?	[ ]	[ ]	[ ]	[ ]
9.	The morning after a heavy drinking session do you need your first drink to get yourself going?	[ ]	[ ]	[ ]	[ ]
10.	The morning after a heavy drinking session do you wake up with a definite shakiness of your hands?	[ ]	[ ]	[ ]	[ ]
11.	After a heavy drinking session do you wake up and retch or vomit?	[ ]	[ ]	[ ]	[ ]
12.	The morning after a heavy drinking session do you go out of your way to avoid people?	[ ]	[ ]	[ ]	[ ]
13.	After a heavy drinking session do you see frightening things that later you realise were imaginary?	[ ]	[ ]	[ ]	[ ]
14.	Do you go drinking and next day find you have forgotten what happened the night before?	[ ]	[ ]	[ ]	[ ]

Scoring: Score 'Never' = 0, 'Sometimes' = 1, 'Often' = 2, and 'Nearly Always' = 3. For the 15 item scale the authors suggest that a total score of 1-9 designates low dependence, 10-19 medium dependence and a score over 20, high dependence. This would be conservative for the 14 item scale

QUESTIONNAIRES NOT TO BE ADMINISTERED WITHOUT APPROPRIATE TRAINING AS INDICATED.