Clinical Toolkit

Clinical Tips: Sexual Health and Substance Use Risks

Be aware of substance use or sexual health risks along with risks of harm to self or others. A non-exhaustive list of potential risks is outlined below. The headspace Practice Principles: Assessing and managing risk of harm version 1.0 recommend clinicians:

- **Conduct a risk assessment**
- **Develop a safety plan and manage risk(s)**
- **Regularly reassess and manage risk.**

It is important to assess risk in a sensitive way. The risks of suicide, self-harm, and exposure to violence are elevated in Aboriginal and Torres Strait Islander young people. Let the young person know you always ask about personal safety with any young person. Clinicians should consider the young person's developmental stage when assessing and managing risks. For example, a person aged 12 could be asked *if* they drink alcohol, while a person aged 22 could be asked *how much* alcohol they drink and *how often*.

More information can be found in the Risk and vulnerability section of the YSAS Withdrawal Guidelines 2016.

Substance Use Risks

- Are they experiencing direct harm from use? This may include financial risks, work or social problems, trouble concentrating, depression, extreme weight loss due to reduced appetite, disturbed sleep, skin sores.
- Are they at risk of indirect harm from use? This may include increased risk of violence, injury, STIs, unplanned pregnancy, trauma and forensic/legal involvement, and increased risk of depression or psychosis.
- If injecting, are they at risk of blood born viruses such as HIV and Hepatitis C?
- Does the young person have sex under the influence of substances and does this impact any sexual health risks?
    - There may be a risk of acquiring HIV and other BBVs through injection and sexual risk behaviours of the young person's partner(s).
    - Coercion to use substances and/or coercion to have unprotected sex can occur.
    - Is there a risk of foetal alcohol syndrome or other substance-related harm to an unborn child?
- Does the young person's pattern of use risk dependency?
    - Risk of alcohol withdrawal.
    - Risk of cannabis withdrawal.
    - Risk of withdrawal from other substances.

Sexual Health Risks

- Is the young person sexually active?
- For AHPs it might be appropriate for the clinician to ask more general questions such as;
    - Are you using any form of contraception to avoid pregnancy and/or STIs?
    - If not, brief exploration of the risks of pregnancy is indicated.
- Current use and knowledge of contraceptives?
    - Risks of STIs
    - Risk of unplanned pregnancy
    - Was a GP consulted, and how was this contraceptive chosen?
    - Is the contraceptive suitable and effective as used by the young person?
- Has sex has ever been forced upon them or they ever felt coerced into having sex?
    - Is there a history of coercion to have unprotected sex in a context of consent to sexual activity?
    - Does the young person have sex under the influence of substances?
    - Does the person have a mental health problem that may reduce their ability to negotiate boundaries?
- Are they at risk of, or currently experiencing, intimate partner violence? Questions that may help assess this include:
    - Has your partner ever physically threatened or hurt you?

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- Is there a lot of tension in your relationship? How do you resolve arguments?
- Sometimes partners react strongly in arguments and use physical force. Is this happening to you?
- Are you afraid of your partner? Have you ever been afraid of any partner?
- Have you ever felt unsafe in the past?
- Violence is very common in the home. I ask a lot of my patients about abuse because no-one should have to live in fear of their partners.

- Checking vaccination status is important for key vaccine preventable STIs including Hepatitis A and B and HPV (genital warts and cervical cancer).

Risk Discussion and Notes

From Claudio:
I think risks needs to be broader here and I don't think we can just relate to the BPD page content provided.

I can't remember if it is in the content of the training, but we are looking for something holistic, that includes high risk drug taking including risk or overdose or withdrawal, risk of BBV, risk of pregnancy and or STI, risk of criminal justice issues, homelessness, disengagement from school or employment, abuse or neglect, self-harm, harm to others suicide etc.- many of these are covered here, but maybe we may need to write something here, if we don't have this.

An example in https://www.ysas.org.au/sites/default/files/YSAS0106_WithdrawlGuidelines_2016_v14_FA_WEB.pdf page 14: Risk and vulnerability.

The following table represents the psychosocial domains often present in a client's life that may increase their vulnerability.

Criminal justice issues	• Criminal activity in the last 4 weeks or, • Criminal justice system involvement ever
Abuse or neglect	• Experienced abuse, neglect or been a victim of crime (Ever) • Involved in child protection (Ever)
Family issues	• Conflict or disconnection with family relatives (Last 4 weeks)
Problems at school	• Suspended, expelled, or disruptive behaviour at school (Ever)
No meaningful activity	• Not employed or not at school (Current)
Suicide or self-harm	• Attempted suicide or self-harm (Ever)
Housing instability	• Acute housing problems (Last 4 weeks)
Mental health	• Mental health diagnosis (Current)
Quality of life	• Average ATOP score[23] • Score between 0 and 4

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Risks addressed in existing resources

Resources from headspace

From depression clinical toolkit assessment section:

Immediately assess for risk of suicide and involve caregivers, if necessary. Watch a video example below of a GP asking about suicide and self-harm.

Be vigilant for signs of self-harm and assess risk. Watch below video of an example of a GP assessing risk of self-harm.

Video: How to Address Self-Harm in a Clinical Setting (included in current CT draft)

Video: Conducting a Risk Assessment with a Young Person (included in current CT draft)

Assessing risk of harm checklist – operationalises the assessment side of 'Practice Principles: Assessing and Managing Risk of Harm' and refers to a "Managing Risk of Harm Protocol" which I haven't seen / don't have access to.

The **Practice Principles: Assessing and managing risk of harm** is excellent but is 7 pages and not really geared for quick reading. It covers a lot of things that I think would be useful to *link to* in the clinical toolkit if not elaborate on, such as safety plans. I think we should condense some dot-points down from the Recommendations section of this and then refer people on to reading the whole Practice Principles.

Then there is a **safety plan resource** that a clinician can put together with a young person, though it's targeted at non-ATSI YP, and there is a 'Stay Strong Plan' from the Menzies School of Health Research that's recommended in the Practice Principles. The headspace Safety Plan seems to be an internal headspace document so I'm unsure about linking to it from the clinical toolkit, and you'd hope most clinicians or organisations have their own, but it could be a good template for people that don't have one and need to consider it. Includes the following headers:

- My warning signs
- Activities that help
- People and places that distract me
- Family and friends I can contact for support
- Professionals I can contact for help
- Agencies I can contact for help
- How I can make my space safer
- People I will let know about my safety needs / plan
- The things that keep me going…

For young people: what is sex: risks, health & contraception? - Begins with defining sexual health and sexuality, being ready for sex, consent, boundaries, AOD, STIs, contraception, testing.

Clinical Toolkit Clinical Tips: Assessing Risk of Suicide and Self-Harm

https://headspace.org.au/assets/Uploads/Resource-library/Health-professionals/Clinical-Toolkit/CT-Assessing-suicide-and-self-harm.pdf

School Support resource from headspace:

https://headspace.org.au/assets/School-Support/Identifying-risk-factors-and-warning-signs-for-suicide-web.pdf

Suicide only, covers Risk factors for suicide, Warning signs of suicide, Suicide contagion, Responding to warning signs, and Seek further information.

External resources

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Also note that Mental Health First Aid has guidelines from 2016 on suicidal thoughts and behaviours which may be relevant.

https://mhfa.com.au/sites/default/files/MHFA_suicide_guidelinesA4%202014%20Revised.pdf

Risks addressed in current draft clinical toolkit

AOD draft clinical toolkit

Assessment

1. Consider predisposing / risk factors which can increase the likelihood that a young person will develop a substance use disorder.
2.

Management

CT-AOD_risk_factors – asfd

CT-Taking_a_drug_history

Remember to note the following:

- Age at first and last use, including reasons for initiating use
- Amount used and frequency – try to be specific e.g. 2 grams 3 x per day
- Whether the young person uses morning, daytime or night-time
- Methods
- Under what circumstances does the use occur (parties, clubs, with friends)
- Presence of others
- How the drug affects the young person
- Attempts to control use in the past, including drug free periods (days/weeks/months) and any previous treatment for control
- Withdrawal symptoms
- The young person's goals for future use or reduction.

CT-Assessing_substance_use – this contains the DSM criteria and some tips, plus the following section which covers risk:

3. Risky use

Continuing the use of a substance despite health problems caused or worsened by it. This can be in the domain of mental health (psychological problems may include depressed mood, sleep disturbance, anxiety, or "blackouts") or physical health.

Repeated use of the substance in a dangerous situation (for example, when having to operate heavy machinery, when driving a car)

CT-Sexual_history_assessment

You must obtain consent from the young person before assessing their sexual history. Some questions you may ask in a sexual history assessment, but are not limited to, are:

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- Is your current partner your first sexual partner? When did you commence sexual activity? What it consensual? Was it an enjoyable experience?
- Have you ever participated in oral sex, and are you aware of the STI risk?
- Current use of contraceptives and date of last unprotected intercourse
- The number of sexual partners in the last 3 months, whether all partners were of the same sex, and whether condoms were used
- Have you participated in anal/vaginal sex and were condoms used in each type?
- Have you ever been diagnosed with a STI before?
- How many sexual partners has your partner had, and have they been diagnosed with an STI before?
- Do you have any discharge, dysuria, fever, rash, painful intercourse, perineal pain or general pelvic pain?
- In females: date of menarche, where are you in your menstrual cycle and are your periods regular?
- Have you ever had 'unwanted' sex or a non-consentual sexual experience, or been coerced into having sex?

Risks specifically addressed in training AOD risks

Direct harm from use, noting harm can begin with mild use and increases as use increases from mild to heavy.

Indirect harm from use including increased risk of violence, injury, STIs, unplanned pregnancy, trauma and forensic/legal involvement.

Risk of dependency.

Risk of alcohol withdrawal.

Risk of cannabis withdrawal.

Risk of other withdrawals.

Risk of comorbid mental health problem.

Risk of blood born viruses such as HIV and Hepatitis C if injecting.

Risk of Financial, work or social problems, Trouble concentrating, depression, Extreme weight loss due to reduced appetite, disturbed sleep, Skin sores, dependence and withdrawal

Risk of acquiring HIV and other BBVs through injection and sexual risk behaviours of the young person's partner

Risk of coercion to use substances and/or coercion to have unprotected sex

Risk of foetal alcohol syndrome or other substance-related harm to an unborn child

~~Psychosis risks~~
~~Any use of cannabis can double the risk of schizophrenia in those who are vulnerable, and bring on a first episode up to two and a half years earlier. Use of cannabis at a young age and heavy use of cannabis are associated with up to six times the risk for schizophrenia; especially smoking three or more times per week before the age of fifteen. Cannabis has clearly been shown to make psychotic symptoms worse in people who already have a psychotic disorder such as schizophrenia.~~

~~Along with the traditional high, cannabis use can cause paranoia, delusions and hallucinations in people who don't have a mental illness, *even in small doses*., although drug induced psychosis is *uncommon* and usually resolves with the cessation of marijuana.~~

Predominantly pregnancy and STI risks

Has she ever had 'unwanted' sex / non-consensual sexual experience?

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Date of last unprotected intercourse.

Risk of STIs

Is Jack her first sexual partner? When did they commence sexual activity?

Current use of contraceptives

Has she ever been diagnosed with a STI before?

Has sex has ever been forced upon her. Has she ever felt coerced into having sex?

Discharge, dysuria, fever, rash, painful intercourse, perineal pain and general pelvic pain.

The number of sexual partners in the last 3 months, whether all partners were male and whether condoms were used.

Oral/anal/vaginal sex and whether condoms are used in each type.

For AHPs it might be appropriate for the clinician to ask more general questions such as;

Are you using any form of contraception to avoid pregnancy?

If not, brief exploration of the risks of pregnancy is indicated.

It must be stressed hormonal contraceptives do not protect against sexually transmitted diseases.

Do you mind telling me what contraception you use? How did you decide on this form of contraception? Did you consult with a GP?

Depending on the responses provided, the AHP may then refer the patient to either a GP known to the younger person; and / or to educational resources – appropriate websites. The AHP could write a brief clinical letter to a GP introducing the patient and their reasons for referral / consultation re: contraception.

They have mainly had sex after binge drinking.

For AHPs: Although STIs are not your area of expertise, Angelina has confided information that she has engaged in some low risk behavior in regard to potential acquisition of a STI.

Sexual Boundaries and Consent

IPV

You are concerned that Angelina is a victim of intimate partner violence (IPV). You decide to ask a few questions.

Which two questions would you ask? Pick from the drop down menu.

Has your partner ever physically threatened or hurt you?

Is there a lot of tension in your relationship? How do you resolve arguments?

Sometimes partners react strongly in arguments and use physical force. Is this happening to you?

Are you afraid of your partner? Have you ever been afraid of any partner?

Have you ever felt unsafe in the past?

Violence is very common in the home. I ask a lot of my patients about abuse because no-one should have to live in fear of their partners.

Answer

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Green Questions, however, any of the above questions can be used depending on the patient and clinical context.

Is there a history of coercion to have unprotected sex in a context of consent to sexual activity?

Consider the RACGP nine steps to intervention where IPV is present:

- Role with patients who are experiencing abuse and violence. (GPs are likely to be the first professional contact for survivors of any abuse and violence. This role should be recognized and embraced.)
- Readiness to be open.
- Recognise symptoms of abuse and violence, ask directly and sensitively.
- Respond to disclosures of violence with empathic listening and explore.
- Risk and safety issues – is the patient safe to go home?
- Review the patient for follow-up and support.
- Refer appropriately – be aware of referral services.
- Reflect on our own attitudes and management of abuse and violence.
- Respect for our patients, our colleagues and ourselves is an overarching principle of this sensitive work.

IPV accounts for a very significant proportion of suicide burden and impacts substance use and mental health.

Other notes

Domain 6: Conduct difficulties and Risk Taking

Screening questions

- Have you deliberately harmed or injured yourself – like cutting, burning, or scratching yourself – when not feeling suicidal?
- When did it start? How often? Do you do this to manage stress, emotions, to cope? Have you had to get medical assistance for this?
- Have you put yourself in unsafe situations (e.g. unsafe sex, risky driving)?
- Have you ever wanted to hurt someone else? Have you acted on this? What has stopped you from doing anything?
- Do you often feel out of control (with your behaviour)?

Probing questions

- Many young people get frustrated with others. Have you ever felt like this or acted on your frustrations? How?
- Have you ever thought about or felt like hurting someone else?
- Have you ever done something on the spur of the moment that you later regretted?

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- Do you get in lots of arguments with your family because they have problems with your behaviour?
- Are you in trouble at school? Do you feel picked on by teachers?
- Have you ever been involved with the police? Have you ever been charged?
- Do you belong to a group/gang?

• Do you have any tattoos or body piercings? Where did you get these done? If not at a licensed tattoo parlour or beautician, the young person should be referred to a GP for appropriate STI and Blood Borne Virus tests. See http://www.stipu.nsw.gov.au/icms_docs/117571_GP_STI_Testing_Tool.pdf for information.

Assess risk in a sensitive way. The risks of suicide, self-harm, and exposure to violence are elevated in Aboriginal and Torres Strait Islander young people. Let the young person know you always ask about personal safety with any young person.

It will be important to take a sexual history if possible, including risk assessment (type, frequency, protected / unprotected), any STI symptoms, past screening, and past history.

As an AHP, you can advise Marl that it is good that he is being proactive about seeking screening for STIs. You ask if he practises safe sex in terms of exposure to STIs and also contraception. You might ask if he has ever seen, his doctor (GP) for sexual health check-ups. You explain that he can consult his GP and have simple tests for common STIs that will ensure he is not affected as it is not uncommon to be asymptomatic with some common infections such as Chlamydia. You explain that routine screening may would usually involve tests for common STIs such as Chlamydia, Gonorrhoea, Syphilis, HIV, Hep C and possibly some other conditions. You commend his request for screening and point out that this may save him from embarrassment, guilt or worry down the track.

You would refer Marl to either a GP known to him or a local GP if he does not have a regular doctor; and / or to educational resources – appropriate websites. It would be appropriate to write a brief clinical letter to a GP introducing the patient and their reasons for referral / consultation re: STI screening.

Background information for AHPs

Routine screening would usually involve tests for common STIs such as Chlamydia, Gonorrhoea, Syphilis, HIV, and Hep C. Hep B status should be checked if unknow

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