THE VICTORIAN YOUTH ALCOHOL AND OTHER DRUG SERVICE SYSTEM

A VISION REALISED
Executive Summary

Introduction

Substance misuse and dependence continues to be a leading cause of harm for Victorian young people and their families.

Victoria has an established, youth alcohol and other drug (AOD) service system that works with young people and their families to reduce risk of harm and prevent problems from escalating.

The purpose of this report is to provide policy makers and service planners with a deeper understanding of the Youth AOD service system in Victoria as well as offer recommendations to advance practice within the current system.

Victoria is well positioned to demonstrate leadership in this emerging field by investing in developing an evidence-base that informs the design of effective treatment, early intervention and health promotion initiatives for young people affected by alcohol and drug problems.

Structure

The report has two parts.

Part 1 provides the historical and political context for the establishment of the youth AOD system and a profile of clients engaged in Youth AOD services with data from the State-wide Youth Needs Census (SYNC).

The SYNC study found that:

- Cannabis, Alcohol and Methamphetamine are the primary drugs of concern
- It is very rare for clients under 15 years of age to use drugs other than cannabis and alcohol or to inject drugs
- Clients have extremely high levels of psychological, social, educational, legal, housing and mental health problems
- A very high proportion of clients have experienced abuse and neglect with the reported rate being significantly higher for young women
- Of the 53 cultural groups are represented, young people from Aboriginal and Torres Strait Islander and African and Pacific Islander backgrounds are most commonly represented
On advice of the Premier’s Drug Advisory Council, the Victorian Youth AOD system was established in 1998 with a focus on engaging and maintaining connection with young people experiencing serious substance related harm. Outreach was adopted as the method for delivering specialist AOD treatment services for young people. Outreach also facilitated better linkages for young people to other vital health and community services. The Youth AOD system integrated Day Programs, Residential Withdrawal and Rehabilitation to provide continuous care for young people. This continues to be a defining feature of the youth AOD service system.

Part 1 also explains why there is a need for a differentiated Youth AOD service system. In particular, the economic benefits associated with young people’s AOD treatment is highlighted. There is considerable evidence pointing to the fact that providing AOD services to young people (costs) will reduce economic and social costs of alcohol and substance use in the long term (benefits).

Part 1 also examines the findings of four relevant reviews of the current system. These emphatically support and acknowledge the achievements of the current system but also offer a number of considerations for its improvement. Particular emphasis is on ensuring the system remains well integrated with other youth focussed services and capable of providing continuous care in response to the ongoing needs of young people as they emerge.

Drawing on these reviews and contemporary research findings as well as current policy imperatives in Victoria, Part 2 proposes a ten-point action plan that, if implemented, could further enhance the current system. The rationale and evidence for including each item is provided with a series of recommendations for consideration by policy makers and service planners.

Part 2 also provides a detailed analysis of the Youth AOD needs identification and intervention planning matrix, a resource developed by Youth Support and Advocacy Service (YSAS) and Turning Point. This matrix helps to identify particular cohorts among the adolescent population with different needs and experiences in relation to alcohol and other drugs and thereby requiring differently targeted intervention. This tool could be used to guide the development and implementation of the proposed changes contained in the action plan.

Part 1 and Part 2 are complementary but can also be read and used as stand-alone documents.

There is an overwhelming consensus from across the Youth AOD sector, that in order to further improve client benefits, a collaborative, whole sector and whole-of-government approach is required.

**TEN POINT ACTION PLAN**

1. Prioritise young people that are most at risk
2. Maximise capacity for early intervention
3. Focus on proactive engagement and treatment retention
4. Ensure youth AOD services are fully integrated with other youth and health service systems
5. Create capacity for services to involve families and carers
6. Adopt an evidence-based, trauma-informed care framework
7. Maintain an emphasis on psychosocial stability as the basis of all behaviour change
8. Create options to increase the social and economic participation of youth AOD clients
9. Build capacity to identify and respond to emerging AOD related needs in youth populations
10. Incorporate the participation of young people and families in developing and maintaining high quality services
What services are available under the current system?
The Youth AOD service system is multifaceted and the diverse range of services mean clients can be offered continuity of care.

The current State funded Youth AOD system in Victoria comprises a range of integrated service types including:

1. **Outreach** as a flexible and responsive medium for connecting with and delivering evidence-based interventions and broader support to hard to reach groups. Outreach also constitutes a critical mechanism for linking and coordinating activities across related services and sectors including youth homelessness, Criminal Justice, Child Protection, education and employment and mental health.

2. **Counselling, consultancy and continuing care** services for young people that provide them with evidence-based therapeutic interventions in a clinical setting. Counselling is generally provided on a weekly basis to young people and families where appropriate. AOD related secondary consultation and support is provided to non-specialist services encountering AOD related issues.

3. **Community Youth Residential Withdrawal Services and Home-Based Withdrawal** as viable options that allows young people to access medically supervised withdrawal, to stabilise and to connect with a range of pro-social and helpful others, including community services and health professionals.

4. **Day programs** that provide safe, stimulating and flexible environments that young people may access in their own time and to the extent that they desire. Day programs boost the capacity of Outreach services to attract young people and provide primary health care for young people and offer programs and social enterprises that facilitate greater social and economic participation.

5. **Residential Rehabilitation and Supported Accommodation** that provide a ‘step up’ option from both Outreach and CYRWS to provide the Youth AOD service system with the capacity to offer better continuity of care for clients. Supported accommodation provides rehabilitation in the community or a ‘step-down’ from residential rehabilitation into a less structured, community-based setting.

6. **Online and telephone counselling and support** that increases the accessibility and efficiency of the service system in reaching and supporting young people who are concerned about their own or someone else’s substance use. Young people can be linked to more intensive support if appropriate.

**BACKGROUND**

Victoria is the only Australian State with a comprehensive and fully integrated Youth AOD service system. It was established in 1998 on the recommendation of the Premier’s Drug Advisory Council (PDAC). Chaired by Professor David Penington and comprising an expert panel, PDAC was convened to advise the Victorian Government on how the State’s illicit drug problem should be addressed.

Due largely to a fragmented and inaccessible service system, the AOD service system was not adequately engaging and retaining young people with substance abuse and related problems. To this end, PDAC identified engagement and treatment retention as imperatives for Youth AOD services. PDAC recommended Outreach as the primary Youth AOD service type as it allowed agencies to be proactive in making contact with young people in need and taking services to them. PDAC also recommended that Outreach services be integrated with “intensive supportive care”, provided in a residential setting. On this advice, Community Youth Residential Withdrawal Services (CYRWS) were established. CYRWS offered young people a safe, secure and age appropriate environment to stabilise, withdraw from substances and establish a healthier developmental pathway.

The implementation of the new Victorian AOD service system saw an immediate and sharp increase in the number of young people being assisted and the proportion represented in the overall AOD treatment population. For example, in 1997/8, the State government Alcohol and Drug Information System revealed that 9% of service users were 21 or under, whereas in the following year, with the establishment of the Youth AOD service system this figure grew to 26%.

**WHAT ARE THE AIMS OF THE VICTORIAN YOUTH AOD SERVICE SYSTEM?**

The Victorian Youth AOD service system aims to address the impact of harmful substance use on young people’s:

- Safety, health and well-being
- Capacity to meet their needs, fulfil their aspirations and cope with life stressors
- Development and future prospects

Youth AOD services seek to reduce the risk of immediate harm from substance use and enable young people to find constructive alternatives to substance use as a way of managing in life.

**What services are available under the current system?**

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6. **Online and telephone counselling and support** that increases the accessibility and efficiency of the service system in reaching and supporting young people who are concerned about their own or someone else’s substance use. Young people can be linked to more intensive support if appropriate.
7. A range of **Specialist Youth AOD programs** that are targeted at particular groups of young people in order to meet needs that are specific and unique to those groups or as a means of delivering specialist interventions provided by practitioners with specific expertise not possessed by the mainstream workforce (e.g. medical care, specialist mental health nursing). Not all specialist programs are provided systematically across Victoria and not all are State government funded.

**EXAMPLES OF INNOVATIVE SPECIALIST YOUTH AOD PROGRAMS**

- Alcohol and Drug Youth Consultants working with State Out of Home Care services
- Rural Outreach Diversion services
- Programs for young parents with AOD problems
- Outdoor Adventure Therapy programs
- Dual Diagnosis programs focussing on young people with coexisting mental health and drug and alcohol problems
- Family Alcohol and Other Drug Counselling programs
- The Building Resilience in Community Schools program providing a range of AOD services for students and families as well as secondary consultation and staff professional development
- Assertive Outreach programs targeting refugees and newly arrived communities

While all of these service types are available for young people and families, there is a discrete, specifically designed service system in place for young people and families from Aboriginal and Torres Strait Islander backgrounds (ATSI).

Pharmacotherapy is also available for young people where appropriate but is not a youth specific service. Further, formal and structured peer-support and self-help programs such as Alcoholics Anonymous, Narcotics Anonymous and NarcAnon (for the partners, families and friends of substance users) are available. These options are not government funded but provide high levels of mutual support, social contact and understanding between members.

**WHO ARE THE CLIENTS OF THE VICTORIAN YOUTH AOD SERVICE SYSTEM?**

The ‘State-wide Youth Needs Census’ (SYNC) provides contemporary data on the clients of Youth AOD services from Victoria. It provides a descriptive analysis of surveys completed for 1,000 young people aged 8-27 who were registered clients of specialist Youth AOD treatment services on June 6, 2013. The survey incorporated questions from relevant validated questionnaires that enabled the severity of clients AOD use to be measured together with the interrelated factors that create life complexity and vulnerability. As the census is a snapshot in time, young clients were at differing points in their continuous course of treatment when it was completed.

The SYNC study findings are commensurate with the findings of four other important Australian studies that have examined the co-occurrence of substance misuse with other psychosocial problems from the perspective of young people attending AOD services (see Appendix 1). A summary of the methodological features of these studies as well as data on indicators of both AOD severity and psychosocial complexity that corresponds with the SYNC study is included at Appendix 2.

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SUMMARY OF THE KEY COMPONENTS OF SYNC

Substance use

- The substances that were used most in the four weeks prior to the survey were cannabis (64%) and alcohol (63%). However, cannabis was more likely to be used on a daily basis (48%) and be the primary drug of concern (38%);
- Twenty per cent of young people engaged in daily use of alcohol and this was the primary drug of concern in treatment for 22% of Youth AOD clients;
- Methamphetamine was the primary drug of concern in treatment for 26% of clients, a figure much higher than for the rate of daily use (13%); and
- Heroin was used by 7% and it was the primary drug of concern in treatment for 4.5% of Youth AOD clients. Heroin users experienced the highest rates of substance use severity and psychosocial complexity when compared to those who used other substances.

Figure 1: Percentage of clients who used each drug in the last 4 weeks, used daily or almost daily, and primary drug of concern

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Drugs used in the past 4 weeks</th>
<th>Drug used daily or almost daily</th>
<th>Primary drug of concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>64%</td>
<td>48%</td>
<td>38%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>63%</td>
<td>20%</td>
<td>22%</td>
</tr>
<tr>
<td>Meth/amphetamine</td>
<td>35%</td>
<td>13%</td>
<td>26%</td>
</tr>
<tr>
<td>Heroin</td>
<td>7.1%</td>
<td>2.9%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Tobacco</td>
<td>52%</td>
<td>41%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

On all indicators of substance use severity (see Figure 2), Youth AOD clients far exceed young people of the same age from the general population.3

Figure 2: Percentage of clients who met the criteria for each substance use severity indicator.

<table>
<thead>
<tr>
<th>Severity indicator</th>
<th>Definition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily drug use</td>
<td>Any drug used daily or almost daily (excluding tobacco)</td>
<td>66%</td>
</tr>
<tr>
<td>Dependence</td>
<td>Worker rating of dependence (yes/no)</td>
<td>54%</td>
</tr>
<tr>
<td>Drug use harms</td>
<td>Experienced serious drug related harms in the last 3 months</td>
<td>39%</td>
</tr>
<tr>
<td>Multiple drug use</td>
<td>Used 3 or more drugs in the last 4 weeks or used 2 or more drugs in the last 4 weeks and 15 years of age and younger (excluding tobacco)</td>
<td>34%</td>
</tr>
<tr>
<td>Intravenous drug use</td>
<td>Ever used a drug by injection</td>
<td>22%</td>
</tr>
<tr>
<td>Illicit drug use</td>
<td>Used any drug in the last 4 weeks if 17 years and younger or used any illicit drug in the last 4 weeks if 18 years and older (excluding tobacco)</td>
<td>79%</td>
</tr>
</tbody>
</table>

Level of psychosocial complexity

Young people attending AOD services have extremely high levels of psychological, social, educational, legal, housing and mental health problems. Sixty six per cent have Criminal Justice system involvement. 67% have experienced abuse and neglect and 61% have significant family problems. These are referred to as ‘complexity factors’. The presence of 4 to 9 factors was coded as ‘Severe’ (613 clients), 2 or 3 factors was classified as ‘High’ (271 clients), 1 factor as ‘Low’ (86 clients) and no factors or typical as ‘None’ (30 clients). The majority of clients (61%) had 4 or more of these serious psychosocial problems.

Figure 3: Percentage of clients who currently or have in the past experienced complexity factors.

<table>
<thead>
<tr>
<th>Complexity factor</th>
<th>Definition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Justice issues</td>
<td>Criminal activity in the last 4 weeks or ever involved in the Criminal Justice system</td>
<td>66%</td>
</tr>
<tr>
<td>Abuse or neglect</td>
<td>Ever experienced neglect, physical, emotional or sexual abuse or been a victim of crime or ever involved in the child protection system</td>
<td>67%</td>
</tr>
<tr>
<td>Family issues</td>
<td>Conflict with family or relatives in the last 4 weeks or disconnected with family or relatives</td>
<td>61%</td>
</tr>
<tr>
<td>Problems at school</td>
<td>Ever suspended, expelled or disruptive behaviour at school</td>
<td>51%</td>
</tr>
<tr>
<td>No meaningful daily activity</td>
<td>Not currently employed or not at school</td>
<td>46%</td>
</tr>
<tr>
<td>Suicide or self-harm</td>
<td>Ever attempted suicide or self-harmed</td>
<td>43%</td>
</tr>
<tr>
<td>Housing instability</td>
<td>Acute housing problems in the last 4 weeks</td>
<td>19%</td>
</tr>
<tr>
<td>Mental health</td>
<td>Current mental health diagnosis</td>
<td>35%</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>Based on the ATOP (Australian Treatment Outcomes Profile) score between 0 and 4 (poor)</td>
<td>32%</td>
</tr>
</tbody>
</table>

Drug use severity and level of psychosocial complexity

Cross-referencing degree of substance use severity with level of psychosocial complexity reveals that the majority of Youth AOD clients (69%) experience high levels of both simultaneously.

Figure 4. Percentage of total sample in each quadrant of Youth Support and Advocacy Service categories of severity and complexity (N = 1,000).

It is compelling that 331 clients (33.1%) were found to have 4 or more indicators of substance use severity and psychosocial complexity (see Figure 4). When compared to all other clients, this extremely vulnerable population:

- Were more likely to use meth/amphetamine (35% vs. 22%) and heroin and other opiates (13% vs. 2%)
- Were less likely to have alcohol and cannabis as their primary drug of concern (alcohol 10% vs. 29% / cannabis 35% vs. 41%)
- Had significantly lower scores on physical health, psychological health and quality of life when compared to all other clients
- Were more likely to be engaged in Outreach services and withdrawal services (residential and outpatient or home-based) and were less likely to be engaged in centre-based counselling programs.
Figure 5: Percentage of clients within each severity and complexity cross-tabulated classification. (Multiply by 10 to gain number of clients, N = 1000).

<table>
<thead>
<tr>
<th>Drug use severity</th>
<th>Severe</th>
<th>Low</th>
<th>High</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.3%</td>
<td>0.6%</td>
<td>6.2%</td>
<td>33.1%</td>
<td></td>
</tr>
<tr>
<td>1.3%</td>
<td>3.6%</td>
<td>10.4%</td>
<td>19.3%</td>
<td></td>
</tr>
<tr>
<td>0.4%</td>
<td>2.2%</td>
<td>6.2%</td>
<td>5.2%</td>
<td></td>
</tr>
<tr>
<td>1.0%</td>
<td>2.2%</td>
<td>4.3%</td>
<td>3.7%</td>
<td></td>
</tr>
</tbody>
</table>

Psychosocial complexity

Differences according to age and gender

Client age had a significant influence on substance use severity. Alcohol and cannabis were far more likely to be the primary drug of concern in treatment for the youngest age cohort (15 years of age and under). This cohort also had lower rates of multiple substance use or injecting. Methamphetamine and heroin were rarely used and featured more in the substance use patterns of the older cohorts. While the younger cohort had almost equally high levels of psychosocial complexity as older clients they were more likely to live with their family and be involved with education.

Gender was a significant factor in differences in level of psychosocial complexity but not substance use severity. The prevalence of psychosocial problems such as homelessness, poor psychological and physical health, self-injury and family disconnection were significantly higher for young women. Criminal Justice system involvement and/or offending were the only issues more prevalent among male clients.

High levels of abuse and neglect

For all clients, the level of both past and present abuse and neglect was at an extremely high level (64%) and associated with both increased severity of substance use problems and higher levels of psychosocial complexity for these clients. The rate of abuse and neglect among young women (77%) was extreme, which may be associated with the increased level of psychosocial complexity among female clients.

Cultural diversity

There were fifty-three cultural groups represented. The three largest culturally and linguistically diverse/ATSI groups were: ATSI (8%), young people from African cultures (5%) and Pacific Islander or Maori young people (5%). The service type through which these groups were most likely to be engaged was Outreach and there were very low levels of involvement in the counselling service type.

Related areas of unmet need

There were four areas of need that were most identified as being unmet by services. These were:

- Assistance with family relationships
- Finding employment
- Engagement in education
- Addressing mental health issues (unmet mental health need was greater among clients from rural areas)

Patterns treatment involvement

The length of current involvement in treatment was found to increase with substance use severity and level of psychosocial complexity. Also, Youth AOD clients with the highest level of substance use severity and the highest level of psychosocial complexity are considerably more likely to return to treatment.

Structured withdrawal programs, both residential and non-residential, had on average the youngest clients and those most early in their current course of treatment (average 3.6 weeks). This suggests that participation in structured withdrawal programs might act as a gateway into services and facilitate early treatment engagement.

Why is there a need for youth specific AOD treatment services?

Substance misuse and dependence is the most common and potentially harmful of all complex issues faced by young people in Victoria. There is strong evidence that an investment in alcohol and drug prevention, early intervention and treatment at the local level can modify the risks to young people and protect the health and well-being of families and communities.

There is also strong evidence that tailoring services to meet individual needs or subgroup characteristics not only positively influences treatment outcomes but also the likelihood of treatment involvement and retention\(^4\). The Victorian Drug Policy Expert Committee (2004) and the State Government commissioned Youth Service System Review\(^5\) both endorsed the

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continued need for a specialised and discrete youth AOD service system response for Victorian young people and their families. This is line with research confirming that adolescents with AOD and other psychosocial difficulties are best served by services that are developmentally appropriate.6 10 14 15

Merely being ‘adolescent specific’ does not guarantee developmentally appropriate service provision. A sophisticated approach demands the deliberate use of strategies that are tailored to the requirements of young people at particular developmental stages. It also takes account of the changing needs of young people as they develop over time.

THE FIVE KEY REASONS FOR A DIFFERENTIATED YOUTH AOD SERVICE SYSTEM

1. AOD problems more prevalent and dangerous during adolescence

Problems with alcohol and other drugs are both more prevalent and more dangerous in adolescence and early adulthood than they are in later adulthood. Among young people, overdoses of alcohol and other drugs compete with road crashes as leading causes of death, and the contribution of AOD intoxication and misuse to suicide, homicide, injuries, and poisoning is well established.14 15 In addition, adolescents who enter the transition to adulthood with problematic substance use are more likely than others to demonstrate negative outcomes in young adulthood such as elevated levels of drug use, lower educational and occupational attainment and higher levels of aggressive and violent behaviour.15

2. Adolescence is the key developmental period for the emergence of substance use problems

Adolescence is the key developmental period for the emergence of substance use disorders (SUD) and problems. While SUD are rarely seen in children under 12, there is a sharp increase in the prevalence from ages 12 to 18.13 Further, people who develop SUD in adolescence are more likely to have those symptoms continue into adulthood. It could be argued that based on prevalence alone, adolescents and young adults warrant larger numbers of AOD treatment places per head of population than other age groups.

3. Intervention at the earliest possible time produces better health outcomes

The earlier young people developing a SUD can be engaged and retained in treatment, the more likely it is that a healthy and constructive developmental pathway can be established or restored. This requires working not only with the young person but also others involved with their care and their social networks.

4. Potential for exploitation and antisocial modelling in the adult AOD system

The World Youth Report found that young people with drug problems were often placed in adult programs even though developmental, psychological, social, cognitive and family differences suggest the need for specialised treatment. The Victorian Drug Policy Expert Committee (2000) was explicitly concerned about the risks involved with combining adults and young people together in AOD treatment. They reported that young people have particular needs that often mean placing them in a drug treatment service targeted at adults can have a detrimental effect and deter them from seeking out other treatment options. There is also the danger of exposing young people to more entrenched drug use if they are placed in an adult service. The potential for anti-social role-modelling and the exploitation of young people by adult AOD clients is greatly heightened in residential environments and/or intensive therapeutic programs.
5. Cost effectiveness

A recent cost benefit analysis commissioned by the department of education in the UK found that specialist drug and alcohol services for young people proved to be an extremely cost effective option. This study demonstrates that significant social and economic gains can be returned to society when early intervention is prioritised. The report concluded:

“How is Youth AOD treatment different from Adult AOD treatment?”

The fundamental differences between youth specific AOD services and adult AOD services are:

1. Youth AOD services have more of a multi-systemic focus, endeavouring to create healthy connections for young people within families, schools and communities that are vital to promoting constructive development. Disruption or disturbance of processes that link individuals into these systems is actively addressed so as to prevent progression of AOD related problems.

2. Youth AOD services are embedded within youth specific service systems including Youth Justice, youth homelessness, youth mental health, Child Protection and secure welfare, local Government youth services and the Primary and Secondary school system. Specific knowledge of how different youth specific programs and services operate and establishing networks within them is vital in facilitating the achievement of young people’s treatment goals.

3. Youth AOD services are focused entirely on being appealing and accessible for young people promoting the potential for treatment engagement and retention. This includes:
   - Setting up youth friendly waiting areas and program spaces
   - Proactive collaboration with referring agencies and practitioners from the youth health and community services
   - Limiting complex intake processes and being able to make a useful response to issues of most pressing concern for the young person and/or their family (including responding to crisis in a timely way)
   - Having the flexibility to engage young people in the places that they congregate and feel comfortable
   - Using Outreach as a vehicle has a far greater capacity for assertive follow up and to be able to deliver services in a range of contexts including other agencies, their home or in a range of community settings
   - Youth AOD services are sensitive to the developmental needs of clients. This includes:
     - Taking account of the unique statutory provisions applying to children and young people (i.e. duty of care and consent, status as a minor, unique Youth Justice and Child Protection systems)
     - An active approach that is behavioural and experiential rather than being based on counselling

The UK Youth AOD service system prior to 2010 was very similar to the Victoria in that it offered young people “a care planned medical, psychosocial or specialist harm reduction intervention”. Further, the characteristics of clients in the system were also similar in that young people were mainly treated for alcohol (37%) or cannabis (53%) misuse, with the remaining 10% misusing ‘Class A’ drugs such as heroin and crack. Like Victorian Youth AOD clients they also experienced a range of other problems including involvement in crime (shoplifting, theft, assault), housing instability and not being in education, employment or training.

The return on investment comprises short-term savings in crime and health costs as well as long-term reductions in the costs associated with adult dependency, including the prospects of education and employment.

“Overall, the study has shown that the immediate and long-term benefits of specialist substance misuse treatment for young people are likely to significantly outweigh the cost of providing this treatment. In particular, we have estimated a benefit of £4.66 - £8.38 for every £1 spent on young people’s drug and alcohol treatment.”
- Combining treatment with experiences that promote progress towards achieving developmental tasks such as exploring their social and vocational identity, developing life skills, practicing contingency planning and learning to make mature judgments
- Undertaking developmentally targeted risk assessment and management

**HOW HAS THE CURRENT VICTORIA YOUTH AOD SYSTEM BEEN EVALUATED?**

Three reviews have been conducted on behalf of the State Government to evaluate the Youth AOD service system since its inception in 1998. More recently, the previous State Government commissioned a Youth Cohort study. This study investigated young people’s pathways through and experience of Youth AOD treatment services. An overview and the key findings of the three reviews and the Youth Cohort study are provided below.

1. **Youth AOD Outreach in Victoria (1999)**

The first review was of the then newly established ‘Youth AOD Outreach’ service type. Outreach services were the first to become operational and represented an innovative response to young people’s AOD issues. The State Government wanted this approach better articulated and tested for effectiveness.

**Key Findings**
- Relationships with youth, welfare and accommodation services were of high quality
- Service delivery was highly responsive and flexible
- The management of confidentiality and family tensions was especially valued
- Professional advice and secondary consultation by the services was valued by a wide range of other service providers
- Some services were taking a lead in establishing recreation and other youth program activities for young people, particularly in areas that lacked these programs
- The services had articulated and developed effective strategies for pre- and post-withdrawal support to young people


The second review conducted by the Victorian Drug Policy Expert Committee was part of a broader evaluation into the effectiveness of the reforms based on the recommendations of PDAC from five years earlier. The Victorian Drug Policy Expert Committee reported that other State jurisdictions were emulating innovative, youth-specific models of practice developed in Victoria and recommended that an expert group be convened to continue the development of the best model of care for young problematic substance users, and set criteria to assess the relevance of services to the target group. This recommendation was not implemented.

**Key findings pertaining to Youth AOD clients and services**
- There was a rapid increase in the number of young people accessing AOD treatment
- The degree of dependence among a significant number of young people was underestimated. The severity of dependence, the involvement of family and the need for time away from a set of particular social or geographic settings were flagged in consultations
- For some young people, it may be important to keep them outside the drug treatment service system, which can further expose them to drugs and drug-using careers
- Young people have particular needs that often mean placing them in a drug treatment service targeted at adults can have a detrimental effect. The danger of exposing young people to more entrenched drug use was identified
- Many young people who are using drugs will need other services and might not identify themselves as having a drug problem
- Youth AOD Outreach is accessible and has an important referral and linkage role as workers connect with young people with a range of problems
- The model of care for young people with problematic substance use should be integrated with other youth focussed services and systems such as generic youth Outreach services, youth suicide prevention, mental health, crime prevention and education (school nurse programs and student welfare)
- Sources of funding should be explored with an eye to shared arrangements with other youth focussed service systems

The ‘Youth Service System Review’\textsuperscript{20}, conducted by Turning Point Alcohol and Drug Centre is the most comprehensive and rigorous analysis of the Youth AOD service system in Victoria.

**Key findings**

- The need for a discrete, youth specific AOD treatment response to the needs of Victorian young people and families was confirmed
- More investment could be made in ‘indicated prevention’, targeted at young people who are at risk of developing, but have not yet developed AOD problems
- The key features of the youth-specific AOD treatment response in Victoria that could be improved were:
  - Relationship-based service delivery
  - Treatment flexibility and responsiveness according to the ongoing needs of young people
  - Harm minimisation/reduction approach
  - A “youth friendly” environment
  - A holistic response/continuity of care
  - Core business covers indicated prevention and treatment
  - Outreach as unique service type

4. The Youth Cohort Study (2012)

The Victorian Department of Health (DOH) commissioned Turning Point Alcohol and Drug Centre to undertake a cohort study based on the experiences of young people engaging in AOD treatment in Melbourne, Victoria\textsuperscript{21}.

Overall the aims of the study were to outline the profile of young people accessing specialist AOD Youth services and to assess the configuration of services that they accessed in and out of the AOD system. Their service experiences were mapped over time and their treatment pathways linked to changes both in AOD use and wider measures of wellbeing and life functioning. This involved observing indicators of psychological, behavioural and environmental change over time in relation to patterns of substance use.

**Key findings**

- The study confirmed that young people in Youth AOD treatment services typically experienced a wide range of problems, with high levels of substance dependence, poly-drug use, psychiatric diagnoses (including histories of self-harm and suicide attempts), low levels of social and family engagement, involvement with the Criminal Justice system and considerable domestic stability
- The study found that this group:
  - Engaged well in specialist Youth AOD treatment services
  - Highly valued their relationships with Youth AOD workers
  - Achieved overall positive changes in a range of markers of substance use severity and risk and in wider life domains over the 18 months of the study
  - While the majority of young people benefited and made positive changes, close to one in eight did not improve or substance use problems continued to escalate. This group, among them entrenched injectors, had ongoing issues with social functioning and family relationships, as well as low levels of engagement in meaningful activities
- Young people were found to develop strong meaningful relationships with AOD workers and their commitment to these relationships is evidenced by their dissatisfaction when the therapeutic alliance is ended by the worker
- Relatively few ‘desisters’ stopped all substance use and risk behaviours over the window of the study. This is attributed to the complexities of the population who invariably had a troubled history and multiple disadvantage and pathology at the start of the process


• Resolution or amelioration of problems rest with creating the stability and foundations for addressing complex issues and problems. CRYWS (identified in the study as inpatient detoxification) is seen as valuable and to be recommended, not least because it provides the respite and space young people may feel they need.

• The study also found that there is considerable evidence for the need of differentiated screening and assessment processes as well as more effective joint working and continuity of care across service domains.”

Summary
Part 1 of this report highlights several key components of the current Youth AOD service system in Victoria. While Victoria is considered a leader in this field there are a number of opportunities to enhance the system. Part 2 provides policy makers and service planners with a series of recommendations to further improve the system.
PART 2 THE NEXT GENERATION OF YOUTH ALCOHOL AND OTHER DRUG SERVICES IN VICTORIA

THE CURRENT POLICY CONTEXT IN VICTORIA

Beginning in 2012, the Victorian Government, through the Department of Health (DOH) and the Department of Human Services (DHS), undertook significant reforms in the way that services are funded and delivered. Many of these changes pertain to Victoria’s most disadvantaged and vulnerable children and young people, including those affected by serious substance use problems. They include changes to key program areas such as alcohol and drug treatment services, mental health services and out-of-home-care services. These changes have influenced the ways that these and other sectors work together. The relevant policies include:

1. New Directions for Alcohol and Drug Treatment Services – A Roadmap (DOH)
2. Victoria’s priorities for mental health reform 2013-15 (DOH)
3. Service Sector Reform (DHS)
4. Services Connect (DHS)
5. Victoria’s Vulnerable Children - Our Shared Responsibility (DHS)

New Directions for Alcohol and Drug Treatment Services – A Roadmap (the Roadmap) is most relevant to the Youth AOD service system. This roadmap articulates a clear set of principles and desired features of the Youth AOD service system (see Appendix 3). It is commensurate with the key directions being articulated from within the sector as well as from the reviews outlined in Part 1. These principles and features are incorporated into the Action Plan.

These directions advocate that the Youth AOD service system needs to be more:

- **Integrated** across different program areas within DHS and across sectors such as health, education and Criminal Justice
- **Person-centred and individualised** in the sense that services are organised around and tailored to the holistic individual needs of clients and families, and that clients are actively involved in decision-making
- **Family inclusive**, focused or sensitive in the sense of being responsive to family context and circumstances
- **Early intervention capable** in terms of being able to respond earlier in the course of development of emerging issues
- **Accessible** and easier to navigate by streamlining and simplifying access to services and better managing service pathways
- **Outcomes-focused and evidence-based** through the measurement, monitoring and reporting of client outcomes, evaluation and translating findings from research into practice
- **Productive and sustainable** in terms of the use of available resources

The Youth AOD needs identification and intervention planning matrix

Young people and their families encounter alcohol and drug use in different ways. Consumption rates, usage patterns, degree of harm experienced and impact on health and development vary widely. As such, an effective whole-of-population response has to be multifaceted, targeting specific cohorts of young people within the broader population and matching alcohol and drug interventions to their particular alcohol and drug related needs and issues.

International demand modelling research\(^22\) considers in populations both the severity of substance use issues alongside the degree of psychosocial complexity identified.

**Identifying substance use severity and psychosocial complexity in Victoria’s adolescent population**

To properly identify substance use severity in an adolescent population, six indicators have been identified (see Figure 7). Substance dependence is incorporated as it is the sole marker in previous demand modelling research\(^23\) in the addictions field. To correctly identify substance use severity for adolescents, other indicators have been added according to developmental work undertaken by Turning Point and YSAS on the Youth Cohort Study\(^24\) and in the YSAS client census pilot.\(^25\)

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Figure 7: Severity of Substance use definition and criteria.

<table>
<thead>
<tr>
<th>Daily drug use</th>
<th>• Any drug used daily or almost daily (Excluding tobacco)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependence</td>
<td>• Worker rating of dependence</td>
</tr>
<tr>
<td>Drug use harms</td>
<td>• Serious drug related harms (Last 3 months)</td>
</tr>
<tr>
<td></td>
<td>• Harmful binge style pattern of use (Last 1 month)</td>
</tr>
<tr>
<td>Multi drug use</td>
<td>• Used 3 or more drugs in last 4 weeks OR</td>
</tr>
<tr>
<td></td>
<td>• Used 2 or more drugs in last 4 weeks and 15 years or younger</td>
</tr>
<tr>
<td>IV use</td>
<td>• Ever used a drug by injection</td>
</tr>
<tr>
<td>Illicit Drug use</td>
<td>• Used any drug in the last 4 weeks if 17 years and younger (excluding tobacco).</td>
</tr>
<tr>
<td></td>
<td>• OR, used any illicit drug in the last 4 weeks if 18 years and older.</td>
</tr>
</tbody>
</table>

One point is assigned for the presence of each indicator (if present), then summed, and re-categorised. A score of 0 was coded as ‘None’, 1 as ‘Low’, 2 or 3 as ‘High’, and 4 to 6 as ‘Severe’.

When determining severity, developmental vulnerability is also considered. For example, daily or almost daily use of a substance by a 13-year old is considered more severe than that for a 21-year old. As such additional points are assigned, where appropriate.

YSAS and Turning Point also identify nine indicators of psychosocial complexity. As with substance use severity, a composite score for complexity was calculated by assigning one point to each indicator (if present), then summed, and re-categorised. A score of 0 was coded as ‘Typical’, 1 as ‘Additional’, 2 or 3 as ‘High’, and 4 to 9 as ‘Severe’. No additional points were assigned for developmental vulnerability.
THE YOUTH AOD NEEDS IDENTIFICATION AND INTERVENTION PLANNING MATRIX

Drawing on this, YSAS and Turning Point have developed a way of identifying particular cohorts among the adolescent population by cross referencing the level of substance use severity and the degree of psychosocial complexity experienced. This forms the Youth AOD needs and identification and intervention planning matrix ('the matrix') (see Figure 9). The matrix allows policy makers and service planners to identify increasing levels of risk and actual harm associated with particular populations and in turn to develop better-targeted responses.

The matrix organises young people into 6 cohorts each with particular needs and characteristics that service planners and policy makers can consider in designing a well-rounded and responsive Youth AOD service system.

Figure 8: Complexity of psychosocial issues: definition and criteria.

- 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 or 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
  - Score between 0 and 4
The vertical axis of the matrix maps the four levels of AOD severity including a category indicating no severity. The horizontal axis maps psychosocial complexity spanning from a level that is ‘typically’ expected for the age group to extreme complexity where four or more problems (such as homelessness, mental illness, family conflict and disconnection, Criminal Justice system involvement etc.) are impacting on the young person concurrently.

SIX COHORTS WITH REQUIRING A TARGETED AOD RESPONSE

Cohort 1: Young people experiencing high to severe AOD problems interrelated with high to extreme psychosocial complexity. These young people are expected to need interventions that simultaneously address the interrelated AOD problems and complex psychosocial issues that they experience.

Cohort 2: Young people whose lives feature high to extreme psychosocial complexity but with low level or emerging AOD use. These young people are expected to be younger but at serious risk of AOD problems developing and escalating. Early intervention would be required to prevent transition to entrenched and harmful substance use.

Cohort 3: Young people with a high or severe level AOD problem combined with an indicator of additional psychosocial complexity. These young people are expected to have stable living circumstances and connection with family, school and/or employment. Specific AOD intervention is required and possibly early intervention to maintain connectedness and participation and to prevent further psychosocial complexity and transition to cohort 1.

Cohort 4: Young people who are not using substances but experiencing high to extreme levels of psychosocial complexity putting them at high risk of developing AOD problems. This group is suitable for ‘indicated’ prevention involving mentoring, reinforcement of engagement in constructive activity and challenging the normalisation of substance use.

Cohort 5: Young people who are likely to be family, school and/or work connected and undergoing typical adolescent transition but engaged in occasional intensive AOD use such as binge use of alcohol and/or amphetamine type stimulants. These young people are anticipated to need targeted approaches based on moderating risk and enabling parents to set more effective limits around the substance using behavior. These interventions fall into the category of selective prevention.

Cohort 6: The majority of young people in communities across Victoria will be in this cohort. These young people are expected to have an age typical relationship with AOD use and low exposure to risk factors for problematic substance use. Universal prevention strategies are expected to be sufficient for this group. Universal prevention interventions are directed at whole populations that have not been identified on the basis of risk and are aimed at improving the overall health and resilience of a population. Programs are often targeted at building community connectedness in local neighbourhoods and the delivery of age appropriate education programs.
The current Victorian Youth AOD service system provides treatment and direct care for cohort 1, 2 and 3. Even so, young people in cohort 2 are particularly under serviced given that psychosocial problems that they experience are known determinants of substance misuse and dependence. This makes them a suitable target for early intervention.

Young people in cohort 5 use substances intensively but aren’t experiencing any psychosocial issues and consequently do not seek treatment and are not engaged by the system. Youth AOD treatment services also do not target young people in the cohorts 4 and 6 as they are not using or only using substances at low levels and should be targeted by effective AOD prevention initiatives.

Government has not formally validated the matrix but it does have widespread sector endorsement. Given its functionality, it has the capacity to become the primary tool for service development and provision across both the Government and the Youth AOD sector.

**THE TEN POINT PLAN**

The key principles outlined in the ten-point action plan concentrate on refining, evolving and building on the current Youth AOD service system model in Victoria. The plan aims to keep pace with changes and demands as well as foster innovation and best practice.

The action plan draws on:

- The New Directions for Alcohol and Drug Treatment Services - A roadmap
- Recommendations from the reviews outlined in Part 1 - A Vision Realised: Victoria’s Youth Alcohol and Other Drug Service System

1. **Prioritise young people that are most at risk**

   Young people who are most at risk experience the highest levels of substance use severity and psychosocial complexity. It is vital that both are addressed simultaneously if positive outcomes are to be achieved. This means addressing substance use and mental health problems, engagement in criminal behaviour, homelessness and a range of other issues that severely limit the social and economic participation in community life.

   An effective Youth AOD service system, collaborating with other relevant youth services, can mitigate the extreme cost of the criminal activity and adverse health outcomes associated with problematic substance use in the short and long term. This benefits individuals and families, local communities and has significant economic value.

   There is an opportunity to build on the effectiveness of the current Youth AOD service system in engaging and enabling this most at risk population of young people to stabilise and make positive changes.

   **Evidence**

   - Reviews indicate that the intensity of an intervention needs to match the severity of problems and the risks faced by the individual\(^{26, 27}\).
   - The Victorian Youth AOD service system enables an extremely complex client group to achieve positive changes overall in a range of markers of substance use severity and risk and in wider life domains\(^{28}\).
   - The Youth Cohort study identified entrenched injectors as a particularly vulnerable group that had ongoing issues with social functioning and family relationships as well as low


levels of engagement in meaningful activities
  • A strong correlation was found between substance use severity and level of psychosocial complexity29
  • A recent cost benefit analysis by the ‘Home Office’ in the UK30 examined the role specialist, youth drug and alcohol services in mitigating criminal activity and adverse health outcomes associated with short and long term substance misuse. The immediate and long-term impacts for potential clients, their families and the community were considered and specialist drug and alcohol services for young people proved to be an extremely cost effective option
  • The World Youth Report31 delineated between those young substance users who are mainstream as compared to those who are ‘especially vulnerable’. The investigation in substance use patterns of young people found that the ‘especially vulnerable’ group is strongly linked to coping with difficult life circumstances. Especially vulnerable young people were found to greatly benefit from Outreach, case management or more intensive treatment based on sound assessment
  • Resolution or amelioration of problems rest with creating the stability and foundations for addressing complex issues and problems. Community Youth Residential Withdrawal Services (CRYWS) are seen as valuable and to be recommended, not least because they provide the respite and space young people may feel they need32.

Recommendations
The Youth AOD service system in Victoria should:
1. Have sufficient capacity to be able to simultaneously address substance use problems and the complex psychosocial issues that act as determinants for substance use problems.
2. Develop more accurate and useful screening and assessment processes to identify and plan to adequately address the needs of the most at risk client group.
3. Retain and enhance Outreach as an effective method of delivering interventions and providing continuous care to youth AOD clients that are most at risk.
4. Retain and enhance youth-specific residential withdrawal and intensive programming that enable clients to create stable foundations to address complex problems.
5. Further integrate with other youth-focussed service systems capable of addressing complex psychosocial issues.

2. Maximise capacity for early intervention
In addition to quality treatment services, there is strong evidence that an investment in AOD early intervention at the local level can modify the risks to young people and protect the health and wellbeing of families and communities.

Early intervention refers to interventions targeting people displaying the early or emerging signs and symptoms of drug and alcohol problem developing. This requires the early identification of these young people to enable a timely, effective and appropriate response that prevents the problem from progressing and becoming entrenched.

Prevention is defined as interventions that occur before alcohol and drugs are used or before individuals or groups are showing signs that problems are likely to develop. The prevention of alcohol and drug problems relies on reducing the alcohol and drug risk factors as well as enhancing the protective factors that build the resilience of young people and promote their healthy participation in community life.

Consistent across all relevant policies in Victoria, is the need to prioritise early intervention in terms of being able to respond earlier in the course of development of emerging issues of substance use. The Centre for Mental Health at the University of Melbourne’s School of Population and Global Health (the ‘Centre’) identifies that early intervention is necessary and that all sectors need to work together to identify priority populations and common risk and protective factors that will be targeted in collaborative intervention programs33.

30 Frontier economics (2011) Specialist drug and alcohol services for young people – a cost benefit analysis. Department of Education UK
33 Mitchell, P.F. (2014) Victoria’s most disadvantaged and vulnerable young people: a fresh look at needs for health and social care services. The Centre for Mental Health: Melbourne School of Population and Global Health, University of Melbourne.
The Roadmap identifies that youth alcohol and drug responses need to be delivered in settings where young people’s substance use issues first become apparent. The Centre points out that there is little evidence to support the contention in the Roadmap that headspace centres, subacute mental health services and youth housing programs are the settings where young people’s AOD problems first become apparent. Rather the Centre supports early intervention that is able to:

1. Identify young people who have disconnected or are at risk of disconnecting from school, and provide supports that retain or reconnect them with education or supported employment.
2. Identify and support families under pressure.
3. Target and deliver AOD interventions for Victoria’s most disadvantaged and vulnerable young people such as those in out-of-home care and Youth Justice settings.

The most effective way of enhancing identification of problems is routine and systematic screening for substance use issues in these settings. Early interventions need to be timely and attractive to young people who do not yet see their substance use as a problem or at least not one requiring treatment.

Practitioners that are mobile, expert at engaging and qualified to work with young people and families are critical.

Evidence

- Individuals who develop substance abuse disorders in adolescence are more likely to have those symptoms persist into adulthood.
- Adolescents who enter the transition to adulthood with problematic substance use are more likely than others to demonstrate negative outcomes in young adulthood such as lower educational and occupational attainment and higher levels of aggressive and violent behaviour.
- The Victorian Youth Drug Reporting System found the age that illicit drugs are first used by AOD and youth service users was extremely young when compared to the age of first use for illicit drug users in the general population (see Figure 10).

- Youth AOD clients in the SYNC study were segmented according to age so that developmental differences could be investigated. The study found that:
  - Clients in the youngest age cohort (15 years of age and under) had lower rates of multiple substance use and it was very rare for them to use methamphetamine, heroin or to inject. They were also more likely to live with their family and be involved with education. Young people in the 15 and under cohort are also most likely to be involved with Child Protection (41%).
  - Cannabis as the ‘primary drug of concern’ for clients decreases with age whereas methamphetamine as the ‘primary drug of concern’ increases with age.
  - Clients’ level of engagement in either education or employment (meaningful activity) decreases with age and plateaus in the 19 to 21 and 22-plus age cohorts.
  - Clients who are 18 and under are much more likely to engage through the Outreach service type.
  - Structured withdrawal programs, both residential and non-residential, had on average the youngest clients.

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The Chief Psychiatrist’s (Victoria) guideline: ‘Priority Access for out-of-home care’ (2011)\(^{38}\) recognises that the emergence of problems with substance use and mental health issues for this group is notably higher than in the general community.

The ‘Protecting Victoria’s Vulnerable Children Inquiry’ (2012)\(^{39}\) also reports that young people in and transitioning from out of home care experience high rates of mental health problems and drug and alcohol abuse.

**Recommendations**

The Youth AOD service system requires more targeted responses for the cohort that is 15 years of age and under, that focus on:

1. Preventing progression to methamphetamine and opiate use, multiple substance use and injecting.
2. Strengthening and protecting healthy connectedness with family/carers and to school, work or other meaningful activity.
3. Building the capacity of Youth AOD services to assist families, carers and school communities to identify and respond to young people with emerging substance use issues.
4. Maximising the use of Outreach as a service type for:
   - Engaging younger clients and retaining them in treatment
   - Taking early intervention programming into schools, out of home care and justice settings
5. Creating targeted programs that engage young people at risk of developing serious AOD problems in pro-social risk taking and connect them to constructive activities and relationships that are not compatible with problematic substance use.

**3. Focus on proactive engagement and treatment retention**

Youth AOD treatment and early intervention services can only be effective if young people and families affected by substance use problems can be engaged and retained in treatment.

The current Youth AOD service system has been effective in making treatment accessible to all young people in need through a number of ways, including providing multiple and varied points of entry to services and maintaining strong links with potential referrers such as Child Protection and Youth Justice.

This is critical as young people, particularly those who experience psychosocial problems, are less proactive than adults in seeking treatment for health concerns. Additional barriers to service access for young people with substance use problems and high levels of psychosocial complexity include:

- Complex and impersonal intake processes
- Not perceiving a need for treatment of AOD problems
- Lacking knowledge of what assistance is available or how to find what they need
- Inadequate help seeking support and limited personal power or confidence to negotiate for services in an adult-centred system
- General mistrust of adults and professionals
- Treatment providers not being equipped or prepared to address the range of problems young people face and offer what they need

In an effort to simplify and streamline intake processes for clients seeking health and community services, several key policies in Victoria advocate to centralise and standardise a set of technical procedures including screening, assessment and care planning. The aim of these policies is to avoid either service gaps or overlaps that can be distressing or confusing for clients. Although ‘coordinating’ intake to services is crucial for the above reasons, it is critical that work to ‘centralise’ intake to services does not:

- Restrict access points for young people in engaging services
- Compromise the ability of service providers to offer assessment over an extended period of time at a pace dictated by the young person, and for young people to choose who to share what information with
- Limit the ability of specialist youth-focused services, including Youth AOD services to conduct Outreach to places where vulnerable disconnected young people spend time and form connections based on respect and trust built over time

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Evidence

Research in treatment effectiveness makes it clear that:

- Focused engagement and retention strategies are a key characteristic of effective AOD treatment programs38-41.
- Young people need to be exposed to enough of an intervention for it to have an effect42 and for changes to endure over time43.
- There is strong consensus among practitioners and researchers that adolescents with more problems and fewer supports require greater intensity and duration of intervention, be it treatment or early intervention44-45.
- Adolescents with complex needs and multiple developmental challenges require a much longer duration of treatment involvement46.
- Adolescents with substance and mental health problems have lower access or use than adults47.
- Young people in general want attractive, youth-friendly spaces in accessible central locations48-49.
- Young people are sensitive to the potential for stigmatisation, so it is important that services are inclusive and do not make young people feel different from their peers50.
- For young people experiencing instability in their lives, a space that is physically and emotionally safe and provides respite from violence at home or the dangers of street life is a critical starting point51-52.

Various authorities have observed that feeling safe and secure is an important prerequisite for resolving AOD problems53.

- Enabling access to services for highly marginalised young people often requires support through crisis and providing for basic needs such as clothing, food, washing facilities, accommodation and practical help. Until these basic needs are met, the effectiveness of AOD counselling or skill building will be minimal54-55.
- Assertive Outreach or mobile services in a wide variety of settings where vulnerable youth may be found, facilitates better access to services56,57 as does providing a variety of different services in a single location58.
- In the absence of multipurpose services, care coordination or case management is critical to the ongoing engagement of young people with complex needs59; and
- Strong referral networks, awareness raising, and collaborative links among gateway service systems (such as Youth Justice, mental health, child welfare, school counselling and homeless support) also help to identify and refer young people to AOD services60.

Recommendations

The Youth AOD service system should continue to prioritise accessibility through:

1. Having multiple access points and a capacity to respond to the issues of most pressing concern to the young person at intake.
2. Limiting complex and impersonal intake systems and processes.
3. Improving family-focussed intake processes and options for treatment and support.
4. Being proactive in making initial contact with potential clients.
5. Maintaining strong links with potential referers including
the option of joint care planning.

6. Having a presence in local communities and service networks to ensure that the range of youth AOD services and how they can be accessed is clearly understood.

7. Maximise the use of Outreach as a vehicle for engaging and retaining those clients in treatment who:
   - Experience the most serious AOD problems and who are lacking in help seeking support
   - Are from ATSI, African and Pacific Island backgrounds

8. Develop more primary health and activity-based youth AOD day programs in local communities that give young people control over when they attend.

9. Build on the effectiveness of structured withdrawal, particularly residential withdrawal programs, that act as a gateway into services and a facilitator of early treatment engagement.

4. Ensure youth AOD services are fully integrated with other youth and health service systems

Youth AOD clients with serious substance use problems also experience co-occurring emotional and behavioural issues and a variety of psychosocial issues that create life complexity. In order to enable Youth AOD clients to respond effectively to the range of issues and risks they are contending with, the Youth AOD service system needs to be integrated with other youth and health service systems, including youth homelessness, youth justice, child protection, out of home care, education, mental health, primary health, and sexual health.

Within the current Youth AOD system, the flexibility and mobility of Outreach enables effective collaboration and care coordination, including facilitation of linkages to useful health and community services and institutions.

Fixed site services such as day programs, CYRWS and Residential Rehabilitation services consider themselves part of the broader youth sector. The AOD service system and the local communities in which they are based. They all invite participation from external health, recreation, education and community service providers in order to implement a well-rounded program for their clients. From these fixed site services, programming is also conducted in the community and with other organisations.

The building of collaborative relationships between services often depends heavily upon the interests, skills and leadership of particular individuals. The spirit in which this collaboration occurs within the current youth AOD service system must be retained but responsibility for the provision of comprehensive and coordinated responses to client need should be authorised and formally supported by the leadership of organisations. Such work at the systems level and within peak bodies and service networks provides an opportunity for grassroots collaboration to succeed.

In addition, organisations and services need to clearly communicate their contribution to other services within the broader system in order for meaningful cross-sectoral work to take place.

Evidence

- SYNC found that youth AOD clients have coexisting school, housing and mental health issues. They are also often involved with the Criminal Justice system (66%) and child protection (33%)
- Dedication of some time to care coordination or case management is critical for young people with complex needs
- For Youth AOD clients experiencing psychosocial complexity, a comprehensive or multisystemic approach is more effective than the use of singular treatments
- Providing a variety of services at single locations like drop-in centres or primary health care services has been repeatedly identified as an effective service model for transient and homeless youth with AOD and mental health problems
- Young people in Child Protection and Youth Justice systems tend to have higher rates of AOD and mental health than the general population


**Recommendations**

1. Ensure that the assertive linkage aspect of Outreach-based youth AOD treatment continues to:
   - Increase options for collaborative care planning
   - Maximise the efficiency of other services and treatments provided within other sectors
   - Reduce the exclusion from services based on geographic isolation

2. Strengthen assessment processes to enable practitioners to identify and respond to psychosocial complexity.

3. Retain a capacity for singular treatments such as centre-based counselling for young people and families encountering low levels of psychosocial complexity.

4. Encourage Youth AOD services to be located or have a presence in local multiple service hubs.

5. Develop the leadership within organisations to work at the systems level with peak bodies and service networks to:
   - Support effective frontline collaboration; and
   - Identify and correct service gaps or overlaps.

6. Develop formal protocols that articulate how Day programs, CYRWS, Residential Rehabilitation and Supported Accommodation services (as fixed site services) can function as step up / step down options from programs in other sectors.

5. Increase capacity for services to involve families and carers

   For the most disadvantaged and vulnerable young people, including those with substance use problems, families are almost universally both a key source of stress and risk, and the most important source of protective resources.

   Whether or not families are functioning poorly, many possess under-utilised and under-recognised resources that can be helpful for young people.

   Youth AOD services across a range of service types seek to collaborate with families and carers on the common goals of protecting their child’s safety, health and wellbeing and future prospects. The goals of family focused interventions are to:
   - Engage families in the care and support process as far as possible
   - Motivate family members as supporters of their young person
   - Build the capacity of family members to provide emotional and practical support that assists the young person along a positive developmental pathway

   Family members include caregivers who may not be kin, such as foster parents. Young people who are parents are also a group that requires proactive engagement and specialist assistance.

   Not all young people will want to involve family members directly. Sometimes family involvement is inappropriate, and sometimes the young person will benefit from working individually for a period of time and become open to family involvement at a later stage.

**Evidence**

- SYNC findings show that:
  - 53% of young people experience high levels of family conflict and disconnection
  - 58% of young people accessing youth AOD services in Victoria have been identified as having a current need for support in regards to problems they are having in their family relationships
  - 24% of young people accessing youth AOD services in Victoria have problems in their family relationships that have been identified but they have not been able to find a service to meet those needs

- There is now a large evidence base for the effectiveness of specially designed, culturally sensitive strategies in achieving high rates of family engagement and better outcomes for highly marginalised and vulnerable young people

- The Youth Cohort Study found that “domestic instability and family conflict are the factors most strongly predictive of intractable substance related and wider life problems”.

**Recommendations**

1. Develop standards for all Youth AOD service types that specify what families and carers can expect from Youth AOD services and visa-versa.

2. Ensure that working with families and carers, even when the young person is not involved, can be accounted for as work endorsed by DOH or any other funding provider.

3. Provide telephone or web-based services that support the help seeking of families and carers.

4. Develop and facilitate a ‘community of practice’ among Victorian youth AOD agencies and practitioners focused on effective intervention and support for families and carers.

5. Ensure that youth AOD practitioners have access to secondary consultation and professional development on


effectively supporting and involving families and carers.

6. Create protocols for how youth AOD services can collaborate more effectively with community-based family therapists.

7. Build the capacity of community-based family therapists to understand and respond effectively to the needs of young people and families with AOD issues.

6. Adopt an evidence-based trauma-informed care framework

Many clients with substance use problems have histories featuring abuse and neglect, experiences of violence (either as a witness or victim), insecure attachment and grief and loss issues. Substance use can be a way that young people manage the distressing symptoms associated with such traumatic experiences. Using substances can also diminish their capacity to cope with a traumatic experience. For some people, the consequences of their trauma experiences impact on their capacity to engage easily in relationships, and make finding and following through with supports and treatments difficult.

Trauma-informed care aims to actively manage worker and service delivery factors that might interact with a service user’s trauma experiences. This improves the likelihood that supports and services will be more effective. Rather than an intervention, trauma-informed care is a set of principles and practices that provide support, treatment and care. Trauma-informed care is strengths-based and grounded in an understanding of and responsiveness to the impact of trauma that emphasises physical, psychological and emotional safety for both providers and survivors. This creates opportunities for survivors to rebuild a sense of control and empowerment.

Evidence

- SYNC found that 62% of youth AOD clients were reported to have experienced at least one form of abuse, neglect or violence over the course of their lives and 26% in the previous 4 weeks. This includes a large percentage of clients who reported not knowing (see Figure 11).
- The Australian Centre for Posttraumatic Mental Health\(^7\) cites evidence suggesting that:
  - Providing trauma-informed treatment and support leads to better retention rates for clients with substance use problems\(^7\).
  - Interventions have limited success with helping people modify their substance use when underlying trauma-related problems are not addressed\(^7\).


Recommendations

1. Develop Youth AOD trauma-informed care protocols based on principles formulated by the Australian Centre for Post-Traumatic Mental Health.\(^6\)

2. Develop a trauma-informed care auditing tool for youth AOD services based on the above protocols that can be self-administered to highlight areas requiring development (for example organisational, program and workforce).

3. Ensure that youth AOD services have access to resources to implement the youth AOD trauma-informed care protocols.

7. Maintain an emphasis on psychosocial stability as the basis of all behaviour change

In order to gain control over the range of health compromising issues and behaviours that underlie problematic substance use, some degree of stability in life circumstances is paramount.

Many youth AOD clients have experienced extended periods of instability in their past, including periods where basic needs may not have been met. This can undermine the young person’s stability and sense of security. This is often the experience of young people who are homeless. At times, some young people may find aspects of a more transient lifestyle exhilarating and even preferable, but when it is not a choice this is rarely the case. A hand-to-mouth existence and the lack of safe physical and social environments make the short-term relief or alternative experience that substance use offers attractive.

Creating psychosocial stability involves young people having the capacity to meet basic needs and have a secure base from which to develop. This may include having access to sufficient resources and adequate income, housing, nutrition, clothing.
information technology and transportation. These resources enable young people to participate in constructive, socially valued activities and are essential for dealing effectively with a range of health and behavioural issues such as problematic substance use.

Young people’s family and social networks also have a crucial role in creating psychosocial stability. Certainly, young people, particularly minors, have a right to expect those involved in their care will provide stable conditions in which to develop. Where these protective relationships are not available, Youth AOD services have a role in collaborating with other service providers to establish stable conditions.

Evidence
• Only when basic needs are met are people free to pursue their goals and achieve their potential83
• Often health is not considered a priority in a chaotic life where survival takes precedence84
• The capacity to meet basic needs has been found to be integral to the process of resolving substance use problems for disadvantaged young people85,86
• Inequalities in income and material resources, coupled with the resulting social exclusion and marginalisation, are linked to poor health87
• Young people and their carers can learn how to predict and prevent crisis. Planning and preparation can reduce the number of crises and the degree of harm experienced by clients88

Recommendations
1. Ensure that the model of care instituted by youth AOD services in Victoria continues to focus on the needs of young people for safety, stability and a sense of security.
2. Ensure that the intake and assessment processes of youth AOD services include the capacity to respond to crisis.
3. Retain CRYWS for their role in enabling young people to establish psychosocial stability.
4. Ensure youth AOD services in Victoria are integrated with housing and welfare services as well as emergency services.


8. Create options to increase the social and economic participation of Youth AOD clients

Engagement in pro-social activities and better pathways into education, employment and training provide an alternative to problematic substance use and the associated lifestyle. Engagement in pro-social activities over time promotes social inclusion and economic participation. Alternatively, disconnection from social institutions such as schools, workplaces and sporting clubs means missing crucial development experiences and opportunities to develop new social connections and networks.

Youth AOD services actively seek to motivate and enable young people to either initiate or maintain participation in constructive activity that is varying degrees satisfying, rewarding and socially valued. In most cases, problematic substance use is incompatible with participation in constructive activity. Young people who feel strongly attached to one or more constructive, pro-social activities have a reason not to let substance use become so problematic that it restricts their involvement.

Evidence
• The adoption of problematic substance use patterns by young people is linked with a lack of opportunities for recreation and participation in activity that is socially integrative89
• Constructive activity, be it schooling, work or recreational pursuits, can counteract ‘boredom’ but can also be a vehicle for the “development and demonstration of new competencies, problem solving, helpfulness and other positive attributes associated with resilience”88
• Young people participating in a major Melbourne-based study into youth homelessness commented that “all other dominating activities fell by the wayside as drug taking or getting money for drugs became their prime activities”89
• Positive functioning and healthy development for young people is strongly associated with engagement in structured, pro-social activities90
• Through pro-social activity each young person has an opportunity to make healthy bonds with significant others who are in a position to positively reward their participation. This offers a young person the chance to test their capacities and demonstrate qualities that may have been previously unrecognised. Over time, continued
participation can promote the development of emotional, cognitive and behavioural skills that allow the young person to continue earning and experiencing positive reinforcement. Heightened expectations often result as others with significance in the lives of young people recognise such learning and growth. This has been shown to increase motivation for further participation in pro-social action and encourage young people to envision and work towards a better future.

- Premature exclusion from school is strongly associated with the development of substance use problems and involvement in the Criminal Justice system.

**Recommendations**

1. Ensure that the model of care instituted by youth AOD services in Victoria includes a focus on social and economic participation.
2. Extend funding to day programs (with an emphasis on satisfying, socially integrative activity) in more local communities across Victoria.
3. Include programming that enables young people to develop the skills, values and beliefs that facilitate involvement in recreational activity, education and work.
4. Ensure youth AOD services in Victoria are integrated with agencies that facilitate the connection of young people to employment, education and training.

**9. Build capacity to identify and respond to emerging AOD related needs in youth populations**

Youth AOD clients are a heterogeneous group. They differ according to:

- Maturity and developmental stage
- Gender
- Ethnicity and cultural identity
- Religious affiliations
- Socio-economic status and access to income
- Place of residence
- Legal status
- Sexual identity
- Identification with particular youth sub-cultures

Each of these differences can be associated with particular AOD related issues and trends. This translates into the need for specialised prevention, early intervention and treatment responses.

Since the establishment of the youth AOD service system in Victoria in 1998 there have been several innovations and adaptations in response to:

- Previously unidentified service gaps and unmet client needs (this includes identification of special needs populations facing specific AOD related challenges)
- Changing substance use patterns and trends more broadly and in youth populations
- Geographical issues and trends

These responses have been well received but there is no formal and systematic process currently in place for the Youth AOD sector (and related sectors) to respond to emerging need in special populations and changing substance use patterns and trends in Victoria.

The following special needs populations clearly require a more effective response from youth AOD services:

- Young people from ATSI backgrounds
- Young people from Pacific Island and Maori backgrounds
- Young people who are refugees and unaccompanied minors
- Young women
- Lesbian, gay, bi, trans, intersex and queer young people
- Young parents
- Young people in Out of Home Care

There is also a need to ensure that effective Youth AOD services are available for young people and families in rural and remote locations and those in newly established communities on Melbourne’s urban fringe.

**Evidence**

- SYNC found significant differences in the substance using behaviour and psychosocial complexity of clients based on gender, cultural background and parental status:
  - When compared to males, female youth AOD clients experienced significantly higher levels of psychosocial complexity
  - Youth AOD clients are a culturally diverse group. The major cultural groups of the 53 represented were ATSI (8%), young people from African cultures (5%) and Pacific Islander or Maori young people (5%). Clients from an ATSI background were the most likely to have a trusted adult they could rely on but each of these groups experienced significantly more psychosocial complexity
- The 15% of youth AOD clients that are parents were less likely to be involved in education, employment and/or training than non-parents experienced a much bigger problem with insecure housing compared to clients who are not parents
- Young people from rural and regional Victoria were found to have significantly more unmet treatment need, particularly in the areas of mental health and housing

**Recommendations**

1. Institute a system for:
   - Identifying emerging needs in special populations and changing substance use patterns and trends in Victoria
   - Developing a systematic practice response to the identified need (including building on the strengths of the Youth AOD and related sectors)
   - Formally incorporating effective practices and programming into the youth AOD service system
   - Evaluating new practices and programming and disseminating findings to further build service system capacity to respond to special needs populations
2. Ensure that the Youth AOD system includes properly customised, effective AOD services for all special needs populations. This will mean they are properly resourced and applied more systematically across the sector.
3. Establish a capacity building program to ensure that youth AOD service providers and practitioners develop cultural competence in understanding and responding to special needs populations.
4. Ensure that young people and families in rural and remote locations and those in newly established communities on Melbourne’s urban fringe have access to effective youth AOD services.
5. Continue to support Aboriginal Community Controlled Heath Services to provide AOD services for ATSI young people in Victoria.
6. Continue to support the Outreach service type as an effective way of engaging and supporting young people from special needs populations.

**10. Incorporate the participation of young people and families in developing and maintaining high quality services**

Young people have a right to be involved in decisions that affect them, ranging from treatment planning through to program improvement and service design. Participation empowers young people through:
- Building self-confidence that supports an active role in their own health management
- Providing a sense of meaning, control and connectedness
- Improving health care available by making services that are more accessible and efficient

In order to meaningfully engage a young person and their family, dedicated resources ranging from specific program funding, staff time and participation as well as specific space and equipment are required.

A clear participation framework that is enshrined in organisational policy and supported by endorsed procedures should include:
- Systematic engagement of client feedback and mechanisms for a prompt response
- Training and development for young people in their participation role
- Systems to monitor and evaluate youth participation strategies and outcomes
- A clear communications mechanism to ensure young people, staff and stakeholders are aware of youth participation outcomes

There has been considerable effort and success on the part of AOD services and DOH in developing consumer participation practices within the sector. However, consumer participation in the AOD sector is still lagging behind that of the health and mental health arenas.

**Evidence**

- Many participation activities are isolated, ad hoc and often occur at the lowest levels of involvement
- Shaping the future: The Victorian AOD Quality Framework states: “…a client-centred system has been defined as one that meaningfully engages clients in planning, implementation, delivery and evaluation of interventions and services”
- The Victorian Dual Diagnosis Initiative includes service development outcomes that requires consumers and carers

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are involved in the planning and evaluation of service responses at mental health and AOD agencies

- Consumer participation is also a feature of quality assurance/accreditation tools for AOD services. For example, there are two core standards in Quality Improvement and Community Services Accreditation relating solely to service user rights and complaints and input into review and planning

- The Victorian Alcohol and Drug Association (VAADA) has been funded by DOH for a two year sector development project that includes “strengthening client and family input into service planning and development” as one of its main objectives

Recommendations

1. Establish minimum standards and best practice guidelines for client participation (including young people and families).

2. Build the capacity of Youth AOD services to facilitate the participation of clients that meet at least minimum standards.

3. Establish and maintain a system for the management and monitoring of client participation within the Youth AOD sector.

4. Institute a system for engaging Youth AOD clients in policy development and broader sector planning.
CONCLUSION: STRENGTHENING AND EVOLVING VICTORIA’S YOUTH AOD RESPONSE

At present, there is a great opportunity to both consolidate and build on an effective Youth AOD service system. This requires bringing together expert practitioners and service providers with researchers and policy makers to develop an evidence-base that can inform the design of effective treatment, early intervention and health-promotion initiatives for young people and families affected by substance use problems.

The ‘Victorian Drug Policy Expect Committee’, on reviewing the Youth AOD service system after five years of operation, made a similar recommendation suggesting that an expert group be formed to investigate the best model of care for young people with AOD problems. The committee had recognised that other States were emulating the innovative, youth-specific models of AOD practice developed in Victoria. There have been many advances in Youth AOD practice since that time and there continues to be strong interest from services and practitioners in working together to evolve the Youth AOD service system in Victoria. This was confirmed at the ‘Youth AOD Practice Summit 2014’ where 300 Youth AOD Practitioners called for more collaborative research to build on the expertise developed within the field. Participants believed that practice-based research could inform sound policy and create a culture of critical enquiry that drives innovation and the generation of further evidence.

There are key resources and current projects underway in Victoria that can contribute to the evolution of the Youth AOD service system such as YoDAA (Youth Drug and Alcohol Advice), the YouthAOD Toolbox and the Evidence-based Therapeutic Framework for Youth AOD Practice developed by YSAS in consultation with service providers across Victoria.

KEY RESOURCES

Youth Drug and Alcohol Advice (YoDAA) is a state-wide response to young peoples AOD problems through a collaboration of Youth AOD services in Victoria. YoDAA provides online content, a phone line, live webchat and email services all contributing to a more accessible, coordinated and navigable Youth AOD service system in Victoria. For practitioners, YoDAA offers secondary consultation on care planning and service system navigation. YoDAA is a platform to share innovative practices and useful resources together with news, events and Information on emerging research.

With support from the Victorian department of health, YSAS published an Evidence-based Therapeutic Framework for Youth AOD Practice to inform effective assessment and care planning and the integration of therapeutic interventions with outcome measurement. The framework was developed through a comprehensive review of the literature on therapeutic effectiveness in adolescent specific AOD treatment combined with extensive consultation involving expert practitioners and academics.

The Youth AOD Practice Toolbox www.youthaodtoolbox.org integrates the best evidence with practice wisdom to provide a practical and comprehensive guide to working with young people with drug and alcohol problems. The toolbox is comprised of modules (incorporating text, audio, video & downloadable resources) that presents Information on all topics relevant to youth AOD practice and demonstrate how evidence based approaches can be applied in real world settings. The Youth AOD Toolbox is designed to be functional on mobile devices.

Any evolution of the youth AOD service system in Victoria must be based on a clear understanding of the needs and characteristics of young people and families experiencing AOD related problems and how they both engage with services and respond to treatment. The ‘Statewide Youth Needs Census (SYNC)’ and the ‘Youth Cohort Study (YoCo)’, both reported on in Part 1 of this document provide useful data that can inform the design of services but more is required. The ‘Statewide Youth Needs Census (SYNC)’ will be repeated in 2015 but can only provide detail on the needs and characteristics of youth AOD clients at one point in time and does not investigate the effectiveness of services in reducing the severity of substance use problems. The YoCo study went some way to demonstrating this but there are currently no plans to implement a similar study.

In particular, the sector would benefit greatly from a minimum data set and valid outcome measures that are suitable for Youth AOD practice. As this is essential for performance measurement and service development, YSAS is funding and conducting a study with Deakin University and the University of Sydney (Associate Professor Nick Linzeris) to develop the ‘Australian treatment Outcome Profile – Youth (ATOP-Y). The ATOP-Y will be adapted from the Australian Treatment Outcomes Profile (ATOP) that has been designed for the adult AOD sector. The ATOP-Y will measure the severity of each young person’s drug and alcohol use, and the complexity of social, family, legal and psychological issues experienced by the client. A web-based practitioner-youth interface is being designed and strong emphasis will be on ensuring that the process of implementing ATOP-Y is viable and acceptable for youth workers and their clients.

A project is also being conducted to transform the evidence informed youth AOD practice framework into a coherent care-planning model that integrates ATOP-Y and is linked to effective therapeutic practices. The implementation of this model can be supported by YoDAA and through the provision of an online Youth AOD Learning Hub that is being developed through the Youth AOD Capabilities project by YSAS, ReGen, Odyssey, Turning Point and the Bouverie Centre. The Youth AOD Capabilities project is an initiative of the Victorian Department of Health that will identify and customise relevant capabilities for Youth AOD work in the context of a broader Mental Health and AOD capability framework. The Learning Hub will draw on the YouthAOD Toolbox and be freely available to practitioners, allowing them to increase their skills and knowledge and be guided in how to integrate these capabilities into their practice.

Health outcomes can also be improved for young people through empowering workforces from the service systems that integrate with the youth AOD service system including:

- Mental health
- Homelessness
- Education
- Justice
- Child Protection

Collaborative research and practice development has the potential to identify emerging AOD-related issues and trends outside of the Youth AOD system and faster better-targeted service development and planning. YoDAA is a platform through which connections with services and practitioners from a range of sectors are being made and evidence is being disseminated and critical feedback gained.

The Youth AOD sector in Victoria and collaborators are well positioned to cooperate with the State Government in evolving the service system to continue meeting the changing needs of young people and families affected by drug and alcohol problems.
The SYNC study findings are commensurate with the findings of four other important Australian studies that have examined the co-occurrence of substance misuse with other psychosocial problems from the perspective of young people attending AOD services. They studies are:

- Dean, McBride, MacDonald, Connolly and McDermott (2010) analysed administrative data collected on 262 young people aged 13-18 years admitted to a short-term withdrawal treatment service in Brisbane, Queensland. Data was extracted for admissions between March 2000 and September 2004.

- MacLean, Kutin, Best, Bruun and Green (2013) report findings from a survey of 163 young people aged 13-24 years attending youth AOD services across Melbourne, Victoria. Relying on convenience sampling, young people were recruited through referrals from workers and through participants referring friends to the study (i.e. “snowballing”) over the 6-month period from October 2006 to March 2007. This study is known as the Youth Drug Reporting System (YDRS).

- Best et al (2012) The Youth Cohort Study (YoCo) (Victorian), conducted structured interviews with 150 young people aged 16 to 21 attending 11 different youth AOD services, mostly in Melbourne (Best, Wilson, Reed, Harney et al. 2012). A convenience sampling procedure was used and youth were recruited from a variety of settings and modalities including residential withdrawal (52%), outpatient (35%), and residential rehabilitation (13%) via referrals from workers. Data were collected between June 2009 and April 2010.

- The YSAS (2012) The YSAS Pilot Census (Victorian) was a practitioner-completed census based on the complete population of current AOD clients on the census day. Surveys were returned for 374 clients aged between 12 and 24 years.
### Table 1. Methodological features of four studies based in Youth AOD settings (published 2009 to 2013)

<table>
<thead>
<tr>
<th>Methodological features</th>
<th>YSAS Census</th>
<th>Best et al</th>
<th>MacLean et al</th>
<th>Dean et al</th>
</tr>
</thead>
<tbody>
<tr>
<td>Method of data collection</td>
<td>Practitioner-completed census</td>
<td>Youth self-report survey</td>
<td>Youth self-report survey</td>
<td>Administrative data (retrospective review of admissions)</td>
</tr>
<tr>
<td>Location</td>
<td>Victoria, Australia</td>
<td>Victoria, Australia</td>
<td>Victoria, Australia</td>
<td>Queensland, Australia</td>
</tr>
<tr>
<td>Service types included</td>
<td>7% residential, 93% outpatient</td>
<td>52% residential, 48% outpatient</td>
<td>100% outpatient</td>
<td>100% residential</td>
</tr>
<tr>
<td>Sample size</td>
<td>N = 371</td>
<td>N = 150</td>
<td>N = 163</td>
<td>N = 262</td>
</tr>
<tr>
<td>Age range</td>
<td>12 to 22 years</td>
<td>16 to 21 years</td>
<td>13 to 24 years</td>
<td>13 to 18 years</td>
</tr>
<tr>
<td>Gender</td>
<td>Males = 64%</td>
<td>Males = 60%</td>
<td>Males = 56%</td>
<td>Males = 53%</td>
</tr>
<tr>
<td>Sampling method</td>
<td>Complete population of current clients on the census day</td>
<td>Convenience sample</td>
<td>Convenience sample</td>
<td>Complete population</td>
</tr>
<tr>
<td>Mental health screening or diagnostic tool</td>
<td>None</td>
<td>K10</td>
<td>K10</td>
<td>None</td>
</tr>
<tr>
<td>Substance use scales</td>
<td>None</td>
<td>Severity of Dependence Scale</td>
<td>Severity of Dependence Scale</td>
<td>None</td>
</tr>
</tbody>
</table>

### Table 2. Severity of substance use: comparison across six studies based in Youth AOD settings (published 2009 to 2013)

<table>
<thead>
<tr>
<th>Substance use</th>
<th>YSAS Census</th>
<th>Best et al</th>
<th>MacLean et al</th>
<th>Dean et al</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily / almost daily use of any substance other than tobacco</td>
<td>89% (past 4 weeks)</td>
<td>88% (past 3 months)</td>
<td>100% (a primary drug of concern in the past 6 months)</td>
<td>Not reported</td>
</tr>
<tr>
<td>Heroin or other opiates (daily/almost daily)</td>
<td>4% (past 4 weeks)</td>
<td>20% (past 3 months)</td>
<td>7% (past 6 months)</td>
<td>26.0% of females &amp; 10.8% of males (primary drug of concern at intake)</td>
</tr>
<tr>
<td>Poly-drug use (daily or almost daily)</td>
<td>1.5 (average number of substances used)</td>
<td>1.9 (main drugs of concern)</td>
<td>Only 3 out of 163 did not have a second drug of concern</td>
<td>Not reported</td>
</tr>
<tr>
<td>Injected</td>
<td>9% (past 4 weeks)</td>
<td>22% (past 3 months)</td>
<td>36% (past 6 months)</td>
<td>64.2% of females &amp; 51.8% of males (currently)</td>
</tr>
<tr>
<td>Assessed as dependent</td>
<td>62%</td>
<td>99% (Severity of Dependence Scale)</td>
<td>73% (Severity of Dependence Scale)</td>
<td>Not reported</td>
</tr>
<tr>
<td>Overdosed</td>
<td>Not reported</td>
<td>15% (past 6 months)</td>
<td>12% (past 6 months)</td>
<td>Not reported</td>
</tr>
</tbody>
</table>

---

**APPENDIX 2**
Table 3. Prevalence of co-occurring issues: comparison across four studies based in Youth AOD settings (published 2009 to 2013)

<table>
<thead>
<tr>
<th>Co-occurring issues</th>
<th>YSAS Census</th>
<th>Best et al</th>
<th>MacLean et al</th>
<th>Dean et al</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis of mental disorders (current)</td>
<td>34%</td>
<td>62% (affective disorder only, K10 cut-off = 27)</td>
<td>Not collected</td>
<td>Not reported</td>
</tr>
<tr>
<td>Diagnosis of mental disorder (lifetime)</td>
<td>45%</td>
<td>55%</td>
<td>38%</td>
<td>Not reported</td>
</tr>
<tr>
<td>Psychological distress</td>
<td>63% (past 4 weeks)</td>
<td>77% (K10, past 4 weeks)</td>
<td>49% (K10, past 4 weeks)</td>
<td>73% of females &amp; 47% of males³</td>
</tr>
<tr>
<td>Any mental health issue or problem</td>
<td>Not asked</td>
<td>29% (past 6 months)</td>
<td>66% (had felt depressed or anxious for no reason)</td>
<td>88% (recorded at intake)</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>28% (lifetime)</td>
<td>13% (past 6 months)</td>
<td>29% (past 6 months)</td>
<td>Not reported</td>
</tr>
<tr>
<td>Deliberate self harm</td>
<td>43% (lifetime)</td>
<td>29% (past 6 months)</td>
<td>33% (past 6 months)</td>
<td>19% of females and 9% of males⁵</td>
</tr>
<tr>
<td>Criminal activity other than drug use</td>
<td>29% (past 4 weeks)</td>
<td>66% (past month)</td>
<td>54% (past month)</td>
<td>71% of females &amp; 76% of males²</td>
</tr>
<tr>
<td>Justice system involvement</td>
<td>71% (ever, non-specific)</td>
<td>44% (ever incarcerated)</td>
<td>39% (ever incarcerated)</td>
<td>Not reported</td>
</tr>
<tr>
<td>Child protection involvement</td>
<td>45% (ever)</td>
<td>36% (ever)</td>
<td>31% (13-15 year olds currently living in foster or residential care)</td>
<td>Not reported</td>
</tr>
<tr>
<td>Not involved in meaningful activities</td>
<td>60% (past 4 weeks)</td>
<td>77% (past 6 months)</td>
<td>57% (at time of interview)</td>
<td>88% not attending school</td>
</tr>
<tr>
<td>Conflict with family</td>
<td>57% (past 4 weeks)</td>
<td>36% (frequent conflict over past 6 months)</td>
<td>Not collected</td>
<td>Not reported</td>
</tr>
<tr>
<td>Insecure housing or homeless</td>
<td>26% (past 4 weeks)</td>
<td>20% (homeless or in short term crisis accommodation in past 6 months)</td>
<td>8% homeless and 7% in temporary or crisis accommodation at time of interview</td>
<td>11% homeless</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>17.5% of females &amp; 5.5% of males homeless</td>
</tr>
</tbody>
</table>

APPENDIX 3

Victorian Alcohol and Drug treatment principles

1. Substance dependence is a complex but treatable condition that affects brain function and influences behaviour.
2. Treatment is accessible.
3. Treatment is person-centred.
4. Treatment involves people who are significant to the consumer.
5. Policy and practice are evidence-informed.
6. Treatment involves integrated and holistic care responses.
7. The treatment system provides for continuity of care.
8. Treatment includes a variety of biopsychosocial approaches, interventions and modalities oriented towards people’s recovery.
9. The lived experience of alcohol and drug consumers and their families is embedded at all levels of the alcohol and drug treatment system.
10. The treatment system is responsive to diversity.