Victorian Youth AOD Service System Blueprint 2026


Acknowledgement of Country and First Nations Leadership

The Victorian Youth AOD providers contributing to this Blueprint acknowledge Aboriginal and Torres Strait Islander peoples as the Traditional Owners of the lands and waters on which we live, work and provide services. We recognise that Aboriginal and Torres Strait Islander peoples were the first to establish sovereign Nations on this continent, and that sovereignty has never been ceded.

We pay our respects to Elders past and present, and acknowledge the continuing strength, wisdom, culture and leadership of Aboriginal and Torres Strait Islander communities. We recognise the deep connection Aboriginal and Torres Strait Islander peoples have to Country, culture, family, kinship and community, and the central role these connections play in social and emotional wellbeing.

The Victorian Youth AOD providers acknowledge the ongoing impacts of colonisation, dispossession, forced child removal, systemic racism and structural injustice. We recognise that these harms continue to shape the lives of Aboriginal and Torres Strait Islander young people, families and communities, including through over-representation in child protection, youth justice, homelessness, health and alcohol and other drug service systems.

This Blueprint is grounded in a commitment to Aboriginal self-determination, cultural safety, truth-telling and justice. Youth AOD reform must recognise that culture, identity, community connection and self-determination are not peripheral to care; they are central to healing, wellbeing and developmental restoration.

The Victorian Youth AOD providers also acknowledge the important contribution of the Koorie Youth Council in supporting YSAS and the 2025 Youth AOD Census, particularly through guidance on how data relating to Aboriginal and Torres Strait Islander young people and families should be understood, interpreted and presented. This contribution strengthened the cultural integrity of the Census and has informed the development of this Blueprint.

We are committed to continuing to learn from Aboriginal Community Controlled Organisations, Aboriginal leaders, young people, families and communities about how Youth AOD services can better support justice, healing, cultural connection and better futures for First Nations young people.

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YSAS

Produced by YSAS in partnership with the Victorian youth AOD sector.

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About the Victorian Youth AOD Service System Blueprint

The Victorian Youth Alcohol and Other Drug (AOD) Service System Blueprint has been developed to strengthen how Victoria responds to the needs of young people experiencing, or at risk of experiencing, harms associated with their AOD use.

The Blueprint builds on the findings of the 2025 Youth AOD Census, which provides contemporary insight into the needs and characteristics of young people accessing specialist Youth AOD services in Victoria. The Census included data from 893 young people across 13 Victorian Youth AOD organisations. Following the Census, YSAS convened a workshop with Victorian Youth AOD providers to review the findings, discuss their implications for service delivery, and identify priority areas for action. Twenty-two Victorian Youth AOD providers were invited, with 18 organisations and VAADA represented at the meeting (Barwon Health, Peninsula Health, Anglicare, EACH, Gateway Health Limited, Gippsland Lakes Complete Health Limited, Grampians Community Health Limited, Latrobe Community Health Service Limited, Meli, Odyssey Victoria, SHARC, Sunraysia Community Health Service, Uniting, Western Health Drug and Alcohol Service, Windana, WRAD, Youth Projects, YSAS).

The shared practice wisdom of Youth AOD providers was applied to analysing the Census findings and reviewing best available evidence to set out a practical reform agenda for Youth AOD service system design. The Blueprint identifies the service responses, workforce capabilities, partnerships, funding settings and system conditions required to better meet the needs of young people and families experiencing AOD-related harm.

The Blueprint is intended to support implementation of the Victorian Alcohol and Other Drugs Strategy 2025–2035, particularly the Strategy's commitment to ensure age-appropriate supports are available across the lifespan and to review and strengthen the Youth AOD service system. It provides a youth-specific interpretation of the Strategy's broader directions, including prevention and early intervention, harm reduction, trauma-informed and person-centred care, culturally safe and self-determined responses for Aboriginal Victorians, integrated care, workforce capability, evidence-informed reform and cross-system collaboration.

Executive Summary

The Victorian Youth Alcohol and Other Drug (AOD) Service System Blueprint sets out a practical reform agenda for strengthening specialist Youth AOD responses across Victoria. It translates the findings of the 2025 Youth AOD Census, the shared practice wisdom of Victorian Youth AOD providers, and the best available evidence into priorities for service system design, commissioning, workforce development and cross-government accountability.

Victoria has had a discrete Youth AOD service system since 1998. It was established as a result of a recommendation from The Premier's Drug Advisory Council, a panel of experts who found that young people experiencing substance use related harm required a specialised service that is developmentally responsive and capable of meeting their unique needs. The system, that has evolved over time, includes outreach, counselling and therapeutic intervention, community-based and residential withdrawal, day programs, residential rehabilitation, supported accommodation, online and telephone support, and a range of bespoke specialist programs.

The need for a strong Youth AOD Service System that can enable young people and families to respond to contemporary challenges is now more pressing than ever. The 2025 Youth AOD Census — surveying 893 young people across 13 Victorian organisations — demonstrates that young people accessing specialist Youth AOD services are experiencing high levels of substance use severity combined with extreme psychosocial complexity.

The Census findings are striking in their convergence. Across the 893 young people surveyed, 84.3% presented with high or extreme substance use severity, 86.9% with high or extreme psychosocial complexity, and 74.9% with both simultaneously. Cannabis (49.0%), alcohol (18.9%) and methamphetamine (18.1%) were the primary drugs of concern; 67.6% were dependent on a substance and 60.8% were using daily. Across psychosocial domains, 59% had a diagnosed mental health condition, 59.7% had experienced abuse, 47.1% had a history of self-injury or suicide attempt, 48.4% had prior criminal justice involvement, and 64.7% were experiencing family conflict or disconnection. Full Census findings are set out in Part 1.

The Victorian Government's Client Pathways analysis further demonstrates that young people accessing AOD treatment are involved with multiple government systems at rates far above the broader youth population, including mental health services, justice and custody-related systems,

homelessness services, child protection, emergency health and family violence responses. Youth AOD services operate at the intersection of all these systems. Investment in Youth AOD therefore has whole-of-government significance.

The Victorian Government's Client Pathways Report 2 — produced by the Department of Treasury and Finance using linked administrative data from the Victorian Social Investment Integrated Data Resource — demonstrates that young people accessing Youth AOD services generate costs across justice, mental health, housing, child protection, emergency health and education at rates dramatically exceeding the general youth population. This cost burden is distributed across multiple departmental budgets rather than contained within any single portfolio — making this, fundamentally, a whole-of-government investment question.

The investment question is not whether government will pay for these young people's needs — it already is. The question is whether it continues to pay predominantly through crisis systems or invests in responses capable of moderating developmental trajectories before harm becomes entrenched.

The Client Pathways Report shows that:

- complexity and acuity have increased since 2016
- the cost burden is distributed across multiple government portfolios rather than contained within any single departmental budget
- the pattern of service interaction points to a clear window for earlier and more effective intervention

Investment in Youth AOD services means more young people - who might otherwise have experienced poor developmental outcomes without intervention - will be safer, healthier and have a more hopeful future to work toward. It is not simply an investment in treatment. It is a whole-of-government social, developmental and fiscal investment in Victoria's future.

Part 3 sets out the full investment case. Against this foundation, Part 4 sets out ten reform priorities that translate this evidence base into a practical agenda for service system design.

Developmentally Attuned Resilience-Based Practice provides the theoretical and conceptual foundation for the reform priorities identified in the Blueprint. This approach recognises that young people develop positively when they can access the resources and opportunities they require to meet their core developmental needs in constructive and health-affirming ways. Where access to essential resources and opportunities, is disrupted, developmental needs may remain unmet or be met in ways that are harmful. Youth AOD intervention is therefore not limited to addressing substance use related risk alone - its focus is on creating or restoring the conditions in which young people can meet developmental needs in safer, healthier and more constructive ways.

The ten reform priorities are:

1. Connect Psychosocial Stability with Sustained Developmental Pathway Support
2. Safe and Effective Responses for Priority Populations

3. Proactive Engagement and Early Intervention
4. Integrated Needs-Led Care Embedding Specialist Clinical and Psychosocial Support
5. Responsivity for Young People with Mental Health Challenges, Trauma Experiences and Neurodevelopmental Needs
6. Strengthen Family, Kinship, Peer and Community Connection
7. Strengthen Participation, Education and Employment Pathways
8. Reduce Justice-System Involvement Through Diversion and Health-Led Responses
9. Build a Skilled and Reflective Workforce
10. Strengthen Commissioning, Evaluation and Cross-Government Accountability

[Part 1] About the Victorian Youth AOD Service System

History of the Victorian Youth AOD Service System

Victoria is the only Australian state with a comprehensive and fully integrated Youth Alcohol and Other Drug service system. It was established in 1998 on the recommendation of the Premier's Drug Advisory Council (PDAC), chaired by Professor David Penington and convened to advise the Victorian Government on how the state's illicit drug problem should be addressed.

Prior to 1998, a fragmented and inaccessible service system was failing to adequately engage and retain young people with substance use and related problems. PDAC identified engagement and treatment retention as imperatives for Youth AOD services and recommended Outreach as the primary service type. Outreach enabled agencies to be proactive in making contact with young people in need and taking services to them, rather than relying on young people to seek help through adult-oriented or clinic-based systems.

PDAC also recommended that Outreach services be integrated with intensive supportive care provided in a residential setting, leading to the establishment of Community Youth Residential Withdrawal Services. These services 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 Youth AOD service system produced an immediate and significant increase in the number of young people being assisted. In 1997-98, the State Government's Alcohol and Drug Information System recorded that 9% of service users were 21 years of age or under. In the year following the establishment of the Youth AOD service system, this figure grew to 26%.

From this foundation, the Victorian Youth AOD system evolved to integrate

Outreach, Day Programs, Residential Withdrawal, Supported Accommodation and Residential Rehabilitation, alongside counselling, continuing care and specialist targeted responses. This integrated and multifaceted model remains a defining feature of the Victorian Youth AOD service system.

Four significant reviews and studies have evaluated the Victorian Youth AOD service system since its inception. Collectively, these reviews affirmed the achievements of the current system while identifying opportunities for enhancement. They confirmed the need for a discrete, youth-specific AOD service system; endorsed relationship-based, flexible and holistic service delivery; highlighted the importance of integration with youth-focused service systems; and underscored the value of Outreach as the primary vehicle for engagement, retention and continuity of care. The Youth Cohort Study (Best et al. 2012) further confirmed that young people engaged well with Youth AOD services, highly valued their relationships with Youth AOD workers, and achieved positive changes across markers of substance use severity, risk and wider life domains over 18 months.

Current Youth AOD Service System Architecture

Victoria's Youth AOD service system responds to the developmental, psychosocial and behavioural needs of young people experiencing substance use related harm. The system was established because young people experiencing harmful substance use frequently encounter barriers engaging with adult-oriented treatment systems and most often require flexible, developmentally responsive and integrated intervention capable of addressing both substance use and the broader psychosocial factors shaping their lives.

The Victorian Youth AOD system comprises a range of interconnected service types, including Outreach, counselling and therapeutic intervention, community-based and residential withdrawal, day programs, residential rehabilitation, supported accommodation, online and telephone support, and specialist targeted Youth AOD responses.

Together, these service types operate as a broader developmental support system. Their purpose is not only to reduce substance-related harm, but also to strengthen psychosocial stability, improve emotional, behavioural and relational functioning, support participation in education, employment and community life, and shift the developmental trajectories toward long-term wellbeing.

Within the Youth AOD system, Outreach operates not only as a mechanism for proactive engagement, but as the primary vehicle for delivering continuity-of-care and developmental navigation across the broader service pathway. Through flexible, relationship-based and community-connected practice, Youth AOD Outreach workers integrate care planning, coordinate multidisciplinary responses and facilitate transitions between service types and systems. This includes supporting integration across mental health, housing, family services, child protection, education, employment and the justice system. In

this way, Outreach is vital for maintaining continuity, relational stability and coordinated developmental support for young people and families over time.

Young People Accessing the Youth AOD Service System

The 2025 Youth AOD Census provides a contemporary snapshot of young people engaged with the Victorian Youth AOD system and highlights the extent to which harmful substance use commonly occurs alongside overlapping developmental, psychosocial, mental health, housing, education, employment, family violence, child protection and justice-related needs.

The Census demonstrates that young people accessing specialist Youth AOD services are not a homogenous group. They include young people from diverse cultural, social and geographic backgrounds, including Aboriginal and Torres Strait Islander young people, culturally and linguistically diverse young people, LGBTQIA+ young people, young people involved with child protection and justice systems, young people experiencing homelessness and housing instability, and young people affected by trauma, family violence, mental ill-health and social exclusion.

While the severity and nature of need vary across individuals, the Census and Victorian Government Client Pathways analysis both demonstrate that many young people accessing AOD treatment experience multiple and interacting forms of disadvantage. Compared with the broader youth population, young people accessing AOD treatment are substantially more likely to interact with mental health, justice, homelessness, child protection, emergency health and family violence service systems. These interactions frequently occur simultaneously rather than in isolation, reflecting the interconnected nature of the challenges many young people experience.

Taken together, these findings suggest that harmful substance use is often only one element of a broader developmental picture. For many young people, substance use occurs within contexts characterised by trauma exposure, disrupted care relationships, mental health challenges, educational disengagement, housing instability, social exclusion, justice-system involvement and reduced access to supportive developmental opportunities. Effective Youth AOD responses therefore require more than substance-focused intervention alone. They require integrated, developmentally responsive and relationship-based approaches capable of addressing the broader circumstances shaping young people's lives and future pathways.

Substance Use

Substance use exists along a continuum and is not always harmful, problematic or associated with dependency, impairment or developmental disruption. Young people accessing the Youth AOD Service System, like all young people, use alcohol and other drugs for a wide range of reasons including experimentation, peer connection, pleasure, identity exploration, social participation, recreation, coping, belonging, curiosity or attempts to manage distress and adversity. Even

where substance use becomes harmful, persistent or associated with significant risk, it may continue to serve important psychological, relational, developmental or social functions for the young person.

Young people accessing the Youth AOD Service System often use substances as an attempt to regulate overwhelming emotions, cope with trauma or distress, reduce anxiety or emotional pain, manage loneliness or social exclusion, establish belonging, achieve status or recognition, experience pleasure or escape, increase confidence, manage boredom or hopelessness, create a sense of control, or cope with grief, shame or disconnection.

Harmful substance use may therefore represent an adaptive response to adversity that has an immediate effect, but that has longer-term consequences — potentially contributing to additional harm, instability or developmental disruption.

Youth AOD service providers should therefore seek to understand not only what harms are associated with substance use, but also what function and meaning it holds for the young person. Sustainable change is more likely when young people gain access to safer and more constructive ways of meeting the emotional, relational, developmental and social needs that substance use may previously have served.

The 2025 Youth AOD Census found:

- 59.7% of young people were experiencing extreme substance use severity on entry to service
- A further 24.6% were experiencing high-level substance use severity — meaning 84.3% presented with high or extreme severity
- 60.8% were using a substance daily
- 67.6% were dependent on a substance
- The three most common primary drugs of concern were cannabis (49.0%), alcohol (18.9%) and methamphetamine (18.1%)
- 68.6% were using multiple substances
- 37.5% had experienced a substance-related harm in the preceding three months, including hospital admission, physical injury or violence

Psychosocial Complexity

Young people accessing Youth AOD services have regularly had to contend with cumulative adversity across multiple domains of life. Mental health challenges, experiences of abuse and violence, family conflict, child protection involvement, housing instability, educational disengagement and justice-system involvement commonly overlap rather than occurring independently. These interacting experiences can contribute to developmental disruption, reduce access to supportive relationships and opportunities, and increase vulnerability to ongoing harm.

The 2025 Youth AOD Census found:

- 52.5% were experiencing extreme psychosocial complexity; a further 34.4% were experiencing a high level — meaning 86.9% presented with high or extreme complexity
- 59% had a diagnosed mental health condition
- 59.7% had experienced some form of abuse (emotional, physical, sexual or neglect)

- 52.7% had been exposed to violence, including family violence, intimate partner violence or violent crime
- 47.1% had a history of self-injury or suicide attempt
- 48.4% had prior criminal justice system involvement
- 36.1% were victim-survivors of family violence
- 33.8% had previous Child Protection involvement; 11.1% were currently in out-of-home care
- 49.3% were not engaged in meaningful education or employment
- 31.2% were experiencing a housing problem, including 22.8% in unstable housing
- 64.7% were experiencing family conflict or disconnection

The convergence of high or extreme substance use severity and psychosocial complexity is striking, with 74.9% of young people in this cohort experiencing both simultaneously (Rintala et al. 2025).

The Victorian Government's Client Pathways analysis similarly found that young people accessing AOD treatment interact with multiple government systems at dramatically elevated rates compared with the broader population. Young people accessing AOD treatment were 39 times more likely to experience nights in custody, 28 times more likely to use mental health services, and significantly more likely to experience homelessness, child protection involvement, emergency department presentations and family violence-related service use (Victorian Government 2024).

Young people seeking assistance from services require integrated, flexible and developmentally responsive systems capable of supporting long-term developmental progression rather than short-term episodic intervention alone.

[Part 2] The Case for a Differentiated Youth AOD Service System

The evidence suggests that young people, regardless of the challenge before them, are best served by services that are developmentally appropriate and youth specific.

Merely being youth specific does not guarantee developmentally appropriate service provision. Effective Youth AOD systems require deliberate strategies tailored to the developmental requirements of each young person that are responsive to their changing needs over time.

1. AOD Problems Are More Prevalent During Adolescence

Problems with alcohol and other drugs are both more prevalent and more dangerous in adolescence and early adulthood than in later adulthood. Among young people, AOD related harm and road crashes are the leading causes of death. The contribution of AOD intoxication to suicide, homicide, injuries and poisoning is well established. Adolescents who enter the transition to adulthood with problematic substance use are significantly more likely than others to experience negative outcomes, including elevated drug use, lower educational and occupational attainment and higher levels of aggressive and violent behaviour.

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 and problems. While substance use disorders are rarely seen in children under 12, there is a sharp increase in prevalence from ages 12 to 18. People who develop substance use disorders in adolescence are more likely to have those symptoms continue into adulthood. On the basis of prevalence alone, adolescents and young adults warrant greater access to AOD treatment.

3. Earlier Intervention Produces Better Health and Developmental Outcomes

The earlier young people can be engaged

and retained in treatment, the more likely it is that a healthy and constructive developmental pathway can be established or restored – and substance use related harm diminished.

Earlier intervention is not only clinically important; it is developmentally important. It can reduce immediate harm, interrupt harmful developmental cascades, strengthen protective relationships, and increase access to education, employment, family support, community participation and other developmental resources.

This requires working not only with the young person but also with families, carers, peers, communities and other systems involved in their care. Investment in Youth AOD early intervention can therefore modify risk and strengthen the health, wellbeing and future participation of young people, families and communities.

4. Risks of Exposure and Antisocial Modelling in Adult Services

Young people have particular developmental and safeguarding needs that mean placing them in adult-oriented drug treatment services can have a detrimental effect and deter them from seeking further support. There is also the risk of exposing young people to more entrenched substance use, antisocial modelling, exploitation or unsafe relationships within adult settings. These risks are heightened in residential environments and intensive therapeutic programs. Youth AOD services must therefore be embedded within youth-specific service systems with appropriate safeguards, developmental expectations and relational approaches.

5. Whole-of-Government Impacts and Cost Effectiveness

Youth AOD services work with young people whose needs and risks cut across multiple government systems. The Victorian Client Pathways analysis demonstrates that young people accessing AOD treatment are among the most intensive users of multiple service systems, including mental health, justice, homelessness, child protection, emergency health and family violence responses (Victorian Government 2024).

These interactions are not isolated service contacts. They reflect cumulative developmental adversity that can extend across adolescence and into adulthood if effective support is not available. Because Youth AOD services work at the intersection of these systems, effective intervention has the potential to influence outcomes across multiple portfolios simultaneously.

Investment in Youth AOD services can therefore contribute to reduced justice-system involvement, improved mental health and wellbeing, increased educational participation, reduced homelessness, reduced emergency service utilisation, increased workforce participation and improved community safety. The Client Pathways analysis also shows that although AOD treatment itself may be time-limited, interactions with broader government systems before and after treatment remain substantial, reinforcing the importance of sustained, coordinated and developmentally attuned intervention.

International evidence has also demonstrated that the immediate and long-term benefits of specialist substance use treatment for young

people can significantly outweigh the costs of providing that treatment. Earlier United Kingdom cost-benefit analysis estimated returns of between £4.66 and £8.38 for every £1 spent, reflecting short-term savings in crime and health costs as well as long-term reductions associated with adult dependency and improved education and employment prospects. While this is supporting rather than primary evidence for the Victorian context, it is consistent with the broader investment logic demonstrated by Victorian Client Pathways data and earlier Victorian Youth AOD system analysis.

Investment in Youth AOD services is therefore not only a clinical and ethical imperative. The investment case presented draws on the Victorian Government's own linked administrative data to demonstrate the scale of the cross-portfolio cost burden — and the window for earlier, more effective intervention.

[Part 3]
The Investment Case

Young people accessing Youth AOD services in Victoria generate costs across justice, mental health, housing, child protection, emergency health and education at rates that substantially exceed the general youth population.

Two evidence sources, read together, provide a robust foundation for earlier and better-targeted intervention that moderates the developmental trajectories of young people before AOD related harm becomes entrenched:

- The 2025 Youth AOD Census (Rintala et al., 2025), led by La Trobe University and facilitated by YSAS, provides a contemporary sector-level snapshot of the complexity and acuity of young people accessing specialist AOD services.
- The Victorian Client Pathways Report 2 (Department of Treasury and Finance, 2024), produced using linked administrative data from the Victorian Social Investment Integrated Data Resource, independently corroborates and extends that picture.

Together, these sources make clear that investment in the Youth AOD Service System is both a clinical imperative and a whole-of-government fiscal opportunity.

1. Young People Accessing Youth AOD Services Are Among the Highest Users of Multiple Government Systems

The Client Pathways analysis examined the service usage of 3,172 young people aged 12 to 25 who accessed AOD treatment for the first time in 2019. Using linked administrative data spanning health, mental health, child protection, homelessness, housing, justice and education, it found that this cohort interacted with other government services at dramatically elevated rates compared with the general youth population (Department of Treasury and Finance, 2024).

Table 1

Service System	Overrepresentation vs General Youth Population
School absences	56 times higher
Nights in custody / corrections orders	39 times higher
Family violence services (perpetrator)	29 times higher
Clinical mental health services	28 times higher
Nights in homelessness accommodation	11 times higher
Emergency department presentations	Multiple times higher
Child protection reports	Multiple times higher
Nights in out-of-home care	Multiple times higher

Source: State of Victoria, Department of Treasury and Finance, Client Pathways Report 2 (2024), Fig. 7.

These are not modest differentials. Young people accessing AOD services are experiencing, at peak, nearly 40 times the rate of custody interactions, 28 times the rate of mental health service use, and more than 50 times the rate of school absenteeism compared with their peers. Each of these interactions carries a direct and measurable cost to government — in beds, caseworkers, custody operations, emergency departments, and crisis accommodation.

Importantly, the Client Pathways analysis also reveals that service usage across all these systems peaks in the same year as first AOD treatment - and in most cases, begins escalating in the years immediately prior. This pattern is consistent with the hypothesis that earlier, better-integrated Youth AOD intervention could moderate this peak of cross-system crisis contact, reducing simultaneous demand on multiple portfolios.

2. Complexity Has Increased Since the Last Measurement Point

The 2025 Youth AOD Census provides a direct comparison with the 2016 Youth AOD Census (Hallam et al., 2018), enabling a trajectory analysis of change in complexity and acuity over a nine-year period. The findings are consistent with a pattern of increasing complexity that, without commensurate investment in early and integrated intervention, will continue to generate escalating costs across government.

Table 2

Indicator	2016 Census	2025 Census	Change
Cannabis dependence	42%	58%	+16 percentage points
Recent cannabis use (past 4 weeks)	64%	70%	+6 percentage points
Recent alcohol use (past 4 weeks)	45%	56%	+11 percentage points
Alcohol dependence	11%	15%	+4 percentage points
Methamphetamine dependence	13%	17%	+4 percentage points
Prior criminal justice system involvement	33%	48%	+15 percentage points

Sources: Rintala et al. (2025); Hallam et al. (2018).

Substance dependence has increased across all three primary drugs of concern. Justice system involvement has grown substantially — from one in three to nearly one in two young people presenting with prior justice contact. These increases occurred against a backdrop of the Victorian Government's own data showing that proceedings against young people for primary drug offences reached their lowest recorded level in 2023–24 (ABS, 2025). This suggests the justice system overrepresentation is not primarily a product of drug-specific policing but reflects the broader developmental complexity and disadvantage accumulating among young people who eventually access AOD services.

The implication is clear: without investment in earlier and more effective intervention, the level of complexity, and associated cross-system cost, will continue to compound over time.

3. The Cost Burden Is Distributed Across Multiple Government Portfolios

A defining feature of this population is that the costs they generate are not concentrated in any single government system. They are distributed simultaneously and persistently across health, mental health, justice, child protection, housing, homelessness and education. This has two important fiscal implications.

First, the investment case for Youth AOD Service System investment cannot be assessed within any single departmental budget. An analysis confined to the health or AOD portfolio will systematically understate the return, because a substantial proportion of the benefit of earlier and more effective Youth AOD intervention accrues to other portfolios — particularly justice, mental health, child protection, and housing. This is precisely why the Client Pathways analysis, produced by Treasury and Finance rather than the Department of

Health, is such a significant contribution to the reform evidence base.

Second, whole-of-government analysis of the kind the Client Pathways framework enables is the appropriate instrument for understanding the investment logic. The Victorian Government's Early Intervention Investment Framework is specifically designed to capture this cross-portfolio logic, and the Client Pathways report was commissioned expressly to inform future investment proposals through that framework.

Table 3

Indicative Cost Context		
Cost Domain	**Indicative Annual Cost**	**Basis**
Acute mental health inpatient care	~$39,000	*Avg. 26 nights/yr for AOD+MH cohort at ~$1,500/night (Productivity Commission, 2024)*
Youth justice custody	~$118,000	*Avg. 118 nights/yr for custody sub-cohort at ~$1,000/night*
Emergency department presentations	Significantly elevated	*Multiple times higher than general youth population (Client Pathways, 2024)*
Homelessness accommodation	Significantly elevated	*11× overrepresentation vs general youth population*
Child protection case management	Multiple contacts	*Substantially over-represented vs general youth population (Client Pathways, 2024)*
Indicative total (highest-complexity sub-cohort)	**>$200,000 per person**	*Across justice, mental health, homelessness, child protection and health portfolios*

These figures are indicative and intended to frame the order of magnitude of the investment logic. Even modest reductions in peak crisis contact through earlier intervention would represent substantial cross-portfolio savings. The EIIF linked data framework is the appropriate vehicle for a validated cost-benefit analysis.

4. Educational Disengagement Creates a Long-Term Fiscal Drag

Approximately half of all young people entering Youth AOD services are not engaged in education, training or employment (Rintala et al., 2025). The Client Pathways analysis found that the AOD cohort experienced 56 times the rate of school absenteeism compared with the general youth population, with average unapproved absences among school-age young people reaching 54 days per year — nearly three times the threshold for chronic absenteeism — in the year of first treatment (Department of Treasury and Finance, 2024).

Educational disengagement is not simply a welfare concern. It generates a long-term fiscal cost through reduced lifetime earnings, reduced tax contributions, increased welfare dependence, and continued interaction with health and justice systems into adulthood. Published Australian estimates of the lifetime fiscal cost of a young person failing to complete secondary education, accounting for foregone tax revenue and increased social service utilisation, run to several hundred thousand dollars per person (Productivity Commission, 2014; KPMG, 2015). With nearly half of the Youth AOD cohort disengaged from both education and employment, and with the Census demonstrating this has not improved since 2016, the long-term fiscal argument for investing in participation-focused Youth AOD responses is substantial.

5. The Pattern of Service Interaction Suggests a Window for Earlier Intervention

One of the most policy-relevant findings of the Client Pathways analysis is the temporal pattern of service interaction. For almost every service system measured — mental health, emergency departments, justice, homelessness, child protection — usage rises steadily in the years before first AOD treatment, peaks at or around the year of first treatment, and in most cases begins to decline thereafter (Department of Treasury and Finance, 2024).

This pattern has two significant implications. First, it confirms that the point of first AOD treatment is not the beginning of disadvantage — it is typically a late point of crystallisation, after years of accumulating contact with multiple systems. This strengthens the case for earlier identification and intervention pathways well before young people reach the threshold for specialist AOD treatment.

Second, the post-treatment trajectory — while variable across service types and cohorts — is generally more favourable than the trajectory leading into treatment. This is consistent with the hypothesis that AOD treatment engagement, even in the current system, generates some moderating effect on acute crisis contact. A more capable, earlier-intervening and better-integrated system would be expected to shift this curve further and earlier.

The Prevention Logic in Plain Terms

The Client Pathways data shows that by the time a young person accesses AOD services for the first time, they have typically already been interacting with multiple government systems for years — at high intensity and high cost. The investment question is not whether government will pay for these young people's needs. It already is. The question is whether it will continue to pay predominantly through crisis systems, or whether it will invest earlier and more effectively in responses capable of moderating the trajectory before crisis becomes entrenched.

6. International Evidence Supports a Positive Return on Investment

While no Victorian-specific return-on-investment study has been conducted on Youth AOD services, international evidence is consistent in demonstrating that specialist youth AOD treatment generates returns that substantially exceed its cost. UK analysis estimated returns of between £4.66 and £8.38 for every £1 invested in youth AOD services, reflecting short-term savings in justice and health expenditure and long-term reductions in adult dependency and associated service utilisation (National Treatment Agency, 2012).

Longitudinal data from the Program for Adolescent Life Management (PALM) — a residential youth AOD program in New South Wales followed for up to 16 years — found significantly lower rates of hospitalisation for mental health problems, substance use disorder and physical injury following treatment, as well as improved criminal conviction trajectories for those with prior offending histories (Whitten et al., 2022, 2023). These outcome improvements, sustained over 16 years of follow-up, are consistent with the cross-portfolio cost reduction logic supported by the Victorian Client Pathways analysis.

The PALM data also indicated that mortality rates among young people who accessed residential AOD treatment were four to twelve times that of the general population — a finding that underlines both the severity of need and the stakes of inadequate intervention. Improved investment in earlier and more capable Youth AOD responses is not only an economic argument; it is also a matter of preventable mortality.

7. The Investment Case Is Strengthened by the EIIF Framework

The Victorian Government's Early Intervention Investment Framework is specifically designed to identify the most cost-effective points of intervention for young people experiencing complex and intersecting disadvantage. The Client Pathways Report 2 was produced by DTF under that framework, explicitly to inform future investment proposals and Partnerships Addressing Disadvantage.

This Blueprint's reform agenda aligns closely with the EIIF's investment logic. The ten design priorities set out in Part 4, particularly those focussed on psychosocial stability, proactive engagement, integrated care, education and employment pathways, and justice diversion, map directly onto the domains in which the Client Pathways analysis has demonstrated elevated and costly service utilisation among young people accessing AOD services.

The EIIF framework provides the mechanism through which the investment case set out in this section can be operationalised into specific, costed reform proposals. The Victorian Government has already invested in generating the linked data infrastructure - through VSIIDR - that enables a more granular cost-benefit analysis than has previously been possible. The Youth AOD service providers who have authored this Blueprint, strongly support the development of a validated, whole-of-government cost-effectiveness analysis of system reform as a priority early action. The providers similarly support a whole-of-system assessment of demand, service capacity and access – including waitlists, workforce capacity, and geographic and timeliness gaps in

the availability of care – as a companion early action, to ensure reform is matched to the scale and distribution of need.

Summary: The Investment Logic

The case for investment in Youth AOD reform rests on four converging arguments:

1. Government is already paying — through the wrong systems.

Young people in the Youth AOD cohort generate costs across justice, mental health, housing, child protection, emergency health and education at rates far exceeding the general youth population. These costs are real and can be reduced through enhancing the capacity of Victorian Youth AOD Services to intervene earlier to prevent harmful AOD use from becoming entrenched.

2. Complexity is increasing over time.

Census trend data shows that substance dependence, justice involvement and psychosocial complexity have all increased since 2016, meaning the downstream cost burden will continue to grow without investment in earlier and more effective intervention.

3. The benefit is distributed across portfolios.

Investment in the Youth AOD Service System can produce returns across justice, mental health, housing, child protection, education and health — making it one of the few social investments capable of generating positive fiscal outcomes simultaneously across multiple departmental budgets.

4. The evidence infrastructure exists to make the case rigorously.

The VSIIDR linked data platform, the Client Pathways framework, and the 2025 Youth AOD Census together constitute the strongest evidence foundation yet assembled for Victorian Youth AOD investment. A validated cost-benefit analysis is achievable with existing data infrastructure and should be an early priority in any reform process.

[Part 4] Service System Design Priorities

Ten Service System Design priorities have been identified by Victorian Youth AOD Service Providers who are united by a shared vision: A Victoria in which all young people experiencing substance use related problems have timely access to integrated, developmentally responsive and culturally safe supports that strengthen psychosocial stability, reduce harm and support healthy transitions to adulthood.

Priority 1: Connect Psychosocial Stability with Sustained Developmental Pathway Support

The substance use of most young people accessing the system is associated with complex and concurrent psychosocial challenges. Effective treatment and positive developmental progression are only possible when young people can attain a reasonable level of stability that can be sustained.

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The 2025 Youth AOD Census confirms that most young people accessing specialist Youth AOD services experience severe substance-related harm alongside high or extreme psychosocial complexity (Rintala et al., 2025). Housing instability, family conflict, trauma exposure, emotional dysregulation, mental ill-health, and disengagement from education and employment are highly prevalent and frequently co-occurring. The Victorian Client Pathways analysis reinforces this picture, demonstrating extensive cross-system interaction across mental health, homelessness, child protection, emergency health and justice — reflecting cumulative disadvantage across multiple life domains (Victorian Government, 2024).

Research from developmental criminology, adolescent neuroscience and the study of trauma demonstrates that cumulative adversity and toxic stress

during adolescence can significantly disrupt emotional regulation, executive functioning, identity formation and long-term health and behavioural outcomes (Moffitt, 1993; Shonkoff et al., 2012; WHO, 2024). Violence warrants specific attention in this context. For some young people, violence is a source of serious trauma, victimisation and fear. For others, the use or threat of violence may function as a mechanism for obtaining status, protection, belonging, resources or control within unsafe social environments. Both dynamics can significantly disrupt developmental progression and require careful assessment, intervention and support.

Psychosocial instability is not a secondary issue to be addressed once substance use is stabilised. It is central to young people gaining more control over their substance use. Psychosocial stability is not simply the absence of crisis. It reflects the presence of sufficient relational continuity, emotional containment, practical support, educational participation, cultural connection, stable housing and developmental opportunity for positive development to remain possible. In this sense, psychosocial stability is itself developmentally protective and a necessary foundation for sustained behavioural change.

Evidence consistently demonstrates that positive developmental outcomes are more likely when young people have access to safe relationships, stable environments, meaningful participation and supportive communities (Hawkins & Catalano, 1992; Ungar, 2011). Longitudinal research further indicates that educational engagement, workforce participation and stable housing are independently associated with reduced long-term vulnerability to substance-related harm, offending and homelessness (Fergus & Zimmerman, 2005; Fitzpatrick-Lewis et al., 2011).

This reflects a broader understanding that young people's safety, wellbeing and developmental outcomes are shaped not only by individual behaviour but also by the relational, social and environmental contexts in which they live. Effective responses therefore seek to strengthen the protective conditions surrounding young people, including families, peer networks, education settings, housing, community connections and service relationships. Intervention should not focus solely on reducing immediate risk behaviours, but also on reducing the pressures and adversities that contribute to vulnerability, disrupting pathways into harm and exploitation, and strengthening the protective relationships, opportunities and supports that promote healthy development.

Particular attention is required during periods of transition, including movement between placements, return to family, entry into independent living, release from custody, discharge from treatment and transition between youth and adult services. These periods often involve the loss of established relationships, routines and supports at precisely the time vulnerability may increase. Sustained developmental pathway support therefore requires continuity of care that extends beyond episodes of treatment and remains focused on maintaining stability, participation and connection during periods of change.

Effective Youth AOD responses support the restoration of positive developmental pathways by addressing the conditions

that sustain harm, not only its symptoms. This requires a service system that actively promotes psychosocial stability, strengthens protective environments and relationships, and supports young people to build and sustain pathways towards safety, wellbeing, participation and long-term developmental success.

Priority 2: Safe and Effective Responses for Priority Populations

Some groups face disproportionate harm, greater barriers to help, and poorer outcomes under universal approaches. Equity requires responses specifically designed for the young people most likely to be left behind.

Young people experiencing substance-related harm are not affected by adversity in the same way, nor is access to services or achievement of outcomes equitable.

The Youth AOD Census demonstrates substantial over-representation of young people experiencing structural disadvantage, discrimination, social exclusion and systemic inequity, including Aboriginal and Torres Strait Islander young people, LGBTQIA+ young people, culturally and linguistically diverse young people, young people in out-of-home care, neurodiverse young people and young people involved in justice systems (Rintala et al. 2025).

Evidence on the social determinants of health, minority stress, trauma and cultural wellbeing demonstrates that structural inequality, discrimination, racism, stigma, social exclusion and identity-based marginalisation are strongly associated with poorer mental health, substance-related harm, housing instability and reduced access to care (Meyer 2003; Dudgeon et al. 2014). These experiences can significantly affect developmental pathways, social connection, emotional wellbeing and help-seeking behaviour across adolescence and emerging adulthood.

Universal or culturally neutral approaches are insufficient to achieve equitable engagement and outcomes for many vulnerable young people. Youth AOD Service System reform must therefore incorporate culturally safe, inclusive and identity-affirming responses that recognise the impact of structural inequality, discrimination, trauma and exclusion on developmental pathways and in driving substance-related harm.

Priority population responses should be co-designed, culturally governed and evaluated with communities, recognising that while the equity rationale is strong, intervention-outcome evidence remains uneven across populations. Current evidence supports the importance of culturally safe, affirming and inclusive practice environments, although high-quality longitudinal evidence regarding the comparative effectiveness of specific culturally adapted Youth AOD interventions remains limited in Australia and internationally. Further longitudinal and intervention-outcome research is needed to strengthen understanding of which specific adaptations, engagement models and culturally informed

interventions are most effective across diverse Youth AOD populations.

First Nations Young People and Families

Aboriginal and Torres Strait Islander young people are significantly over-represented within the Victorian Youth AOD service system. The 2025 Youth AOD Census found that approximately 14% of young people accessing Youth AOD services identified as Aboriginal and/or Torres Strait Islander — substantially higher than their representation in the broader Victorian youth population (Rintala et al., 2025). Over-representation is most pronounced in residential withdrawal and rehabilitation, reflecting disproportionate levels of cumulative and intergenerational trauma rooted in colonisation: violent land dispossession, the forcible removal of children, and cultural suppression. The ongoing impacts of these experiences — compounded by systemic racism and structural inequity — are evident in elevated rates of homelessness, statutory system involvement and complex psychosocial need among First Nations young people and families.

Research on Aboriginal social and emotional wellbeing consistently demonstrates that culture, kinship, identity, community connection and self-determination are not supplementary considerations -they are central protective and healing factors that support resilience and wellbeing (Dudgeon et al., 2014; Kirmayer et al., 2011). For First Nations young people, cultural connection and belonging are foundational to developmental progression.

Youth AOD responses must move well beyond culturally neutral practice. This requires Aboriginal-led service design and governance, and services that strengthen:

- partnerships with Aboriginal Community Controlled Organisations
- culturally safe engagement and care planning
- family and kinship-based approaches
- access to cultural healing and connection
- Aboriginal workforce capability and leadership
- flexible outreach and community-based responses
- and integrated pathways across health, housing, education and justice systems

The Victorian Government has affirmed its commitment to providing culturally safe and responsive AOD services for Aboriginal people in Victoria, recognising that self-determined, culturally safe mainstream and Aboriginal-specific services are central to supporting social and emotional wellbeing and to achieving Closing the Gap commitments. The authors of this Blueprint strongly support the continuation and strengthening of a separately funded Aboriginal AOD service system, with funding directed to and governed by Aboriginal Community Controlled Health Organisations. Resources allocated to Aboriginal-specific AOD responses should remain within community control - not

absorbed into mainstream funding arrangements or subject to competitive tendering processes that disadvantage community-controlled providers.

At the same time, Aboriginal and Torres Strait Islander young people and families who choose to access mainstream Youth AOD services must be able to do so without encountering culturally unsafe or unwelcoming practice. Mainstream services carry an independent obligation to be genuinely inclusive — not as an alternative to the community-controlled sector, but because self-determination includes the right to choose where to seek support. This requires mainstream Youth AOD services to move beyond procedural cultural competency toward practice environments where First Nations young people and families experience genuine safety, respect and effectiveness. Both systems must be adequately resourced, mutually reinforcing, and oriented toward the same goal: improved social and emotional wellbeing and developmental outcomes for Aboriginal and Torres Strait Islander young people in Victoria.

LGBTQIA+ Young People

LGBTQIA+ young people experience elevated rates of discrimination, family rejection, homelessness, mental ill-health, self-harm and social exclusion, all of which increase vulnerability to problematic substance use and create barriers to help-seeking.

The Youth AOD Census demonstrates that LGBTQIA+ young people accessing Youth AOD services experience disproportionately high rates of emotional abuse, family violence, intimate partner violence and sexual abuse compared with heterosexual and cisgender peers (Rintala et al. 2025). Census findings also indicate elevated rates of self-harm, suicidality, housing instability and mental health complexity among LGBTQIA+ young people, reinforcing the cumulative impact of stigma, exclusion and unsafe environments on developmental wellbeing and help-seeking.

Minority stress theory demonstrates that experiences of stigma, discrimination, social exclusion and identity invalidation can contribute to chronic stress exposure, psychological distress and elevated vulnerability to mental health and substance use difficulties among LGBTQIA+ populations (Meyer 2003). Affirming environments, safe relationships and inclusive services are associated with improved engagement, emotional wellbeing and help-seeking.

While the evidence base supporting affirming and inclusive practice environments for LGBTQIA+ young people is well-established, high-quality longitudinal evidence regarding the effectiveness of specific LGBTQIA+-adapted Youth AOD interventions remains limited in Australia and internationally. Current evidence more strongly supports affirming, safe and inclusive practice environments than validated LGBTQIA+-specific treatment models. Services should treat co-design with LGBTQIA+ community organisations, and evaluation of affirming practice approaches, as priorities for continuous

improvement.

Youth AOD services should therefore strengthen:

- LGBTQIA+ inclusive practice
- gender-affirming and identity-affirming care
- psychologically safe service environments
- workforce capability in responding to sexuality and gender diversity
- responses to family rejection, violence and social exclusion
- partnerships with LGBTQIA+ community organisations.

Young People and Families from Backgrounds of Cultural and Linguistic Diversity (CALD)

Young people from culturally and linguistically diverse backgrounds are not a homogeneous group. Their experiences of substance-related harm and barriers to service access vary by country of origin, migration pathway, generational status, language, and the specific forms of racism and exclusion they encounter. The Youth AOD Census identifies culturally and linguistically diverse young people as a priority population, with elevated rates of family conflict, discrimination, educational disengagement and mental health complexity (Rintala et al. 2025).

For some young people and families, stigma associated with substance use, mental health and service engagement can further delay help-seeking and reduce access to early intervention.

Structural determinants research demonstrates that racism, exclusion and social marginalisation can significantly influence access to healthcare, educational participation, housing stability and developmental opportunities. Migration-related trauma, cultural dislocation and family stress may also contribute to emotional distress and barriers to engagement for some young people and families.

Evidence regarding the effectiveness of specific culturally adapted Youth AOD interventions in Australia remains limited. Current evidence more strongly supports culturally responsive engagement, bicultural workforce capability and community partnership models than validated CALD-specific treatment approaches. Co-design with community organisations and rigorous evaluation of culturally adapted models should be treated as a priority for the sector.

Youth AOD services should therefore strengthen:

- culturally responsive engagement
- bicultural workforce capability
- interpreter access
- partnerships with cultural community-led organisations
- family-inclusive approaches responsive to cultural context
- anti-racist and equity-oriented practice.

Gender-Responsive Practice

Young women and gender-diverse young people accessing Youth AOD services frequently experience high rates of trauma exposure, family violence, exploitation, coercive relationships and mental ill-health.

The Youth AOD Census found that young women were significantly more likely than young men to report experiences of family violence, intimate partner violence, emotional abuse and sexual abuse (Rintala et al. 2025). Young women accessing Youth AOD services also experience elevated rates of self-harm, trauma-related mental health challenges and unsafe relationships, reinforcing the need for gender-responsive and trauma-responsive approaches to care.

Evidence from trauma and gender-based violence literature indicates that experiences of coercion, exploitation, unsafe relationships and gendered violence can significantly shape substance use, emotional wellbeing, help-seeking and developmental outcomes for young women and gender-diverse young people.

Youth AOD systems should therefore strengthen:

- gender-responsive care
- family violence capability
- trauma-sensitive responses to exploitation, coercion and other gendered violence harms
- integrated sexual health and wellbeing responses.

Safe, affirming service environments are foundational to engagement, trust and long-term developmental progression for young women and gender-diverse young people. Gender-responsive practice is not a discrete program model — it is a practice orientation that must be embedded across service types, assessment processes, care planning and workforce capability. Evidence on gender-specific Youth AOD interventions is growing but remains limited in the Australian context; current evidence more strongly supports gender-responsive practice principles than validated gender-specific treatment models. Services should treat co-design with young women, gender-diverse young people, and specialist family violence and sexual assault organisations as a necessary condition for effective gender-responsive practice.

Priority 3: Proactive Engagement and Early Intervention

By the time most young people access specialist services, harm is already well established. Intervening earlier — through outreach, schools and community settings — reduces long-term harm and changes developmental trajectories.

There is strong evidence supporting a strengthening of proactive engagement and earlier intervention pathways that identify and respond to developmental disruption, substance-related harm and psychosocial instability before problems escalate into entrenched disadvantage and crisis-system involvement.

The Youth AOD Census indicates that comparatively few young people access specialist Youth AOD services before the age of 15, suggesting many young people do not receive support until substance use and associated harms are already well established (Rintala et al. 2025). The case for early intervention is further supported by evidence that earlier onset substance use is associated

with greater severity of later substance-related harm, poorer developmental outcomes and increased risk of chronic health and psychosocial difficulties (Degenhardt et al. 2016).

Research from prevention science, developmental health and Adverse Childhood Experiences (ACEs) literature consistently demonstrates that exposure to trauma, adversity, family conflict, violence, social exclusion and early substance use is associated with elevated risk of later mental ill-health, substance dependence, educational disengagement, chronic health problems and justice-system involvement across the life course (Felitti et al. 1998; Hawkins, Catalano & Miller 1992; Shonkoff et al. 2012; Hughes et al. 2017; Gautam et al. 2024). Contemporary longitudinal research further demonstrates that cumulative childhood adversity can disrupt neurodevelopment, emotional regulation, attachment security, social functioning and developmental trajectories, particularly where adversity is chronic, relational and occurs without stable protective relationships or supportive environments.

Young people with emerging substance use problems may already be visible in schools, child and family services, out-of-home care, homelessness services, youth justice diversion pathways and community settings. However, without targeted and proactive engagement strategies, existing service arrangements will continue to respond when substance use, trauma exposure and social exclusion have become more entrenched.

Developmental and prevention research suggests that adolescence represents a critical period for intervention, where supportive relationships, school connection, family functioning and access to timely psychosocial support can significantly influence developmental trajectories and reduce the likelihood of later harm (Patton et al. 2016; World Health Organization 2024). Evidence also demonstrates that strong school connectedness, family-inclusive intervention and multisystemic responses are associated with improved emotional wellbeing, reduced substance-related harm and reduced later justice-system involvement (Hawkins, Catalano & Miller 1992).

Youth AOD reform should strengthen:

- assertive outreach and engagement
- school-based Youth AOD capability
- early identification and intervention pathways
- outreach to disengaged and highly marginalised young people
- family-inclusive prevention responses
- integrated responses with child and family services
- targeted responses for young people in out-of-home care
- youth justice diversion partnerships
- culturally responsive prevention initiatives.

Proactive engagement is particularly important for young people who are unlikely to seek help through traditional service pathways or who have developed mistrust of institutions and mainstream systems.

Earlier intervention is associated with reduced long-term harm, lower likelihood

of justice-system involvement, improved educational engagement and reduced chronic service dependence. It may also increase the likelihood that young people maintain connection to family, education, culture and community before patterns of instability and exclusion become more entrenched.

Evidence supporting family-based interventions, school-based prevention and multisystemic approaches is comparatively strong within adolescent prevention literature. Outreach approaches are therefore likely to be most effective when integrated with sustained relational support, multidisciplinary intervention and accessible treatment pathways rather than operating as stand-alone engagement mechanisms.

Place-based integrated service hubs for highly excluded young people may also function as promising engagement infrastructure for young people who are reluctant to access traditional institutional settings. Emerging practice evidence suggests these models may strengthen engagement, trust and continuity of care for highly marginalised cohorts, particularly where services are relationship-based, low-threshold and integrated across psychosocial and health supports. However, controlled longitudinal evidence regarding the effectiveness of specific hub models remains limited.

Priority 4: Integrated Needs-Led Care Embedding Specialist Clinical and Psychosocial Support

Substance use rarely exists in isolation. Young people with multiple and intersecting needs require coordinated clinical and psychosocial care, not sequential or fragmented service contact.

Young people accessing Youth AOD services frequently experience severe substance use related harm alongside complex mental health, psychiatric, neurodevelopmental, physical health and psychosocial needs. The Youth AOD Census and Victorian Client Pathways analysis demonstrate that many young people simultaneously interact with mental health, housing, homelessness, child protection, emergency health, family violence and justice systems, reflecting the cumulative and interconnected nature of disadvantage and developmental disruption (Rintala et al. 2025; Victorian Government 2024).

Many highly vulnerable young people encounter fragmented systems that are difficult to navigate, poorly coordinated and insufficiently responsive to changing developmental, clinical and psychosocial needs. Fragmented service systems are associated with disengagement, repeated crisis presentations, avoidable

justice-system involvement and poorer long-term developmental outcomes. Evidence from integrated care, dual diagnosis and coordinated care literature consistently demonstrates that young people with complex and co-occurring needs experience improved engagement and service retention when care is coordinated across clinical, psychosocial and community support systems (Minkoff & Cline 2004; Hetrick et al. 2017).

For many young people, substance use occurs within broader contexts of trauma exposure, violence, family conflict, social exclusion, unstable housing and disrupted developmental pathways. Clinical presentations therefore cannot be understood or effectively addressed in isolation from the psychosocial and developmental environments in which they occur.

The Blueprint therefore recognises that effective Youth AOD responses require specialist clinical, medical and psychiatric care to be integrated within broader psychosocial, developmental and family-focused systems of support. Contemporary evidence from integrated youth mental health, wraparound care and "no wrong door" approaches supports flexible, multidisciplinary and developmentally responsive systems capable of reducing service fragmentation and improving continuity of care for young people with complex needs (Hodges, Ferreira & Israel 2006; Hetrick et al. 2017).

Youth AOD services should therefore operate as sustained, integrated and needs-led systems of care capable of responding to the full complexity of young people's lives. This requires coordinated responses that combine specialist clinical care with:

- housing and practical support
- trauma-responsive therapeutic interventions
- family support and relational repair
- educational and vocational participation
- cultural connection and community inclusion
- violence prevention and safety planning
- long-term relational continuity and active outreach
- pathways into stable housing, education and employment
- opportunities for participation, belonging and positive identity development.

Integrated and sustained care is required because developmental progression is rarely linear. Young people experiencing extreme psychosocial complexity often move in and out of crisis and contact with services. There are high rates of disengagement, housing instability, justice-system involvement and mental health deterioration over extended periods of time.

Evidence from Assertive Community Treatment (ACT) and wraparound care approaches suggests that continuity of engagement, multidisciplinary coordination and persistent outreach can improve retention and engagement among highly vulnerable populations with complex psychosocial needs, although evidence regarding the optimal intensity, duration and structure of these models for Youth AOD populations remains variable (Mueser et al. 2003; Hodges, Ferreira & Israel 2006).

Youth AOD services currently deliver outreach and assertive engagement and long-term relational continuity where possible. They would be enhanced by the systematic incorporation of:

- wraparound responses that address both clinical complexity and psychosocial instability
- embedded mental health and psychiatric capability
- shared care planning and coordinated multidisciplinary responses
- integrated primary health and pharmacotherapy access
- proactive re-engagement following crisis or disengagement
- low-threshold access to support
- family-inclusive and culturally responsive practice
- flexible long-term engagement responsive to relapse, crisis and changing developmental needs

Place-based integrated service hubs can be vehicle for consolidation of the above service offering for young people experiencing serious disadvantage and disconnection from mainstream services. Some highly vulnerable young people linked to street culture and street-based social environments are reluctant to engage with traditional institutional settings and often require spaces where they feel accepted, safe and socially comfortable before they are open to receiving help.

Place-based integrated service hubs that combine outreach, psychosocial support, health care, harm reduction and clinical intervention may create pathways into sustained engagement where clinicians and workers are trusted, vouched for by peers and embedded within environments that reduce stigma and fear of judgement. Emerging practice evidence suggests these approaches are promising engagement infrastructure for highly excluded young people, although controlled evidence regarding the comparative effectiveness and cost-effectiveness of specific integrated hub models remains limited.

While evidence strongly supports the importance of integrated and coordinated care conceptually, less evidence currently exists regarding the optimal structure, duration and intensity of highly integrated Youth AOD service models. Integration quality, relational continuity and accessibility are likely to be critical determinants of effectiveness, rather than integration alone.

Priority 5: Responsivity for Young People with Mental Health Challenges, Trauma Experiences and Neurodevelopmental Needs

The majority of young people entering Youth AOD services have co-occurring mental health, trauma and neurodevelopmental needs. Services that cannot recognise and adapt to these needs will fail to engage the people who need them most.

The Youth AOD Census demonstrates extremely high rates of co-occurring mental health conditions, self-harm, suicidality, trauma exposure, family violence and neurodevelopmental complexity among young people accessing Youth AOD services (Rintala et al. 2025).

Many young people entering Youth AOD treatment have experienced chronic trauma, disrupted attachment, emotional dysregulation, learning difficulties, neurodevelopmental differences and significant barriers to accessing integrated mental health support. These experiences frequently shape engagement, emotional regulation, risk-taking behaviour, participation and long-term developmental outcomes.

Research from developmental psychology, neurodisability and youth justice literature demonstrates that executive functioning difficulties, communication impairments, learning disorders, ADHD and autism spectrum differences are significantly over-represented among vulnerable youth populations, including young people involved in justice and mental health systems (Snow & Bagley 2015; Hughes et al. 2012). These neurodevelopmental factors can influence attention, emotional regulation, planning, impulse control, social communication and capacity to engage effectively in traditional service environments.

Youth AOD systems must therefore strengthen responsivity and capability in:

- dual-diagnosis practice
- trauma-responsive care
- suicide prevention
- Responses to family, domestic and sexual violence victimisation
- ADHD and autism-informed practice
- neuro-affirming approaches
- emotional regulation support
- sensory-responsive environments
- integrated mental health partnerships
- developmentally responsive assessment and care planning.

Evidence from trauma and developmental neuroscience literature demonstrates that chronic stress exposure, trauma and adverse childhood experiences can significantly affect emotional regulation, cognitive processing, executive functioning and behavioural responses over time (Shonkoff et al. 2012). Similarly, ADHD and related executive functioning difficulties are associated with elevated risk of impulsivity, school disengagement, substance-related harm and justice-system involvement where needs remain unrecognised or unsupported (Young et al. 2015).

Services should recognise that many behaviours associated with substance use, aggression, disengagement or emotional dysregulation may reflect trauma adaptation, neurodevelopmental difference, unmet mental health needs or chronic stress exposure rather than deliberate non-compliance or behavioural resistance.

Research also indicates that language and communication difficulties are highly prevalent among justice-involved and highly vulnerable young people, potentially affecting comprehension, emotional expression, service engagement and participation in

therapeutic interventions (Snow & Bagley 2015). Responsivity therefore requires services to adapt environments, communication styles, interventions and engagement approaches to the developmental, emotional, cognitive and cultural needs of each young person.

This may include:

- flexible communication approaches
- sensory-responsive environments
- shorter and more structured interactions
- visual supports and simplified language
- repetition and scaffolded learning
- practical coaching and behavioural rehearsal
- coordinated mental health and neurodevelopmental assessment pathways
- consistent relational engagement and predictable routines.

Evidence supporting trauma-responsive, developmentally tailored practice that caters for neurodiversity is now substantial across youth mental health, youth justice and adolescent service literature. However, evidence regarding specific neuro-affirming Youth AOD interventions remains comparatively underdeveloped. Current evidence more strongly supports adapted practice principles and responsivity-informed service design than validated neurodiversity-specific Youth AOD treatment models.

This priority aligns strongly with the Victorian Alcohol and Other Drugs Strategy 2025–2035 through its emphasis on integrated mental health and AOD responses, trauma-responsive care, equity and inclusion, person-centred practice, and reducing long-term harm and system fragmentation.

Priority 6: Strengthen Family, Kinship, Peer and Community Connection

Relationships are among the most powerful drivers of developmental restoration. Strengthening safe connections to family, kin, peers and community is not supplementary to treatment — it is central to it.

Family conflict and disconnection are highly prevalent among young people accessing Youth AOD services. Census data indicates that 60.1% of young people report family conflict at entry and 36.2% are disconnected from family (Rintala et al. 2025).

Families, carers, kinship networks, peers and communities are central influences on young people's developmental pathways, coping strategies, identity formation and developmental progression. Family systems, attachment and adolescent development research consistently demonstrate that relationships with caregivers, peers and broader social environments significantly influence emotional regulation, behavioural development, help-seeking, substance use trajectories and long-term psychosocial outcomes (Bowlby 1988; Bronfenbrenner 1979).

Where safe and appropriate, strengthening these relational systems can improve engagement, reduce harm and support long-term developmental progression. Evidence from family therapy, Multidimensional Family Therapy (MDFT), Functional Family Therapy (FFT) and Multisystemic Therapy (MST) demonstrates that structured family-inclusive interventions can reduce adolescent substance use, improve family functioning and strengthen engagement among young people with complex behavioural and psychosocial needs (Liddle 2010; Henggeler & Schaeffer 2016).

Evidence also demonstrates that peer relationships exert significant influence during adolescence. Positive peer connection can strengthen belonging, participation and identity development, while harmful peer association may reinforce substance use, offending behaviour and social exclusion. The so-called peer contagion literature highlights the importance of carefully structured peer interventions that strengthen pro-social belonging while minimising reinforcement of harmful behaviours and antisocial norms (Dishion & Tipsord 2011).

Youth AOD services should strengthen:

- family-inclusive assessment and care planning
- access to family therapy and support where necessary
- standalone support for parents and carers
- kinship and caregiver engagement
- peer support and lived experience roles
- community participation pathways
- cultural and recreational connection
- opportunities for positive peer belonging.

Family-inclusive practice should be available even where the young person is ambivalent about family involvement and should include support for families and carers in their own right. This is particularly important where family conflict, violence, grief, disconnection or intergenerational trauma are part of the young person's developmental context.

Attachment and developmental research suggest that consistent, supportive and emotionally safe relationships can strengthen emotional regulation, resilience, self-efficacy and long-term developmental outcomes. For some young people, strengthening family relationships may involve repair and reconnection. For others, it may involve building alternative safe relational supports through kinship networks, mentors, cultural connection, peers, workers or community participation.

Participation and belonging should therefore be understood as both developmental needs and protective factors. Strengthening connection to family, kinship, peers, culture and community may support young people to build identity, confidence, relational capability and hope.

Evidence supporting structured family interventions is comparatively strong within adolescent substance use and behavioural intervention literature. By comparison, evidence regarding broader community participation and social connection approaches remains more theoretically and developmentally

informed than experimentally validated. Community participation, recreation, cultural engagement and positive peer belonging are strongly associated with improved developmental and psychosocial outcomes, although these mechanisms can be more difficult to operationalise and measure causally across complex Youth AOD populations.

Family, kinship, peer and community connection should therefore be strengthened where safe, appropriate and young-person-centred, with specific safeguards for family violence, coercion, confidentiality, unsafe peer influence and cultural safety.

Priority 7: Strengthen Participation, Education and Employment Pathways

Half of young people entering Youth AOD services are not engaged in education, training or employment (Rintala et al. 2025). Participation is not an outcome that follows treatment - it is a mechanism through which developmental progression becomes possible.

The 2025 Youth AOD Census found that almost half of young people accessing specialist Youth AOD services were not engaged in meaningful education or employment, while the Victorian Government's Client Pathways analysis demonstrated rates of school absenteeism more than fifty times higher than the broader youth population (Department of Treasury and Finance 2024; Rintala et al. 2025). These findings highlight the extent to which developmental pathways associated with learning, skill development, achievement and economic participation have been disrupted for many young people entering the Youth AOD service system.

Participation in education, training, employment, recreation, culture and community life is a core developmental need during adolescence and emerging adulthood. These experiences provide young people with opportunities to develop competence, confidence, identity, social connection, purpose and hope for the future. They also create access to positive peer networks, adult role models, social recognition and practical life opportunities that support healthy transitions into adulthood.

Research consistently demonstrates that disengagement from education and employment is associated with increased vulnerability to harmful substance use, mental health difficulties, homelessness, social exclusion and justice-system involvement (Sampson & Laub 1993; Fergus & Zimmerman 2005). Conversely, sustained participation is associated with improved wellbeing, strengthened self-efficacy, increased social inclusion, reduced offending and more positive long-term developmental outcomes (Maruna 2001; Patton et al. 2016). Participation is therefore not simply a marker of success; it is itself a protective factor and developmental intervention.

For many young people accessing Youth AOD services, barriers to participation extend beyond substance use alone. Trauma exposure, mental

health challenges, neurodevelopmental differences, unstable housing, family conflict, financial disadvantage, school exclusion and justice-system involvement can all limit access to meaningful participation opportunities. Effective Youth AOD responses must therefore address both the practical barriers to participation and the broader psychosocial conditions that undermine engagement.

Youth AOD services should strengthen:

- school re-engagement pathways
- partnerships with schools, TAFEs, universities and training providers
- vocational participation and employment pathways
- Individual Placement and Support (IPS) and other evidence-informed employment approaches
- supported transitions into education, training and work
- advocacy against exclusionary disciplinary practices
- flexible learning and participation models
- pathways into sport, recreation, arts, culture and community participation
- opportunities for volunteering, leadership and civic engagement
- practical assistance with transport, technology, documentation and other participation barriers.

Participation pathways are most effective when combined with stable relationships, psychosocial support, identity development and practical assistance rather than operating as standalone interventions. Connecting young people to education, employment or training in the absence of broader developmental and relational support is unlikely to produce sustained reductions in substance-related harm or offending.

The goal is not simply placement into education or employment. It is supporting young people to develop meaningful roles, relationships, skills, achievements and aspirations that strengthen identity, belonging and hope. Participation creates opportunities to experience success, contribute to community life and build a future worth investing in. As such, strengthening participation pathways should be understood as a central component of Youth AOD intervention and a critical driver of long-term developmental progression.

Strengthening education and employment pathways should therefore be understood as a dual investment. It is a preventative social investment that reduces the risk of entrenched substance-related harm, mental ill-health, homelessness and justice-system involvement; and it is an economic investment that supports future workforce participation and productivity while reducing long-term reliance on health, justice, housing and income-support systems. As demonstrated in the Investment Case (Part 3), educational and vocational disengagement carries a substantial long-term fiscal cost, and sustained participation is among the most effective levers available for improving both developmental outcomes and whole-of-government returns.

Priority 8: Reduce Justice-System Involvement Through Diversion and Health-Led Responses

Health-led responses that divert young people away from custody reduce long-term harm and avoid disadvantage becoming entrenched.

Nearly half of young people accessing Youth AOD services have had contact with the criminal justice system (Rintala et al., 2025), and the Victorian Client Pathways analysis demonstrates dramatic over-representation in custody-related justice involvement compared with the broader youth population (Victorian Government, 2024). For most young people, this reflects unaddressed criminogenic need — including substance-related harm, emotional dysregulation, antisocial cognition and harmful peer association — rather than entrenched criminal intent.

Developmental criminology and life-course research demonstrate that justice involvement is strongly shaped by cumulative and intersecting disadvantage, including family instability, disengagement from education and employment, harmful peer association, untreated mental health conditions and social exclusion (Moffitt, 1993; Sampson & Laub, 1993). Effective responses must therefore address both immediate offending behaviour and the broader developmental conditions that sustain it. The Risk-Need-Responsivity model provides a well-evidenced framework for this work, directing services to match intervention intensity to level of risk, target the criminogenic needs associated with offending, and tailor approaches to the young person's developmental stage, trauma history, communication needs and psychosocial functioning (Andrews & Bonta, 2024). Desistance and Good Lives research further demonstrates that sustained behaviour change is more likely when young people are supported to develop positive future orientation, stable relationships, strengthened identity and access to meaningful participation — not through justice-system processing alone (Maruna, 2001; Ward & Maruna, 2007). Structured cognitive-behavioural interventions, family-based approaches and peer-focused responses have demonstrated effectiveness in reducing recidivism when applied within this developmental frame (Lipsey, 2009).

It should be noted that an integrated practice model combining RNR principles with trauma-responsive and developmental approaches is an emerging rather than fully validated direction. Current evidence more strongly supports the individual components than any single integrated model, and services should apply these frameworks with appropriate clinical judgement.

Reform should strengthen forensic Youth AOD capability through:

- interventions targeting key criminogenic risks - antisocial cognition, harmful peer association, emotional dysregulation and substance-related harm;

- responsivity-informed practice tailored to neurodevelopmental vulnerability, trauma exposure and developmental stage
- therapeutic responses to adolescent use of violence
- diversion-focused responses and outreach within justice settings
- integrated responses with youth justice, police and courts
- support for education, training, employment and pro-social participation;
- practical assistance with housing, family stressors and barriers to participation
- post-release transition support.

Reducing justice-system involvement produces improved long-term outcomes for young people while reducing pressure on courts, custody and community corrections. This priority aligns with the Victorian Alcohol and Other Drugs Strategy 2025–2035 through its focus on harm reduction, diversion and integrated responses for people with complex needs.

Priority 9: Build a Skilled and Reflective Workforce

A capable, supported and stable workforce is the primary vehicle through which every other priority is delivered. No reform agenda succeeds without the people to implement it.

The increasing acuity and complexity of presentations within Youth AOD services requires a workforce that is highly skilled, trauma-responsive, developmentally informed, culturally safe and supported to sustain relational practice over time.

Youth AOD workers are increasingly required to respond to trauma exposure, mental health challenges, suicidality, self-injury, neurodevelopmental needs, family violence, homelessness, justice-system involvement and service-system fragmentation. This requires advanced capability that extends beyond entry-level AOD or youth work training.

Implementation science, workforce wellbeing and supervision literature consistently demonstrate that workforce capability, reflective supervision, organisational support and practice fidelity are critical implementation conditions for safe, consistent and effective service delivery within complex human services environments (Fixsen et al. 2005). Research also indicates that workforce burnout, vicarious trauma and high turnover can negatively affect continuity of care, relational engagement, implementation quality and organisational stability (Morse et al. 2012).

Youth AOD reform should invest in:

- workforce development
- reflective supervision
- practice leadership through VAADA
- trauma-responsive capability
- dual-diagnosis capability
- family violence capability
- neurodevelopmental and neuro-affirming practice

- cultural safety capability
- regional workforce development
- lived experience workforce pathways
- workforce wellbeing and retention.

Reflective supervision evidence suggests that regular supervision, practice reflection and organisational support can strengthen practitioner capability, reduce burnout risk and support implementation of trauma-responsive and relational practice approaches (Carpenter et al. 2013). Workforce retention literature also demonstrates that sustained workforce stability is strongly associated with manageable workload, professional development opportunities, organisational support and psychologically safe workplace cultures.

A sustainable and supported workforce is foundational to continuity, quality and safety of care. High workforce turnover undermines relational continuity, weakens engagement and limits the sector's capacity to implement reform.

Realising this workforce vision requires honest acknowledgement of the conditions in which services currently operate. Rising demand and complexity are meeting real constraints on capacity, including workforce shortages and recruitment and retention difficulties, service waitlists, uneven geographic coverage across regional and rural Victoria, and delays in timely access to care. These pressures are experienced directly by young people, families and practitioners, and they shape what any reform agenda can achieve. Strengthening workforce and service capacity, and improving the timeliness and geographic reach of care, should therefore be treated as core enabling conditions for the priorities set out in this Blueprint rather than as separate operational concerns.

Workforce investment should therefore be presented as a necessary implementation condition for safe, consistent and high-quality Youth AOD care, with evaluation of supervision, training, fidelity, wellbeing, retention and client outcomes.

Workforce development must also include lived and living experience roles as valued and supported components of the Youth AOD workforce. Evidence from lived experience workforce literature suggests that peer and lived experience roles may strengthen engagement, trust, hope and service responsiveness when adequately supported and integrated within broader multidisciplinary teams.

While implementation science and workforce literature strongly support the importance of workforce capability, supervision and retention, evidence directly linking workforce wellbeing interventions to improved client outcomes within Youth AOD settings remains comparatively limited. Current evidence more strongly supports workforce investment as a foundational condition for implementation quality, continuity and service safety.

This priority aligns with the Victorian Alcohol and Other Drugs Strategy 2025–2035 through its emphasis on workforce capability, lived experience, safe practice and system sustainability.

Priority 10: Strengthen Commissioning, Evaluation and Cross-Government Accountability

Commissioning reform is the structural condition that makes integrated, sustained and developmentally responsive care possible at scale.

Oversight of Youth AOD service system reform should be a cross-government endeavour incorporating strategic planning, service integration, outcomes monitoring, workforce development, evaluation and linked-data capability, and lived experience participation.

The Victorian Client Pathways analysis demonstrates that the costs associated with young people accessing AOD treatment are distributed across multiple government portfolios, including health, mental health, justice, child protection, housing, homelessness and education (Victorian Government, 2024). Equally, the benefits of effective intervention are shared across these same portfolios through reduced crisis-service demand, improved participation, stronger wellbeing and reduced long-term disadvantage.

This means Youth AOD reform cannot be understood as the responsibility of any single department or service system. No individual portfolio owns the problem in its entirety, and no individual portfolio captures the full benefit of successful reform. Effective governance therefore requires a model of shared stewardship, collective accountability and coordinated investment across government.

The purpose of governance is not simply to oversee service delivery. It is to provide system leadership for improving developmental outcomes for vulnerable young people and to ensure that investment, policy and service design remain aligned with that objective over time.

Representation should include:

- Department of Health
- Department of Education
- Department of Families, Fairness and Housing
- Department of Justice and Community Safety
- Youth AOD providers
- Aboriginal Community Controlled Organisations
- VAADA
- research partners
- lived experience representatives.

Governance should support implementation of reforms, monitor progress against service system design priorities, identify emerging risks and opportunities, and enable continuous improvement. Progress reporting should draw on service data, linked administrative data, sector insights and lived experience, with transparent reporting supporting shared accountability between government, providers and communities.

Governance arrangements should specifically incorporate:

- staged implementation and continuous improvement
- practice-based evidence generation and evaluation of emerging models
- linked-data learning systems
- co-design with young people, families and communities
- fidelity and implementation monitoring
- developmental and long-term outcome measurement
- adaptation to emerging evidence and changing population needs.

Accountability should extend beyond service activity and throughput measures to include shared responsibility for outcomes. This includes improvements in psychosocial stability, educational engagement, participation, housing security, family and community connection, reduced justice-system involvement and long-term developmental progression. These outcomes should be monitored through a shared outcomes framework capable of tracking change across service systems and over time.

A mature governance framework should also create mechanisms through which the benefits of successful intervention are visible across portfolios. Linked-data capability, longitudinal evaluation and whole-of-government reporting are critical to demonstrating how investment in Youth AOD services contributes to improved outcomes not only for young people and families, but also for health, education, justice, housing and community systems.

Ultimately, governance should function as a mechanism for sustained stewardship of developmental outcomes. Its purpose is to ensure that the collective efforts of government, communities, service providers and young people remain focused on a shared objective: creating the conditions in which vulnerable young people can establish and sustain positive developmental pathways into adulthood.

Conclusion

Victoria has established Australia's most comprehensive Youth AOD service system.

Evidence from the Youth AOD Census and Client Pathways analysis demonstrates that young people accessing the specialist Youth AOD service system in Victoria frequently experience exposure to violence and trauma, mental health challenges, homelessness, educational disengagement and justice-system involvement (Rintala et al., 2025; Victorian Government, 2024). The broader evidence base confirms that effective Youth AOD practice is strongly associated with developmentally responsive, relationship-based, trauma-responsive, culturally safe and integrated approaches that strengthen young people's capabilities, connections and opportunities over time (Bruun & Mitchell, 2012; Degenhardt et al., 2016; Fadus et al., 2019).

The priorities outlined in this Blueprint establish an evidence-informed foundation for service system reform that creates the conditions for future innovation, practice refinement and longitudinal evaluation. Youth AOD service system reform is both a treatment response and a long-term developmental, social and community investment. Young people experiencing serious disadvantage require sustained opportunities for safety, connection, participation, identity development and enduring relational support before meaningful and lasting change can occur.

Victoria is positioned to build a world-leading Youth AOD service system that:

- intervenes earlier and responds more effectively to complexity
- strengthens developmental progression, family connection and cultural safety
- improves participation, belonging and social and economic inclusion
- reduces avoidable justice-system involvement and long-term harm
- continuously evolves through evidence, evaluation and lived experience.

The central proposition of this Blueprint is that young people become safer, healthier and more connected when systems create the conditions for positive developmental pathways to emerge and be sustained. Harmful substance use rarely develops in isolation, and lasting change rarely occurs through treatment alone. It is strengthened when young people can access the relationships, opportunities, resources and experiences required to meet their developmental needs in healthy and constructive ways.

The challenge for government is therefore not simply to fund treatment services, but to invest in a service system capable of supporting developmental progression over time. The opportunity is substantial. A stronger Youth AOD service system has the potential to reduce harm, strengthen wellbeing, improve participation, support safer communities and moderate long-term demand on crisis-driven government systems.

Investment in Youth AOD services is ultimately an investment in young people's futures. It is an investment in the conditions that enable young people to develop, participate, contribute and thrive. In doing so, it is also an investment in stronger families, stronger communities and Victoria's social and economic future.

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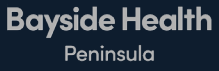
Collaborating Organisations



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