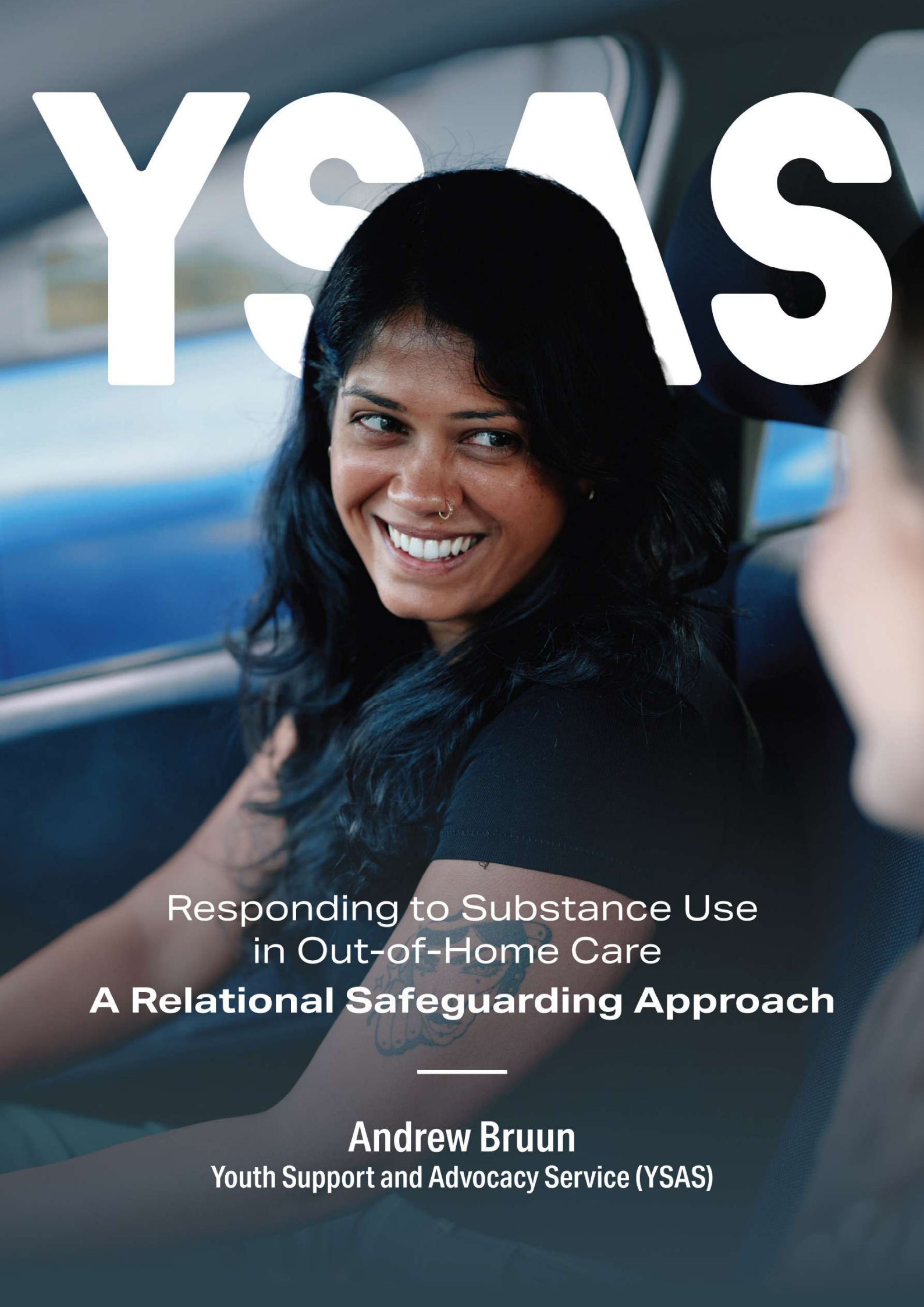


YSAS



Responding to Substance Use
in Out-of-Home Care
A Relational Safeguarding Approach

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Artwork by Alisha F

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Acknowledgement

Aboriginal and Torres Strait Islander peoples are the Traditional Owners of the lands and waters on which we live, work and provide services. Aboriginal and Torres Strait Islander peoples were the first to establish sovereign Nations on this continent, and that sovereignty has never been ceded.

Aboriginal and Torres Strait Islander peoples have a deep connection to Country, culture, family, kinship and community - these connections are central to social and emotional wellbeing.

Thanks and respect go to Elders past and present for their strength, wisdom, and leadership of Aboriginal and Torres Strait Islander communities.

The ongoing impacts of colonisation, dispossession, forced child removal, systemic racism and structural injustice continue to resonate, shaping the lives of Aboriginal and Torres Strait Islander young people, families and communities. The extent of the injustice and trauma these practices inflicted, sheds light on the over-representation of Aboriginal and Torres Strait Islander peoples in child protection, youth justice, and alcohol and other drug service systems.

Aboriginal and Torres Strait Islander peoples show us all how culture, identity, community connection and self-determination are central to healing and wellbeing.

As the author, I am committed to continuing to learn from Aboriginal Community Controlled Organisations, Aboriginal leaders and their communities about how to best support justice and better futures for First Nation's young people.

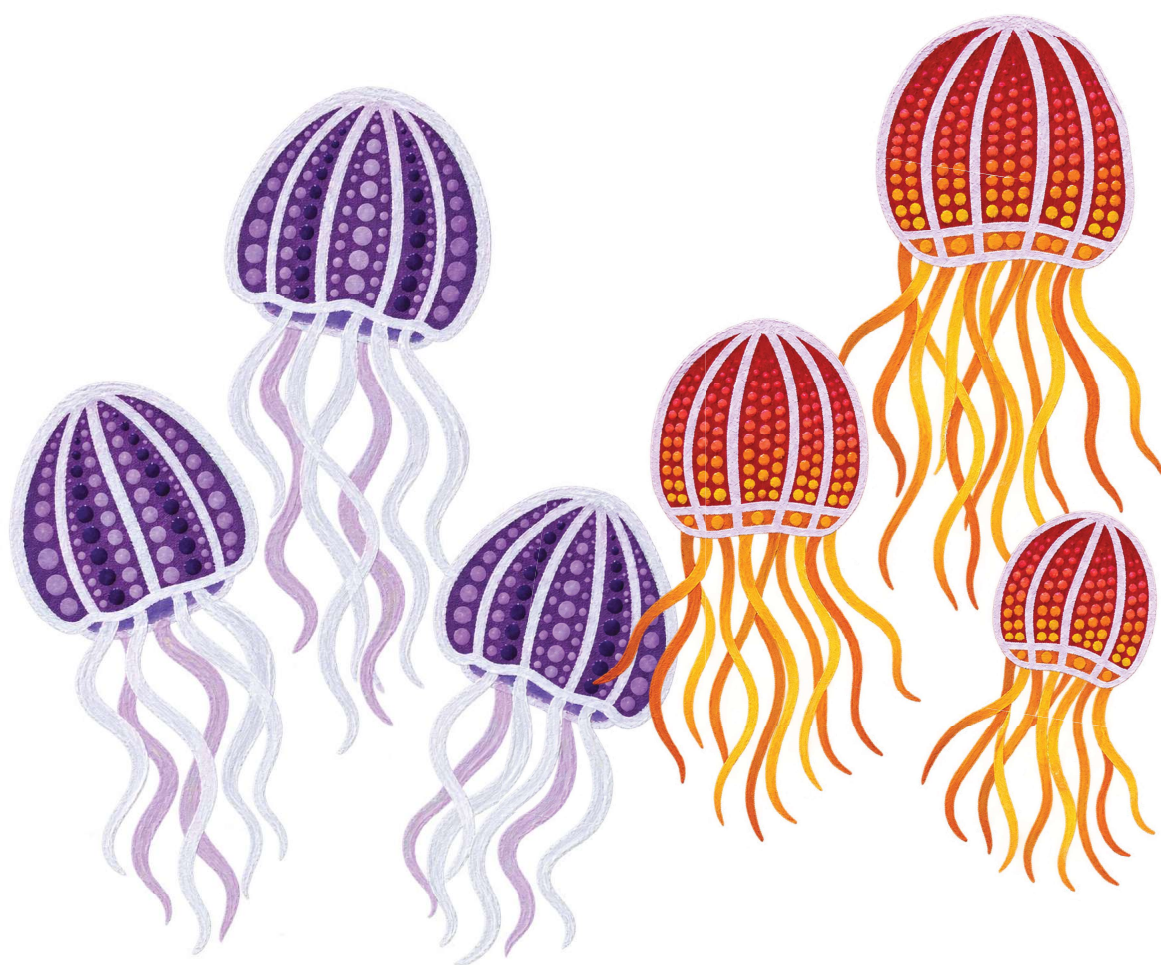


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Executive Summary

Young people in residential out-of-home care (OOHC) experience disproportionate rates of substance use-related harm. The same conditions that bring young people into care - trauma, disrupted attachment, family violence, poverty, social marginalisation and repeated relational rupture - are the conditions that make substance use both an understandable response and a significant risk. Understanding this is the necessary starting point for any effective response.

Two major Victorian inquiries tabled in 2026 - the Commission for Children and Young People's systemic inquiry Left Behind and the Victorian Auditor-General's independent assurance report on OOHC - document a child and family system characterised by persistent fragmentation and no single party holding coordinated responsibility for a young person's safety. As a result, the non-government sector delivering residential care increasingly carries risk beyond what its service model was designed to manage. Young people in residential care average eleven placement changes over four to five years. Sixty per cent of children identified in child death inquiries died as adolescents (CCYP, 2026). These are not background statistics, they are a call to action.

The evidence supports the primary response to substance use-related harm in residential OOHC being relational. Young people do not become safer because risky behaviour is prohibited. They become safer when the adults and systems around them remain coordinated, trustworthy, emotionally regulated and focused on young people's stability and growth - preserving the conditions under which disclosure, help-seeking and positive change remain possible. Zero tolerance is not a safeguarding approach - it frequently produces the opposite of its intended effect: driving risk underground, collapsing disclosure pathways and disconnecting young people from the very adults and environments capable of keeping them safe.

For children and young people growing up in residential care, the place they live is not simply where they are supervised. It is their home, and the primary place in which their development is supported. Residential workers are the adults with whom they share everyday life, and through

hundreds of ordinary interactions - meals, routines, conversations, crises, celebrations, setbacks and transitions - they help young people learn to regulate emotions, negotiate relationships, solve problems, participate in community life and develop hope for the future. This everyday role in helping young people grow up is inseparable from safeguarding. Relational safeguarding strengthens this essential developmental role with coordinated specialist intervention.

Relational safeguarding is the intentional organisation of relationships around a young person to both protect them from harm and support their positive development. Every developing child, particularly when they enter adolescence, needs relationships that cover two different functions:

- The "have-to" function - where limits are set around potentially risky experiences and behaviours to regulate exposure to harm.
- The "how-to" function - enabling young people to reflect on and learn from their experiences as they develop.

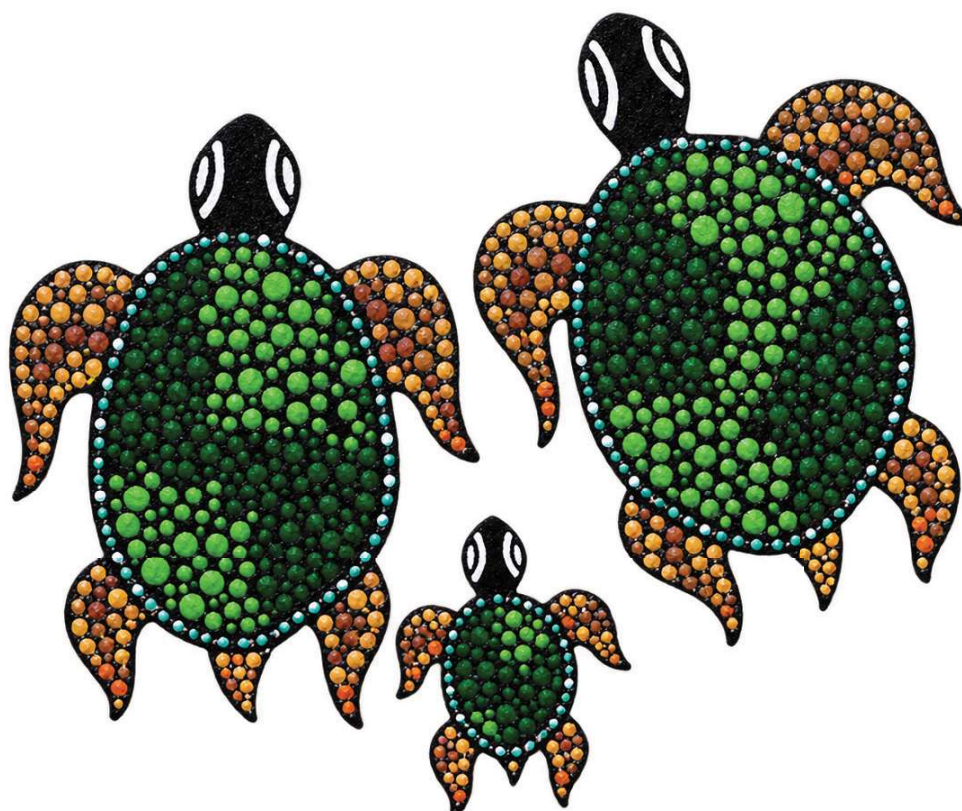
These are functions, not job descriptions. Residential workers perform both every day: they hold boundaries and manage risk, and they also co-regulate emotion, coach, model, build skills and support identity and hope. There is, however, one genuine constraint that applies - young people are highly unlikely to disclose details about risky behaviours and experiences to workers with the responsibility to limit their exposure to the risks associated with those same behaviours and experiences. This is a predictable feature of relationships holding responsibility for the have-to (limit setting) role within relational safeguarding - not a failure. It is why young people also need other trusted relationships with adults who have no limit-setting responsibilities, where those disclosures can be made without fear of consequence. In relation to substance using behaviour, these added relationships are often provided by Youth AOD practitioners but can also be provided by youth workers, mentors and Elders.

Effective relational safeguarding requires the trusted adults in young people's lives to be clear

on their role and operate in coordinated and complementary ways. The aim is for young people in care to experience coherence and predictability rather than fragmentation or an adversarial dynamic.

The document is structured in five parts:

- Part 1 establishes the developmental and contextual foundation - focusing first on young people in OOHC, making a link between serious disadvantage and harmful substance use and identifying seven categories of substance use-related harm that effective responses address.
- Part 2 defines safeguarding, establishes psychosocial stability as a core safeguarding foundation, and explains why a zero tolerance approach to addressing the substance use of young people in OOHC may be well intentioned but is counterproductive and ineffective.
- Part 3 develops the theory of relational safeguarding, including the "have-to" and "how-to" distinction and the essential features of both risk containment and effective pro-social enabling. The reason why open disclosure pathways are essential for effective relational safeguarding is explained with importance of role differentiation and coordination between practitioners. A case is described in detail to demonstrate relational safeguarding in action.
- Part 4 provides an account of how relational safeguarding works in practice, with specific guidance on effective limit-setting, pro-social enabling, and the circumstances in which confidentiality must be overridden - closing a disclosure pathway - and how that pathway can be repaired afterwards.
- Part 5 turns to the operational relationship between Statutory services, OOHC providers and Youth AOD services. It covers the shared knowledge these roles depend on, how differentiated roles are coordinated rather than collapsed, care planning that names who provides the push and who provides the pull, and the reflective supervision, organisational commitment and residential care management that hold the approach in place.



Part 1

Young People in Out-of-Home Care and Substance Use

Part 1 focuses on young people in care, and why their substance use needs to be understood developmentally and managed relationally rather than purely behaviourally.

Young people in Victoria's out-of-home care (OOHC) system carry disproportionate burdens of trauma, adversity and complex need. As of 30 June 2025, there were 9,353 children and young people in OOHC in Victoria.

The Commission for Children and Young People's (CCYP) systemic inquiry Left Behind (2026) - an analysis of 35 child death inquiries involving children and young people subject to multiple Child Protection reports - found that the most common risk factors that brought young people into contact with Child Protection and ultimately into OOHC, were family violence, substance misuse and mental ill-health - with at least two of these three factors present in the majority of cases. The Left Behind inquiry also observed that missed opportunities for early intervention increase the likelihood of young people themselves experiencing substance use disorders, mental health difficulties, educational disengagement and involvement in the criminal justice system (CCYP, 2026).

For young people placed in residential OOHC, the most complex and least stable placement type in Victoria's system, serving primarily those aged 12 to 17 - these intersecting vulnerabilities are particularly acute. The Victorian Auditor-General's Office (VAGO, 2026) found that residential care is the least stable placement type, with young people in residential care for four to five years averaging 11

placements across that period. The combination of placement instability, high complexity of need and the developmental vulnerabilities of adolescence creates conditions in which substance use is both a predictable response to unresolved trauma and a significant risk.

1.1 A Developmental Perspective on Young People's Substance Use

Adolescence is a period of rapid developmental change. Young people seek greater independence, test limits, form identities, rely increasingly on peers and experiment with experiences that sit beyond direct adult control. These behaviours are at times portrayed as pathological but are in fact central to the developmental transition from childhood to adulthood. Substance use is one of those behaviours that most young people, at some stage throughout their adolescence or into young adulthood, will experiment with.

Adolescence is also a period of heightened vulnerability. Contemporary neuroscience demonstrates that novelty seeking, the need for peer affiliation, emotional intensity and reward sensitivity that drives risk-taking and sensation-seeking tend to develop earlier than systems associated with executive functioning, impulse control, emotional regulation and future planning (Casey, Jones & Hare, 2008; Steinberg, 2014). As a result, young people may understand risks while

still struggling to regulate behaviour in emotionally charged, socially pressured or fast-moving situations. Development is driven through everyday interactions with people and through experiences that are repeated over time; a young person's capacities are either built or eroded (Bronfenbrenner and Morris, 2006).

This is not primarily a failure to recognise risk. Research indicates that adolescents assess risk using similar cognitive strategies to adults, and often overestimate rather than underestimate the likelihood of harm (Reyna & Farley, 2006). What differs is weighting: heightened dopamine sensitivity during adolescence increases the value placed on potential reward, so that in situations where risk promises something desired - status, belonging, excitement - young people assign it greater weight than adults typically would. Risk-taking and sensation-seeking, understood this way, are not defects to be corrected. They are functional features of healthy development that call for guidance and structure rather than suppression.

For children and young people in OOHC, these ordinary developmental pressures often occur in the context of significant adversity. Many have experienced abuse, neglect, family violence, disrupted attachment, educational exclusion, poverty, social marginalisation and repeated relational rupture (Mendes, Johnson & Moslehuddin, 2011). Many also experience neurodevelopmental vulnerabilities including ADHD, executive functioning difficulties, language disorder, emotional dysregulation and trauma-related cognitive impacts (Snow & Powell, 2011; Hughes et al., 2017). Yet adversity is not developmental destiny. The resilience literature consistently demonstrates that even young people exposed to profound adversity retain the capacity for positive progression when they have access to what Masten (2014) calls 'ordinary magic' - the ordinary but powerful protective systems, particularly caring and consistent relationships with competent adults, that support development. The task of developmental safeguarding is to build and sustain those systems.

Where family and kinship relationships remain available to a young person in care, they represent a further protective system in their own right. Family resilience is not only a matter of individual coping but of shared belief systems, adaptable family organisation and open communication that help a family - and the young person within it - make sense of adversity and sustain connection through it (Walsh, 2016).

1.2 The Link Between Serious Disadvantage and Harmful Substance Use

Substance use exists along a continuum and is not always harmful, problematic or associated with dependency, impairment or developmental

disruption. Young people in OOHC, 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. Substance use will always serve a purpose, even if a young person isn't fully aware of what it is. This fact remains, even when the substance use is clearly associated with significant risk and harm.

For young people in Residential OOHC, substance use may also be intertwined with processes of exploitation. Young people may be targeted and groomed through the provision of substances, intentionally intoxicated to reduce resistance or increase compliance, coerced into drug-related criminal activity, or they may use substances as a way of coping with the emotional impacts of exploitation. These pathways reinforce the need to understand substance use not simply as an individual behaviour but as a phenomenon that may be embedded within broader relational and social contexts.

This means that simplistic behavioural responses to a young person's substance use focused on enforcing rules are often ineffective and counterproductive as they risk intensifying secrecy, shame and disengagement. This increases rather than reduces the likelihood of harm.

A practical implication follows from this. Workers and care teams need to ask not only whether substance use has occurred, but what function and meaning it has for the young person and under what circumstances it is most likely to occur.

Victorian residential care guidance usefully identifies several starting points for this inquiry: when use began, when the young person feels most inclined to use, what happens when they use, how they feel before and after use, and whether there are times when the urge to use is weaker (Department of Families, Fairness and Housing, 2026). These questions are consistent with a safeguarding approach because they move the response from surface behaviour to function, timing, context, motivation and protective opportunity.

Young people in residential care require more than crisis response, behavioural management or information provision. They require the intentional creation of relational structures that reduce harm and promote positive development.

A useful way of understanding what shapes a young person's trajectory is the interaction of push factors, pull factors and protective factors:

- **Push factors** are experiences that increase the likelihood of a young person moving away from safety, stability and pro-social engagement - including conflict, rejection, loneliness, boredom, trauma, placement instability, educational disengagement and unmet growth and developmental needs.

- **Pull factors** are influences that attract young people toward unsafe people, groups or environments by offering belonging, status, excitement, affection, protection, money, substances or a sense of identity that they are not finding elsewhere.
- **Protective factors** operate in the opposite direction: trusted relationships, cultural connection, educational participation, pro-social belonging and access to caring adults that strengthen a young person's capacity to resist harmful influences and pursue safer pathways.

Understanding the balance between these three forces in a specific young person's life often provides a more useful basis for intervention than focusing exclusively on the presenting behaviour.

Effective relational safeguarding seeks to reduce push factors, disrupt pull factors and strengthen protective factors simultaneously. It can also go further: as section 3.6 develops, a coordinated safeguarding system can deliberately generate its own pull, drawing young people toward safe, caring and pro-social relationships.

1.3 Types of Substance Use Related Harm

The following seven categories describe the range of harms associated with substance use that can be experienced by young people in OOHC. They are not mutually exclusive - harms in one category frequently intensify harms in others.

Immediate harms

Acute risks that may result in serious injury, medical crisis or death in the short term, including overdose, severe intoxication, unsafe injecting, acute psychosis, suicidal behaviour, violence and immediate exploitation. These require rapid assessment and proportionate intervention.

Even in acute crisis, how intervention occurs matters. Responses that are punitive, humiliating or emotionally dysregulated may reduce immediate risk while simultaneously increasing longer-term harm through shame, distrust and collapse of disclosure pathways.

Cumulative harms

The gradual build-up of adverse impacts that may not appear catastrophic in any single incident but that over time significantly damage wellbeing, functioning and future trajectory. Patterns established during adolescence can progressively narrow future opportunity. Cumulative harms associated with substance use include:

- chronic disengagement from education, training and employment, and the loss of the developmental experiences these provide

- progressive deterioration in physical health, including nutritional depletion, sleep disruption, increased vulnerability to illness and, where injecting is involved, blood-borne virus risk
- deepening social isolation as substance use increasingly organises peer relationships and displaces pro-social connection
- gradual erosion of emotional regulation capacity, reflective functioning and executive capability through repeated cycles of intoxication, withdrawal and crisis
- accumulating justice-system contact that narrows future options and strengthens criminalised identity
- progressive weakening of placement stability and relational continuity as repeated crises strain the care relationships on which healthy development depends
- narrowing future orientation as the young person loses access to the experiences, relationships and opportunities through which aspiration and identity are built.

Developmental harms

Impacts that interfere with the young person's transition into adulthood. Across the five core developmental domains, substance use may disrupt progression in recognisable ways:

- **Safety and Stability** - chronic dysregulation, impaired sleep and physical health, and intensifying placement instability can erode the felt sense of safety that healthy development depends upon.
- **Agency** - weakened impulse control and reflective capacity, combined with substance use increasingly organising daily life, progressively undermine self-efficacy and the young person's belief in their own capacity to change.
- **Connection** - withdrawal from trusted adults, collapsing disclosure pathways and the replacement of pro-social relationships with others involved in harmful substance use reduce the relational foundation on which development occurs.
- **Participation** - disrupted through school disengagement and withdrawal from structured activity, with the loss of the competence, achievement and legitimate belonging these experiences provide.
- **Identity** - substance use can become the primary self-concept, cultural connection weakens, and future orientation narrows or disappears.

Some interventions, particularly those involving excessive behavioural control, exclusionary responses or relentless surveillance, can

themselves create developmental harm by weakening autonomy, reflective functioning and internal locus of control.

Relational harms

Harms occurring within or through relationships, including collapse of trust in adults, attachment disruption, emotional abandonment, chronic conflict, humiliation, coercive peer relationships and emotionally unsafe caregiving. Young people who lose trust in pro-social adults may increasingly turn toward harmful peer systems or exploitative relationships to meet their needs.

Psychosocial harms

Harms affecting the young person's overall stability and capacity to maintain a viable developmental pathway, including placement instability, chronic absconding, homelessness, school exclusion and loss of cultural connection. Psychosocial instability is treated within this framework as a core harm category rather than merely background context, because it creates the conditions in which all other harms escalate.

Exploitation harms

Harms arising through relationships or systems in which the young person is manipulated, coerced or used for the benefit of others, including criminal and sexual exploitation, debt bondage, coercive relationships and forced offending. Substances may be used to groom, reward, control, create dependency or strengthen loyalty to exploitative systems. Young people may remain emotionally attached to exploitative systems because those systems meet real growth and developmental needs - providing belonging, identity, predictability, status or protection in ways that fragmented care systems sometimes fail to deliver. Removal from exploitation without strengthening alternative relational systems rarely produces lasting safety.

Where substance use is identified, practitioners should consider whether it provides important information about exploitation risk. The following questions can help assess the relational context surrounding use:

- Who is supplying the substances, and what is the nature of that relationship?
- Is anyone benefiting financially, socially or otherwise from the young person's use?
- Is the young person carrying, storing, delivering or selling substances on behalf of others?
- Are substances being exchanged for accommodation, transport, affection, protection, money or sexual activity?
- Does the young person appear fearful, unusually loyal or protective of particular individuals connected to their use?

- Have trusted adults lost visibility of where the young person is spending time, who they are with, or how substances are being obtained?

The presence of one or more of these indicators does not confirm exploitation, but they should prompt further inquiry, consultation and information gathering. The purpose is not to prove exploitation, but to remain alert to whether substance use is occurring within a broader pattern of grooming, coercion or harmful influence.

Systemic harms

Harms created, intensified or maintained by service systems, institutional responses or structural conditions, including criminalisation, over-policing, exclusionary practice, fragmented service responses, culturally unsafe practice, unnecessary placement breakdown and responses that collapse disclosure and trust. These harms are often unintended but may significantly affect young people's safety, development and future opportunity.

For Aboriginal and Torres Strait Islander young people, who remain significantly over-represented in Victorian OOHC, systemic harm carries additional weight. Racism experienced within service systems is independently associated with poorer mental health, disrupted identity development and reduced academic engagement (Uink et al., 2022), and the impact of intergenerational trauma arising from colonisation and forced removal continues to shape how safety and authority are experienced within statutory systems (Bessarab & Ng'andu, 2010). Culturally unsafe practice is therefore not a peripheral risk for this population but a primary pathway through which systemic harm is produced.

Part 2

What is Safeguarding?

Having described young people in OOHC and the defining features of their substance use, Part 2 turns to what safeguarding actually requires – and why approaches built around zero tolerance fall short of it.

Safeguarding is the ongoing process of protecting children and young people from harm, reducing vulnerability and risk, strengthening protective relationships and environments, and creating the conditions that support their safety, wellbeing and healthy development (Holmes, 2022).

Safeguarding extends beyond responding to incidents of harm. It involves the proactive identification and reduction of risk, the strengthening of protective relationships and environments, the promotion of children's rights and participation, and the creation of conditions that support children and young people to grow, develop and thrive.

A safeguarding approach recognises that children and young people are entitled to protection from physical, sexual, emotional and psychological harm, neglect, family violence, exploitation, discrimination and other adverse experiences. It requires caregivers, especially those in professional roles, to:

- identify and respond to concerns, disclosures, allegations and indicators of harm
- work collaboratively with children, families and service providers
- take reasonable steps to prevent harm wherever possible.

Contemporary safeguarding frameworks recognise that children's safety depends not only on individual relationships but also on the wider social, cultural, institutional and environmental contexts in which

they live. Effective safeguarding therefore seeks to strengthen the safety of the environments surrounding children (i.e. families, schools, care settings, peer groups, communities and online spaces). This is consistent with Firmin's (2020) contextual safeguarding framework, which argues that adolescent harm occurring beyond the family requires practitioners to assess and intervene in the social fields that shape young people's exposure to risk (i.e. peer relationships, local environments and institutional settings), rather than focusing solely on individual behaviour or family functioning. Understanding the relational context surrounding substance use is therefore a core safeguarding task.

Safeguarding also recognises that vulnerability and safety are shaped by the interaction of push, pull and protective factors described in section 1.2. Effective safeguarding seeks to reduce push factors, disrupt pull factors and strengthen protective factors through coordinated, relational and informed support – and, where roles are well delineated, to generate a deliberate pull toward safe and protective relationships (section 3.6).

Central to safeguarding is the recognition that children and young people are rights holders. They must be listened to, taken seriously, provided with opportunities to participate in decisions affecting them, and supported to exercise agency in ways that are appropriate and safe.

2.1 Safeguarding Foundations – The Role of Psychosocial Stability

Psychosocial stability is the degree to which a young person has sufficient relational continuity, placement stability, emotional containment, school

participation, cultural connection and predictable support to sustain constructive development.

In residential care, the conditions that undermine psychosocial stability are well documented. High rates of placement movement, sibling separation, concentrated complexity and declining foster care capacity mean that residential care increasingly absorbs those for whom no stable home-based placement is available. This further concentrates developmental risk in settings that are structurally least able to provide the relational continuity that effective safeguarding requires.

Psychosocial instability increases vulnerability not only to immediate harm, but also to exploitation, disengagement, hopelessness and a narrowing of future pathways.

This means interventions should not be evaluated solely according to whether they suppress visible risk behaviour. They should also be evaluated according to whether they:

- strengthen or weaken psychosocial stability
- preserve or collapse disclosure pathways
- increase or reduce exploitation vulnerability
- support or undermine positive participation
- expand or narrow future opportunity.

Psychosocial stability also needs to be considered at points of transition. Young people leaving a residential placement or transitioning from care may lose access to familiar adults, routines, service relationships and practical supports at precisely the time when stress, loneliness or exposure to unsafe networks can increase. Victorian guidance emphasises that AOD care planning for young people leaving residential care should identify specific ongoing AOD supports and ensure connections are in place before transition occurs (Department of Families, Fairness and Housing, 2026).

2.2 Why Zero Tolerance is Not Safeguarding

Substance use by young people in residential OOHC can create serious risks and should never be ignored, normalised or treated as developmentally insignificant. Residential care providers and government-mandated services (courts, Child Protection, Youth Justice) have a clear responsibility to identify substance-related risk, respond to immediate harm, reduce exposure to unsafe environments, and connect young people with appropriate support.

The central issue is not whether substance use is ever safe - it is whether the response by those responsible for a young person's care makes them safer. A rule or policy may be intended to protect safety, but safeguarding requires more

than protective intent. It requires careful attention to the actual impact of the response on the young person's safety, wellbeing, relationships, likelihood of disclosure, placement stability, and future pathway. A rule applied without consideration of these impacts may appear protective while increasing harm.

Safety Requires More Than Rule Enforcement

Zero tolerance approaches often begin from a superficially clear proposition: because substance use can be harmful, the system must take a firm stance against it. Safeguarding requires clear expectations, boundaries and active intervention but is more than rule enforcement. Safety is created when young people remain connected to adults, environments and systems capable of reducing harm, preserving communication, strengthening psychosocial stability and supporting positive developmental progression. Prohibition and behavioural suppression, which are the hallmarks of a zero tolerance approach, are frequently at odds with these safeguarding foundations.

A response that focuses only on whether rules have been complied with or transgressed may fail to understand why the behaviour is occurring, the associated risks, and what needs to change for safer behaviour to become possible.

Firm limits, and even direct intervention to contain a young person at risk of serious harm, can be followed through on in ways that remain relational and preserve connection and dignity - communicating to the young person that they are not being rejected, abandoned or reduced to a behaviour. Purely compliance-based approaches work against this possibility, risking stigma and alienation rather than safety.

How Zero Tolerance Increases Concealment and Risk of Harm

The danger of zero tolerance is that it confuses visible control with actual safety. As evidenced in Part 1, many young people in OOHC use substances to manage distress, regulate emotion and feel in control - the reality is that they are often not ready or able to stop. For these young people, a zero-tolerance response is more likely to produce concealment than change: so as not to be sanctioned, they may avoid their placement, abscond for longer periods, stop disclosing use, stop returning when intoxicated, stop telling workers where they are going and who they are with, and use in unmonitored, high-risk settings. They may also withhold information about supply, debt, coercion or exploitation.

This is particularly concerning in residential care, where the placement may be one of the few protective structures in a young person's life. Each of these behaviours moves risk further from the influence of adults best placed to mitigate it, and responsible for doing so, leaving the young person

more susceptible to exploitative adults and unsafe peers - so a response intended to reduce harm ends up increasing it.

Safeguarding is a Trauma-Informed Practice - Zero Tolerance is Not

Safeguarding is a trauma-informed practice, commensurate with OOHC sector-wide standards in Victoria that are enshrined in both service agreements with government and organisational models of care. Trauma-informed therapeutic and relational practice is incompatible with a zero tolerance approach to addressing young people's substance use, because the two rest on contradictory assumptions about what produces safety and change.

From a trauma-informed perspective, the young person's felt sense of physical and psychological safety is central, not the absence of a prohibited behaviour.

Under zero tolerance, if honesty in disclosure about substance use is met with sanction, the trust and transparency essential for effective trauma-informed care will be eroded. The same applies to other essential aspects of a trauma-informed approach to safeguarding like collaboration and mutuality, and empowerment and voice. Both are bound to be undermined whenever a young person's options for sharing and exploring their experiences and concerns in an authentic way are subordinated to a fixed rule, applied without regard to context.

Disclosure as Safeguarding Infrastructure

A young person who believes that disclosure will automatically lead to sanctions, police involvement, increased surveillance, loss of autonomy, placement instability or rejection is less likely to seek help early. Fear of such consequences can prevent young people from reaching out to safe adults when risk is escalating and help is most needed. In this way, zero tolerance can unintentionally weaken one of the most important protective mechanisms in residential care - the young person's willingness to stay visible to adults who can help.

A young person's capacity to say, "I used," "I feel unsafe," "I don't know what I took," "I owe someone money," "I am being pressured," or "I need help getting home" may be the difference between manageable risk and serious harm. Responses that collapse these pathways do not simply create therapeutic difficulty. They create safeguarding risk.

This is particularly important in the context of exploitation. Young people who are being groomed, coerced, manipulated or controlled often disclose concerns gradually, indirectly or only after significant trust has been established with a worker. If responses are experienced as punitive, rejecting or overwhelmingly controlling, opportunities to identify exploitation may be lost.

Safeguarding responses reduce immediate harm while also preserving or strengthening the young person's connection to safe adults, safe environments, cultural and community supports, education, therapeutic help and future opportunity.

The Safeguarding Test

The difference between safeguarding and zero tolerance is not between action and inaction - it is the difference between rule enforcement, as an end in itself, and safety-oriented intervention that is continuously tested against its effects.

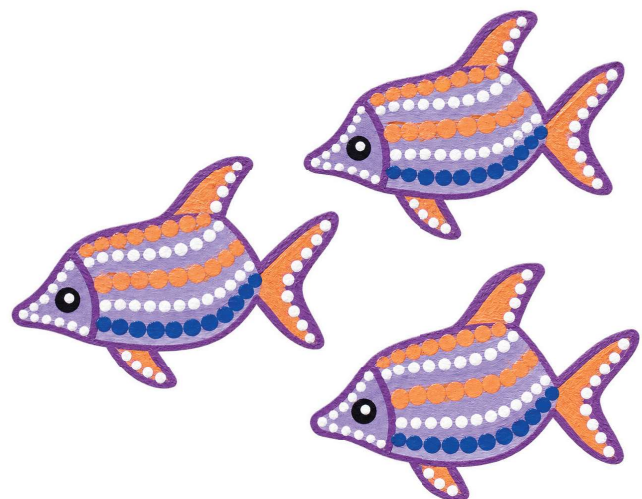
The safeguarding question is not:

"Was the rule enforced?"

The deeper question is:

"Did the response keep this young person safer, more visible, more connected and better supported to learn from their experiences and develop?"

Across each of the seven types of substance use related harm, specified in section 1.3, there is a common thread. Harms intensify when young people become disconnected from safe adults, safe environments and systems capable of responding proportionately - with young people's development in mind. These harms are more likely to reduce when those relational systems remain coordinated, trustworthy and focused on both immediate safety and longer-term positive progression.



Part 3

What is Relational Safeguarding?

Part 2 explained what safeguarding requires in principle. Part 3 develops this into a full theory of relational safeguarding.

Everyday Development - Growing Up in Residential Care

Young people's development does not occur primarily during formal interventions or appointments. It occurs through participation in everyday life. This is a well-established finding of developmental science: Bronfenbrenner and Morris (2006) identify the repeated, everyday interactions between a young person and the people in their immediate environment, what they term proximal processes, as the primary engines of development. Masten's (2014) "ordinary magic" locates resilience in the same place: ordinary, consistent, caring relationships with competent adults. Anglin's (2002) study of residential care reaches a convergent conclusion: developmental change is produced less by behavioural control than by the daily relational culture staff create.

For a child or young person growing up in residential care, that everyday environment is their home, and the adults who make it a home are the residential workers who share it with them. It is in ordinary daily life that young people learn how conflict is resolved, how emotions are managed, how relationships endure, how routines are maintained, how trust develops, how setbacks are repaired, and how people care for one another.

These thousands of everyday interactions are not the backdrop to developmental work; they are themselves developmental interventions. Youth AOD practitioners, mental health clinicians, Child Protection practitioners and others contribute

important specialist expertise, but they do not, as a rule, share the daily life of the young person. Residential workers do. Relational safeguarding therefore begins with strengthening the developmental quality of everyday residential care, and then adds other trusted relationships around it.

3.1 Managing Competing Interests

Throughout young people's journey from childhood to becoming an adult, there are competing interests at play. They need containment and clear boundaries to regulate their exposure to risk and ensure they develop within safe limits. At the same time, they need room to explore, test limits and learn, since this exploration is how autonomy and self-regulation are built. For their carers and the adults supporting them, the instinct to protect can pull against the need to allow growth. This is not a problem to be solved but a natural tension that needs to be managed.

Although this resource focuses on young people in residential OOH, the need for relational safeguarding is not unique to statutory care. Adolescent vulnerability is universal, even if it is not evenly distributed. All young people require trusted adults, accurate information and emotionally safe pathways for seeking help when faced with uncertainty, experimentation and risk.

The Tragic Case of Anna Wood

The death of Anna Wood remains one of Australia's most significant illustrations of adolescent vulnerability and the importance of timely access to trusted adults.

Anna was a 15-year-old navigating increasing

independence, peer affiliation and experimentation within a largely normative future trajectory. In October 1995, she attended a dance party in Sydney where she consumed MDMA. After becoming physically unwell, she experienced vomiting, confusion and progressive deterioration in consciousness.

Coronial findings concluded that Anna's death resulted from acute water intoxication (hyponatraemia leading to cerebral oedema and hypoxic encephalopathy) associated with MDMA use, rather than a simple overdose. Excessive water consumption, combined with the physiological effects of MDMA on fluid regulation, resulted in catastrophic swelling of the brain.

This distinction is important because the developmental safeguarding lessons extend beyond drug education. The tragedy involved a group of frightened adolescents attempting to manage a rapidly escalating medical emergency without accurate information, confidence to seek help, or immediate access to trusted adults capable of interpreting what was occurring. In attempting to help Anna, her friends reportedly continued encouraging water intake, unaware that this was worsening the developing hyponatraemia.

The significance of Anna Wood's death therefore lies not only in the risks associated with substance use, but in the broader reality that adolescents can become highly vulnerable when they are:

- operating without trusted adult guidance
- relying primarily on peer interpretation during crisis
- fearful of disclosure or punishment
- lacking accurate harm reduction information
- disconnected from safe help-seeking relationships.

The developmental safeguarding lesson is clear: young people require relational structures that preserve communication, support timely help-seeking and provide access to trustworthy guidance during periods of experimentation, uncertainty and vulnerability.

3.2 Structuring Relationships to Prevent Harm and Promote Positive Development

Anna's story shows how preventable harm can be the result of substance use experimentation. The next sections set out the two distinct functions adults can provide to prevent harm.

Young people experiencing, or at risk of experiencing, substance use-related harm require more than behavioural management, surveillance, punishment or crisis intervention. They require

relational systems capable of reducing risk while preserving communication, psychosocial stability, pro-social participation and hope.

Relational safeguarding is the intentional organisation of relationships around a young person to both protect them from harm and support their positive development. Young people do not become safer simply because risky behaviour is prohibited. They become safer when the adults and systems around them remain coordinated, trustworthy, emotionally regulated and focused on young people's growth, allowing disclosure, reflection, learning and help-seeking to remain possible.

Central to relational safeguarding is the understanding that there are two key roles for the adults in a young person's life, each with its own purpose:

- The "have-to" role - setting limits around potentially risky experiences and behaviours to regulate exposure to harm and provide containment.
- The "how-to" role - providing space and support for young people to reflect on and learn from their experiences as they develop, promoting empowerment.

Put simply, the "have-to" role provides containment, and the "how-to" role promotes empowerment. Relational safeguarding is a dynamic and continuous process of holding these competing priorities together to create a system of care that enables a young person to develop in a safe and constructive way.

3.3 Limit Setting and Containment - The "Have-To" Role

All children and young people require adults who carry responsibility for their protection and who regulate their exposure to risk. This is the containment function of the "have-to" role: one vital aspect of it is the setting of limits around potentially risky behaviours and experiences.

Those who fulfil a "have-to" function include parents, carers, kinship caregivers, residential care staff, Child Protection and Youth Justice practitioners.

The "have-to" function, however, is only one part of what parents, carers, kinship caregivers and residential care workers do. For example, alongside setting limits, residential workers and carers often have the strongest connection with young people in care and simultaneously provide emotional co-regulation, attachment experiences, modelling, opportunities for participation, identity development, hope, practical skill-building and advocacy.

Even so, residential workers and carers have

responsibility for limiting and containing potentially harmful behaviours, such as substance use. The flow on effect is that young people will naturally be reluctant to share details concerning those behaviours, particularly when they could be transgressing rules or agreements made to keep them safe. For this reason, in relation to substance use, those relationships fulfilling the vital have-to role, need to be complemented by relationships free of limit-setting responsibility (see Section 3.4).

The purpose of limit-setting is not simply to control or contain behaviour. Effective safeguarding relationships create the stability and structure within which positive development becomes possible. They help preserve safety, educational continuity, emotional containment, relational continuity and access to developmental opportunities.

Research in residential care strongly supports this understanding. Anglin's (2002) grounded theory study found that behaviours such as aggression, self-harm, absconding and substance use are often expressions of pain, trauma, attachment disruption and unmet growth and developmental needs rather than simple defiance. The most effective residential environments were characterised not by behavioural control alone, but by relational congruence - cultures in which staff combined clear boundaries with genuine care and understanding of the developmental meaning behind behaviour.

This is consistent with findings from the child welfare literature more broadly. Carers who receive structured trauma-informed training report greater confidence in managing difficult behaviour and are less likely to request a placement change (Sullivan, Murray & Ake, 2016) - evidence that adequate training is itself a safeguarding investment, not simply a workforce development activity.

Importantly, developmental learning cannot occur when a young person is acutely unsafe, heavily embedded in exploitative systems, persistently intoxicated, severely dysregulated or disconnected from protective relationships. Effective limit-setting therefore regulates exposure to overwhelming risk and harm - sufficiently for learning, growth and positive development to occur.

Young people are more likely to experience authority as protective when adults remain emotionally connected, genuinely interested in their wellbeing and committed to their future. Containment of this kind does not compete with a young person's growth toward autonomy; it is the stable ground from which that growth - and the empowerment offered through "how-to" relationships - becomes possible.

Essential Features of Effective Limit Setting and Containment (the "Have-To" Role)

Effective "have-to" relationships:

- protect from serious harm

- set clear and consistent limits with genuine care
- provide stability, structure and predictability
- preserve safety and continuity
- exercise authority when needed in a way that feels protective
- set the foundations for growing autonomy.

3.4 "How-To" Relationships and Pro-Social Enabling

The "how-to" role requires young people to be offered the space in which they feel able to reflect, disclose, make sense of experiences, seek help and gradually develop self-regulation.

Those in purely "how-to" relationships carry no positional or statutory power over a young person's circumstances (the authority to impose limits, make placement decisions and enact consequences). So young people largely choose who will be in a "how-to" role, or at minimum choose whether to invest in the relationship - in doing so they bestow on those adults the capacity to influence them. Professionals in "how-to" rely more on credibility and trust than on authority. "How-to" practitioners seek no formal power in a young person's life. The young person determines the degree of influence a practitioner is granted, and that influence has to be earned rather than assumed (Bruun & Hynan, 2006).

These relationships may include Youth AOD workers, youth workers, mentors, teachers, coaches, Elders and trusted community adults. When experienced as safe, respectful and useful, they are often the relationships through which young people first disclose substance use, exploitation, emotional distress, fear or uncertainty. Residential workers, too, hold this how-to space with young people, where reflection happens but often disclosure pathways close or become constrained in relation to specific risk behaviours like substance use, where limits apply.

For Aboriginal and Torres Strait Islander young people, connection to culture, community and Elders functions as a protective factor in its own right, independently reducing the likelihood of harmful substance use (National Indigenous Drug and Alcohol Committee, 2019). Elders occupy a "how-to" role that is not simply substitutable by other trusted adults; their teaching and mentoring carry cultural authority that strengthens identity and belonging in ways specific to that relationship (Kennedy et al., 2022).

Communication frequently collapses when young people believe disclosure will result in punishment, criminalisation, placement instability or loss of control. Once communication closes, risk becomes hidden, exploitative influences gain strength and opportunities for positive intervention diminish.

Essential Features of Effective Pro-Social Enabling (the “How-To” Role)

Effective “how-to” relationships:

- build trust and credibility
- preserve disclosure pathways
- support reflection and problem-solving
- teach harm reduction and risk management
- strengthen positive participation
- support identity formation
- encourage help-seeking
- assist young people to internalise self-regulation over time.

This describes what an effective “how-to” relationship does. Just as important is how the role is fulfilled. Effective “how-to” practitioners are truthful and reliable, follow through on the commitments they make and do not make promises they cannot keep. They hold a realistic optimism, grounded in a genuine belief in the value of the work and in the young person’s capacity to be helped. Alongside this, they carry enough insight into their own limitations and biases to recognise when those are shaping their judgement. They bring the confidence and persistence to remain engaged and continue working alongside a young person over extended periods, rather than disengaging when progress stalls (Bruun & Hynan, 2006).

Underlying all of this is a simple commitment: authenticity and transparency in every dealing with the young person, even when the truth is uncomfortable, is a foundational practice condition rather than an optional relational style. The most effective “how-to” practice is genuinely flexible and guided by the direction each young person sets for themselves.

Importantly, pro-social enabling is not permissiveness, collusion or opposition to authority. Effective “how-to” relationships remain connected to broader safeguarding responsibilities while preserving the trust and emotional safety necessary for disclosure and developmental learning.

3.5 Role Differentiation and Complementarity

Young people benefit most when the relationships surrounding them are both differentiated and coordinated.

The “have-to” and “how-to” functions described in sections 3.3 and 3.4 are not separate job descriptions. They are roles that adults – professional or otherwise – occupy in a young person’s life, and both can operate within the same

relationship. Residential workers perform both every day: holding boundaries while also co-regulating, coaching, modelling and supporting a young person’s development.

Combining the roles does, however, have a limit. As section 3.3 established, where limits and consequences apply to a behaviour such as substance use, a young person is highly unlikely to disclose the details of that behaviour to the very adult who sets and enforces those limits. The constraint is a narrow one – it applies only to certain sensitive disclosures and takes nothing away from the rest of a dual-role adult’s developmental work – but it is precisely why complementary “how-to” relationships, free of limit-setting responsibility, are so important. Practitioners without a limit-setting role can offer the space for disclosure, reflection and learning that an adult with a dual role cannot reliably provide.

Differentiation

This is what differentiation means in practice. Some adults carry primary responsibility for limit-setting and protection alongside their broader supportive influence; others provide support with no limit-setting responsibility at all. Responsibility for limit-setting creates a qualitative difference between the two kinds of relationship, but not a contradiction.

Complementarity

Complementarity is the other half. Neither function is sufficient on its own. Safeguarding systems that become overly focused on limit-setting and surveillance drive risk underground by closing disclosure pathways, while supportive relationships that become disconnected from broader safeguarding responsibilities can leave young people exposed to exploitation, instability and escalating harm. Keeping disclosure pathways open is as essential to relational safeguarding as setting limits and fair consequences to control risk. Effective relational safeguarding depends on both.

“Have to” and “How to” Roles are Mutually Reinforcing

The relationship between the two functions is not simply parallel – it is mutually reinforcing. Limit-setting delivered calmly, consistently, proportionately and within a caring relationship creates the psychosocial stability and predictability that “how-to” work depends upon. A young person who experiences their living environment as containing and trustworthy – where limits are clear, adults follow through, and authority is not arbitrary or punitive – is better placed to use what “how-to” practitioners have to offer. This is why the quality of limit-setting practice experienced by young people in care is not a peripheral concern for Youth AOD workers and others in “how-to” roles.

Equally, a “how-to” practitioner can help a young person make sense of the limits and rules being

applied in their care and work through how to respond, increasing the likelihood that the young person experiences a coherent relational system rather than an adversarial one. In this way the “how-to” role actively strengthens the effectiveness of limit-setting. Neither role is complete without the other.

The task, then, is not to collapse all functions into a single relationship, nor to divide a young person’s loyalties. It is to ensure that differentiated roles operate in ways that are coordinated, complementary and beneficial, so that young people experience limit-setting and enabling relationships as different parts of the same supportive system rather than as opposing forces. The central operational question becomes:

How do we organise the relational structures surrounding this young person in ways that maximise and preserve disclosure, regulate risk, maintain psychosocial stability and support positive progression over time?

3.6 Promoting Effective Coordination – Striking the Right Balance

Relational safeguarding does not occur by accident. It requires a deliberate effort to create and maintain organisational structures and practices that maintain coherence across practitioners, services and systems.

Without coordination, systems can become organised primarily around behavioural incidents, compliance and crisis response. Coordinated relational safeguarding instead requires a shared understanding of each young person’s:

- substance use (type, pattern, function, risk of harm)
- psychosocial stability and growth and developmental needs
- emotional regulation capacity
- exploitation vulnerability
- relational strengths and protective factors
- future goals and future trajectory.

When practitioners share a common understanding, responses can be planned and delivered in ways that are more likely to be consistent, predictable and supportive of both safety and development.

Turning Push and Pull Toward Safety and Positive Development

Section 1.2 described how push, pull and protective factors shape a young person’s trajectory toward potentially harmful behaviours and experiences. Exploitative adults – along with other young

people at the margins – are often skilled at pulling vulnerable young people toward them by offering belonging, status, excitement, affection, protection, money and identity. A coordinated safeguarding system can do more than defend against this dynamic. It can deliberately run the same dynamic in the opposite direction, generating movement toward safety.

The two relational safeguarding roles are equipped for the different but aligned aspects of this work. For example, when seeking to address potentially harmful substance-using behaviours, adults in the “have-to” role hold positional authority and can use it legitimately to provide a push towards a Youth AOD worker. This can be done by making a warm referral, requiring attendance where a mandate exists, removing practical barriers and timing introductions around moments of openness.

The push towards a Youth AOD worker is best orchestrated with them – in the knowledge that for a worker in a “how-to” role to have any influence, they must be chosen. The ways in which they can become an attractive option for a young person at risk are described below (see “The Pull of Caring Pro-Social Support”).

The delineation of roles is what makes this possible without contradiction. A limit-setter’s power legitimately extends to compelling attendance, because attendance is a behaviour, and behaviour is in the “have-to” domain. It does not extend to engagement. What a young person says, shares and invests in a relationship with a Youth AOD worker can only ever be chosen. Both parties can therefore be explicit that the requirement to attend belongs to the limit-setter alone and is not conferred on the practitioner. The push and the pull remain separate but at the same time can be aligned and coordinated.

Strengthening the Pull of Caring Pro-Social Support

Because being pushed toward the support that can be provided by Youth AOD workers, the pull must begin with handing back control – as much as possible. The practitioner’s opening move is to ensure that each young person understands that the choice over whether they discuss anything, what they discuss and what they do is theirs to make and will be respected. In a life that they may feel is crowded with adults telling them what to do, a connection with an adult who gives them the power to decide can be attractive.

To become an attractive option, the Youth AOD worker must also have something genuine to offer. This includes being a resource who can provide reliable information, guidance and support – as much as possible on the young person’s terms. Each young person needs to know that a Youth AOD worker can help with anything to do with substance use – accurate information, safer using practices, reducing harm, and support to make changes if and

when they want to – all offered without coercion and when (and if) the young person is ready.

The Youth AOD worker can also offer activity-based participation – to do something with the young person that is of interest to them. Again, while working out how time will be spent is negotiated, this is the young person's choice. An activity of this kind is not a reward or a distraction from the "real work" – it is the real work. It provides an experience of an adult relationship that is not organised around scrutiny or correction, and it creates the relaxed, chosen space in which questions, reflection and disclosure become possible.

Mark's story (section 3.9) shows precisely how this can work.

Two conditions protect this dynamic:

- the separation must be real and demonstrated, not merely asserted - young people will test it, and if the practitioner is seen to report back to limit-setters beyond genuine safety thresholds (section 4.4), the pull collapses and is very difficult to rebuild.
- the separation should be named out loud by both the adult in the "have-to" role and the worker in the "how-to" role - naming it in a transparent way creates the conditions for a constructive and helpful pro-social relationship to form (section 3.5).

3.7 Preventing the Breakdown of Effective Safeguarding

Relational safeguarding becomes vulnerable when adults and services charged with supporting a young person become polarised, disconnected or confused about their respective roles.

Breakdowns commonly occur when:

- practitioners hold moralistic or intransigent attitudes toward substance use that work against an understanding of the purpose it serves for young people and/or supporting safer using practices
- practitioners hold competing views about risk and safety
- roles and responsibilities are unclear
- communication is inconsistent
- shared planning is absent
- emotional reactivity begins to drive decision-making.

When workers begin positioning one another as "the problem", young people are often drawn into the resulting split. They may lose trust in parts of the system, withdraw disclosure, disengage from support or increasingly rely on peer-based or exploitative relationships instead.

As disclosure pathways close, adults lose visibility of emerging or serious risks. Harm becomes hidden, exploitative relationships become more influential, psychosocial instability increases and opportunities for timely intervention narrow.

Young people living within fragmented systems frequently become highly attuned to relational inconsistency. Some disengage altogether. Others begin splitting workers against each other, withholding information, absconding, escalating behaviour or aligning themselves with relational systems that feel more coherent and predictable.

For this reason, effective relational safeguarding is not simply about the quality of individual relationships. It is about the coherence and coordination of the entire relational system surrounding the young person. When that system remains connected, trustworthy and focused on young people's growth, it becomes significantly more capable of preventing harm while supporting positive progression over time.

3.8 The Importance of Disclosure Pathways

Disclosure pathways are often the first casualty of this kind of breakdown. Because they are so central to safeguarding, they warrant closer examination in their own right.

What Is a Disclosure Pathway?

A disclosure pathway is the relational channel through which a young person communicates risk, vulnerability, harm or need to an adult capable of responding. These pathways are not limited to formal disclosures of abuse or exploitation. They include any communication, direct or indirect, verbal or behavioural, through which a young person signals that something is happening in their life that requires adult attention in the form of information, guidance or at times protective intervention. A young person who says "I used last night," who asks a worker what happens if someone takes too much of something, who mentions a name or a location, who appears distressed after contact with a particular peer, or who asks to stay in rather than going out - all of these are disclosure pathway activity. They are the means by which risk becomes visible while adults can still do something about it.

Understood this way, disclosure pathways are not communication channels that exist alongside safeguarding. They are part of the infrastructure through which safeguarding becomes possible. Just as a building requires structural supports to remain standing, a safeguarding system requires disclosure pathways to remain open if it is to function. Adults can only respond to risks they know about. Policies, procedures and care plans provide no protection when the young person has stopped telling anyone who can help, what is happening.

Why These Pathways Are Fragile

The fragility of these pathways is often underappreciated as trust builds slowly and can be lost quickly. Young people continuously assess whether the adults around them are safe to approach. These assessments are rarely conscious. They emerge through accumulated experience - whether adults remained calm when things went wrong, whether they kept their word, whether they responded proportionately, whether they treated the young person with dignity, whether they remained present after a difficult disclosure or withdrew. The answers to these questions shape future behaviour.

A young person who has experienced a disclosure met with shame, punishment or abrupt relational rupture becomes less likely to disclose again - not because they are being difficult, but because the experience taught them that disclosure made things worse.

Reduced Disclosure Does Not Mean Reduced Risk

Reduced disclosure means increased invisibility. When a young person stops telling adults about substance use, the substance use does not stop. When they stop talking about peer relationships, those relationships do not become safer. When they stop returning to the placement in states of intoxication, they have not necessarily stopped drinking or using. The risk moves away from the influence of safe adults and safe environments and into spaces where it cannot be monitored, assessed or interrupted.

A system that has successfully discouraged a young person from disclosure may appear calmer - fewer incidents, fewer notifications, fewer difficult conversations - while the young person's actual vulnerability is increasing.

Disclosure and Exploitation

This is particularly significant in the context of exploitation. Young people who are being groomed, coerced or controlled rarely disclose directly or immediately. Disclosure occurs gradually, indirectly and often only after extended periods of trust-building. A young person testing whether an adult can be trusted with a small piece of information before sharing something larger is engaging in disclosure pathway activity. If that test produces a punitive, dismissive or disproportionate response, the larger disclosure may never come. Exploitative relationships gain strength in the silence that follows.

Creating Disclosure-Rich Environments

The practical implication is that relational safeguarding must cultivate disclosure-rich environments - care settings in which adults are experienced as approachable, emotionally regulated, honest about their responsibilities,

and genuinely curious about the young person's experience. This does not mean adults accept or ignore risk. It means they respond to emerging risk in ways that make the young person more likely, rather than less likely, to bring it to their attention. The question after every significant conversation or incident is not only "how was the immediate risk managed?" but "is this young person more or less likely to come to us next time?"

Disclosure and the "Have-To"/"How-To" Distinction

Disclosure pathways are also the primary mechanism through which the "have-to" and "how-to" distinction operates in practice. Young people typically disclose different things to different adults. They may tell a Youth AOD worker about substance use that they would not disclose to a residential worker or Child Protection practitioner. They may tell a youth worker about a relationship that they have not before mentioned to carers. They may raise concerns with an Elder or mentor that they have never brought to a professional. This is not evidence of manipulation or divided loyalty. It is a rational response to the reality that not all relationships serve the same purpose.

Effective relational safeguarding honours these differences. It does not demand that all disclosure flow through formal channels. It maintains enough coordination across the relational system that information shared in one part of it can reach the parts of the system capable of responding, without destroying the trust that made the disclosure possible in the first place.

The account that follows, conveyed through Mark's story, illustrates what it looks like when relational safeguarding works. Further exploration of the limits of confidentiality - and what practitioners must do when a disclosure pathway has to be overridden, and how the relationship can be repaired afterwards - are addressed in section 4.4.

3.9 How Relational Safeguarding can work in practice – Mark's Story

The following account illustrates how relational safeguarding works to reduce substance use related harm and to promote positive progression. It describes a real case, with identifying details changed. It is written from the first person perspective of the Youth AOD worker who was involved.

The Referral

Mark was just turning 15 when I first met him. He was living in a residential OOHC unit in Dandenong and was subject to a Youth Attendance Order requiring him to engage in alcohol and other drug treatment. I was the Youth AOD worker to whom he had been

referred.

At the time of referral, the workers around Mark believed cannabis was the primary issue. Staff described him as highly disengaged, increasingly aggressive and difficult to contain. He regularly damaged property, absconded for days at a time, was not attending school and appeared disconnected from structured activity and pro-social relationships in the community. The residential placement itself was unstable. Workers experienced him as hostile, resistant and volatile, while Mark experienced the adults around him primarily as people attempting to control him.

Before accepting the referral, I attended a care team meeting involving Youth Justice, Child Protection and residential care staff. What became immediately apparent was that most intervention concerning Mark was organised almost entirely around behavioural management and limit-setting. Staff knew he was smoking cannabis heavily, although the details remained vague because Mark kept most aspects of his substance use off the radar. The only relationship consistently identified as important to him was with his 19-year-old brother, who was dependent on heroin and whom Mark deeply admired. At that stage, no one involved in Mark's care knew he had already begun experimenting with heroin himself.

A Different Kind of Relationship

I explained that my initial focus would not be his substance use. Instead, my role would be to establish a relationship through which Mark might eventually feel safe enough to disclose what was happening in his life. I explained that if he experienced me simply as another surveillance or control mechanism, the likelihood of engagement and a meaningful disclosure pathway would be extremely low.

Importantly, this did not mean abandoning safeguarding or limit-setting. Rather, it meant differentiating relational roles within a coordinated safeguarding structure. Residential care staff, Child Protection and Youth Justice occupied necessary "have-to" roles involving boundaries, supervision and behavioural containment. My role was different. Within clear safeguarding and confidentiality arrangements, I would attempt to position myself as someone Mark could approach if he needed accurate information, support, help understanding risk or assistance managing situations he did not fully understand.

First Contact

The arrangement was that Mark would be compelled to attend at least six sessions with me to satisfy the conditions of his Youth Attendance Order. In our first meeting, he gave me the silent treatment - an entirely understandable response for a young person being compelled to attend counselling against his will. He clearly expected that

I would lecture him about drugs, attempt to force abstinence or report everything he said back to Youth Justice or Child Protection.

Because of this, I deliberately confirmed confidentiality arrangements in front of both Mark and his Youth Justice worker who brought him to the appointment before she left the room. I explained that I was not there to get him off drugs; that there was no requirement that he talk to me about substance use; that I would not routinely report our conversations back to Child Protection or Youth Justice, with the proviso that if sharing the information could prevent him or another person from experiencing serious harm, I would share it, but in a targeted and contained way.

From this initial contact, Mark had a high level of control over how we used the time together.

When his worker left, I asked Mark how he felt about being forced to see me. He shrugged. Then I asked him what he wanted to do for the session. Several suggestions produced no reaction until I mentioned the local amusement arcade. The possibility of not having to pay to play Daytona for an hour was enough to secure his interest.

Building Trust

For the next several weeks our sessions followed a similar pattern: a brief conversation offering him space to ask questions and talk about drugs, followed by Daytona. Mark was exceptionally good at it. I was not, despite having a driver's licence - and he did not. He enjoyed beating me time after time, even working out a handicap system. I was a dramatic loser. Although it may have looked insignificant from the outside, something important was occurring relationally. Mark was beginning to experience an adult relationship not organised entirely around scrutiny, judgement, compliance or behavioural correction. This is best understood as creating an "enabling environment" focused on increasing Mark's capacity to build trust and pursue his own goals (Moore & Dietze, 2005). The Daytona sessions functioned as a "context for action": an ordinary shared activity through which Mark could experience an adult relationship on his own terms and in which he felt comfortable enough, eventually, to make a disclosure. Creating a conducive "context for action" is a specific and repeatable technique for building the relational conditions on which disclosure depends. This is the pull described in section 3.6 operating in practice: a mandated encounter, converted into a chosen relationship through handed-back control and a negotiated activity that mattered to Mark.

Over time, the resentment softened and he attended willingly. By the fifth session, things changed significantly. That day, before we had the chance to set out to play Daytona, when still in my office, he asked me whether cannabis use caused mental illness. We talked for the whole session without going out.

The Disclosure

What emerged was profoundly important. Mark disclosed that he had already used heroin four times during the previous six months. Each time, his older brother had injected him. No one in his care system knew this. At that stage heroin still made him physically sick and he remained ambivalent about it, but his trajectory was extremely concerning.

The disclosure itself illustrated the central safeguarding issue. The broader and more robust disclosure pathway that eventually emerged did not develop through surveillance, coercion or repeated interrogation about drug use. It developed through the gradual establishment of relational safety, role clarity and trust.

Mark also revealed that most of what he understood about heroin, cannabis and drug use generally had come from peers and his brother. Much of the information was inaccurate, incomplete or dangerous. He was genuinely concerned for his brother and did not want to travel the same path. He needed to learn how to tell his brother that he no longer wanted to use heroin, while making clear that he cared about him and didn't want him to feel rejected.

Talking About the Future

From that time, Mark would see me every week. Once, when he was going to have to catch a train home after our session, I offered to buy him a comic so he had something to read. He produced from his bag a copy of *For Whom the Bell Tolls*, a novel by Ernest Hemingway. I had no idea that he was a voracious reader and highly articulate beneath the defensive presentation that adults usually encountered. For the first time, he spoke at length about something he genuinely cared about and felt competent discussing. The conversation eventually moved toward school and his future.

In the context of Mark's modest hopes for the future, he talked less about drugs and focused more on his anger about being unable to live with his parents and his confusion about why. There were very good reasons why this happened (that I validated) but for Mark, the forced removal and restrictions on him, meant that his relationship with Child Protection and his current carers was adversarial. This highlighted one of the most important functions of the "how-to" role: helping a young person work through feelings about imposed limits, understand the rationale behind safeguarding decisions, develop strategies for managing frustration and anger, and begin internalising the capacity to set limits for themselves over time.

A Shift in the System Around Mark

At the same time, something important was occurring in Mark's relationship with his Youth Justice worker. Because she transported him to sessions every week, spent time with him

outside purely disciplinary contexts and remained consistent and emotionally regulated, Mark gradually stopped experiencing her as merely 'YJ'. He began recognising that she was genuinely concerned for his wellbeing. One day the three of us went bowling together, and this time I won. It was fun, ordinary and relationally important. These moments mattered because they humanised relationships that had previously existed within an adversarial dynamic.

This was the profound shift for Mark. The coordinated relational structure surrounding him began functioning differently. Those with "have-to" responsibilities continued setting necessary boundaries and maintaining safety, but he had at least some understanding of why, and was largely prepared to comply.

What Changed

Over time, Mark made a series of increasingly constructive developmental moves. He returned to school. Much later on he eventually maintained a place of his own. He continued using cannabis in a relatively controlled way and did not progress into ongoing heroin use. Most importantly, he chose to continue engaging with both me and his Youth Justice worker well after the legal order had expired. The relationship with the Youth Justice worker continued to be in a professional context and was endorsed and supervised by his Manager.

Mark's story demonstrates that effective developmental safeguarding is rarely achieved through behavioural control alone. Young people become safer when the relational structures surrounding them regulate risk, preserve disclosure pathways, maintain psychosocial stability, provide accurate information, support reflection and strengthen the young person's capacity to internalise safer forms of self-regulation over time.

Mark's story also points forward. A young person's AOD plan and the practice of developmental safeguarding should continue across placement exits and transitions from care, identifying who will remain connected, what supports will continue, how risk will be monitored and how the young person can seek help after the placement changes. Psychosocial continuity across transitions is not aftercare - it is safeguarding.

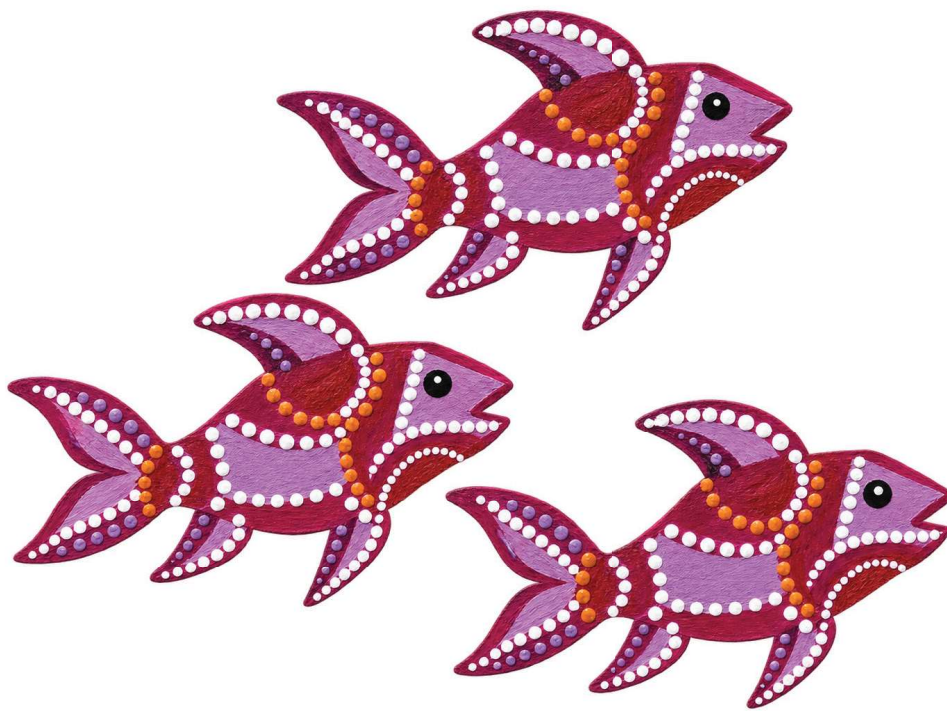
Effective safeguarding therefore requires more than risk management. It requires systems capable of understanding the meaning of behaviour with a developmental context, while still regulating exposure to overwhelming harm. The central safeguarding task is relational rather than purely procedural.

The question is not simply: "How do we stop young people engaging in risky behaviour?" The deeper developmental question is: "How do we organise the relational structures surrounding young people in ways that preserve communication, regulate risk, sustain hope and support movement toward safer

and more positive future lives?”

A note on perspective

Mark's story is told from a Youth AOD worker's vantage point. Practice took place outside of Mark's home, so there is no commentary about how his relationship with residential care workers changed as he stabilised and progressed. They provided Mark's daily care and supported his development, with a key role in connecting him to education. The pivotal role of the Youth Justice worker, representing his care team and keeping up the connections, also meant that the Youth AOD worker had little reason to engage Mark's carers or connect with him proactively in his home environment.



Part 4

The Practice of Relational Safeguarding

The preceding sections have established why relational safeguarding is necessary and what it requires conceptually.

4.1 From Theory to Practice

This Part describes how relational safeguarding works in practice - how workers with different responsibilities exercise authority in ways that remain coherent, and work together to build the relational conditions on which disclosure and developmental learning depend.

Effective safeguarding requires clarity and coordination so that each young person experiences a coherent, trustworthy system of care rather than a fragmented or adversarial one.

4.2 Putting the "Have-To" Function into Practice – Effective Limit-Setting

Relational safeguarding incorporates the setting of limits and the application of adult authority but distinguishes between whether the purpose is containment and control:

- Control - seeks to impose behaviour from the outside. It asks whether behaviour has stopped, whether the rule has been enforced, whether compliance has been achieved
- Containment - seeks to create the relational and environmental conditions within which a young person can gradually develop the capacity to regulate their own behaviour from the inside. It provides enough structure, predictability and adult presence for learning to occur. Containment keeps a focus on whether a young person is becoming more capable of navigating future challenges safely.

Containment is consistent with the broader evidence on adolescent risk-taking. The goal of limit-setting is not to eliminate risk from a young person's life, but to create conditions in which risk-taking and sensation-seeking - a normal and developmentally functional feature of adolescence - can occur within boundaries that limit extreme harm (Coleman & Hendry, 1990).

Young people's orientation toward exploration and connection with peers can also mean that their

perspectives on their substance use and other behaviours can differ sharply from the adults involved in their care.

So a young person is likely to calculate risk quite differently to adult limit-setters. Some potential differences are captured in the table below (Bruun & Palmer, 1998).

Common adult perspective on risk-taking behaviour	Young person's perspective
Foolish	Exciting / fun
Easily influenced	Sense of belonging
Acting without regard for consequence	Testing limits / exploring / gaining status
Dangerous	Thrilling / exciting
Withdrawn	Needing privacy

The task is not to decide which perspective is correct, but to hold both in mind - taking the risk seriously while understanding what the behaviour means to the young person - rather than defaulting to the adult perspective as the only true account of what is happening.

Sometimes, young people are at risk not because their judgement is impaired, but because they have not yet had the experience or opportunity to develop the skills and judgement that only learning through participation in age-appropriate activity can supply (Bessant, 2008). Understood this way, containment is not the opposite of opportunity. It is what makes safe opportunity possible.

This distinction matters because it changes what success looks like. A limit-setting response that achieves compliance but weakens trust, closes disclosure pathways or increases the young person's sense of shame or rejection may have controlled behaviour temporarily while undermining genuine containment. The young person might seem to comply, in front of adults, while becoming less likely to seek help, less willing to remain visible and less capable of internalising the self-regulation that actual safety requires.

Conversely, a relational safeguarding approach that keeps the young person engaged with the adults and the environment capable of supporting them may not produce immediate compliance. But it sets foundations for lasting change and constructive development. The test of effective limit-setting is therefore not whether authority was exercised - it is whether the response made the young person safer in ways that endure.

Relationships with "have-to" responsibilities provide the safeguarding, developmental containment and regulation of exposure to harm that make positive development possible. Workers in these roles (carers, residential staff, Child Protection practitioners, Youth Justice practitioners) carry specific responsibilities for limit-setting. The

following steps describe how to exercise those responsibilities in developmentally effective ways - in relation to a young person's substance use.

Step 1

Understand the behaviour before responding

Before taking action, adults should attempt to understand what the substance use or associated behaviour means, what need it is meeting and what context surrounds it. Substance use may function as coping, belonging, trauma adaptation, identity expression, peer affiliation or emotional regulation. Understanding function ensures the limit setting addresses the actual drivers of substance related harm rather than only the surface behaviour.

Step 2

Define the risk clearly

Identify specifically what harm is occurring or at risk of occurring. Consider: What is the immediate risk? What cumulative risks are emerging over time? What developmental impacts are likely if this pattern continues? This should include consideration of overdose risk, exploitation, unsafe peer influence, violence, educational disengagement and worsening psychosocial instability.

Step 3

Consult and involve the young person

Wherever safe and practicable, consult the young person before finalising a response. Explain what you are concerned about and why. Ask what they think and what they need. Adolescents are more likely to engage with limits when they understand

the rationale, experience fairness and remain emotionally connected to the adult implementing them. Participation strengthens agency, reflective functioning and internal locus of control.

Step 4

Take responsibility for the final decision

Young people may be consulted, heard and involved. But adults remain responsible for the safety of those in their care. After consultation, the adult exercises their responsibility and makes the decision. This should be communicated clearly, respectfully and without apology.

Step 5

Communicate the limit clearly

Limits should be communicated calmly, respectfully, specifically and in appropriate language. Avoid humiliation, escalating language or responses that signal rejection of the young person as a person rather than concern about the behaviour. The purpose is containment and developmental guidance, not dominance. A young person who feels humiliated by a limit is less likely to comply with it and less likely to disclose risk in future.

Step 6

Establish realistic and proportionate consequences

Consequences should be realistic, proportionate to the risk, developmentally meaningful, and able to be applied consistently. Disproportionate consequences - especially those that destabilise a placement, increase isolation or intensify shame - tend to produce the opposite of what is intended. And a consequence that is threatened but not enacted undermines the authority of the limit-setter, so it is better never to threaten one that cannot be followed through.

For this reason, limits and consequences should be graded rather than absolute. A one-strike approach where an ultimatum is backed by the most serious possible consequence, is both reckless and hard to implement. This is because the threatened consequence usually cannot be followed through on without causing more harm than the behaviour it was meant to address. Expelling a young person from a unit for a first transgression, for example, is disproportionate and may do more damage than the original risk. Graded consequences instead escalate in proportion to the behaviour, and are designed to keep the young person within reach of safe adults and safe environments - which makes it more likely that the limit-setter and the young person can stay in a constructive relationship through difficult periods. A proportionate first consequence might

be as simple as helping with extra chores alongside carers.

Step 7

Ensure consequences support learning

Consequences should support the young person to understand and learn rather than simply comply. The young person should understand what occurred, who was affected, what risks emerged and what repair or learning is required. Restorative conversations after consequences are applied are more developmentally useful than punitive responses during it. Where possible, consequences being applied should be a learning opportunity rather than simply marking that a rule was broken. A challenge without the opportunity to respond constructively is demeaning. A challenge accompanied by a genuine opportunity to make amends, contribute and demonstrate capacity is developmentally empowering. The consequence that asks something meaningful of the young person, and supports them to deliver on what is required, teaches far more than the consequence that simply imposes a cost.

Step 8

Follow through consistently

Consistency is essential. This creates the predictability and containment that young people who have experienced repeated relational rupture most need. However, consistency should not become rigidity: where circumstances change or where following through on a consequence is clearly increasing overall harm, adults should be willing to review, renegotiate and explain the change to the young person directly.

Step 9

Review and renegotiate limits over time

Adolescence involves rapid developmental change. Limits that are appropriate for a 13-year-old are unlikely to be appropriate for a 17-year-old. Limits should be reviewed and adjusted in response to developmental growth, increasing capacity and changing circumstances. Broadly, younger adolescents tend to respond well to more 'black and white' limits with clear consequences that are less open to negotiation. Older adolescents require increasing scope for autonomy and consequential decision-making as their capacity for future-oriented thinking develops (Steinberg & Morris, 2001; Nation et al., 2003).

The process for developing limits and consequences needs to be more inclusive and nuanced. Limits calibrated wrongly - too loose for

an early adolescent still needing structure, or too restrictive for one ready for greater autonomy - are equally likely to undermine engagement and disclosure. Reviewing a limit is not weakness - it is developmentally responsive practice.

Step 10

Embed limits within ongoing relational connection

Young people are most likely to experience authority as protective, and to comply with limits, when adults remain emotionally connected, interested in them as people, and demonstrate genuine belief in their capacity and future. Limit-setting that occurs within an ongoing, caring relationship is qualitatively different from the same action occurring within an adversarial one. The relationship is not separate from the limit-setting. It is the condition that makes limit-setting effective.

4.3 Implementing "How-To" Relationships: Pro-Social Enabling

The "how-to" role requires a relational space to be created in which young people can reflect, disclose, seek help, regulate emotion and gradually internalise safer forms of self-regulation. All workers can take up the "how-to" role but those responsible for "have-to" limit setting will struggle to create the relational space for disclosure and reflection around behaviours and experiences that are subject to the limits they apply.

Workers in purely "how-to" roles - Youth AOD practitioners, youth workers, Elders, mentors, coaches, trusted teachers - are not encumbered by the responsibility to set limits on behaviours like substance use.

What "How-To" relationships are not

"How-to" relationships are not anti-authority positioning. Effective "how-to" practitioners do not collude with the young person against the safeguarding system, undermine carers or residential staff, or operate as if relational warmth and accountability are incompatible. "How-to" relationships remain differentiated from, but constructively connected to, broader safeguarding systems. A practitioner who positions themselves as the young person's ally against the system has misunderstood their role and is likely to cause harm.

The following describes what is required to build and maintain these "how-to" relationships effectively.

Priority 1

Establish credibility and trust

The first task is to establish credibility and trust. Where young people are compelled to meet and work with a practitioner in a "how-to", they frequently approach the relationship with hostility and resistance. This is understandable - many have been burned by previous relationships with adults. The practitioner's job in the early stages is to establish rapport and become someone the young person experiences as genuinely helpful, safe and different from the adults who are focused on surveillance and control.

Practical guidance for the early engagement phase:

- Meet the young person on their own terms, in the environments in which they actually live and are comfortable, rather than expecting engagement to occur only within clinical or office-based settings. This demonstrates respect and a genuine openness to working from where the young person is at, rather than where the service would prefer or require them to be (Bruun & Hynan, 2006).
- Clarify confidentiality arrangements explicitly and in the young person's presence, including the safeguarding limits on confidentiality, while limit setters (i.e. statutory workers and carers) who referred them leave the room.
- Make clear that the young person is not required to discuss substance use, and that they have meaningful control over how sessions are used.
- Follow the young person's lead on topic and pace.
- Create 'Contexts for Action' involving activity that generates genuine relational connection.
- Resist the temptation to require detailed assessment in early sessions. Trust precedes disclosure; disclosure does not precede trust.
- Be practical and useful - offer to help with things that matter to the young person, including things unrelated to substance use.

Priority 2

Protect Disclosure Pathways

Once initial engagement is established, the practitioner's ongoing task is to preserve the conditions under which disclosure and developmental learning are possible:

- Remain emotionally regulated, including when the young person tests the relationship with hostility, absence or provocative behaviour.
- Be transparent about safeguarding responsibilities - a young person who understands a practitioner's safeguarding obligations and trusts that only relevant information will be shared and used

proportionately is more likely to continue disclosing than one who has experienced unexpected escalation.

- Keeping commitments. Reliability is experienced by young people with attachment disruption as rare and significant.

Priority 3

Reduce harm and build motivation

The first conversations about substance use are particularly important because they can either open or close future disclosure. Effective practice begins with curiosity rather than interrogation. Questions about what the young person experiences, what role substance use plays in their life, what helps them stay safer and who they would contact if something went wrong are often more productive than questions focused solely on compliance or behaviour.

Once sufficient relational safety exists, “how-to” practitioners are well placed to deliver harm reduction that would not be received from those in a “have-to” role. Harm reduction in this context includes:

- Accurate information about the substances the young person is using, including risks, unsafe combinations and signs of overdose.
- Overdose prevention and response planning, including naloxone education where opioid use is present or possible.
- Safer use information: hydration, nutrition, avoiding use alone, not mixing substances, knowing where to get help.
- Sexual health support, including understanding the relationship between substance use, exploitation and sexual risk.
- Help with peer risk assessment: how to think about who is safe, what situations increase risk and how to exit dangerous situations.
- Honest conversation about the relationship between the young person’s substance use and what is happening in the rest of their life.

Motivation for young people to invest in positive change toward being safer and healthier is also built through these conversations - rather than being a precondition for them. It develops when a young person identifies what they actually want to change, which is often not their substance use, at least initially.

Young people frequently experience problems as tangled together and therefore insurmountable, and helping them separate those problems out and prioritise among them tends to leave them feeling more hopeful and more able to act. Motivation

strengthens when change seems realistically possible, which is why goals are best kept achievable and built on existing strengths.

Priority 4

Build Resilience and Support Self-Efficacy

A core function of “how-to” relationships is building the young person’s capacity to reflect on their own behaviour, emotions and relationships. This includes:

- Helping the young person understand what needs their substance use is addressing, and what it might be costing them personally in the immediate and long term.
- Supporting the young person to work through feelings about imposed limits, including the “have-to” decisions they experience as unjust.
- Helping the young person understand the rationale behind safeguarding decisions they disagree with, without undermining the authority of those who made them.
- Building strategies for managing frustration, boredom, emotional pain and peer pressure without defaulting to substance use.
- Strengthening the young person’s sense of identity, aspiration and future orientation.
- Recognising and naming small, everyday achievements rather than waiting for major milestones. Smaller and more frequent recognition of everyday achievements and contributions can build a young person’s sense of worth and belonging more effectively than occasional recognition of larger accomplishments, and directly challenges self-limiting beliefs over time (Bruun & Hyman, 2006).

Priority 5

Strengthen Young People’s Connection with Limit Setters

Workers in “how-to” relationships also help the young person understand the important role of limit setting in their lives - someone who cares enough to make the effort to regulate the risks that they are exposed to and act in the interests of their care and protection.

Young people in residential OOHC can develop adversarial feelings towards people who set and enforce the rules that they are subject to. Often this is because the young person doesn’t understand the rationale behind decisions, or feels unable to manage the feelings of anger and powerlessness that those decisions generate.

The “how-to” practitioner is positioned to help the

young person to:

- work through those feelings without acting them out
- understand the perspective of the limit setter (even where they disagree with a particular decision)
- begin developing their own internal framework for what constitutes fair and reasonable limits.

This is not the same as defending poor practice by those in authority - where limit-setting genuinely is unreasonable or poorly communicated. The practitioner in the "how-to" role can help the young person find constructive ways to challenge decisions they believe are unfair without taking sides. Helpful work can be done with a young person to move from an entirely adversarial relationship with those in authority, toward one in which they can engage, negotiate and sometimes comply with limits without experiencing compliance as defeat. That capacity will serve them well beyond the OOHC context.

4.4 Overriding Confidentiality to protect from serious harm

There are circumstances in which a "how-to" practitioner - a Youth AOD worker, a youth worker, a mentor - learns something that cannot be kept confidential, regardless of the young person's wishes.

The Threshold for Override

The threshold for override is high and specific. It is not reached by serious substance use in the abstract, by poor decision-making, by ongoing risk that is being actively managed, or by practitioner discomfort with information that is difficult to hold. The threshold is reached when the practitioner becomes aware of a risk that is serious, credible and not manageable through any means other than disclosure to someone with the authority and capacity to intervene - and when withholding that information would make them complicit in preventable harm.

In a substance use context this might include: a credible and imminent overdose risk the young person is concealing from everyone capable of responding; active exploitation where the young person is in immediate danger and cannot or will not seek help; or escalating harm where every avenue short of external disclosure has genuinely been exhausted. These are not common situations. When they arise, the practitioner's responsibility is clear. But the manner in which that responsibility is exercised matters profoundly - both ethically and for the longer-term safety of the young person.

Clarifying Role in a Crisis

It is also important to be clear about role. Youth AOD

workers, youth workers and mentors seldom hold the authority to intervene directly in a crisis. They are not typically in a position to initiate emergency protective responses, invoke statutory powers or make placement decisions. What they can do, and in these circumstances must do, is share what they know with the people who do hold that authority: residential managers, Child Protection practitioners, statutory workers or emergency services. This is not a failure of the "how-to" role. It is the coordinated safeguarding system functioning as it should - with information flowing to the part of the system capable of acting on it.

Telling, Not Asking

Where at all possible, the young person should be told before information is shared, not asked for permission they cannot give, but told. A practitioner who says "I have to tell someone about this because I'm worried you could be seriously hurt, and I'm telling you that before I do it" is doing something important even in a moment of necessary rupture. They are maintaining the relational honesty on which the entire framework depends. They are modelling the kind of accountable, non-abandoning adult behaviour that the young person may rarely have encountered. And they are making explicit that the override is an act of concern, not of punishment or rejection. This will not always prevent the young person from feeling betrayed. It cannot. But it preserves the possibility of repair in a way that covert escalation does not.

Staying Present

The practitioner should also, wherever possible, remain present through the process rather than handing off and withdrawing. The young person's experience of being abandoned by the one adult they had trusted, at exactly the moment when statutory or emergency processes take over, can confirm every prior belief that trusting adults leads to loss of control and rejection. Where the practitioner can remain alongside the young person as external processes unfold, this continuity of presence is itself a safeguarding act. It communicates, through behaviour rather than words, that the relationship has not ended and that the practitioner's commitment to the young person was not contingent on the young person behaving in ways the practitioner found comfortable.

Repairing the Rupture

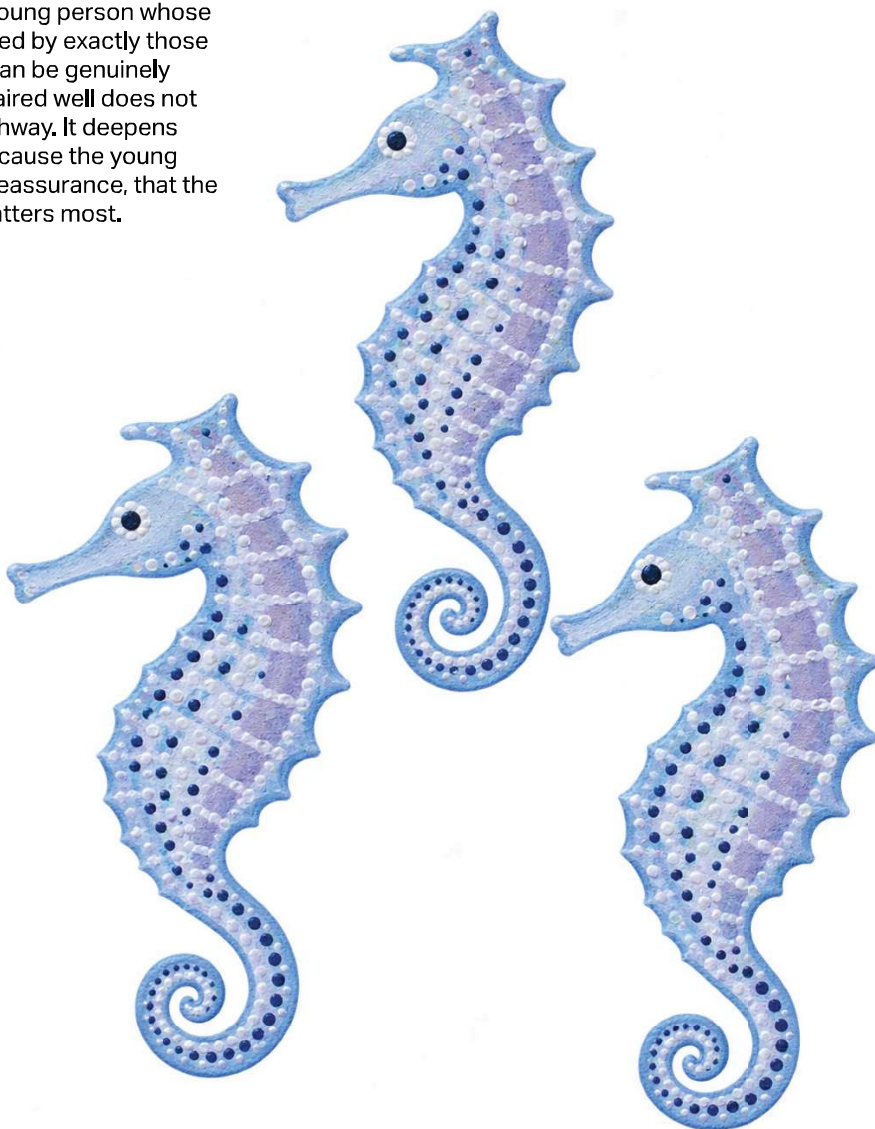
A disclosure pathway that has been ruptured through necessary override will not simply restore itself. If the practitioner simply continues as before without acknowledgement, the young person is likely to experience the relationship as permanently altered - either withdrawing, testing the practitioner with escalating disclosures to see whether they will respond with further override, or superficially re-engaging while withholding anything of real significance. None of these outcomes serves the young person's safety.

Repair requires the practitioner to return to the rupture directly, and soon. Not to justify defensively or seek reassurance that the young person is not angry, but to acknowledge what happened and hold space for the young person's response to it. This might sound like: "I want to talk about what happened last week. I know that wasn't what you wanted me to do. It was difficult and I'm aware it might have changed how you see me. I did it because I was genuinely worried about your safety, and I'm telling you that directly because I think you deserve honesty from me even when it's uncomfortable." The young person may respond with anger, silence or denial. All of these are understandable. The practitioner's task is to remain regulated, present and to not require the young person to reassure them or resolve the discomfort quickly.

Research on therapeutic rupture and repair consistently demonstrates that relationships which survive a rupture often become stronger than they were before (Meares, 2001). This is often because the adult remained honest, regulated and committed throughout, and because the young person discovers that the practitioner did not collapse, did not disappear and did not withdraw care when things became difficult. For a young person whose relational history is characterised by exactly those adult failures, this experience can be genuinely formative. A rupture that is repaired well does not simply restore a disclosure pathway. It deepens it and makes it more robust, because the young person has evidence, not just reassurance, that the adult can be trusted when it matters most.

The Role of Supervision

Supervision plays an essential role in supporting practitioners through these situations. Deciding whether the threshold for override has been reached; managing the process of disclosure transparently and with care; remaining present through statutory or emergency responses; and initiating repair conversations are all demanding practice tasks. Practitioners should not be expected to navigate them alone or in the moment without support. Reflective supervision that creates space to think through these decisions before they are made, and to process their relational consequences afterwards, is not an optional enhancement to this kind of practice. It is the organisational condition that makes it possible.



Part 5

Creating the Conditions for Effective Relational Safeguarding

Part 4 addressed how relational safeguarding is applied in practice.

Part 5 sets out how Youth AOD Practitioners, OOHC providers and Statutory Services can apply relational safeguarding in responding to the substance use of young people in residential OOHC.

5.1 A Shared Knowledge Foundation

Relational safeguarding that addresses substance-using behaviour in residential OOHC requires coordination between Statutory Services, OOHC providers and Youth AOD services. This depends on more than goodwill and clear roles. It depends on practitioners having enough shared understanding of substance use to interpret what they observe, respond proportionately and communicate meaningfully across professional boundaries. This is a question of literacy, not clinical expertise: enough knowledge to distinguish presentations that call for immediate medical response from those that call for calm support and follow-up conversation, and to understand the function of substance use in a young person's life.

Young people are safer when the adults around them can recognise common substance presentations, respond calmly to intoxication, identify when

medical assistance is required, and avoid responses that escalate fear, shame or dysregulation. Victorian residential care guidance offers practical examples of this immediate care orientation: calm, non-invasive interaction; reduced stimulation; a safe space for movement; hydration and nutrition; sleep support; not arguing with delusional or paranoid content; and access to naloxone where opioid use is possible (Department of Families, Fairness and Housing, 2026).

Equally, Youth AOD practitioners must develop literacy of the OOHC context: the legislative requirements and guidelines governing residential care, the responsibilities and constraints of residential workers and Child Protection practitioners, the significance of placement stability, and the dynamics of a care environment where multiple workers engage the same young person across shifts and contexts. Youth AOD practice that draws only on clinical considerations, without this structural understanding, is less effective and more likely to generate the role tensions described in section 5.4.

Residential staff and care teams don't need pharmacology expertise - they need enough grounding to recognise when a young person may be intoxicated, sedated, overstimulated, confused, paranoid, medically compromised, or at risk of overdose.

Attachment 1 adapts common presentations from Victorian residential care guidance as a prompt for that safety awareness, not as a diagnostic tool (Department of Families, Fairness and Housing, 2026).

To build a shared knowledge foundation the following practices are recommended:

- joint induction sessions when a new worker joins a young person's care team
- shared access to relevant case notes and safety plans across agencies within agreed confidentiality arrangements
- a standing agenda item on substance use and safety at care team meetings rather than raising it only once something has gone wrong.
- cross-agency shadowing - a Youth AOD worker spending time in a residential unit, or residential staff observing a Youth AOD session with the young person's consent – this builds the kind of practical, first-hand understanding that policy documents and guidelines alone cannot provide.

These proposed actions protect the have-to/how-to distinction itself, rather than blur it.

Shared knowledge of what to look for and how to respond is one way to support effective relational safeguarding. The other is clarity about who is best placed to do what, and how the response for a young person is coordinated.

Statutory services, OOHC services and Youth AOD services perform different but complementary functions. Statutory and OOHC workers typically hold responsibility for limit-setting and containment, while also providing support and everyday developmental experiences for the young person. Youth AOD practitioners work without that limit-setting responsibility, but with respect for its purpose, focusing on specialised therapeutic engagement, harm reduction and building motivation for change. Everyone has responsibility for working to keep disclosure pathways open.

This differentiation works best when workers actively support one another to perform their role, rather than staying in their own lane. This includes protecting each other's credibility with the young person even when privately there is some form of disagreement (working through disagreement using the processes set out in 5.3). Safeguarding is the shared responsibility of everyone involved in a young person's life, not a function that belongs to some roles and not others. What differs between roles is the distinctive contribution each makes to that shared task, and how each can actively strengthen the others - as set out in the table below.

5.2 Maximising benefits from differentiated but complementary roles

Position	Responsibility	Safeguarding – strengthening the shared task
OOHC / residential workers and carers	Everyday developmental environment and daily relational continuity; emotional co-regulation, coaching and skill-building; containment and limit-setting; placement stability.	Provide the stable, predictable everyday environment that disclosure, reflection and how-to work depend on. Protect disclosure pathways by responding to what young people share in ways that keep them open rather than punitive, and by treating a Youth AOD worker's confidentiality arrangements as a legitimate part of the safeguarding system rather than a gap in it.
OOHC / residential Unit Managers	Lead and sustain the therapeutic culture of the unit; protect reflective practice and supervision; ensure consistency across shifts; build and maintain relationships with partner services.	Shape whether a relational approach can take root and be sustained. Hold the unit steady against punitive drift after serious incidents, keep the care plan understood and applied consistently from one shift to the next, and build the cross-agency relationships that make coordination possible before it is needed.

Position	Responsibility	Safeguarding – strengthening the shared task
Child Protection / Statutory practitioners	Legal authority, care planning, case coordination, oversight of the overall care and safety picture.	Can protect how-to space by not requiring Youth AOD workers to routinely report disclosures, and by treating a Youth AOD worker's confidentiality arrangements with a young person as essential for protecting disclosure pathways and a legitimate part of the safeguarding system rather than a gap in it.
Youth Justice practitioners	Legal compliance, accountability, risk management, referral and transport.	Can strengthen disclosure pathways by explaining the reasoning behind their decisions directly to the young person, rather than leaving this explanatory work entirely to how-to practitioners.
Youth AOD practitioners	Specialised therapeutic engagement, harm reduction expertise, disclosure facilitation, reflective support.	Keep disclosure pathways open through negotiated, transparent confidentiality. Support the have-to function by helping the young person understand and work through the limits being applied, rather than positioning themselves as separate from or opposed to them.
Youth workers	Relational continuity, pro-social connection, identity support.	Offer a how-to relationship free of any limit-setting role; sustain engagement and pro-social participation through periods of withdrawal, and help a young person make sense of the limits others are applying.
Elders and mentors	Cultural connection and guidance, family and community support.	Provide a how-to relationship carrying cultural authority that other trusted adults cannot substitute for, strengthening identity and belonging in ways that independently reduce the likelihood of harmful substance use.
Mental health practitioners	Clinical assessment, trauma treatment, medication, crisis response.	Contribute clinical understanding to shared formulation, helping the team read behaviour developmentally and distinguish trauma and mental-health presentations from defiance, so responses remain proportionate rather than punitive.

5.3 Coordinating Relational Safeguarding Between Services

Coordination operates at two levels:

- Partnership governance - relates to the conditions that leadership and organisations put in place so that coordination is possible at all
- The intentional coordination of relational structures - concerns what care teams do at the

casework level, day to day, to keep the system around a young person coherent.

Partnership Governance

Coordination between services holds together less through goodwill between individual workers than through relationships built at a service and management level before they are needed. Building and maintaining an inter-organisational authorising environment to support effective safeguarding naturally sits with those in leadership and

management roles.

This requires counterparts in Child Protection, Youth Justice and Youth AOD services to create an overarching agreement on roles, how confidentiality and escalation will work and a way of resolving conflict should it be required. Where this kind of authorising environment exists, frontline coordination is far easier. Where it isn't in place, workers are often left to improvise cooperation under pressure.

This means investing time to build a shared knowledge foundation (see 5.1), and in each service articulating clearly what it can realistically offer, what it cannot, and what it needs from partners.

The responsibilities that Statutory services and organisations providing OOHC and Youth AOD services hold in making relational safeguarding work include:

- Ensuring workers have access to regular, quality reflective supervision, delivered as a function distinct from line management and administrative oversight, so that emotional processing and practice reflection are not displaced by performance or compliance discussion.
- Provide training in developmental safeguarding, trauma-informed practice, harm reduction and the specific demands of working with exploitation-affected young people, delivered through structured programs (Sullivan, Murray & Ake, 2016).
- Ensure that training and practice are culturally safe, and that Aboriginal-led and community-designed responses inform how relational safeguarding is delivered to Aboriginal and Torres Strait Islander young people, in recognition that culturally responsive practice must be grounded in family, community and cultural strength rather than imposed from outside it (Butler et al., 2019).
- Support multidisciplinary consultation and care team processes that enable shared developmental formulation.
- Create organisational cultures that can tolerate complexity, uncertainty and non-linear progress without defaulting to punitive or escalatory responses.
- Ensure that practitioners are not placed in impossible positions by expecting them to simultaneously occupy "have-to" and "how-to" roles without acknowledgement of the inherent tension.

Intentional coordination of relational structures

Relational governance is the intentional coordination of relational structures surrounding the young person in ways that reduce harm and promote positive development. The following operational

practices support effective coordination:

- **Shared formulation** - All practitioners involved with a young person should develop a shared understanding of the risks associated with the young person's substance use and its function, their psychosocial stability, key relational dynamics, exploitation vulnerability and future trajectory. Without shared formulation, systems default to incident management.
- **Role clarity**. Each practitioner should understand their specific function within the relational system and how it complements, rather than competes with, the functions of others.
- **Negotiated confidentiality**. Youth AOD practitioners require sufficient confidentiality to build the relational safety on which disclosure depends. Practitioners should negotiate explicit confidentiality arrangements with the young person, and communicate the safeguarding limits on those arrangements transparently. Information sharing should occur intentionally, proportionately and in ways that preserve relational safety wherever possible.
- **Agreed safeguarding thresholds** - Practitioners should understand and agree on what information requires escalation, and to whom. Indiscriminate information sharing undermines the disclosure pathways that make safeguarding possible.
- **Regular reflective communication** - Care teams should meet regularly - not only during crisis - to review developmental progress, discuss emerging risks, examine relational dynamics and coordinate strategy. Communication organised primarily around incidents produces reactive, fragmented practice.
- **Conflict resolution processes** - Disagreement between practitioners and service providers is inevitable and when well-managed, can be productive. Unresolved conflict becomes problematic when it places the young person in the middle of system tension, destabilises intervention or collapses relational coherence. Disputes should be resolved directly, respectfully and outside the young person's presence wherever possible.

What this looks like in practice

A shared formulation discussion does not need to be a separate, additional meeting – it can be built into an existing care team meeting, provided time is protected for it. It should cover what is currently understood about young person's substance use (function, risks, etc), what has changed since the last review, what each practitioner is currently observing that others may not have visibility of, and what, if anything, needs to shift in how the team is responding.

For a Youth AOD worker, negotiating confidentiality

with a young person does not need to be complicated, but it does need to be explicit and delivered early – ideally at first contact, and in the presence of whoever may be fulfilling the “have-to” role. If a worker is not present, then the young person needs to know that the agreement around confidentiality is understood and endorsed by all service providers involved – this provides reassurance and builds trust in the whole safeguarding system of care.

A practical version of this conversation between the Youth AOD worker and the young person might be: ‘What you tell me stays between us, unless I become seriously worried about your safety or someone else’s safety – and if that happens, I’ll do my best to tell you what I am doing, and I’ll only share what’s needed to keep you (or another person) safe.’ Being specific and consistent about the boundary – rather than offering vague reassurances such as ‘don’t worry, this is confidential’ – helps to make the arrangement trustworthy enough for disclosure to occur.

5.4 Planning to Prevent Relational Breakdown Between Statutory and Youth AOD Services

Indications of relational fragmentation

Relational fragmentation - when individual practitioners or service providers begin positioning one another as the problem - is one of the most serious threats to effective safeguarding. Warning signs include:

- Youth AOD or therapeutic practitioners characterising statutory or residential workers as punitive, controlling or uncaring.
- Statutory or residential workers characterising Youth AOD practitioners as collusive, naïve or insufficiently concerned with safety.
- The young person receiving contradictory messages from different parts of the system.
- The young person exploiting relational splits to undermine accountability or avoid disclosure.
- Key practitioners losing visibility of risk because the young person has withdrawn from parts of the system.

When these signs appear, supervisors and managers should act promptly to facilitate direct communication between practitioners, clarify roles and rebuild shared understanding. The young person should never be used as the vehicle for inter-agency communication.

Mechanisms for restoring an effective safeguarding system

In practice, repair is more likely when there is a named, pre-agreed process for raising concerns about another practitioner or service provider – rather than relying on individual workers to raise sensitive concerns informally and risk it being experienced as personal criticism.

Useful mechanisms for restoring an effective safeguarding system include:

- a joint case conference convened specifically to address the relational tension rather than only the young person’s behaviour
- a standing invitation for any practitioner to request an urgent cross-agency conversation when they notice early signs of fragmentation
- a simple reframing question practitioners can use with each other in the moment – ‘are we describing what’s happening, or are we describing each other?’ – to interrupt triangulation before it hardens into a fixed narrative about the young person.

Active coordination requires ongoing structural effort precisely because the service system’s default tendency runs the other way.

Preventing conflict from being redirected toward the young person

One particularly damaging pattern emerges when unresolved inter-service or professional conflict is redirected toward the young person. This is a form of triangulation: where rather than examining their own relational dynamics or practice, workers arrive at a shared negative formulation of the young person as the common problem - labelled manipulative, recalcitrant or self-sabotaging. Without a proper diagnosis, the following labels might be used to describe a young person - personality disorder, conduct disorder, attachment disorder. This is a dangerous, stigmatising practice that should be stopped immediately. Where a young person is inappropriately labelled this way, it often occurs without adequate developmental context and without considering whether the presenting behaviour reflects the young person’s characteristics or the care system’s dysfunction. These labels are difficult to dislodge and carry lasting consequences for how future workers, services and systems approach the young person.

Practitioners should be alert to the possibility that problems may lie at least partly in the relational system those parties have created around them.

5.5 Care Planning and Review

AOD focused Care planning

The care plan is where relational safeguarding becomes coordinated and real. It is the standing structure that holds the have-to and how-to functions together around a young person, keeps

every worker across every shift working to the same understanding, and turns the principles underpinning relational safeguarding into day-to-day practice. What follows describes what makes a care plan effective when substance use is involved.

Effective care planning begins with meaning, not behaviour. A significant episode of substance use carries information - about the young person's circumstances, emotional state, relationships and developmental needs - that is often more important than the use itself. The planning question is therefore not only what happened, but what it reveals: what are the push and pull factors toward substance use, what need was the young person trying to meet, how relationships are shaping the behaviour, whether psychosocial stability is strengthening or deteriorating, and whether the care environment is providing enough of what the young person needs for safer choices to become more likely. This orientation moves a team from managing incidents to understanding developmental trajectories and makes their plans more useful (see also Part 1 on the function of substance use, and Part 4, Step 1).

Plans should also make the relational structure explicit: who in the care team holds the "have-to" role and can legitimately provide the push toward support, and who offers the "how-to" relationship that provides the pull (section 3.6). Naming these roles in the plan turns coordination from an aspiration into an allocated responsibility.

Care planning should be collaborative and dynamic and plans should be time-bound and regularly reviewed. It should not be organised around behavioural compliance alone but should reflect the full developmental picture and risk profile across the seven forms of substance use-related harm set out in section 1.3 - immediate, cumulative, developmental, relational, psychosocial, exploitation and systemic.

Assigning responsibility for those harms is a practical matter of who is best placed to respond:

- Immediate and cumulative harms call first on the have-to function - regulating exposure and responding to acute risk, led by residential workers and statutory practitioners - supported by how-to practitioners who keep disclosure pathways open and hold dedicated reflective space around sensitive behaviours like substance use.
- Developmental, relational and psychosocial harms are addressed primarily through the everyday developmental relationships residential workers have with each young person - the ordinary, repeated interactions of daily life in which regulation, connection and identity are built - supported by how-to practitioners who keep risk visible and coordinate with others responsible for safeguarding.
- Exploitation and systemic harms usually require

both functions together: have-to practitioners to intervene directly where needed, and how-to relationships to help the young person understand and disclose what is happening.

The AOD component of care plans

For any young person with identified substance use, a specific AOD component should be developed as a distinct operational component of the broader care plan. Where possible, it should be developed with the young person and their Care Team (including the Youth AOD practitioner), and initiated before use patterns become entrenched.

Through the lens of relational safeguarding, the AOD component of care plans should explicitly consider:

- The function of the young person's substance use, and the needs it is meeting (including the push and pull factor framing).
- Immediate safety risks and how they will be managed.
- Impact on psychosocial stability: placement, school, relationships, cultural connection.
- Exploitation vulnerability and the relational systems surrounding the young person.
- Safeguarding role clarity and communication arrangements, balancing "have-to" and "how-to" roles.
- Harm reduction strategies that are practical and can be implemented by the people named in the plan.
- Influence of the young person's substance using behaviour and how it is being managed on other residents in the unit.
- How the young person's participation was sought and how it will be maintained.
- Review dates, and the question each review answers: is the overall situation becoming safer and more stable, or not?

For young people leaving a residential placement or transitioning from care, the specific ongoing need for pro-social relational support should be identified - including support from Youth AOD service providers. The availability of these relationships and the level of connection for the young person, should be confirmed before the transition - not initiated at the point of departure. A young person whose AOD support ends when their placement ends loses the relational continuity on which further progress depends, at exactly the moment stress and isolation increase. Transition planning must name specific people and specific services, not categories of support.

Review and evaluation of care plans

Review and Evaluation is continuous and also periodic. The frequency of review should be

commensurate with the acuity of the risk associated with the substance using behaviour. When acuity is high, the actions taken to safeguard a young person must be reviewed closely and within a tight timeframe – hours or days rather than weeks.

Reviews should assess the impact of the care plan - and the specific actions within it - against the measures that show whether safeguarding is working to reduce substance use related harm and create the conditions for positive development. This involves an evaluation of whether:

- psychosocial stability (relational continuity, placement stability, emotional containment, school participation, cultural connection and predictable support) is strengthening or weakening
- disclosure pathways are open or collapsing
- exploitation vulnerability is reducing or increasing
- the young person stays engaged with the adults and services around them
- the young person's future trajectory is broadening or narrowing.

A response that suppresses a behaviour while weakening any of these has not made the young person safer.

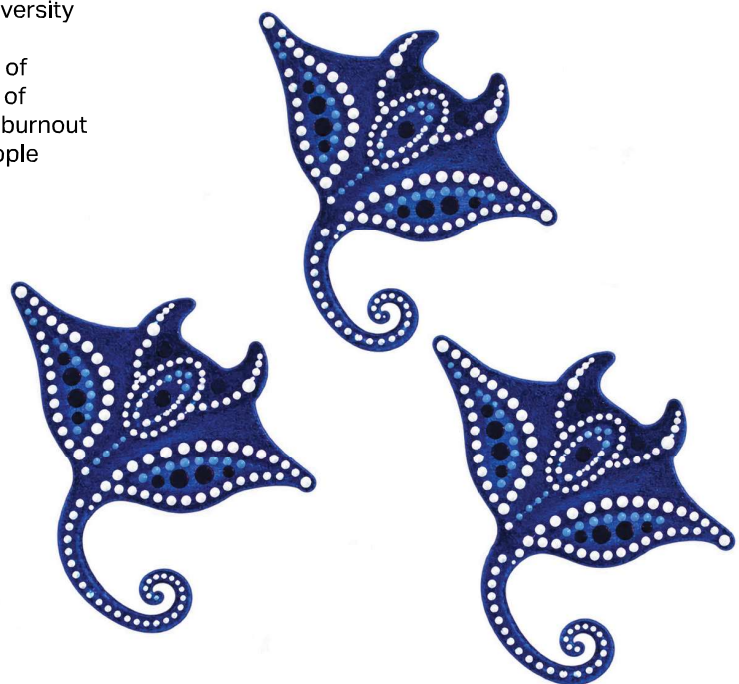
5.6 Reflective Supervision and Workforce Support

Effective relational safeguarding practice cannot be sustained without adequate supervision and organisational support. Working with young people experiencing substance-related harm, exploitation and profound developmental adversity is emotionally demanding. Workers who are not adequately supported are at greater risk of emotional dysregulation, punitive escalation of responses to young people's behaviour and burnout - all of which increase harm to the young people they are trying to help.

What reflective supervision should address

Reflective supervision in this context should assist workers to:

- Process their emotional responses to challenging behaviour and prevent those responses from driving practice decisions
- Recognise and respond to vicarious trauma (the cumulative emotional impact on workers of sustained exposure to others' trauma) which, left unaddressed, increases the risk of the punitive escalation and burnout (Randall, 2013)
- Maintain therapeutic positioning - understanding what young people's behaviour is communicating rather than it being interpreted as deliberate defiance or a personal attack
- Evaluate whether their responses are likely to strengthen or weaken psychosocial stability, disclosure pathways and future trajectory
- Sustain relational engagement during periods of hostility, withdrawal or escalation
- Identify and address emerging role confusion or inter-practitioner conflict before it destabilises the young person's care - including recognising when unresolved tension between workers is being reproduced in how the young person is being responded to (see 5.4)



Conclusion

Children and young people in residential OOHC are among the most disadvantaged members of our community. Most have lived through repeated trauma, disrupted relationships, loss and instability long before they first use alcohol or other drugs. Their substance use cannot be understood apart from those experiences, or addressed by responses that attend only to behaviour. Lasting safety depends on understanding the young person, the meaning their substance use holds for them, and the relationships and environments in which it occurs.

Safeguarding is, at its core, a relational task. Policies, procedures and statutory authority all matter, but children and young people are kept safe through the quality of the relationships and systems around them - when adults stay connected, emotionally regulated and coordinated, when disclosure pathways remain open, when psychosocial stability is protected, and when young people keep experiencing chances to learn, participate and develop through the difficulties they face.

For young people in residential care, those relationships begin with the people they live with every day. Residential care is not a placement or a service setting; it is what makes a young person's living environment a home and the place where they grow up. Residential workers and managers are not simply supervisors of behaviour or managers of risk - through the countless ordinary interactions of daily life, they help young people build emotional regulation, trust, confidence, practical skills, belonging and hope. Relational safeguarding recognises and strengthens this essential developmental role with coordinated specialist intervention. Intentional relationships are structured around every young person so they are both contained and empowered. Getting this balance right matters most when responding to substance use.

Young people rarely become safer because they are told not to take risks. They become safer when they stay connected to adults who know what is happening in their lives and can respond before risk becomes crisis. The aim is not simply to reduce substance use, but to create the conditions in which young people are more likely to seek help, stay visible to safe adults, recover from setbacks and

keep moving toward adulthood.

This asks a good deal of the system. Residential care providers, Child Protection, Youth Justice, Youth AOD services, mental health services, education providers and community organisations work best for young people in care, when they respond as one coherent whole. Young people should never experience these services as competing authorities pulling them in different directions, but as a single coordinated network of adults whose shared purpose is to keep them safe while helping them grow.

The central question is not "How do we stop young people using alcohol and other drugs?" but "How do we organise the relationships, environments and systems around young people so they can grow up as safely as possible, despite the risks and adversities they face?" That question demands more effort - it calls for judgement rather than the rigid application of rules, coordination rather than fragmentation, relationships rather than surveillance - and it is more likely to produce lasting safety.

Adolescence has always involved experimentation, uncertainty and the slow work of becoming independent. Success is young people staying connected to the adults, relationships and opportunities that let them come through those experiences, learn from them, and keep building the capabilities, confidence and hope they will need as adults.

Safeguarding, in the end, is not only about preventing harm - it is about working together to make sure that harm does not define a young person's development. Residential care is where that work happens, every day. Relational safeguarding is what helps it happen in the best possible way.

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[Note]

References to the broader evidence base on adolescent development, OOHHC and relational practice are provided in the main reference list above. The two Victorian inquiry and audit sources cited are:

- Commission for Children and Young People. (2026). *Left behind: Systemic inquiry into responses to children and young people who are the subject of multiple reports to Child Protection*. Commission for Children and Young People.
- Victorian Auditor-General's Office. (2026). *OOHC Services. Independent assurance report to Parliament 2025–26:21*. Victorian Auditor-General's Office.

Attachment 1

Creating the Conditions for Effective Relational Safeguarding

Adapted from Victorian residential care guidance, provided as a prompt for safety awareness rather than a diagnostic tool (Department of Families, Fairness and Housing, 2026).

Substance or presentation	Common signs that may be observed	Immediate safeguarding focus
Cannabis	Relaxed or euphoric mood, slowed reaction time, bloodshot eyes, dry mouth, increased appetite; sometimes anxiety, paranoia or confusion.	Remain calm, assess anxiety or paranoia, avoid shaming, check safety and explore context when the young person is settled.
Stimulants including methamphetamine	Increased energy, alertness, talkativeness, agitation, sweating, rapid heart rate, reduced appetite and difficulty sleeping.	Reduce stimulation, monitor agitation and overheating, support rest when safe. Treat high fever or overheating, severe headache, chest pain, or muscle tremor, spasm or seizures as signs of possible toxicity requiring an immediate ambulance call - not signs to monitor and wait on (Jenner & Lee, 2008).
Benzodiazepines and other sedatives	Drowsiness, slowed thinking or movement, reduced anxiety, confusion or memory lapses.	Monitor consciousness and breathing, reduce environmental risk, avoid leaving the young person unsupported if heavily sedated.
Opioids including heroin or prescription opioids	Heavy limbs, drowsiness or “nodding off”, slowed breathing, confusion, nausea or vomiting.	Treat breathing difficulty or reduced consciousness as urgent. Ensure naloxone is available and call emergency medical assistance when overdose is suspected.

Substance or presentation	Common signs that may be observed	Immediate safeguarding focus
Inhalants	Dizziness, disinhibition, giggling, mood swings, slurred speech, hallucinations or confusion.	Remove access to inhalants where safe, monitor acute distress or confusion, and seek medical advice if presentation is unstable.
GHB or other strong depressants	Deep sleep, vomiting, unusual movements, seizures or unconsciousness.	Prioritise emergency medical response where consciousness, breathing, seizures or vomiting create acute risk.
Ketamine or dissociatives	Detached or floating presentation, confusion, poor coordination, difficulty speaking, numbness, hallucinations or paranoia.	Reduce stimulation, protect from falls or injury, avoid arguing with altered perceptions, and monitor for medical or psychological deterioration.
Alcohol	Slurred speech, impaired judgement, nausea or vomiting, aggression, blackouts, slowed breathing in high doses.	Monitor consciousness, breathing, vomiting and aggression risk; provide calm support and seek medical care when signs indicate acute risk.

[Note] Where an intoxicated young person becomes agitated in a shared space, a single worker is likely to struggle. A team-based response is recommended, with one worker engaging directly with the young person while a second manages the physical environment, keeps other young people at a safe distance and monitors for escalation. This

allows the worker in direct contact to focus entirely on de-escalation and safety, while the service still discharges its duty of care to everyone else present. This division of labour, agreed in advance rather than improvised in the moment, is itself a safeguarding practice.

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