human services

Adolescents and their families

Best interests case practice model
Specialist practice resource

State Government Victoria

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Contents

About specialist practice resources

The Best interests case practice model provides you with a foundation for working with adolescents and their families. *Specialist practice resources* provide additional guidance on: information gathering, analysis and planning; action; and reviewing outcomes in cases where specific problems exist or with particular developmental stages.

This resource consists of two parts. The first part focuses on adolescents, their development, and how past trauma and other events affect development. The second part looks at ways of working with young people and their families. The resource will provide you with information, strategies and tips to engage young people and understand and respond to specific issues that are common for adolescents.

Overview

What is adolescence?

The *Children, Youth and Families Act 2005* defines childhood (including adolescence) as the period from 0 to 17 years. The World Health Organization defines adolescents as individuals aged 10–19 years.[1] The World Health Organization definition of adolescence is adopted for this guide, recognising that the state's mandate for statutory intervention ends when the young person reaches the age of 18 years (21 years for those leaving care).

The Victorian Government's *Vulnerable youth framework* is reflective of an increasingly broader definition of adolescence, recognising that adolescent vulnerability can occur from 10 years of age, due to issues such as school transition, through to 25 years of age, due to delays in leaving home, marriage, parenting and entering the workforce (Department of Human Services 2008).

Adolescence and the Children Youth and Families Act

The grounds for intervention in the Children, Youth and Families Act are the same for adolescents and children of other age groups.

Why do we need a guide on adolescents?

Many biological and psychosocial changes occur in a relatively short period of time in the adolescent years. These changes happen at different rates, meaning that adolescents are physically able to engage in behaviours before they may be able to fully comprehend the meaning or consequences of such behaviours. This mismatch of biological and psychosocial transitions also occurs at a time when society and culture are having a significant impact on young people's lifestyles, attitudes and expectations (Patton & Viner 2007).

However, the common and longstanding myth regarding adolescence as a difficult and problematic period is *not* consistent with current research. In every situation it is important to focus on the individual strengths and resilience of most adolescents, while not minimising indicators of distress and trauma.

The view that 'storm and stress' is associated with the onset of puberty is now largely unsupported (Daniel, Wassell & Gilligan 1999). Rather, around three-quarters of young people move through adolescence with few difficulties and, of the others, the majority will have experienced problems before the adolescent years (Arnett 2007). The implication is that a young person's mood swings may be a sign of emotional distress or a response to trauma, rather than just 'the way things are' because they are an adolescent.

Understanding adolescent development

An understanding of adolescent development is critical to effective work with young people. The common developmental phases and key 'tasks' of the adolescent period include physical, cognitive, sexual, identity, moral and social and emotional development (Viner 2005).

1. www.searo.who.int/en/Section13/Section1245.htm

Physical development

Puberty is often seen as the beginning of adolescence, and the body goes through rapid changes in this phase. The earliest external indicators of puberty are breast buds in girls and enlargement of testes in boys, at around 11 years of age, while menarche (first menstruation) and first ejaculation occur approximately 2–2.5 years later (Patton & Viner 2007). Timing of puberty in comparison to friends is important to young people at this stage, and a key question is 'Am I normal?'

Pubertal delay is most commonly associated with delays in growth and height, chronic illness, severe psychosocial stress and under-nutrition. The impact of childhood abuse or trauma may affect the timing of puberty and the physical size of the young person. If there are no signs of puberty by age 15 years, a young person needs to be medically assessed (Viner 2005).

Brain development

Recent research has shown that the parts of the brain influencing levels of mature judgement, long-term planning, consideration of the consequences of (and alternatives to) behaviour and self-regulation are still developing into the early 20s (Patton & Viner 2007). Therefore, brain immaturity may impact on a young person's emotional and impulse control. An example of this is when a young person can sometimes later explain exactly why something happened in the way it did, but couldn't make the connection at the time of the event. Brain growth research gives us new insight into a biological basis for adolescent behaviours, which has implications for developing age-appropriate interventions.

Puberty has also been highlighted as an important time of 'neural plasticity', that is, the capacity of the structures and functions of the brain to change. This means that in contrast to a view that 'the damage is done', experiences and interventions in adolescence can offset the effects of earlier adversity on the brain (Patton & Viner 2007). Hormonal and genetic changes, nutrition, sensory input and stress levels all have important effects on brain growth at this age and can lead to positive development or vulnerability depending on how they are responded to.

Trauma may limit the development of brain functioning that is responsible for things such as conscious self-awareness and understanding emotionally complex experiences. Stress associated with loss, grief and abuse, and events such as having to attend court or move placements, can overwhelm a young person and leave them unable to think clearly. This is an important consideration in working with young people who may be making little progress in treatments or interventions that require a level of mature thought processes, such as empathy or insight.

Cognitive development

Physical changes are accompanied by changes in young people's values, feelings and attitudes about themselves and their relationships with others. There is a growing interest in ethics and morality. A young person's family, carers, school and community will ideally provide many opportunities to learn and grow. The concepts of concrete and formal operational thinking, as developed by Jean Piaget (e.g. Piaget, 1971), are helpful in understanding that the older one grows in childhood/adolescence, cognition usually becomes more abstract, complex and less self-focused (Daniel, Wassell & Gilligan 1999).

Cumulative harm can lead to impaired cognitive functioning. This in turn has been associated with academic, social and employment disadvantage, which may lead to a young person engaging in self-destructive and self-defeating behaviours (Thompson 2006), such as offending behaviour.

Sexual development

Puberty heralds the growth of reproductive organs, and an increase in hormone production contributes to a growing libido or sexual desire in early to middle adolescence. In a 2008 survey of nearly 3,000 Australian secondary school students (Smith et al. 2009), almost four-fifths of Year 10 and Year 12 students had engaged in some form of sexual activity, with just over half of Year 12 students having experienced sexual intercourse. Of particular concern, however, was the survey finding that almost four in 10 young women reported having experienced unwanted sex (Smith et al. 2009). Young women were more likely than young men to have experienced sex when they did not want to. Students cited being too drunk (17%) or pressure from their partner (18%) as the most common reasons for having sex when they did not want to. An increasing rate of chlamydia is one consequence of sexual behaviour for young people, particularly young women, with approximately 80 per cent of the number of diagnoses in 2008 occurring for young people aged 15–29 years (National Centre in HIV Epidemiology and Clinical Research 2009).

Gender, cultural roles/expectations and social factors play a significant part in emerging sexual identity. These may serve to marginalise some young people such as same-sex-attracted youth, young people with a disability or young people who have experienced sexual abuse.

Sexual activity, if earlier than normal or out of step with other developmental markers (for example, as a result of sexual abuse or assault), can be extremely damaging. In particular, if this early sexual activity was as a result of enduring child sexual abuse, this can result in many negative outcomes, including: guilt; anxiety; a lack of personal boundaries; low self-worth; limited range or expression of emotions; a reduced capacity to judge people or situations; a pseudo-maturity in making and sustaining relationships (relationships develop more quickly to the stage of sexual intimacy); and early sexual initiation. In a large-scale, historical, cohort

linkage study in Australia, female victims of child sexual abuse were shown to be at 40 times higher risk of suicide and 88 times higher risk of accidental fatal overdose, compared with the general population. Male victims of child sexual abuse were 14 times more likely to commit suicide and 38 times more likely to die from accidental overdose (Cutajar et al. 2010).

Same-sex attraction

In a 2008 survey, almost one in 10 students reported that their most recent sexual encounter was with someone of the same sex (Smith et al. 2009). Young people report an increased acceptance of and feeling good about identifying as same-sex attracted. Many, however, still experience unfair treatment, verbal abuse and physical assault (Hillier, Turner & Mitchell 2005). Statistics for levels of binge drinking, intravenous drug use, mental health problems, self-harm and suicidal behaviours are higher for young people who identify as same-sex attracted than other young people, particularly those who have been victims of homophobic abuse and discrimination (Hillier, Turner & Mitchell 2005).

Sexual orientation is important to discuss with young people engaging in risky behaviours, and acceptance and supportive responses by practitioners are critical to enhancing safety and wellbeing.

The Best interests principles in section 10 of the Children Youth and Families Act state that in determining what decision to make or action to take in the best interests of the child, consideration must be given to the child's social, individual and cultural identity and religious faith (if any) and the child's age, maturity, sex and sexual identity.

Identity and social and emotional development

Actively seeking and defining the self through relationships with others is seen as an important part of forming an identity in adolescence. Risk-taking behaviour is evident at this phase, and 'safe' risk-taking can play an important role in helping young people to test their capacities and to demonstrate qualities that help them be accepted by a peer group (Coleman & Hendry 1999). Offering young people the opportunity to engage in activities that provide safe spaces for taking risks and exhibiting competence, such as sport, adventure camps or public speaking for example, is developmentally important.

Although adolescents are often portrayed as separating from family and establishing independent lives, research indicates that while the importance of peer relationships increases, it is not usually at the *expense* of family relationships (Markiewicz et al. 2006; Robinson 2006). In fact, if a close relationship can be maintained between parents and teenagers despite the changes that adolescence brings, a good parental relationship can be a protective factor against negative outcomes.

The attachment system, including the secure base provided by an emotionally supportive, warm and communicative relationship with parents (particularly mothers – see Markiewicz et al. 2006), has an integral role to play in helping develop autonomy and identity in adolescence.

Schofield & Beek (2009) describe five elements of a secure parent/caregiver-adolescent attachment:

- availability – helping young people to trust
- sensitivity – helping young people to manage feelings and behaviours
- acceptance – building the self-esteem of the young person
- cooperation – helping young people to feel effective
- family membership – helping young people feel like they belong

There is evidence that the quality of primary attachment relationships in infancy and early childhood influence later relationships with peers and partners in adolescence and early adulthood (Daniel, Wassell & Gilligan 1999). However, it is important to note that the continuity of attachment organisation from infancy to adolescence and beyond is complex, as internal working models regularly change due to new experiences (Thompson 1999). This is very hopeful, as it indicates that a disorganised or insecure attachment style can become a secure one in the presence of repeated nurturing experiences from committed carers.

Attachment relationships only form part of the story, and workers need to apply attachment theory critically. The effects of each individual's history need to be considered, as attachment relationships are dependent on a range of factors such as temperament, environment, opportunities, culture and community.

What we know about attachment does not mean that any one person's future is determined outright but that there are probable pathways further influenced by risk and protective factors.

Trauma and adolescents

Trauma occurs when a person is exposed to frightening and overwhelming circumstances to which they cannot give meaning. As a result, the body's survival response is triggered – the autonomic nervous system is activated and a freeze/flight/fight response occurs. The body is flooded with a biochemical response, including adrenalin and cortisol, and the victim prepares to fight with, or run away from, the threat (Bloom 1999).

Since children cannot easily physically escape a threat they may respond by psychologically 'escaping' (termed 'dissociation'), a mental mechanism by which a person withdraws attention from the outside world and focuses within (Hellett & Simmonds 2003; Perry 1994). This may involve a detached feeling, a sense of observing the event, or withdrawal into a fantasy world. The intensity of dissociation varies with the intensity of the event, and it may become a primary adaptive response to coping with repeated traumatic experiences (such as abuse, neglect and family violence).

Young people in the child protection system may have suffered repeated exposure to trauma. Many maltreated adolescents will have also experienced other forms of trauma and loss in addition to abuse and neglect, such as the death of a parent, incarcerated parents or separation from siblings (Frederico, Jackson & Black 2005). Further distress and instability

can occur as a consequence of protective services and justice responses to the initial trauma, such as disrupted attachments due to multiple placements in out-of-home care. Consequently, many young people who have experienced trauma may face considerable challenges in developing their ability to control emotions and maintain relationships. This may increase the young person's risk of offending through their inability to manage aggression and regulate their emotions and behaviour. Many young people who are clients of youth justice have been previously involved with child protection.

The way in which an adolescent responds to past trauma may parallel adult responses, including avoidance of reminders of traumatic events, flashbacks, sleep disturbance (including nightmares and fears of falling asleep), depression, anxiety and belligerence. These responses lead to problems such as chronic irritability, anger, anxiety and an inability to manage aggression, problems with relationships, conduct disorder and substance abuse (Becker et al. 2003). Many developmental and psychological diagnoses, such as attention deficit hyperactivity disorder and conduct disorder, may also be related to a history of trauma. Self-blame and/or anger may be present – a young person often feels that the abuse was deserved, or that they should have done more to prevent a situation occurring.

Certain factors influence the level of trauma associated with a particular event, including:

- age, gender and developmental stage of a child
- the relationship they have to the perpetrator
- the inability of the caregiver to protect them against the perpetrator
- the gender of the perpetrator/victim
- the severity, frequency and duration of traumatic events.

If the source of the harm is also the young person's source of safety (an attachment figure) then the level of trauma is increased (Cook et al. 2005).

The effects of trauma can contribute to young people unconsciously re-enacting trauma scenarios from their past (for example, the young woman in residential care who acts out aggressively at bed times) or engaging in behaviours such as substance abuse, sexual exploitation, self-harm or aggression in an attempt to manage intrusive traumatic reminders. Further distress may result from these behaviours being criminalised and leading to the young person's involvement in the youth justice system. These behaviours need to be understood in the context of the trauma and loss associated with a range of life events. While appearing excessive or destructive, it may be the only way that the young person can establish a sense of self-control and soothing (van der Kolk 2005).

Trauma theory is reasonably new and there is a limited amount of research regarding the most effective interventions to meet the needs of adolescents. The work of Bruce Perry[2] and Sandra Bloom[3] are examples of recent models of trauma response and treatment.

2. See: www.childtrauma.org

3. See: www.sanctuaryweb.com

Refer to the *Child development and trauma specialist practice resource* for further guidance on the impact of trauma on adolescent development.

Complex trauma and cumulative harm

Where trauma is repeated and prolonged (for example, development characterised by multiple and repeated abuse and neglect or exposure to family violence) it is referred to as 'complex trauma' (van der Kolk 2005). The experience of complex trauma has been compared to being held in captivity, characterised by continued and prolonged terror, subjugation, isolation and enforced dependency (Herman 1997). This may also be coupled with small rewards or concessions that, over time, destroy the victim's sense of self and autonomy.

Harm caused by multiple adverse circumstances and events accumulates and can damage the developing brain (Bromfield, Gillingham & Higgins 2007). Chronically traumatised children can have distinct changes in their levels of consciousness, and can be completely out of touch with feelings or internal states. Familiar things, even if they are predictable sources of terror, are experienced as safer. This may help to explain why many young people return home, or have a wish to return home, no matter the danger (Bath 2000).

The Children, Youth and Families Act, s. 10(3)(e) requires practitioners to consider the effects of cumulative patterns of harm on a child's health, safety and development. For guidance on recognising, assessing and responding to cumulative harm, refer to the *Cumulative harm specialist practice resource*.

Aboriginal and Torres Strait Islander young people

Working with young people from an Aboriginal and Torres Strait Islander background, who are disproportionately represented in the child protection and juvenile justice systems, requires a particular sensitivity to culture and community. Current problems need to be considered from an ecological perspective, incorporating an understanding of many, cumulative traumatic events that have impacted on generations of families, such as colonisation and the Stolen Generations (Victorian Aboriginal Child Care Agency [VACCA], 2006).

The impacts of the stolen generations have been far reaching and continue today. In the 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), 7 per cent of Aboriginal people reported being removed from their families, and 37.6 per cent had a family member who had been removed. These impacts were even more pronounced in Victorian Aboriginal people living with children, 11.5 per cent of whom reported that they had been removed from their natural family and 47.1 per cent of whom reported that a relative had been removed (Department of Education and Early Childhood Development 2010). Critically, approximately one in five Aboriginal young people aged 12-17 years identifies as belonging to the Stolen Generations (Department of Education and Early Childhood Development 2010).

Collective traumas and associated grief have been compounded due to the impact on natural support and caring networks that Aboriginal and Torres Strait Islander people have, through extended families and communities, and the parenting of subsequent generations has been

affected. Tatz (2005) describes these as “perpetual grief cycles”, and calls for a focus on these issues in suicide prevention initiatives aimed at Aboriginal and Torres Strait Islanders, in preference to a more medical approach.

Some of the key individual, family and community problems associated with unresolved trauma that have been associated with heightened rates of child abuse and neglect in Aboriginal and Torres Strait Islander communities include: alcohol and drug abuse; family violence; social isolation; and overcrowded and inadequate housing (Berlyn & Bromfield 2010). For example, the vast majority (79 per cent) of adults in Victorian Aboriginal families reported having themselves (or family or friends) experience one or more major life stresses (e.g. death of a family member or close friend, serious illness). This is almost double the rate for non-Aboriginal Victorians (Department of Education and Early Childhood Development 2010). In this context, Aboriginal and Torres Strait Islander children living in such circumstances are particularly vulnerable.

The role of family is a particularly important consideration. Aboriginal and Torres Strait Islander young people are more likely to be supported by an extended family, including aunts, uncles and cousins, who are often, or may be willing to be, as close to the young person and involved in his or her upbringing as parents (VACCA, 2006). Non-blood relatives may also play a vital role in the young person’s life, such as Aunties and Uncles. Family, community and connection to culture can all serve as protective factors against the impact and occurrence of traumatic events for Aboriginal and Torres Strait Islander young people.

In Victoria, Aboriginal women under the age of 20 are nearly five times more likely than other women of the same age to become pregnant; overall these mothers face risks of poorer birth outcomes, cessation of education and subsequent unemployment and poor housing conditions compared to older mothers (Department of Education and Early Childhood Development, 2010). A report from the Department of Education and Early Childhood Development (2010) recommends that support for these young women and similar groups will need to take account of the reality that:

- many new parents are still very young themselves;
- significant numbers of Aboriginal children are brought up in sole parent households; and
- fathers are often isolated from their children.

The need for better recognition of the important role of fathers, and the role of services to support them to play a more significant role in bringing up children was also raised. Identity, culture, family and community were seen as central to the tailoring of parenting supports, and to the development and learning of young children (Department of Education and Early Childhood Development, 2010).

Adolescence is the time when there is a significant expansion of cultural identity, which traditionally involved initiation and receiving secret and sacred cultural knowledge (VACCA, 2006). Helping young Aboriginal and Torres Strait Islander people understand where they are from, and finding out for those who do not know, is an important aspect of identity development that can help deal with confusion and anxiety arising from a clash of Aboriginal and mainstream culture.

Practitioners can find many good resources that will help them understand the impact of colonisation and the Stolen Generations, and other relevant cultural information, from agencies such as VACCA and the SNAICC Resource Service. Working in parallel with ACSASS practitioners will help to gain trust and respect from Aboriginal young people and their families.

For child protection practitioners, the development of cultural support plans is critical, and enshrined in legislation. The plan needs to be a dynamic, regularly updated document that is relevant and appropriate for the young person. If the young person has been disconnected from their culture, adolescence is a critically important time to engage with their community to enable a lifelong identity and pride in belonging.

Section 12(a) of the CYFA provides guidance on principles for engaging Aboriginal young people and their families. Refer to the *Aboriginal cultural competence framework* and *Working with Aboriginal children and families: A Guide for Child Protection and Family Welfare Workers 2006*, to guide you.

Culturally and linguistically diverse adolescents and their families

Working with culturally and linguistically diverse families brings a number of challenges and opportunities. For example, refugee and migrant communities may be struggling with unresolved trauma, grief and loss after fleeing from war or oppression, or exposure to trauma and torture (Lewig, Arney, Salveron & Barredo 2010). Adjusting to a new culture and way of life can also put further stress on families and increases adolescents' vulnerability.

Challenges in working with refugee families may include (Lewig, Arney, Salveron & Barredo 2010):

- Differences in cultural practices and values.
- Language and communication.
- The level of refugee families' familiarity with government agencies and their roles to support parents and families.
- Organisational issues, such as lack of time in case work to become familiar with the cultural background of families.

Ways of helping include:

- Encouraging parents to communicate with children.
- Encouraging collaboration between families, communities and schools.
- Providing information to newly arrived families about parenting in Australia.
- Developing flexible ways of working that are culturally responsive.
- Enhancing access to culturally responsive child care.

Section 11 (g)-(j) of the CYFA provides guidance on principles for engaging families from other cultures.

Issues of safety and cumulative harm for infants, children and young people should not be minimised. However western cultural expectations can impact unfairly upon parenting assessments when working with Aboriginal families and families from other cultures. Consultation with cultural experts helps us to balance the needs of children and complex family issues. Seek advice and supervision.

Practice tool

Adolescents and their families

The aim of this tool is to provide some additional guidance about specific things you might consider when working with adolescents and their families.

Information gathering

Gathering a comprehensive history will help you to grasp the most important elements of what underlies a young person's current presentation and behaviours. As a result, practitioners will avoid proceeding along the 'blind alley' of simply following and reacting to trauma-based or 'pain-based' behaviour (Anglin 2002, Anglin 2003). Instead, the young person's behaviour will be seen as a natural and predictable response to traumatic life experiences. It is equally important to gather information about the young person's strengths, competencies and skills to complete the picture and help to build a hopeful future.

Communicating with adolescents

Working with adolescents requires a skilled use of communication, as practitioners will need to use a more advanced level of communication than with children, but not as though they are adults. Due to differences in development, aspects of communication, such as capacity to be involved in decision-making, vulnerability to coercion, and ability to engage in insightful conversation, may vary between individuals.

It may be believed that a practitioner can only engage with an adolescent over time. Adolescents can be engaged quite rapidly, but we often ask questions in a way that can silence them. We can also become so focused on getting a literal response that we miss the things that they are telling us through their behaviour or actions.

The following tips may help in communication with adolescents:

1. How will I start? Build a relationship that leads to engagement in change.

- Let the young person be the expert of their own world – it may help to consider initially working from a 'one-down' position, that is, the practitioner as student. Remain open and curious.
- Be creative. Young people can be interviewed when sitting in a park, a cafe, shooting hoops, walking, patting a dog, sitting outside, driving in a car or hiding under a table. Movement, scenery, companionship, containment and/or the need for limited eye contact are often a great invitation to communicate.
- Be clear about your role and the reasons you are involved, but also talk about normal 'safe' things, such as clothes, sport or music. Enjoy getting to know the young person.

2. How should I ask questions? Delivery.

- Be authentic rather than 'cool' – workers need to demonstrate respectful authority.
- Honesty and straightforwardness is appreciated and appropriate. Ask the young person's permission to be 'upfront'; respond to the non-verbal cues:

  'Is it okay to tell you what I'm thinking?'

  'Tell me if I got it wrong.'

'Is this the wrong time to be having this conversation?'

'The look on your face says that 10 minutes of this conversation is enough and then we'll get a milkshake – deal?'

- Avoid using jargon.
- Negotiate where you can, but be clear about the bottom lines.

  'Staying overnight with [sex offender] is not on, but let's talk about whether you would feel better with your Nan or going back to your Dad's tonight.'

- Talk about the 'talking about'. Help the young person to have a sense of control about the timing and pace of difficult conversation.

  'If we were to talk about what your mum did to you last night, what would be bad about talking about it? What would be good about talking about it?'

  'I reckon you might think that if we talked about the bad stuff and the violence at home it would get even louder inside your head … or that the nightmares would be worse …'

- Try not to ask direct questions – use observations and give space for the young person to respond.

  'Some kids hate talking about the bad stuff but then they find that they sleep better.'

  'Seems like there's a lot of stuff bottled up inside you that just boils over and you find yourself in trouble all the time.'

  'I'm guessing you'd rather be at the dentist now instead of seeing me and going through this.' (Usually with this one you get a bit of a smile and a 'yeah' – it helps then to quickly reassure the young person with, 'Well that's normal!' Giving them the message that they are having a normal response is affirming and often engages them in conversation because they are more relaxed and they know that you 'get it'. The underlying reassurance is that they are normal but what happened to them, or the situation that they are in now, does not feel normal.)

3. What else may help? Technique.

- 'Reflecting in the presence of another' can be useful. This involves a dialogue with a colleague, in the presence of a young person, where the two adults are empathically and respectfully exploring and suggesting what might be going on. Be clear with the young person about what you are doing and if he/she joins in, go with the flow – it can be a powerful engagement tool. If it is annoying the young person, stop and ask about what you are doing or saying that's annoying or getting in the way of being useful.
- Use existing props in the room, or non-verbal cues to answer questions.

  If the young person shrugs their right shoulder, this means 'yes'; a left shrug means 'no'.

  Use arm gestures to show/guess how big the sad/angry/confused feeling is.

Ask him/her to show you on the wall where the bad feelings would come up to, or how much of the room their anger would fill up. Encourage the use of drawing, poetry, story writing or movement to enable the young person to externalise what has happened – for example, ask what his/her sadness would look like in a drawing.

- Playdough can be useful at times for showing or modelling family events or as a soothing device to squeeze as they are talking about difficult things.
- Similarly, things such as chewing gum, taking a break, eating chocolate or getting a warm drink can help the young person to manage the intensity of the session.
- Work out with the young person their signal for when they need a break. Follow through and honour the signal so that you build trust.
- If the young person has a disability, determine the ways in which he/she is most skilled and comfortable in communicating, and seek support if needed.
- Celebrate birthdays and other special events in the young person's life, but remember that anniversary times may be particularly sad and difficult. Predict and prepare for this by openly having conversations with the young person, and increase support at these times.
- Let the young person know that you like him/her. Find something to like!
- If their behaviour is obnoxious, let them know you will 'hang in there' because you don't expect them to trust you straight away. After everything that has happened to them, why should they? However, let them know that you expect to be treated decently; reflect openly about the bottom line of respect and what that looks like.
- Talk out loud about what you imagine they would say to you if they could and use humour to let them know they must be sick of yet another practitioner who does not have a clue!
- Don't be afraid if you have strong emotional responses. Talk about these responses in supervision so that you are supported and your emotional responses can inform your practice, and not overwhelm you.

Competence, coercion and confidentiality

The gradual transition of power for making decisions that affect their lives is a critical component of adolescent development that prepares young people for independence. Practitioners and carers have a role in supporting young people to make this shift to independence. As young people develop autonomy and self-mastery, their views on decisions that affect them will need to be given more weight. However, this developmental shift is gradual and practitioners will need to be alert to the issues of competence, coercion and confidentiality.

The *Best interests principles* in section 10 of the Children Youth and Families Act state that consideration must be given to the child's views and wishes, if they can be reasonably ascertained, and they should be given such weight as is appropriate in the circumstances.

Competence: Is the young person developmentally ready, willing and able to contribute to their own treatment?

Competency includes an ability to understand (in simple terms): the nature, purpose and necessity for proposed action; benefits/risks/alternatives and effect of non-action; and that the information applies to the person (Viner 2005). Maturity, degree of autonomy, age and the complexity of the treatment are important considerations (Darlington & Ramsden 2007). Competence may also be situation specific; for example, a young woman performs well in her job but regresses in situations that require dealing with conflict. It can also be affected by the young person's use of medication, which may take the place of helping the young person acquire the skills necessary to deal with and master difficult situations. Therefore, be aware of what they are taking and how/when an experienced medical officer or adolescent psychiatrist will review it.

Competence is something that is a matter of professional judgement and, in reality, that judgement is difficult to make. You may need to make unpopular decisions, and your skill as a practitioner lies in your ability to communicate, operate fairly and stand firm on difficult but necessary directives.

The wise use of authority demands a balance between empowerment and limit setting. For example, if a young person is assertively stating their 'decision' to engage in sexual exploitation as 'a lifestyle choice', a clear statement of zero tolerance should be given. The young person is usually re-enacting past sexual abuse trauma and a deeply disturbed view of themselves and sexual relationships. Substance abuse issues, enmeshment with a manipulative and often violent pimp/offender and self-loathing often underpin this behaviour rather than an informed decision. Remain calm and non-judgemental and consistently convey through your tone and your behaviour that the young person matters and that they deserve better. Close collaboration and communication within the care team are crucial in these situations.

It is also worth considering that with the right support and at the right time, being involved in decision making may assist a young person's recovery from trauma, especially in cases where a lack of control was an integral part of the trauma.

Coercion: Is the young person making decisions of their own free will and with consideration to all the information presented to them?

Aligned with competence is coercion. If you are providing the opportunity for young people to be involved in decision making, it is important that they have time to consider information and feel they are making an informed choice free from external pressure (Viner 2005). Failure to provide adequate time or facilities to receive and reflect on information may be a subtle form of coercion. Practitioners also need to consider whether the information has been understood, and the impact of cultural norms, such as traditional and/or cultural relationships between young people and authorities (such as elders).

Confidentiality and information sharing: What happens to the information provided by the young person?

Confidentiality is rated very highly, considered very important by adolescents and is crucial to practice (Viner 2005). Young people have a right to confidentiality and, where limited, to have those limits clearly explained. Clarity regarding confidentiality policies and practices needs to be established, including across services. A young person's involvement across a range of services is not in itself a justification for information sharing.

If the young person has disclosed abuse from a parent or significant other, be clear with him/her what you are obliged to do with that information and do not make promises that are unethical. Be very careful to negotiate what information flow is given back to any adult who has perpetrated abuse against him/her and seek legal advice and supervision if you are confused.

Building relationships through the playfulness, acceptance, curiosity, empathy (PACE) technique

It is surprising how we, as professionals, can still leap to assumptions and fail to apply real acceptance, curiosity and empathy. We can become driven by the immediate demands of investigative, court and placement processes, asking only narrowly focused questions to satisfy these requirements. If we are to successfully protect young people who are abused and neglected and help them to achieve a state of greater healing and integration, we must do more than this.

As an interviewing technique PACE assists us to respond to young people in a way that is more likely to open up communication. The underlying approach is one of patient and genuine curiosity. Questions are framed in a calm and reflective manner.

- Playfulness may be used as long as it is respectful and not derisive. Playfulness is not the same as sarcasm or humour at anyone's expense. Young people in stressful situations may, however, respond to a conversation that asks them what animals people in the particular circumstance might remind them of, or some such tool that 'breaks the ice' with them. Playful approaches can include asking questions like 'If your life was a film, what film would it be?'
- Acceptance can be demonstrated through reflective statements such as 'I guess this situation sucks' or a similar comment that uses language they feel comfortable with. It is very important to be patient but not passive. Reflecting in its entirety what you might imagine the young person is making of the current situation, drawing out all the dilemmas and then honestly appraising their options can convey acceptance.
- Curious questioning is an excellent way of opening up communication. The critical factor is that it has to be authentically curious. There are a number of ways that questions can be framed in this way, such as using questions that start 'I wonder…', 'I'm guessing', 'Tell me if I'm right or wrong…' or 'I bet when you were little you didn't know what to expect from Mum…is that what it was like?' Curious questioning can be applied to draw out inner conflict: 'So I bet you think if you tell me what really happened your dad will get into really big trouble, huh?' You can follow along a line of reasoning even in the face of a wall of silence. You can even say after drawing all the possibilities out 'I guess you're sitting there thinking why doesn't she/he just shut up!'
- Empathy allows us to 'feel with' another person; we feel compassion for their struggles or suffering. Empathy eventually allows the young person to acknowledge deeper feelings of fear, sadness, hurt and anger, without fearing judgement. Empathy can be used to soften a young person's defences, for example 'I'm sorry that happened to you, it makes me feel really sad you had to go through that'.

(Hughes 2007; Downey 2009)

Document a comprehensive history

A focus solely on what adolescents 'do' in the here and now can result in an assessment based only on recent information. Documenting the young person's history will help you to focus on what has 'been done' to the young person through infancy and childhood, and the impact of this.

- Read the file! History matters – past trauma is often triggered and played out in the present.
- Summarise the file according to type, frequency, severity, source of harm and duration, as well as available demonstrated sources of protection.
- With the help of the young person, create a timeline of where they have lived with their family, different schools, different placements, key events and so on.
- Record a comprehensive family, health (inclusive of dental), developmental and childcare/educational history for the young person from infancy to the present. Interview family members and past carers and practitioners where possible; significant information may have been lost or inaccurately recorded, or no one might have developed a thorough family history.
- Has your service had previous involvement with the young person, their siblings and/or their parents? What was the outcome of previous interventions?
- Have other services/organisations been involved? For example, what role has the school played in the past with bullying behaviour or school refusal?
- Incorporate all of this information into the file notes.

A comprehensive history will alert you to the effects of cumulative patterns of harm on a young person's health, safety and development – a requirement in the Children, Youth and Families Act s. 10(3)(e). For guidance on recognising, assessing and responding to cumulative harm, refer to the *Cumulative harm specialist practice resource*.

Establish the developmental impacts

The next step is to consider the impact of past events on development and the meaning of this impact.

- At what point have historical events impacted on a young person's development, and in what ways? For example, a series of placements may have influenced the young person's ability to form strong attachment bonds with adults.
- What age and stage of development is the young person at now? Is the adolescent functioning at or below an age-appropriate level for various developmental tasks?
- What are the developmental impacts on the young person's education, in terms of participation and peer relationships?
- If the young person has a disability is there an up-to-date assessment and intervention plan? Is the young person linked into available specialist services?

- Are there grief and/or loss issues? For example, abused adolescents may feel a loss of parents or family, innocence, faith in themselves or others, material losses such as homes or schools and hopes for a normal future. Increased cognitive capacity and maturity in adolescence may also allow a fuller understanding of past losses, bringing about delayed grief responses, for example, recognising that not everyone experienced a disrupted or damaging family.
- Are there impacts on the young person's identity and sense of belonging?

To assist with your assessment, refer to the Child development and trauma guide.

Family and other connections

Connections to family and significant others remain an important source of support and guidance throughout the adolescent years. It is important to assess who is available for the young person during this important growth period. Focus on strengths as well as difficulties.

- Who 'surrounds' the young person, and what is the nature of the relationships? Are they age-appropriate relationships? Are they isolated? Drawing a genogram, ecomap or sociogram (see www.strongbonds.jss.org.au/workers/families/genograms.html) may help to identify those who are close to the young person (whether family or not), and who is aligned with whom. Ask the young person 'where do you feel a sense of belonging?'
- If the young person's parents have separated, be inclusive by exploring both sides of the family.
- Explore peer group, sporting, cultural and community connections. Be curious about the young person's sense of competence in the world. We might be judging him/her to be the parentified child, however, he/she may have a sense of pride and competence that they cook for their mentally ill parent or that they interpret for their non-English speaking parent. Understand their perspective and don't assume to 'know'.
- Are parents/caregivers offering adequate care by being aware of and responding to the young person's developmental, educational, social, emotional, recreational, nutritional and medical needs? If parents/caregivers are not offering this, who is?
- What are the communication patterns in the family? What are the repeating behavioural patterns?
- Are there consistent rules and consequences of behaviour in the family/placement? Are parents'/caregivers' responses to the young person's behaviour based on misunderstanding, frustration, ignorance or anger, and if so, are they responsive to suggestions?
- Are family members involved, or disengaged from or emotionally enmeshed with one another? What are the transgenerational patterns?

Current behaviours

Once a developmental, social and family history is established, as well as an understanding of the impact of these events on the young person's development and wellbeing, an examination of current behaviours can be undertaken.

- Which current behaviours may impact on the health and wellbeing of the young person (or others)? Why are the behaviours happening, and are others involved? Are any behaviours escalating? What are the triggers that precede the offending or self-harming behaviour?
- Does the young person have opportunities to develop responsibilities for decision making and increasing autonomy or self-reliance, within the context of supervision, nurturance and acceptance (which may be in a different form to childhood)?
- To what extent is technology playing a positive, negative or neutral role in the young person's life, for example, are they a victim or perpetrator of any form of cyberbullying? Are they accessing accurate/inaccurate information from the internet? Are they engaging in social networking (such as on Facebook or Twitter)? Are they accessing any support groups online, such as through Reach Out?
- What strengths does the young person have? (See the *Identity, resilience and strengths* section.)

Mental health

Identifying and addressing mental health problems in adolescence is important for two key reasons.

First, there is a growing understanding that mental health problems are a real and significant issue in adolescence. One in four young people (aged 16–24 years) were identified as having a mental health disorder in 2007, with females more likely to experience affective and anxiety disorders and males more likely to have substance use disorders (Slade et al. 2009).

Second, many serious mental illnesses are now recognised as having an onset in adolescence (Australian Institute of Health and Welfare 2007), and early identification gives a young person a chance to access effective and appropriate treatment. For example, entrenched use of dissociation or detachment as a coping mechanism increases the risk of major depression, which under these circumstances is more likely to have an earlier onset, longer duration and poorer response to standard treatments (Cook et al. 2005).

Serious mental health problems are different from day-to-day changes in mood and emotions according to duration (lasts more than a few weeks), persistence (loss of normal fluctuations in mood and behaviour) and impact (such as decreasing functioning in school or work) (Viner 2005). Symptoms in need of assessment by a specialist mental health professional include:

- signs of overt depression, such as persistent/frequent crying, lack of interest in activities
- somatic complaints, such as headache, stomach-ache, sleeping problems
- self-harming
- aggression
- isolation and loneliness
- offending behaviour, such as theft

- drug/alcohol use
- weight loss or stunted growth
- lack of self-care, such as a change in hygiene standards
- lack of self-protection
- withdrawal and disengagement from family, school, sporting and community connections.

Young people with a disability

Young people with a disability may be particularly vulnerable to abuse and neglect, both past and present, due to issues such as extra stress on caregivers arising from discrimination, or characteristics such as aggression or hyperactivity. Communication difficulties, in particular, increase vulnerability, as a young person may have difficulty identifying perpetrating behaviour. Likewise, different stages of development, such as a young person who needs intimate physical care, may also increase vulnerability (Daniel, Wassell & Gilligan 1999).

Carers may also experience fatigue from the ongoing multiple demands of caring for a young person with a disability, and there is consistent evidence that caring is associated with poorer mental health, particularly depression (Robinson, Rodgers & Butterworth 2008). It is important to take these issues into consideration, and get some assistance to understand their impact when gathering information about the young person.

Assessment of life-threatening behaviours

The threat of suicide by a young person is likely to be one of the most difficult and confronting challenges that a worker will face. Threats of suicide are common in young people with a history of abuse, and are often preceded by serious mental health problems, previous suicide attempts, family discord or substance abuse.

It is vital to understand that the common myth that a young person who talks about suicide is merely engaging in attention-seeking behaviour has been firmly disproved. Suicidal behaviours, and talking about or threatening suicide, need to be taken very seriously. Equally, talking to a young person about suicide does not increase the likelihood of him or her completing suicide, and may be a welcome relief for the young person.

Practitioners should routinely check for any history of self-harm or a tendency to abuse substances, and attempt to obtain information about possible signs of suicide risk. Explain the rationale for asking questions about self-harm. For example, 'I am going to ask you some personal questions that we ask all young people because we are interested in your health and safety'.

If a suicide risk is present, there are a series of further key questions that should be asked. Convey that their welfare is important to you, and speak calmly, slowly and acceptingly:

- Have there been any **previous suicide attempts**?
- Is there a family or peer history of suicide or suicide attempts?
- Has the young person spoken recently about suicide, or made **threats to suicide** (explicit or not)?
- Does the young person have a **suicide plan** (day, date, time, method, lethality of chosen method)?
- What **access to weapons or drugs** does the young person have?
- Is a **trusted, supportive person** available to supervise the young person in the immediate term (the first 24–48 hours)? Make a list of all supportive people around the young person and exchange phone numbers. Discuss with the young person what would trigger them to contact someone, for example, he/she is not coping or starts to overuse drugs/alcohol.
- Make a clear and definite arrangement with the young person about the next contact, including time, day and location. Make this a **binding agreement**, in writing if necessary, and gain an undertaking from the young person that he/she will not harm him/herself in the ensuing period.

Where a history of suicidal behaviour is known, practitioners should be aware of: any sudden, apparent improvements in mood, emotion or energy levels; renewed efforts to get their affairs in order; or attempts to give away belongings. This is often an indicator that the person has made a clear resolution to complete suicide.

Responding to suicidal threats and behaviours

While interventions will ultimately be aiming to address the underlying causes of these behaviours, there may be times when you will need immediate help. Child and adolescent mental health services (CAMHS) are able to provide specialist services for young people with serious emotional disturbances. In an emergency, call a crisis assessment and treatment (CAT) team or attend the nearest emergency department.

Suicide in Aboriginal and Torres Strait Islander communities

Suicide was an unknown phenomenon in traditional Aboriginal and Torres Strait Islander communities, but since the 1970s it has become a significant contributor to mortality (Elliott-Farelly 2004). It has been suggested that the causes of suicide in these communities are different from non-Aboriginal populations (Elliott-Farelly 2004; Tatz 2005). Tatz (2005) suggested the following risk factors:

- lack of a sense of purpose
- lack of publicly recognised mentors/role models (outside sport)
- disintegration of family and community supports
- sexual assault
- drug and alcohol abuse
- animosity and jealousy associated with factionalism
- persistent grief
- illiteracy.

Other factors may include family violence, incarceration and the role of 'shame' as a trigger for suicide. It is important to consider these factors in any suicide assessment.

Mental illness is seen as less of a precursor to suicide for Aboriginal and Torres Strait Islander people, whereas the impact of westernisation, colonialism and the stolen generations is particularly important. As a result, responses to youth suicide in Aboriginal and Torres Strait Islander populations may need a different approach. Engagement and connection with family, the community, cultural elders and school is critical in developing a safety plan and ongoing recovery.

Deliberate self-harm

Deliberate self-harm is a common behaviour in young people who have trauma histories. While self-harm is usually distinguished from suicidal behaviours, it may indicate suicide risk. Most commonly, however, self-harm is used to cope with painful and difficult emotions and feelings, communicate a need for support and/or provide a sense of control and 'realness'. It also may bring a sense of immediate relief in times of distress. Similarly to suicidal behaviours and drug/alcohol use, the need to engage in self-harm is likely to diminish as a young person's situation improves. Be curious about the triggers and the meaning of these behaviours for the young person. Don't presume to 'know'; the function of the self-harm may change over time. Collaborate to develop a safety plan.

Assessment of substance use

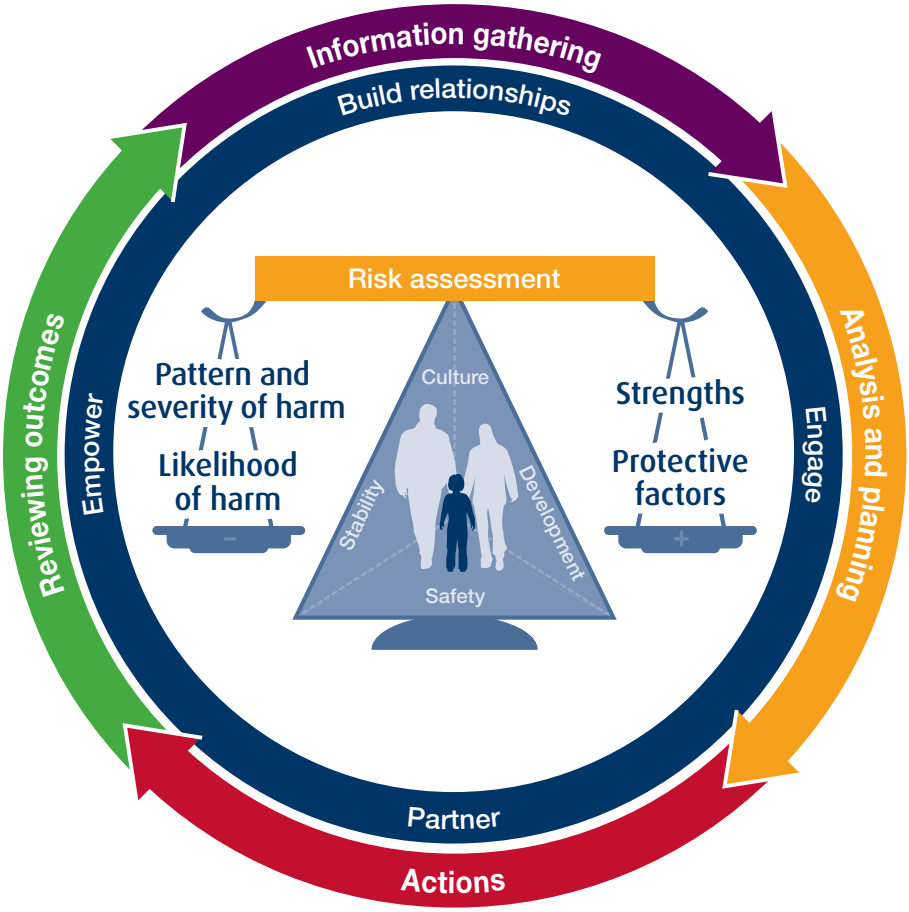
Drug and alcohol use is common among nearly all young people in the care and protection system. Young people are often 'self-medicators', that is, they use substances to escape emotions and feelings, and there is a high rate of comorbidity between drug and alcohol use and mental illness. The upsurge of emotions that may be associated with stopping is often a key factor in continuing use of drugs and alcohol.

It is important to send a message that, as a practitioner, you care about the young person and what happens to them rather than a singular focus on whether or not they should be using drugs and alcohol. Drug and alcohol use should be part of the overall assessment and viewed in conjunction with past and present experiences, to ascertain the purpose and meaning for the young person.

Specific questions that may help in assessing drug and alcohol use include:

- Does the young person believe that their drug/alcohol use is a problem? What does the young person like or dislike about using drugs/alcohol? (Drugs may enhance pleasure or avoid pain but may also give a sense of power and control to the young person, a source of income or a new and exciting group of friends.)
- Are they at a stage of change that is conducive to intervention or treatment? What are their goals around drug/alcohol use (such as continue use, control use, or abstain – for each drug they are using)?
- What purpose does the drug/alcohol use have for the young person? What is it helping him/her to cope with or deal with?
- Has their use escalated? Are they using different drugs/alcohol than last month/year? Has there been any injecting drug use?
- What does the young person do to fund and obtain their preferred drug (such as sex work, drug dealing)? Are harm minimisation/reduction strategies used (such as not sharing needles, not using alone)?
- Have there been past attempts to stop or control use? What happened at these attempts?
- Does their drug/alcohol use impact on their physical or mental health and wellbeing? Have they been diagnosed with any illness as a result of their use, such as hepatitis C or HIV?
- How do others view their drug/alcohol use, such as family members or other practitioners?
- Does the young person have drug-related relationships with partners and/or friends? What role do these people play in the young person's drug use?

Analysis and planning



Risk assessment

To formulate a risk assessment, you need to be a critical thinker and to consider multiple competing needs, prioritising the young person's safety and development. Careful attention needs to be given to the balance of risk and protective factors, strengths and difficulties in the family. Your assessment needs to be forensically astute; and you should consider all sources of information such as observation, previous assessments, advice from all significant people and professionals. Do not rely on phone assessments or parental self report where there are suspicions of non-accidental injury, or where there have been previous concerns or offending behaviour.

Synthesise the information you have gathered about the current context and the pattern and history; and weigh the risk of harm, against the protective factors. Keep in mind that the parents' desire to change dangerous or neglectful behaviours does not equal the capacity to change; and that strengths and protective factors need to be sustained over time. The best predictor of future behaviour is past behaviour. Hold in mind the urgency of the young person's timeframes for safety and secure attachment relationships. Imagine the young person's experience of cumulative harm. Remember, other than the family's characteristics, the quality of the relationship you form with the family is the single most important factor contributing to successful outcomes for the young person.

Characteristics to consider when assessing risk

Based on examination of file records and other data relating to over 1500 children, Reid at al (1995) identified three important organising principles consistently associated with occurrences or recurrences of child abuse or neglect for children:

1. The first and most important dimension of caregivers' characteristics that should be considered, is their prior pattern with respect to the treatment of children. The number of maltreatment events they have initiated, their severity and recency are the most basic of guides to future behaviour. In the absence of effective intervention these behaviour patterns would be expected to continue into the future.
2. If an individual believes that they are correct in their opinions about children, they will attempt to continue their behaviour so long as they are not prevented from doing so.
3. The third dimension concerns the presence of 'complicating factors', most significantly, substance abuse, mental illness, violent behaviour, and social isolation. The relevance of complicating factors is the extent to which they, singularly or in combination, diminish the capacity to provide sufficient care and protection to the child or young person.

The Best interests case practice model is underpinned by a strengths based approach that assesses the risks, whilst building on the protective factors to increase the child's safety.

Attention to safety factors within the risk analysis recognises that:

1. Both the potential for harm and for safety must be considered to achieve balanced risk assessment and risk management
2. Strengths which increase the potential for safety are evident in even the worst case scenarios and these are fundamental building blocks for change
3. A constructive approach to building safety can be taken which may be different to efforts to minimise harm
4. A strengths perspective can be actively (and safely) incorporated into what may otherwise become a 'problem saturated' approach to risk assessment and risk management

(cf. Turnell and Edwards, 1999)

Current risk assessment

Current risk assessment highlights the fact that it is made at a *point in time* and it is therefore limited and will require modification as further information comes to light. Your risk assessment should address the following key questions: Is this child/young person safe? How is this child/young person developing?

1. Given all the information you have gathered, how do you make sense of it?

   Consider the **vulnerability** of the child and the **severity** of the harm:

   - What harm has happened to this child in the past?
   - What is happening to this child now?
2. What is the **likelihood** of the child being harmed in the future if nothing changes? Hold in mind the **strengths and protective factors** for the child and family.
3. What is the **impact** on this child's safety and development, of the harm that has occurred, or is likely to occur?
4. Can the parents hold the child in mind and prioritise the child's safety and developmental needs over their own wants and constraints?
5. From the point of view of each child and family member, what needs to change to enable safety, stability and healthy development of the children?
6. If the circumstances were improved within the family, what would you notice was different – what would there be more of? What who there be less of? Who would notice?

Once information has been gathered, the next step is to integrate all the given information, synthesising current strengths and difficulties (risks and protective factors). Keep in mind that risk can fluctuate and quickly become serious. Assess what needs to be done to increase the young person's safety, stability and development, and develop an action plan, using the steps outlined in the Best interests case practice model.

The following points are useful at the analysis and planning stage:

- Synthesise the information you have gathered and make connections with what you are seeing in present behaviour and what you have discovered about their family history and repeating patterns.
- Use a trauma and attachment framework to undertake a 'critical analysis' of the information. This process needs to incorporate the knowledge and processes we use to consider the impact of cumulative harm. Focus on what has happened to the young person and how they have adapted or compensated to manage their pain and survive.
- Develop multiple hypotheses regarding what in the young person's life experience has led to their presentation and how this may be responded to. Be prepared to be wrong. Your initial hypotheses may well change as you get to know the young person and their family, and growing trust brings new information to light.
- Consider who has the most positive connections with the young person, and their connection to culture, community and school.
- Consider the young person's competence to be involved in case planning. Their involvement, if appropriate, is critical.
- Weight your analysis and planning for the young person's best interests, prioritising safety, connectedness and stability. What is the most important goal right now? Critique your plan through the lens of 'common sense.'

Carefully consider whether crisis intervention is needed. Responses such as placement in secure welfare should be an absolute last resort. Where feasible, avoiding panic responses to the young person's behaviour sends a crucial message; you are in control, you are able to 'hold' the young person through their behaviour and you believe in their ability to stay safe.

If it is clear that they are not safe, this needs to be openly discussed and options need to be explored with the young person and the care team. Realistic plans result from learning what has been tried and failed. The key message to the young person is 'you matter and you have the right to be safe – and so do others.'

Specialist practice resources do not replace the need for supervision, professional development or consultation with specialists. The need to access supervision and give attention to your own self-care is particularly critical when working with adolescents.

Identity, resilience and strengths

When analysing and planning how to respond to a young person's situation, it is important not to lock into a problem mindset. Young people who experience adversity can also be resilient. They can bring a range of personal strengths, coping strategies and ways of eliciting support to the situation. Intervention and prevention should help to increase the young person's self-talk about his/her strengths and abilities, holding hope and succeeding, and reframing the difficulties that he/she faces.

Good practitioners talk about the whole young person and their abilities and capacities, rather than defining them by what has happened to them. Reframe the young person's experiences in ways that acknowledge their responses to difficult situations. This needs to be done in a way that clearly does not endorse or encourage non-developmentally appropriate roles but, as a starting point, tries to 'take the good from the not-so-good'. Such an approach will help young people gain confidence in their own abilities to solve problems and make changes that will lead to healthy and productive lifestyles.

Here are some examples:

- The positive skills gained from taking on a (reasonable) caring role for a family member with a disability or mental illness, such as responsibility, cooking meals or cleaning the house.
- Proficiency at a sport or computer game that shows skills in organisation, time management, problem solving or working as a team.
- Positive strategies that have helped them survive years of neglect, poverty or hardship. Help them to build a positive sense of self by reinforcing the strengths and qualities you see in them.

Maintaining this focus will help to avoid a situation where young people internalise what Gilligan (2006) describes as a 'master-identity' of 'young person at risk' or 'client of social services'.

Action

After you have gathered and analysed information and formulated a plan for the young person, it is time to consider how the plan can be put into action. A practitioner should play a 'scaffolding role' – offering support when needed and holding back when not needed (Gilligan 2006).

Robin Clark's study of exceptional practice indicates that a central focus of direct care and casework practice is the search for that caring, consistent relationship for the young person, and the ongoing support of that relationship. 'In some cases, the exceptional practitioner built bridges between the young person and a parent; in other cases, a lot of time and effort was put into finding the right person amongst the caring staff to establish connectedness with the young person' (Clark, 2000, pp. 40).

A starting point can be a consideration of whether one-to-one therapeutic work is appropriate, or does trust and safety need to be built in the context of a therapeutic relationship first? The young person may need to experience safety and a contained environment before feeling capable of working on further skills.

Ensuring a stable placement and connection to school or other structured activities is vital to the young person's sense of normality and developing competence. Have expectations that the young person will recover and do well, despite set backs.

Acknowledge small indicators of change, celebrate the young person's effort along the way and don't lose heart if the plan is not working; this should be factored in as new information. As a care team, review and critically reflect on what could be done differently. Remaining connected to the young person and their family, seeing them regularly and building your relationship with them is critical to their engagement in change. Always return phone calls from the young person and if you have to cancel appointments, give notice and explain why so that they don't experience it as another rejection. You have to 'earn your stripes' and be reliable as a practitioner in order to gain the young person's trust and respect.

Family involvement

Families, despite their importance, are often seen as outside the scope of treatment when a young person receives professional help. If families have been part of the problem, it makes logical sense that they are part of the solution – if they are capable of involvement in, or being supportive of, treatment or interventions (Robinson, Power & Allan 2010). It is important to remember that family relationships remain an enormous source of pain, and desires for connections are deeply held – physical separation, even over many years, rarely equates to emotional separation (Dwyer & Miller 2006).

Family support (particularly from mothers) has been found to significantly enhance a young person's recovery from a range of presenting problems, including sexual abuse. Make time to engage with non-offending parents who are estranged from the young person, and explore any constraints to their belief or support of the young person. Show empathy and endeavour to work through their issues with the aim of facilitating their relationship with their child. Remain mindful of the manipulation and deceit the mother may have experienced if the offender was her partner or close family member, and that the mother may initially be in shock, requiring a process that helps her to believe and support her child.

A respectful, open and supportive stance towards family members and other significant adults is important. Practitioners need to abandon an 'either/or' understanding of the family as 'goodies or baddies' in favour of a 'both/and' position. Taking a 'both/and' position allows you to be more helpful to the young person as they can openly talk and explore their feelings about 'the good, the bad and the ugly' they have experienced within their family. Young people often fear being judged by professionals because they may have very confused loyalties and feel love towards a family member who has abused them. Taking this position enables the young person to work through their grief and confusion and does not minimise or collude with abuse. As such, responsibility is attributed to the offender while at the same time recognising the powerful, complex ongoing impact of the abuse on all family members and relationships (Miller, 2009).

The absence of parents or family members does not mean that they are not important, and it is common for allegiances to vary over time. Even if a young person has run away or been removed from home, this does not necessarily equate to disconnectedness from family. In situations where practitioners have taken the time to work with family members important to the young person, positive change has often occurred.

If a young person is unable to remain with their family, attention needs to be given to enhancing stability and connectedness in the broadest sense (including parents, siblings, extended family, significant others, peers, schools, community and culture). Help the young person to build and/or strengthen connections with family. If this is not possible, make sense of 'why not?' and what help they need to manage associated feelings. If family is absent, there is some suggestion that connections with other significant adults, mentors and prosocial friends can help to reduce risk (Rayner & Montague 2000). This may be a resource that is largely unexplored or untapped if a practitioner is focused on the nuclear family.

The most challenging adolescents often carry enormous pain because of the loss of sibling relationships, which can be the most enduring relationships for most people.

Access

Understand the young person's views in regard to access arrangements and do not assume that just because the perpetrator of the abuse was a biological parent access is appropriate or wanted by the young person. Supervision of the access does not necessarily prevent the young person from feeling flooded and overwhelmed; the physical presence of the offending parent may trigger traumatic responses. Seek a variation on the court order if necessary.

If the young person is in the process of disclosing past abuse, access with the perpetrator is contraindicated unless there are exceptional circumstances and you have sought consultation and clinical guidance.

If there is a plan to reunify the young person with their parent/s, it is essential that the family is engaged in the process and understands that they are central to good outcomes for the young person. Empathising with their difficulties and exploring their journey with the young person will help them to feel accepted, and consequently more likely to engage in solution-focused work. Make sure that positive change has occurred, supports are established and contingency plans are understood before re-unification takes place.

Do not expose the young person to a perpetrator of violence or abuse unless it is under safe circumstances and thorough preparation has occurred. Family meetings do not have to occur with all family members in the room together. Consider issues from a gendered perspective if there has been violence and sexual abuse and do not minimise the dangerous impact that contact with the perpetrator may have. Powerful manipulation can occur through the tone of voice, the 'look in the eye' and the offender's concealed threats. Nonverbal communication can be a powerful trigger that can re-traumatise the young person. Seek advice and supervision in this regard.

The Best interests principles in section 10 of the Children Youth and Families Act state that in determining what decision to make or action to take in the best interests of the child, consideration must be given to the desirability of continuity and stability in the child's care. The widest possible assistance is required to be provided to the young person and their family.

Secondary wounding

Secondary wounding (re-traumatisation) may also be present, that is, harm that comes from the minimising, disbelieving, blaming or stigmatising attitudes of others, including family reactions to the young person's situation (Matsakis 1996). This can be just as damaging and, in some cases, more so than the initial trauma. As family members may not be aware of this occurring, it may be necessary to help them understand how they are unwittingly involved in secondary wounding and how they can be powerfully involved in the healing process.

Parents may need to understand that it is quite normal for children not to disclose abuse but that adolescence may bring about a greater understanding of acceptable and unacceptable behaviours or an ability to respond differently to the abuse without the same level of fear. A family decision-making meeting may be appropriate at this time, but preparation is vital.

Responding to trauma

The first and foremost response to trauma is to create a sense of safety for the young person. This may require establishing a resource network that will help the young person reach out when needing safety and security. Some adolescents may have no baseline for safety because

they have never felt safe, and cannot respond to efforts to provide a safe place – it may take some time to understand that adults are able to protect them. A longer period may also be needed if there have been multiple traumatic events, or family is implicated (particularly if this has disrupted attachment). Young people who suffer abuse may take on the belief systems of the powerful offender and believe they deserved the abuse because of characteristics such as their behaviour or their looks. They may grow to feel complicit in the abuse and carry shame that they didn't fight or run away. They may believe that they are as much to blame as the perpetrator.

For many young people, there is uncertainty about whether there is anyone who cares about, loves, values, appreciates and wishes to nurture them; in addition, they may not have the skills to elicit this nurturance, love and caring. Responses will often take time, repetition and a 'therapeutic web' of people.

Once safer and in more control, the retelling and remembering of trauma can occur in a therapeutic setting. Through this a reconnection to self and to others can begin.

Cognitive distortions need to be gently discussed and reframed over time in your work with the young person so that the manipulation of the offender is exposed for what it is. This may be a deeply confusing and sad time for the young person who may have also loved and relied on the offender. Avoid trying to talk the young person into being angry with the offender – this may make them feel guilty and 'weird' for being grief stricken and still bound by their loyalty. This will be clarified over time as trust is built and the young person experiences safety and nurture, free from the manipulations of the offender.

Specific communication skills for working with young people on trauma issues include the following.

- Explain events as well as possible, giving developmentally appropriate information. Help to fill the gaps of the story if you can, being open and honest (even if difficult); the young person's speculation may be worse than the truth.
- Clearly and repeatedly assure them that what happened was not okay, and that it was not their fault. Listen, believe, do not blame.
- Encourage, but don't force, discussion.
- Use open ended, non-leading questions.
- Encourage the expression of feelings and emotions, and refrain from passing judgement.
- Listen attentively; where possible, continue the session if the young person is at a 'break through' time and is disclosing traumatic events. You may not get the 'window of opportunity' again.
- When referring to events such as physical abuse or family violence, use specific terms (such as slapping, hitting or punching) rather than more general terms (such as fighting), and check for associated experiences of emotional abuse or neglect.

Other things to be aware of when working on trauma include the following.

- Base interactions with the young person on an emotional, rather than chronological age. Fear, anxiety and frustration can cause regression, which means that a 14-year-old may behave emotionally like a five-year-old. This may be a frustrating but involuntary reaction.
- Nurture and support, provide comfort when sought. Be aware that for those who have been physically or sexually abused, intimacy may be associated with pain, fear, confusion or abandonment, so be attuned to their responses. Respect for the young person's boundaries and enquiring about their wishes is critical (such as their level of comfort with physical affection) and must be balanced with an awareness of appropriate behaviour by a professional/caregiver.
- Help to build a consistent pattern or routine into the young person's day and discuss as soon as possible any changes and why they are occurring. Be consistent and predictable and, if you can't, carefully explain your reasons.
- Model and teach appropriate social behaviours – as you would a younger child. Give gentle lessons about subjects such as hygiene, personal space and appropriate affection. Take them on a fun shopping trip and let the young person choose the hygiene products they require.
- Understand, comfort and build in coping strategies to help the young person deal with traumatic re-enactments that may arise through behaviours, withdrawal, daydreaming or sleep problems. Symptoms may wax and wane, often seemingly for no good reason.
- Help the young person understand what triggers traumatic responses, which may seem like exaggerated behaviours. Work through a list of events or activities that may serve to re-traumatise them, such as watching particular types of movies or visiting certain places. Smells, sounds and other sensory experiences like going to the dentist can trigger traumatic memories.
- Be aware of the lengths to which young people may go to avoid being triggered, such as staying awake all night to avoid nightmares. Punitive responses may only escalate the situation and may cause secondary wounding. Often young people use computers to stay awake because they fear the dark, or smoke dope to relax or to get to sleep. Try to understand the meaning of the behaviours. It is helpful to view them as 'adaptations'.
- Culture may determine trauma symptoms and the way these are understood by family and friends. This may play a part in family roles, parenting and receptivity to therapeutic treatments.
- If you have questions, ask for help. The more you are informed, the more you will understand what is happening for the young person. Keep your supervision times and develop your own self-care/safety plan, including exercise.

Specific considerations around drug and alcohol use include the following.

- Remember it is the young person's choice to use or not use drugs/alcohol, and it may serve as a very important blocker for emotions that are currently too overpowering. While you need to ensure that the message is not about tolerating drug and alcohol use, an understanding of its purpose for the young person will enable you to take action on alternative ways of dealing with emotions.

- Harm-minimisation approaches, that is, information about drugs/alcohol and their effects and strategies, can help reduce the harm associated with use and can be suggested to the young person to help them make informed choices.
- Duty of care will also require the worker to make a judgment on the level of risk to the young person or the community and respond accordingly. Referral to specialised drug/alcohol services may be appropriate when a young person has decided to take action in relation to their substance use.

Broader questions

Key considerations at the action phase include the following.

- Have the young person and family/caregivers been assisted to contain **risk behaviours**, such as managing stress and safe boundary setting? Make sure everyone has a copy of the safety plan. (See the *Personal safety plan* section for advice.)
- Has the young person been given opportunities to consider how their behaviours may emotionally or physically **affect others**? They may need to rehearse concrete anger-management strategies. If the young person has initiated sexually abusive behaviours, they may require line-of-sight supervision in certain contexts. Refer to the *Adolescents with sexually abusive behaviours and their families* specialist practice resource
- Have opportunities been provided for the young person to make, maintain and develop **connections** to family, significant other adults, prosocial peers, community recreational opportunities and culture? For Aboriginal young people the development of their cultural support plan needs to be a key focus.
- Does their current environment support and maintain **development**?
- Have opportunities been provided for the young person to engage in practising and modelling **stress management** skills – such as yoga, relaxation, breathing, art, music, dance and spirituality? Weights training, playing sport and regular gym work, should all be explored.
- If a young person is moving into a new placement, have **health** checks been undertaken? Will they be undertaken annually thereafter? Ensure that existing appointments are known and factored into any placement planning.
- When was the last time the young person went to the dentist? If they have been sexually abused, medical and dental appointments can particularly trigger memories of past abuse. They will need more preparation, comfort and practical support (such as transport, your presence during the procedure and a coffee afterwards). Remember at these times they may be operating emotionally as a very young, frightened child and may seek to avoid or become irritable or even aggressive if they do not feel understood, or experience some sense of control. Empathic preparation is critical.
- Has the young person had the opportunity to attend **sexual health** education? Do not assume that streetwise young people are well informed about sexual health because they have often missed out on basic information due to disrupted family relationships and disconnection from school.
- What plans have been made for the young person's continuing **education**, such as mainstream, alternative, distance education, TAFE or an apprenticeship? Do they have access to a computer?
- What **gender and cultural** considerations are there, and have they been incorporated effectively?

Emotional first aid

When young people are triggered and at risk of hurting themselves or others, practitioners need to be competent in providing 'emotional first aid.' The practice tips in the PAIN model below help to de-escalate a young person who is easily caught in a volatile reaction:

PAIN model

Emotional first aid involves four steps to respond to 'PAIN':

Predicting and planning for crises. Times of risk are often predictable, and may include a time of separation from family, attending a new school, parents separating, someone they care about becoming very sick, an impending court date or a fight with a friend. Young people can be alerted that these times will be difficult and are therefore more prepared for their own emotional response. They can then be helped to use their safety plans at these times.

Acknowledging their feelings and distress. Putting words to feelings is a key element to developing internal control and integrating painful experiences. However, young people who have experienced chronic trauma and disrupted attachment have often not had the opportunity to learn this key emotional developmental competence.

Informing young people about the choices and strategies available to them. When overwhelmed by feelings young people are unlikely to be creative in managing distress and are more likely to resort to old patterns and behaviours. When experiencing high levels of stress or arousal, the thinking part of the brain is not working as well. This is true for all of us. At these times, we can remind the young people of their safety strategies, give simple choices and, if necessary, remind them of consequences.

Nurturing and providing care and emotional containment. Some young people do not expect to be cared for when most vulnerable because this is what their experience has taught them. Therefore, they may respond with their over-determined threat response, such as aggression or avoidance. Providing appropriate nurturance and care can help to soothe distress and channel it into more appropriate expression.

(Dwyer, Frederico, Jackson, & McKenzie, 2010 In Press)

Working in partnership

Working effectively in partnership with other practitioners and organisations involves all parties identifying a lead agency or practitioner, having a strong commitment to a common purpose and goals, and engaging in clear communication and processes. This is particularly important where several agencies with statutory responsibilities may be involved, such as where a young person in out-of-home care has offended (such as youth justice as well as child protection). In order to offset any possibility of 'systems anxiety' occurring when working with young people, there needs to be some clear guidelines set regarding who will manage the system around the young person and how a clear, coherent, contained system of care is to be assured.

Care team meetings and planning are vital mechanisms to organise this, and conflicting views need to be aired in open and robust ways – practitioners in various agencies are likely to have dealt with different issues for the young person, who may also present different 'faces' to practitioners. This is often the case when young people have been victims of abuse and violence and then act out in violent or offensive ways themselves. Remain open and curious about others' views, rather than having to prove that you are 'right'. Seek support from supervisors, an external facilitator or secondary consultation if conflict within the care team is not resolved, or if you believe the level of risk to the young person or others is dangerous or not being adequately addressed.

It is equally important to refrain from an 'over-search' for people or resources to involve in interventions. More is not always better – too many referrals and services can overwhelm the young person and their family. A key group of people should form the core working group in planning interventions and engaging with the family. As a team you need to remain attuned, and flexibly respond to any rapid escalation in the risks facing the young person. Be inclusive of carers, mentors, teachers and other non-professional supports significant to the young person because they are vital members of the care team.

Personalised safety plan

A safety plan should be developed early on, to identify situations where the young person may be at risk of hurting him/herself, others or property. Planning should include strategies to meet safety needs and establish competence, deal with re-enactments, and increase mastery and capacity to focus on pleasurable activities. Young people are encouraged to carry their plans with them, share them with staff and utilise them when needed.

- Make the plan **practical** and **detailed**.
- If a strategy is to call someone, write down after-hours phone numbers and laminate the paper so that it can stay in the young person's bag or pocket without being damaged.
- Put the on-call and after-hours service phone numbers in the young person's mobile phone, and on personal email or social networking sites.
- The plan should identify key points specific to the young person, such as 'Things that make me feel like I want to hurt myself or others' and 'What I need to do when I feel like that'.
- Let the young person know that there will be action if they are missing because 'we care and you matter'. Tell them that a missing person's report will be made to police if they have been missing for more than 24 hours, and that the outreach service and the young person's family will be notified.
- Let the young person know that Youth Justice will be informed if they are facing charges or a court appearance due to offending behaviour. If relevant, make the link between their substance abuse and offending behaviour, which may place them at increased risks of further involvement with the youth justice system and isolate them from more prosocial supports.

Transition plans

As part of their best interests planning all young people in state care aged between 16 and 21 years who were on a custody or guardianship order on their 16th birthday and require assistance in their transition to independence must have a clearly articulated transition plan **at least 12 months prior to leaving care**.

The transition plan must demonstrate, at a minimum, the young person's identified needs and actions to assist them.

Creating the plan

In a 2009 study, almost two-thirds of young people leaving care in Australia did not know they had a care plan or didn't have a plan (McDowell 2009). Of the 471 young people interviewed, nearly one-third were unemployed, more than one-third were homeless and almost half of male respondents had brushes with the youth justice system in the first year of leaving care. This highlights the vulnerability and uncertainty facing young people leaving care and the importance of a care plan.

The *Be heard* report (CREATE Foundation 2009) highlighted how critically important it was to young people to be involved in decisions about leaving care and transition planning (see also the earlier *Competence, coercion and confidentiality* section). It is critical that the young person is:

- **aware of and actively involved in creating and understanding the care plan**
- given information on rights and house rules (include the *Charter for Children in Out of Home Care*), including how these rights/rules are there to help protect them and make them safe
- given a say about the time and place of meetings to discuss plans
- given information on how to make a complaint or provide positive feedback
- allowed adequate time to process the information in the plan and respond to it.

When developing a plan, the young person and worker can go through the Foster Care Association of Victoria (FCAV) checklist (see Appendix 1) to make sure all areas are covered. The following needs to be considered.[4]

Accommodation

- What accommodation would best suit the young person, for example, return to family, lead tenant, transitional housing or public housing?

Education/training/employment

- Have future education and training needs been canvassed, established and understood by the young person?
- Is education in life skills needed? Does the young person know how to cook, budget, access nutrition and legal advice, health support and recreation?

Relationships and connections

- Has a role been found for family in the young person's life and is there a role for the young person in the family's life?

4. Based on: *Things that matter when transition planning… a checklist for case managers*, Department of Human Services

- Are friendship supports in place?
- Is someone the young person trusts available to the young person after hours to provide guidance if needed?
- Does the young person know who their key worker is/care team members are, how to contact them, and what their roles, responsibilities and expectations of the young person are? Who will anchor the young person through the transition?
- Is a Leaving Care Mentoring (LCM) program needed? This aims to provide young people transitioning from care with the opportunities to interact with adults in community settings and to promote interpersonal relationships.
- Has the local post-care support service been contacted/involved in planning and has the young person been assisted to meet with this service?
- Has the young person been helped to access the CREATE website and other youth services and mentoring programs?

Income

- Does the young person have an income?
- Have you applied for Leaving Care brokerage to financially support the young person (if needed)?
- If the young person is soon to turn 18 years of age, and is in home-based care and in education, has there been a request for continuation of caregiver payments for his/her carers?

Identity

- Does the young person have 100 points of identity? Do they know where these documents are kept and how to access them?
- Does the young person have a birth certificate, Youth Allowance and a bank account?
- Does the young person need assistance to gain his/her driver's learner's permit (including help from a licensed driver with whom to gain the required number of supervised practice hours)?

Health

- Does the young person have access to medical, dental and therapeutic services?
- Have other relevant services, such as a therapist, disability worker, youth justice, Centrelink, mental health, alcohol and drug and education, been involved in the transition planning?

Review

- Has a regular ongoing review been built in, so that the young person knows that someone cares and is keeping them in mind?
- Does this young person have a transition plan with which they agree, is meaningful to them and is based on their unique circumstances?

Reviewing outcomes

As outlined earlier, adolescence is a dynamic period of growth, where development occurs in a number of domains. Regular review, therefore, is important to monitor change, particularly in relation to family and other connections and safe/unsafe behaviours.

Questions at review time can include:

- Does the young person feel safe and are they developing well? What has changed?
- What does the young person say is different (outcomes of interventions) and what needs to change in order for them to feel safe?
- How has the young person's sense of identity, thoughts and wellbeing improved? Are they able to be assertive, manage trauma, stress and anger?
- Does the young person have hopes and plans for the future?
- Does the young person have access to a general practitioner, dental and other health services, leisure activities, exercise, good nutrition, and peer and cultural connections?
- Mentoring programs that offer ongoing connection into early adulthood are an excellent resource. Has every effort been made to find the right match for this young person?
- Has the young person and their family received as much support as possible to build and maintain a connection?

Information gathering and analysis/planning should not be seen as one-off events. Thorough and ongoing assessment is needed in recognition of the changing nature of adolescence, particularly in the developmental domains as outlined in the first section of this document. As such, questions outlined in the *Information gathering* section will also be useful at the review phase. The circular diagram on the front of this guide demonstrates that healing and recovery is not linear and that the process of building a relationship with the young person and helping them to build respectful relationships with others needs to be consistently nurtured. This enables good outcomes, including the continuing rights of young people to healthy development, safety and stability.

Further resources

Suicide

Aboriginal Suicide Prevention Information (PDF)

www.lifeline.org.au/__data/assets/pdf_file/0010/8488/Lifeline_AborigSuicidePrev_Toolkit_Feb09.pdf

Lifeline's emotional wellbeing toolkit for Indigenous communities.

LIFE: Living Is For Everyone

www.livingisforeveryone.com.au

A website designed for people across the community who are involved in suicide and self-harm prevention activities.

Health Insite: Support for people affected by suicide

http://www.healthinsite.gov.au/topics/Support_for_People_Affected_by_Suicide

Ministerial Council for Suicide Prevention (WA)

www.mcsp.org.au

A comprehensive online source of information about depression and its relation to suicide.

Suicide Prevention Australia

www.suicidepreventionaust.org

A non-profit, non-government organisation working as a public health advocate in suicide prevention.

Mental illness

ARAFEMI (Vic)

www.arafemi.org.au

ARAFEMI is a non-profit community-based organisation with a mission to promote and improve the wellbeing of people affected by mental illness. Details about professional development, resources and library services are available on the site.

beyondblue: The national depression initiative

www.beyondblue.org.au

beyondblue aims to increase community awareness of depression. The website provides an enormous amount of information on depression, anxiety and bipolar disorder, with resources, research reports, information on projects, symptom checklists and links.

headspace

www.headspace.org.au

headspace provides mental and health wellbeing support, information and services to young people and their families across Australia.

Itsallright

www.itsallright.org

Created by SANE Australia, Itsallright is a website where you can read the diaries of four fictional teenagers touched by mental illness. It also has useful factsheets and provides an online information and referral service on mental illness including schizophrenia, depression and anxiety disorders.

I Just Want You To Be Happy

www.beyondblue.org.au/index.aspx?link_id=59.1165

A book by beyondblue board member and general practitioner Dr Leanne Rowe and colleagues, which aims to address teenage depression and assist parents, families and GPs.

K10

www.beyondblue.org.au/index.aspx?link_id=1.237

The K10 provides a good screening tool for depression and anxiety and is now used widely. It also provides a tool for shared language between practitioners, doctors and allied health professionals, who are increasingly familiar with and use the tool. A high score on the K10 would indicate an increased suicide risk, and flag the need for more specialist intervention.

youthbeyondblue

www.youthbeyondblue.com

youthbeyondblue is all about getting the message out there – that it's okay to talk about depression, and to encourage young people and their family and friends to get help when it's needed.

Alcohol and drug use

Australian Drug Foundation (ADF)

www.adf.org.au

The ADF conducts research on drug issues, and implements drug education programs. Resources are available for workers, individuals and families.

Australian Drug Information Network

www.adin.com.au

A central point of access for internet-based alcohol and other drug information for workers and families.

Counselling Online

www.counsellingonline.org.au

This secure and anonymous service is suited to people who find it difficult to access services, or who may not yet be ready for face-to-face sessions. Counselling Online operates 24 hours a day, seven days a week.

Family Drug Help

www.familydrughelp.org.au

Family Drug Help is a new and innovative service designed specifically to address the support and information needs of parents, other family members and significant others of someone with problematic alcohol or other drug use.

Family Drug Support Australia (FDS)

www.fds.org.au

Support for families including information and education nights, support meetings, and links to special events. FDS is largely volunteer-run, with people who have experienced first hand the difficulties of having family members with a drug dependency.

24hr Family Drug Support Helpline 1300 368 186 (Toll Free)

Turning Point

www.turningpoint.org.au

Turning Point strives to promote and maximise the health and wellbeing of individuals and communities living with and affected by alcohol and other drug-related harms.

Other useful sites

Bursting the Bubble

www.burstingthebubble.com

This website is a resource for young people living with family violence.

Centre for Multicultural Youth

www.cmy.net.au

The Centre for Multicultural Youth (CMY) site has information for workers on young people from different cultural backgrounds, including some great information sheets on newly arrived families (under the NAYSS site, see LH menu).

CREATE

www.create.org.au

CREATE represents the views of children and young people in out-of-home care and advocates for change to improve the care system and life outcomes for children and young people.

Headroom

www.headroom.net.au

Headroom is a South Australian mental health promotion project managed by the Division of Mental Health, Women's and Children's Hospital, Adelaide. This website aims to inform young people, their caregivers and service providers about positive mental health.

Open Place

www.openplace.org.au

This service coordinates and provides direct assistance to address the needs and issues of people who grew up in Victorian state care, helps people deal with the legacy of their childhood experiences and provides support to improve their health and wellbeing.

Peers Outsmarting Homophobia (POSH)

www.latrobe.edu.au/ssay/posh

Outsmarting Homophobia is an excellent new resource designed to help young people who are becoming aware of an attraction to others of the same sex.

ReachOut!

www.reachout.com.au

Reach Out! is a service that helps young people get through tough times. It provides information and support on a range of issues including depression and anxiety; drugs and alcohol; family, friends and relationship problems; suicide, loss and grief; sex and sexuality; and dealing with the pressures of school and university.

Strong Bonds

www.strongbonds.jss.org.au

The Strong Bonds website offers useful information to help parents support a young person through hard times. The site also has a section for youth workers, to help them effectively work with families.

YoungCarers

www.youngcarers.net.au

This site provides information, contacts and support for young carers, parents and primary school teachers.

Your sex health

www.yoursexhealth.org

This website is about reproductive and sexual health. It delivers expert information on emotional, practical and relationship issues and explores real-life dilemmas in the True Stories section.

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Appendix 1: Things that matter when planning for a young person transitioning from state care

A checklist for case planners and case managers

1. This young person is leaving state care aged:

- 15 years
- 15½ years
- 16 years
- over 16 years.

2. Does this young person have a transition plan? Is the young person involved in their transition planning? Does the young person agree with the transition plan?
3. What are the young person's needs?

Needs	Actions
Youth Allowance	
Disability pension	
Does the young person have family supports?	
100 points of identity? Does the young person know where these documents are kept? Does the young person know how to access them?	
A bank account?	
Are other services involved?	
Housing and Community Building, Disability Services, Youth Justice, mental health, alcohol and drug services?	
Are these other services actively involved in the transition planning?	

Needs	Actions
Accommodation plan post-care	
Assistance with education, vocational training and employment	
Medical and/or dental needs	
Is the young person pregnant? What referrals and actions have been undertaken to assist her?	

4. What programs are being sought for the young person during their transition phase to strengthen their capacity to live independently?
5. Where will the young person live after they leave care? Is it a sustainable option?
6. Has there been an application for Leaving Care brokerage for the young person's individual transition needs? Have you considered brokerage to fund:
   - education/classes in their particular interests
   - vocational training
   - short courses to support hobbies, cooking, budgeting or social skills development
   - family planning, sexual and social health
   - employment assistance.
7. Has the regional post-care support service been contacted regarding this young person? Has the young person been assisted to meet with the post-care support service as part of their transition plan?
8. If the young person is soon to turn 18 years of age, and is in home-based care and in education, has there been a request for continuation of caregiver payments for his/her carers?

Appendix 2: Things that matter – a checklist for carers

Planning for a young person transitioning from out-of-home care

Young people in care should be developing life skills throughout their care experience. This prompt sheet has been developed for home-based and residential carers within community service organisations, to guide the support for young people who are transitioning from out-of-home care.

Post-care support

Check the young person is aware of support services available to them post-care including:

- regional post-care support services
- Melbourne Youth Support Service – Leaving Care Helpline 1300 532 846
- Leaving Care brokerage – both for transition and post-care financial support.

Education, training and support

Check the young person has information on:

- education options and how to access them
- Centrelink payments
- employment support
- writing a job application
- preparing for a job interview
- Fair Work Australia (Call 13 13 94).

Identity and 100 points

Check the young person has been helped to obtain and safely keep:

- family-of-origin mementos
- cultural planning
- birth certificate
- Medicare or Health Care Card
- driver's licence.

Managing money

Check the young person has access to:

- income such as a salary, Youth Allowance or disability pension
- budgeting skills
- a bank account or a credit cooperative membership
- paying bills such as online or at a post office
- financial assistance such as Centrelink, Leaving Care brokerage, Commonwealth Transition to Independent Living Allowance (TILA).

Self-care skills

Check the young person knows how to:

- cook a healthy meal
- keep a house clean
- shop within a budget
- maintain personal hygiene
- obtain their driver's licence
- obtain appropriate and adequate clothing.

Health

Check the young person knows how to access (if required):

- medical services such as bulk billing GPs, after-hours GP clinics, community health services
- disability support services
- mental health support
- harm-minimisation practices
- sexual health support
- their immunisation history
- their dentist and treatment history
- hearing and sight impairment assessments.

Relationships

Check the young person has been assisted to develop:

- healthy friendships
- healthy family links
- care for their own children if they are parents
- communication and conflict resolution skills.

Accommodation

Check the young person has been helped to explore post-care accommodation:

- emergency accommodation
- supported accommodation
- private accommodation
- public housing
- financial assistance
- tenancy advice.

Discounted or free items

Check the young person knows how to access:

- material aid
- cheap white goods
- free meals.

Rights and laws

Check the young person knows how to access legal information:

- Youth Law – call 9611 2412
- Victoria Legal Aid – call 9269 0120 or 1800 677 402 (country callers)
- Tenancy Union Victoria – call 9416 2577.

Parenting

Check the young person knows how to access the following supports:

- pregnancy care
- Preparing For Baby
- maternal child health centres
- parenting centres such as Tweddle and Queen Elizabeth
- childcare
- Centrelink Family Assistance payments.

Carer notes

Does the young person identify with a community? Discuss ways that the young person can connect to their local community:

Things to follow up:

Need more Leaving Care materials to give to young people leaving out of home care?

To order more A4 or A3 posters and regional wallet cards for young people in your area email: maria.trombin@dhs.vic.gov.au

Example of Leaving Care Helpline poster

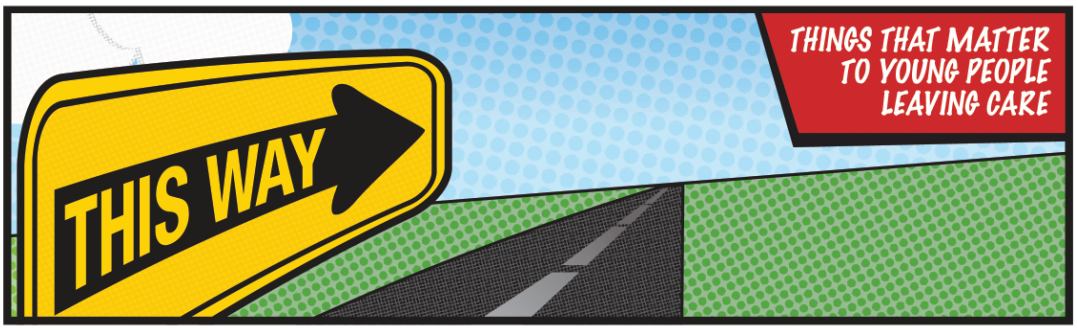
DARE TO CARE

Since 1877 Berry Street We never give up

State Government Victoria Department of Human Services

We would like to acknowledge the support of the Foster Care Association of Victoria (FCAV) and Berry Street Victoria in developing this prompt sheet for carers of young people transitioning from out-of-home care.

Appendix 3: Things that matter to young people leaving care



Here are some common questions that young people often have about leaving out of home care in Victoria. You can use these questions to help talk things through with your carer or case worker.

1. When will my Custody or Guardianship Order finish for the last time?
2. What will happen to me then?
3. Who will help me to plan for when I leave care? Can I go to the meetings?
4. What can I do if I don't agree with what is planned for me?
5. Who will help me get:
   - > My birth certificate
   - > A Medicare card
   - > A passport
   - > A bank account
   - > Youth allowance

   Is there somewhere safe where I can keep my birth certificate and other important documents?
6. Where can I live when I leave out of home care?
   Who will help me find accommodation?
   Will there be someone there that can help me if I need it?
7. My foster parents want me to stay with them after I am 18 years old. Can I?
8. Where can I go for help after I leave out of home care in Victoria?
   Who are the agencies?
   Can I meet with someone before I leave?
9. Can I get help with buying some things I need before I leave care?
10. Can I get help if I run out of money after I leave care?

website: www.cyf.vic.gov.au/leavingcare
Leaving Care Helpline: 1300 532 846

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Department of
Human Services