YSAS
SEEING YOUTH IN A DIFFERENT LIGHT

The Centre for YouthAOD Practice Development

YoDAA YOUTH DRUGS + ALCOHOL ADVICE

THE VICTORIAN YOUTH NEEDS CENSUS:

TECHNICAL REPORT ON THE NEEDS AND CHARACTERISTICS OF YOUNG PEOPLE IN THE YOUTH ALCOHOL AND OTHER DRUG SYSTEM IN 2016-2017.

Hallam, K., T., Landmann, O., Hall, K., Kutin, J., Bruun, A., & Ennis, D.

YOUTH SUPPORT + ADVOCACY SERVICE

A MESSAGE FROM THE YSAS CEO

Victoria is the only Australian State with a comprehensive, fully integrated youth AOD service system that consists of many different 'types' of interventions and programs. It was established in 1998 on the recommendation of the Premiers Drug Advisory Council (PDAC), an expert panel chaired by Professor David Pennington to advise the State Government on how Victoria's illicit drug problem should be tackled.

PDAC found that "... there are large gaps in the network of services available to support young people, particularly those with serious drug abuse and related problems" (PDAC 1996 p.95). The AOD service system at the time was not engaging this population, so engagement and treatment retention was identified as an imperative for youth AOD services.

The implementation of the new Victorian "Youth AOD service system" saw an immediate and sharp increase in the number of young people accessing AOD treatment. This was also reflected in the proportion of young people represented in the overall AOD treatment population. In 1997/8, the State Government Alcohol and Drug Information System (ADIS) revealed that 9% of service users were 21 or under whereas in the following year, with the establishment of the youth AOD service system, this figure grew to 26%.

ThYNC findings demonstrate that nearly two decades later, Youth AOD Services continue to engage and retain young people in care. It also provides many useful insights into the needs and characteristics of these young people, enabling us to shape our service responses accordingly.

ThYNC findings make a strong case for Youth AOD services to intervene as early as possible to prevent the harm that can stem from entrenched and dependent substance use. The findings point to the significance of strengthening and protecting healthy connectedness with family and carers and to school, work or other meaningful activity.

At the same time, ThYNC reminds us that substance use problems very commonly co-exist with mental health problems, engagement in criminal behaviour, homelessness and limited social and economic participation. These issues must be addressed simultaneously, if young people are to achieve positive outcomes.

ThYNC also helps us to understand more about distinct populations of young people who engage with Youth AOD services. You will find within this report strong evidence that as a service system we need to pay special attention to promoting the mental health and well being of same sex attracted young people. I note that compared to other young people within the study, same sex attracted young people had double the amount of suicide attempts and 76.8% of them had deliberately self-injured in the past.

I thank and commend Dr Karen Hallam for leading this important research and Ora Landmann for facilitating the participation of Victorian Youth AOD service providers and practitioners. Karen and Ora were ably supported by Dominic Ennis and Dr Jozica Kutin, who led the original study that the ThYNC methodology is based on.

Finally, my sincere thanks to each of the organisations and practitioners that came together to bring ThYNC to fruition.

Andrew Bruun
YSAS CEO

A MESSAGE FROM THE RESEARCH TEAM

In 2013 YSAS, in collaboration with most Victorian youth AOD services, conducted the first youth needs census in the youth AOD field. The census was conducted to provide services and the sector the information required about the characteristics and needs of the young people engaged with the sector. The first and also the newest census provide the only voice to represent young people in the youth AOD sector. Whilst national trends and databases on substance use provide vital information on the state of substance use in the youth population, this data reflects substance use and related issues in those at the pointy end of use, namely those who engage with services. The ThYNC Technical Report summarises a large quantity of this data for use by services and government. Further, this data provides the foundation for research into the youth AOD sector. We advise readers of this report to keep an eye out over the next 12 months for specialist papers and research articles on specific issues and populations with specific risks and needs.

This report could only be made possible by the involvement of so many services and workers in the youth AOD system across the state. These workers often operate within tight timelines with large caseloads so thank you to all. The work could also not have been done without the financial and staffing support of YSAS. YSAS has a strong commitment to the sector and also the development and conduct of high quality evidence based research. Finally, the report could not have been completed without the support of the staff in the Research, Practice and Advocacy team at YSAS, especially Ms Ora Landmann and Ms Megan O'Leary who rolled out the project and assisted with data analysis. We hope you find the report useful and look forward to sharing more information on ThYNC over the coming year.

Sincerely,

Dr Karen Hallam
PhD(Melb.), MPsych(Clin), BBSc(Hons)
Senior Research Fellow YSAS

CITATION

Hallam, K. T., Landmann, O., Hall, K., Kutin, J., Bruun, A., & Ennis, D. (2018). The Victorian Youth Needs Census: Report on the Needs and Characteristics of Young People in the Youth Alcohol and Other Drug System in 2016-2017. Melbourne, Australia.

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BACKGROUND

The findings from The National Drug Strategy Household Survey (NDSHS, 2016 released in 2017) and the Victorian Secondary School study (conducted in 2011 and published in 2013) provide to the wider community important, accurate information about prevalence and use rates in the general youth population.

Both surveys provide an insight into a sample of the population, aged 12 to 21 years old, who are typically connected to education or have stable housing. The data helps us to understand the greater population of young Australians who use substances, as well as their perceptions and attitudes towards substances.

The NDSHS (2017) and the Victorian Secondary School Survey 2011 (Department of Health, 2013) do not focus on young people already engaged with the youth AOD system (Kutin et al., 2014). This sub sample of young people who are already experiencing the impacts and psychosocial issues around their substance use is typically under-represented in larger sampling studies. This bias creates a bimodal population where the reporting and statistics used for modelling responses to substance use in young people is based on the general population, whilst there is no data available about the needs of young people engaged with the youth AOD system who have the most significant substance use issues and often very complex psychosocial contexts (see Figure 1). The Victorian Youth Needs Census corrects this bias.

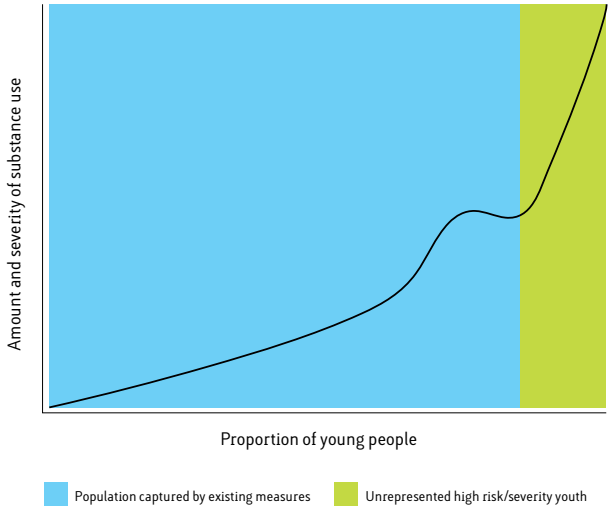

Figure 1. Current measures report on only the less complex and severe young people and exclude those within services. These populations are at greater risk but less represented in research.

The national youth substance use context: National Drug and Household Survey (2016 released in 2017)

NDSHS 2016 released by the Australian Institute of Health and Welfare (AIHW) aims to collect information on alcohol and other substance use from the general population in Australia (AIHW, 2017).

- The NDSHS 2016 show similar substance use profiles to the 2013 survey.
- The NDSHS study contained 24,000 Australian participants in 2016.
- The survey findings look at the Australian population over 14 years of age.
- The NDSHS does not capture data from those who are homeless or in temporary accommodation.

Key findings of the NDSHS 2016 show that there are fewer teenagers taking up tobacco smoking, with 98% having never smoked in 2016, compared to 95% in 2013. Similarly, the findings show that the percentage of teenagers who consume alcohol has decreased from 28% in 2013 to 18% in 2016. We also see the age of first consumption of alcohol increased from roughly 14 years old in 1998 to 16 years old in 2016. This means young people are delaying their first use of alcohol until later in their teenage years. This may reflect greater emphasis on delaying drinking in teens in population level campaigns.

Of Australians, 40% expressed concern about Meth/Amphetamine use, and that this substance has potential to cause the most harm in the community. However, the findings indicate the use of Meth/Amphetamine decreased in 2016. This public concern regarding methamphetamine use may in part reflect the increased focus by federal and state governments around the risks associated with methamphetamine use (including the Victorian Government's Ice Action Plan, 2015).

The Victorian youth substance use context: The Victorian Secondary School Students' Use of Licit and Illicit Substances in 2011:

The Australian Secondary School Alcohol and Drug (ASSAD) Survey is a collaborative project between the Department of Health and Ageing at a Commonwealth, State and Territory level, and the Cancer Council in some states. The Victorian Secondary School Students' Use of Licit and Illicit Substances, released in 2011 is the Victorian sample from this larger study. In 2001, 68 schools in Victoria were involved in the survey and 4797 students participated.

- Young people not enrolled in school at the time of the survey were not included.
- Students who were absent on the day of the survey were not included.

The key findings about alcohol use in 12 to 17 year olds indicate that the percentage of students who had tried alcohol in their

lifetime has decreased from 86% in 2005 to 74% in 2011. The study showed that 59% of 12 year old students had tried alcohol in their lifetime, increasing to 91% in 17 year old students.

Similarly, the findings about tobacco use among 12 to 17 year old students demonstrated that usage increases with age. Findings indicate that 7% of 12 year old students have tried tobacco in their lifetime, with this increasing to 42% of 17 years old. One-quarter of 12 to 17 year old students have tried part of a cigarette in their lifetime.

Understanding the Youth Needs Census 2016:

The Youth Needs Census 2016 (ThYNC 2016) aims to identify those young people aged between 12 to 21 (dependent on service) years old who were accessing specialist Youth Alcohol and Other Drug Services (AOD services) across Victoria, Australia in late November 2016. The survey was conducted by the Research Unit of the Youth Support and Advocacy Service (YSAS), the largest specialised Youth Drug and Alcohol treatment service in Victoria, in conjunction with Victoria's government funded specialised Youth Drug and Alcohol treatment services. The Youth Needs Census was fully ethically approved for conduct with workers by the Eastern Health Low Risk Human Research Committee. Informed consent was obtained for every case reported on in the census, and participation for services and workers was completely voluntary.

Young people accessing Youth AOD services across the state tend to have substance use rated between high to severe and tend to be associated with significant psychosocial complexity. These psychosocial complexities include insecure housing issues, engagement in criminal activity, mental health issues and unstable family relationships. The ThYNC 2016 (and SYNC 2013) provides vital service and advocacy data on the complexity and disadvantage facing these young people to better understand their use of substances through both an ecological and resilience-based lens.

ThYNC 2016 collected important data on young people who may be homeless, couch surfing, or out of education, who have restricted capacity to participate in typical activities appropriate to their age. Similarly, to the NDSHS and the Victorian Secondary School study, ThYNC 2016 (and previously the YSAS Statewide Youth Needs Census, SYNC, 2013) is able to shed light onto the specific cohorts of young people who have increased risk of mental health and substance use issues, including those from the GLBTIQ+, Aboriginal and Torres Strait Islander (ATSI), and CALD communities, all of whom through their identified disadvantage in some area, have been focused on throughout the census. The data from ThYNC 2016 may help to shed some light on how services can create more inclusive programs for those who are currently choosing not to access government funded Youth AOD services. The 2013 SYNC published findings related to gender differences in psychosocial complexity, highlighting the need to again assess these factors (Mitchell, Kutin, Daley, Best & Bruun, 2016). Finally, data throughout the census have been divided by age into three groups. This focus on age reflects the increasing understanding of the different presentation profiles of younger versus more mature young people, and also the increasing acknowledgement and focus that early intervention is as imperative in the area of substance use, criminal diversion, engagement in meaningful activities and family as it has proven in mental health. ThYNC data shows that indeed complexity and severity increases over time, so providing services early and effectively might be the foundation of improved sector responsiveness in the future.

ThYNC 2016 reports on the demographics of young people in the Victorian AOD system including age, gender and sexuality, cultural background, in-depth substance use profile and treatment history, education and/or employment history, family and mental health history, housing, offending behaviour, self-injury and suicidality. Having information about the substance use of young people currently engaged in treatment services will empower providers in a number of different ways, including:

- Inform services about the patterns and trends of substances being used by young people accessing services.
- Enable services an opportunity to speak qualitatively about young people's substance use to media and on social media.
- Provide the opportunity to develop and tailor treatment options to young people who are using the service.
- Provide services with the insight into many different facets of a young person's journey and the complexities they have or are facing.
- Increase the capacity for services in sector (and beyond) to advocate for program and service development based on accurate data of sector needs.

Understanding the Resilience Model for young people who use substances:

Development is a complex and multifaceted driver of personal growth and change in adolescence and young adulthood. During adolescence, many more nuanced elements of development occur. During adolescence, young people need to reach particular milestones and achieve critical developmental stages to ensure they learn how to resolve conflict, develop a sense of self, and learn to self soothe, thus deterring them from risk-taking behaviours. At the same time, significant developmental tasks around physical and sexual development, cognitive, career, and self-concept development concurrently draw the attention of the young person. ThYNC 2016 reports on functioning in a range of areas including secure housing, employment, education, mental and physical health, the young people's experience of negative events (such as family violence and trauma) and criminal involvement. Developmental issues in these areas may have both a direct effect and also downstream life impacts. Struggling in these areas may both lead to, and, be a result of substance use.

The work of Andrew Fuller refers to resilience as one's ability to bungee jump through life (Fuller, 1998). The cord that secures us consists of positive factors such as a connection to family and community and an internal sense of direction, happiness and fulfilment. A person who has fewer of these positive factors may struggle to bounce back from difficulties and personal setbacks. Notably, some factors considered by outside observers to be negative may actually serve to protect a young person from fully experiencing these lows in the absence of other protective factors. Substance use is often considered one of these factors, i.e. using substances may have long term impacts on the individual but in the shorter term helps manage the distress of ups and downs they may be experiencing. In these young people's lives, the youth worker's role is to increase their resilience by supporting them to better understand and manage problems in life (negotiation skills) and navigate them towards supports and services that are meaningful to them in order to receive more help (navigation skills) (Unger, 2012). The role of the worker in these cases is not to hold the cord together themselves, but rather to increase its strength again through navigation (linking with services and supports to maximise positive influences) and negotiation (helping the young person to better cope with their experiences through internal skill development) (Egan, 2013).

The data from the ThYNC and previous SYNC paint a picture of resilience around the young people who use youth AOD services. Factors such as family engagement, school involvement, stable housing, employment, and relationships provide a picture of possible resilience factors. In contrast, factors around mental health issues, trauma experiences, family violence, criminal engagement and justice system involvement, and more severe/frequent substance use highlight ecological factors that may either decrease personal resilience or be a symptom of already depleted personal resilience. This data provides a strong evidence base that the Youth AOD system and services can assess to identify the needs of young people accessing services in the sector. Developing an understanding about a young person's journey enables a worker to facilitate a transition from defensive coping to healthy adaptation. Resilience-based interventions are particularly suitable for young people who use substances as a coping mechanism and YSAS has prepared a comprehensive framework and guide for delivering resilience based practice to this group of young people that forms the theoretical rationale for the continued collection of census data across the sector (Bruun & Mitchell, 2012).

THE VICTORIAN YOUTH NEEDS CENSUS

Description of Methodology

The 2016 Youth Needs Census (ThYNC) was conducted across Victorian Youth Alcohol and Other Drug Services and workers to obtain a statewide snapshot of the young people utilising services on a specific date. The Youth AOD services form a network of interrelated services rather than working as one service provider. YSAS is the largest service provider in this sector and in 2013 developed and conducted the first Statewide Youth Needs Census (SYNC, Kutin et al. 2014).

METHOD

Participating Drug and Alcohol Services

Almost all Youth Alcohol and Other Drug (AOD) services that provide programs for youth in the state of Victoria were invited to participate in the study (N = 48). Some agencies had more than one site, and these were counted separately. A final group of 36 treatment sites and services agreed to participate (75%). Some services were exclusively youth AOD services, while others embedded in community health centres, or had specific workers for youth within an adult AOD service. The size of the 2016 census (N = 857) was down on the 2013 sample size (N = 1000), reflecting the closure of a number of services in the sector.

Procedure

The census date was 21st November 2016. Clients were deemed eligible if they had commenced or were continuing treatment on this date. Each client's key worker was asked to complete an online survey, one survey per client, based on their current knowledge of that client. Workers were provided the option of using their case notes and records to complete this task. Surveys were completed by staff in the two week collection period following the census date. Clients were not contacted or asked to complete survey questions and there were no identifiers of clients on the anonymous online surveys.

On 21st November 2016, the census was conducted across 28 government (some services had numerous sites) funded Youth AOD services (including 14 YSAS sites). Youth AOD Workers from each site/service were asked to complete a 10 minute survey form for each individual client who had an open episode of care on that day. Estimates of numbers through liaison with a site representative at each service and/or site indicated a sample size of 844 expected to be returned (respondents utilised their open cases calculations on their service databases). The actual number of completed surveys was 856 which, after data cleaning for surveys with significant missing variables, equated to 823 individual cases. This sample size represented a 96% response rate across the Victorian Sector.

Questionnaire

A 61-item online quantitative survey was developed utilising existing data set items and questions developed by literature review, existing surveys, and expert consultation. The survey was modelled on the 2013 census for comparability, but included a number of new questions regarding family violence, the role of the youth worker and GLBTIQ status. The majority of items required a yes/no/don't know response, with items from the Australian Treatment Outcome Profile (ATOP) rated on Likert scales. Timing trials with 48 trials over eight workers indicated the survey took an average of 13 minutes to complete (range 6-22 minutes). Statistical analysis indicated a median of 10 minutes to complete the census.

The Youth Needs Census

The survey covered the following domains: demographics, program involvement, drug use (primary drug of concern and recent drug use), drug use harms, involvement in employment, education or training, literacy and numeracy, housing, family conflict and violence, mental health, suicide and self-harm, experience of neglect, physical, emotional and sexual abuse or violence, involvement in the criminal justice system, and key worker assessment of client AOD severity, dependence, and psycho-social vulnerability (See Appendix A). Workers were also asked to rate the client's level of physical health, psychological health, and quality of life using Likert scales from the Australian Treatment Outcome Profile (ATOP, 2016).

Data Analyses

Data were analysed using SPSS version 21. Descriptive data (drug use and demographics) were reported for the sample group as a whole. The sample sizes for the gender comparisons were 339 females and 655 males. Six clients were identified as intersex or transgender, and given the small sample size were only not included in the gender comparisons. Continuous data was analysed using Student's t-test, or one-way analysis of variance (ANOVA) where applicable and categorical data was analysed using Chi-square analyses and descriptive statistics. Significance values were set at the probability value of .01 (**) or .05 (*).

Ethics Approval

The project was approved by the Eastern Health Research and Ethics Committee (ref. E28-1213, dated 4-10-2016), Melbourne, Australia.

1. CLIENT CHARACTERISTICS

Youth workers completed the census on 857 young people. Thirty-five of these surveys were discarded due to more than 50% of the scale being incomplete (n = 20) or the worker indicating they did not consent to the file being used (n=15). Young men were the majority of the sample from the census with 63.4% of the sample (n=522) being identified as male, 35.7% as female (n=294), 0.6% as transgender (n=5) and 0.2% (n=2) young people's gender not stated. Young people ages were between 10 and 27 years of age with the average age being 18.82 years (SD = 2.75). In terms of legal minor versus legal adult, the data indicated that 31.3% (n=258) of the young people were minors (below 18) whilst 68.3% (n=563) were legal adults (ie 18 years or over. In terms of age categories, 12.4% (n=102) were aged between 8-15 years, 18.9% (n=156) between 16-17 years and 68.3% (n=563) between 18-27 years.

Workers were asked to identify if the young person being reported on was a member of a specific population that was a focus for the research. Youth workers reported that 74.5% (*n* = 613) of cases included did not identify as a member of a special focus population while the remainder, 25.5% (n = 210) identified as a member of a special focus population. In terms of cultural background, the data indicated less cultural diversity in the sample in the 2016 census than in the 2013 census (34 versus the previous 53). This drop may reflect the slightly smaller sample size in the 2016 sample (143 cases fewer). The demographic breakdown for specific factors follows.

Client Location

The postcode of the client's current usual place of residence was recorded and is presented in figure 1.1. Twenty one young people were not included in figure 1.1 as they were homeless or their housing location was unknown at the time of the census. The number of surveyed clients within each catchment and each Department of Human Services (DHS) region is detailed.

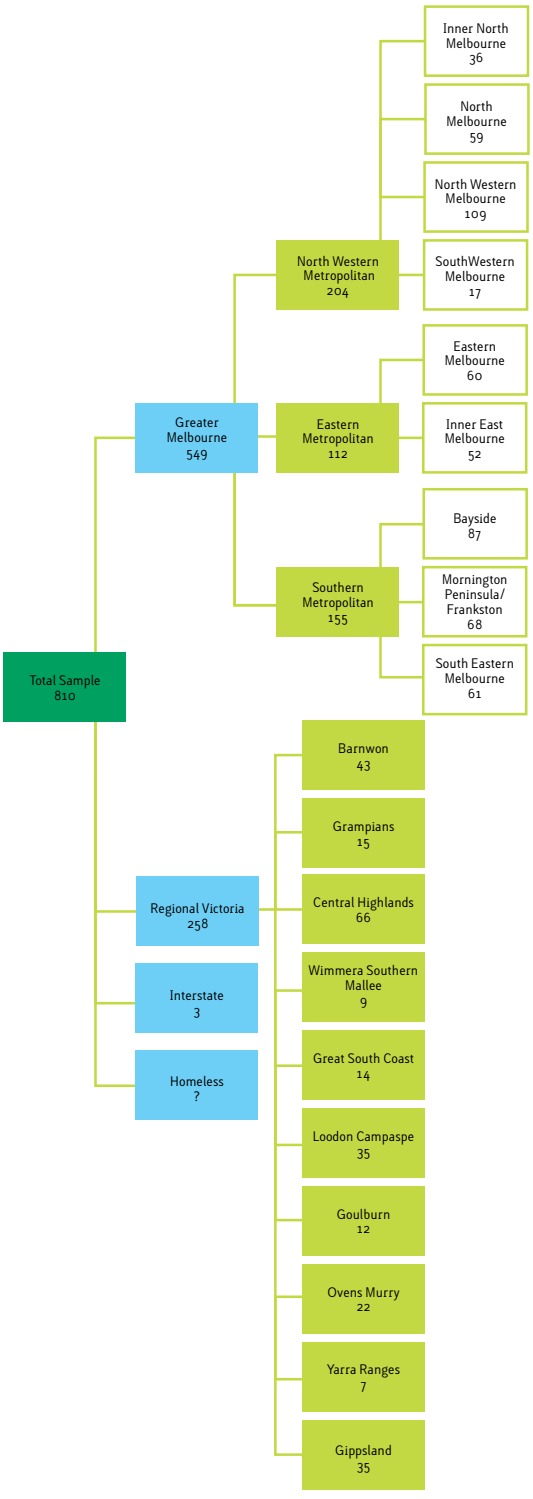

Figure 1.1: Number of surveys completed in DHS region and AOD treatment catchment area

Assessing the needs of marginalised populations

Youth AOD services aim to provide inclusive and safe environments for all young people who wish to access their services. However, many young people who are considered to be part of marginalised communities access specific youth AOD services. The barriers that stop young people in marginalised communities from accessing services range from a perceived lack of support and service options to the stigma behind accessing supports from within those communities. Areas that can be identified as barriers for a young person accessing a service could be their gender and sexual identity, their country of birth and status in Australia, their language, cultures and traditions taught in the home and the inability to access or travel to services. Some young people from these marginalized communities feel that there are not appropriate intake and assessment tools used to capture the correct information about them.

While it is important to ensure that specific services are set up for marginalized communities, it is equally as important that young people in these communities are able to access mainstream specialist services, which enables young people from all walks of life the opportunity to access any service. Without these spaces, this population of young people may not have access to a trusted adult in their life, thereby increasing a young person's risk factors and reducing their resilience and ability to manage stressful situations. The impact of a young person from a marginalised community feeling as if there are no services that they can access for support can result in that young person developing additional feelings of isolation, anger, confusion, and anxiety. It is important for services to understand why marginalised communities are not accessing their services and what changes can be made to create a more inviting environment.

ATSI population

In the 2016 census, 6.8% of the total population was identified as being from an ATSI community. This level did not significantly differ using chi square analysis from the 2013 level of 7.5% ($p=.313$) showing a relatively similar level of engagement with the ATSI community over time. It is notable that whilst these levels are low, they may reflect a relatively lower level of aboriginal communities in Victorian versus other populations. The upcoming Queensland Youth Needs Census results show significantly higher levels of engagement with this population. Unfortunately, due to ethical requirements that sites not be identified in the census in 2016, regional breakdowns of the population are unavailable.

In terms of gender mix, the ATSI population shows a similar skew towards more males within services (62%) than females (35.7%). In relation to age, the data showed a small (but insignificant, using chi square analysis) trend for younger people to be engaged with services. These results are highlighted in table 1.1.

Table 1.1: Young people within different age categories from the ATSI and general populations

Age range	General population	ATSI young people
8-15 years of age	11.8%	20%
16-17 years of age	18.8%	21.8%
18-27 years of age	69.4%	58.2%

Within the ATSI group, the majority of the sample was made up of young people from Aboriginal ancestry (89.1%) versus Torres Strait Islander (7.3%) and a mixture of Aboriginal and Torres Strait Islander heritage (3.6%).

Asylum seeker, refugee or migrant population

The majority of asylum seekers, refugees, and migrants attending youth AOD services in Victoria were male (70.3% versus 29.7%). The data further indicated that most individuals from this group were migrants (i.e. individuals who had moved to Australia in their own lifetime) at 54.1%. An additional 40.5% were classed as refugees and 5.4% as asylum seekers. This shows the heterogeneity within this group in terms of needs. The ages of people attending programs within this cohort was also slightly skewed to older young people (i.e. over 18). This trend is demonstrated in table 1.2.

Table 1.2: Young people within different age categories from the asylum seeker, refugee and migrant populations versus the general populations

Age range	General population	Asylum seeker, refugee and migrant
8-15 years of age	12.8%	2.8%
16-17 years of age	19.6%	5.6%
18-27 years of age	67.6%	91.7%*

*Chi square analysis indicates that asylum seekers, refugees and migrants are significantly older than other young people at youth AOD services.

Member of the GLBTIQ community

Despite the community prevalence of GLBQ individuals being around 10%, the census found a 3.6% prevalence of individuals who identified as GLBQ. This low rate may reflect the youth worker not being familiar with an individual's personal story (particularly early in their engagement), the youth of the sample and the emergence of sexuality across adolescence and adulthood, or that knowledge of an individual's sexual preference does not appear on many services recording systems, despite evidence it places these individuals at higher risk of violence, abuse and mental health concerns. Within our GLBQ sample, 32.1% identified as gay (n=9), 10.7% (n=3) as lesbian, 46.4% (n=13) as bisexual or pansexual and 10.7% as queer (n=3). Members of this population included more male than female (60% versus 40%) young people. The ages of the GLBQ group compared with other young people appear in table 1.3. As demonstrated in the table, the ages of young people in this population closely represent the overall population.

Table 1.3: Young people within different age categories from the GLBQ population

Age range	General population	GLBQ population
8-15 years of age	10%	12.4%
16-17 years of age	16.7%	19.1%
18-27 years of age	73.3%	68.5%

2. SERVICE AND PROGRAM UTILISATION OUTCOMES

Understanding a young person's AOD support needs requires more than just information about how much and how often they are using. It requires drug use severity and the factors that create vulnerability to be considered together, thus leading to a holistic approach to supporting young people accessing Youth AOD Services.

Youth AOD services in Victoria are multifaceted, ranging from phone and web-based modalities, such as Youth Drug and Alcohol Advice (YoDAA) which offers support, advice, and guidance to Day Programs where young people are able to access support from medical and AOD trained staff. Youth AOD outreach and centre-based counselling allow a young person to create goals and learn harm reduction strategies with a counsellor in one-on-one sessions (on a face-to-face basis). Youth-focussed AOD services also include residential programs, such as residential withdrawal (detox) and residential rehabilitation units. A young person is able to develop a number of different skills while accessing residential services, from basic harm reduction education to goal setting and life skills. There are a number of other offerings from Youth AOD services, including access to home-based withdrawal nurses, parenting programs, and accommodation. Of the 28 Youth AOD services that participated in ThYNC 2016, six were residential withdrawal units, one was a residential rehabilitation unit, and 26 services that offered outreach or centre-based counselling support.

Service utilisation

AOD workers who participated in the 2016 census were asked to report on the youth AOD services utilised by the young people they were case managing. Figure 2.1 highlights the average number of services utilised by young people in the youth AOD system at the census date.

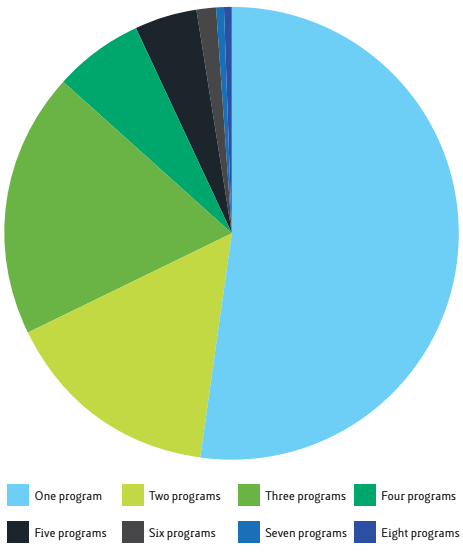

Figure 2.1. Number of programs young people in services attend

The overwhelming majority of young people were engaged with one to two services within services. This is notable as it may indicate silos between different programs that may be suitable for a young person on different levels. Increasingly, practice reflects the evidence base that one worker with one young person is both fiscally inefficient and also under-provides the variety of different services and skills that come with various programs and various workers with specialist skills (e.g. counselling, educational access etc.). This highlights the increasing need to work inter-professionally both within but especially between teams.

Services Used

The data (Table 2.1) revealed that the most common service utilised was outreach. As outreach has been the mainstay for youth work in the AOD sector for many years, this emphasis was expected. In addition, there was a strong use of counselling services, day programs and a range of withdrawal programs. There is a breadth of activity between these programs, from engagement and primary health care provision (day programs) right through to withdrawal support to assist young people in reducing or ceasing drug use. This highlights the continuity of care within services that are able to go from engagement to complex care with young people within or between services.

Table 2.1: Number of Young People Utilizing Services in Participating Victorian Youth AOD Services

Program Type	Primary (N)	Secondary (N)
Outreach	622	30
Counselling	240	61
Outpatient Withdrawal	9	8
Home-Based Withdrawal	58	13
Rural Withdrawal	3	5
Day Program	56	20
Parent Support Program	14	16
Residential Withdrawal	60	60
AOD Supported Accommodation	34	2

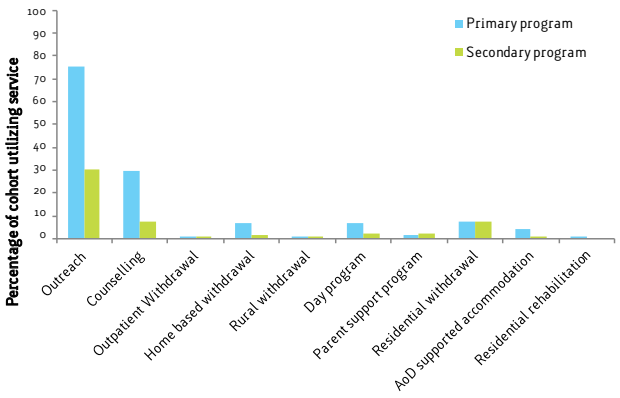

Figure 2.1. Percentage Service Utilisation data in Participating Victorian Youth AOD Services 2016.

Service Utilisation by Age

Data analysis by age using ANOVA indicated significant differences in level of service utilisation between the groups, $F(2, 820)=6.523$, $p=.002$. Post-hoc testing indicated this difference was in the 18 years and over age group using significantly more programs ($M=2.15$, $S.D.=1.4$) than 8-15 year olds ($M=1.75$, $S.D.=1.1$) and 16-17 year olds ($M= 1.81$, $S.D.=1.2$).

In terms of length of care with services, the data again demonstrated that the oldest age group had significantly longer durations of treatment than the younger age group, $F(2, 814)=5.238$, $p=.005$. The average length of treatment for the 8-15 year old group was 23.31($S.D. =28.5$), the 16-17 year old group 31.23 ($S.D.=35.7$) and 38.16 ($S.D.=50.2$) for those 18 years and over. Overall, these data both indicate that individuals over 18 are more likely to utilise multiple services and have a longer duration of service than younger teens.

Service Utilisation by specific groups

Analysis was conducted to explore potential differences in service utilisation based on specific demographic factors. The results of the analysis are depicted in table 2.2.

Table 2.2: Service Usage and Length of Service in Selected Populations

Number of programs accessed	Average number programs used		Average length of treatment (weeks)	
	Gender			
	Female	Male	Female	Male
Gender	1.97 (1.3)	2.15 (1.4)	33(43)	38(48.2)
	Specific Groups			
	Yes	No	Yes	No
Aboriginal or Torres Strait Islander	1.77 (1.4)	2.06 (1.4)	40.13(44.4)	34.5(45.8)
Asylum seeker, refugee or migrant	2.51 (1.8)*	2.02 (1.3)	35.47(40.9)	34.9(45.9)
Member of a specific cultural group	2.35(1.7)*	2.0(1.3)	53.1(72.9)*	32.7(40.7)
GLBQ	2.03(1.4)	2.33(.95)	44.93(50.1)	34.58(34.9)

*Denotes significant difference between groups using independent sample t-tests at α=.05.

The results of this analysis indicate that individuals from the asylum seeker, refugee and migrant communities access more programs than others. In addition, individuals who identify themselves as a part of a specific cultural group are also greater utilisers of programs and also have significantly longer engagement with services. This increased utilisation and treatment length may reflect many services focus on engaging with CALD communities.

Age and service utilisation

Young people were categorised by age in relation to numbers of programs utilized and length of care. The results of this analysis are depicted in table 2.3.

Table 2.3 Average (S.D.) Number of Programs Used and Length of Program Engagement.

	Average number programs used	Average length of treatment (weeks)
8-15 years old	1.8 (1.2)	23.5 (28.6)
16-17 years old	1.8 (1.2)	29.6 (38.4)
18-28 years old	2.2 (1.4)*	37.4 (51.1)*

Note that * indicates the significantly different group following ANOVA and SNK post-hoc testing at α=.05.

The data relating to ages indicated that the older age group used significantly more services and were engaged for a significantly longer period of time with services. This again points to the potential advantages of early intervention in the younger cohorts, before difficulties with substance use and other ecological factors become embedded.

Service Utilisation Contrasts Between 2013 and 2016 Census

The utilisation of individual service types was contrasted between the 2013 Youth Needs Census and the 2016 Youth Needs Census. Questions remained consistent between versions, allowing for direct comparison. The result of the comparisons are presented in Figure 2.1. Chi square analysis (due to categorical data) were utilised to assess whether changes over time were statistically significant. The results of the analysis indicated utilisation of a number of services significantly differed across the survey times. The most notable changes include outreach and counselling changes. In terms of outreach, a 10% increase in outreach service utilisation was observed in the data. As outreach remains a mainstay of youth AOD services, this highlights an increased reach or utilisation of these workers by young people. There was also a doubling of counselling utilisation.

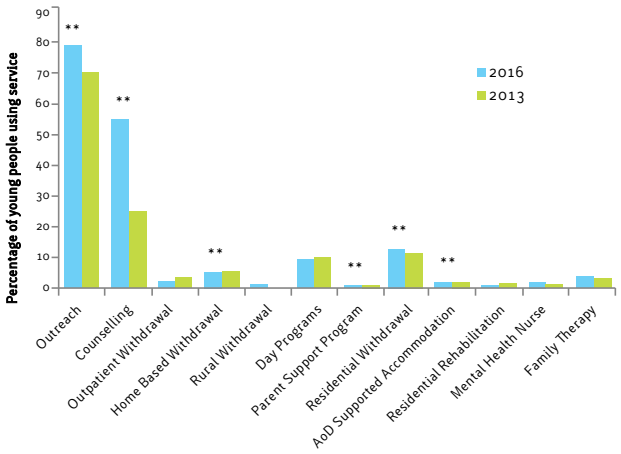

Figure 2.1. Program utilisation in the 2016 and 2013 census.

The number of services accessed in 2013 and 2016 was assessed. The results are depicted in table 1.3. The data indicates that the reason for greater participation in a number of programs in figure 1.1 was that young people in 2016 were more likely to participate in multiple programs in contrast with young people in 2013, $\chi2(7, 1824) = 76.122$, $p<.001$.

Table 2.3: Percentage of cohort using between one and five programs in 2016 and 2013

Number of programs accessed	2016	2013
1	54.4	70.6
2	29.9	22.0
3	10.6	4.9
4	2.8	0.9
5	1.1	0

Note: A small number of individuals accessed up to 8 programs

Sum of programs utilized by primary program type

Data relating to the number of services used when an individual is enrolled in each of the four primary programs was assessed. The results indicate that those engaged in outreach programs were utilizing an average of 1.7 (S.D.1.16) programs whilst those engaged with counselling as a primary contact utilized an average of 2.5 (S.D. 1.4) programs across services. Those primarily engaged with the day program utilized 3.0 (S.D. 1.8) programs whilst the residential withdrawal clients engaged with an average of 2.9 (S.D. 1.9) programs. Overall, these results indicate that those engaged with a worker were the least likely to be utilizing a range of services available across a given provider.

Service Utilisation by special populations

A series of chi-square analysis were conducted to assess variation in service utilisation between the focus special interest populations. The service utilisation levels are demonstrated in Table 2.3.

Table 2.4: Service Utilisation (percentage of sub-group) for specific populations

Program	ATSI	Asylum seeker, refugee or migrant	GLBQ	Member specific cultural group
Outreach	82.1	83.8	90	79.5
Counselling	16.1*	37.8	55.2**	33.7
Outpatient Withdrawal	0	2.7	6.7	3.4
Home Based Withdrawal	10.7*	10.8	0	20.5**
Rural Withdrawal	1.8	0	0	0
Day Program	8.9	13.5	6.7	14.8
Parent Support Program	1.8	0	0	3.4
Residential Withdrawal	14.3	29.7**	26.7	15.9
AOD supported accommodation	7.1	5.4	3.3	3.4
Residential rehabilitation	0	0	0	1.1
MH nursing program	0	2.7	3.3	0
Family therapy	3.6	2.7	3.3	2.3
Other	3.6	9.4	0	19.3**

* Denotes significantly lower rates of service utilisation in this population than other young people using $\chi2$ at $p=.05$.

** Denotes significantly greater service utilisation in this population than other young people using $\chi2$ at $p=.05$.

Length of treatment

Youth workers were asked to report the length of treatment time for each young person. Results are shown in Figure 2.2. It is notable that the time involved in treatment is skewed by the nature of the census with many individuals at the commencement of their care versos others who were nearing completion. Despite these limitations, the data highlights the typical mix of young people at various stages of treatment at any particular time of the year and hence the client mix.

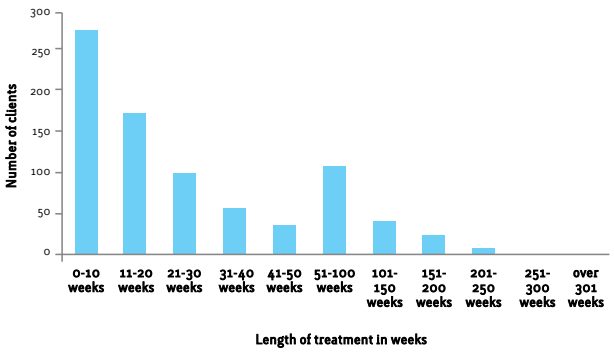

Figure 2.2. Young person's length of involvement in treatment.

Length of treatment data highlighted that most young people are engaged with youth AOD services for a limited period of time between 0-20 weeks. Following this time, there is a gradual decrease followed by a bimodal second peak between 50-100 weeks. This raises the question of whether the services provided to the majority should be early intervention and brief intervention focused, whilst more complex management and care be provided for young people with longer times with services.

Substance use characteristics in four most commonly used services.

The four most frequently used service types were inspected more closely to assess the usage of a variety of substances and determine if differences in substance use profiles existed between services. The results of this analysis are presented in Figure 2.2.

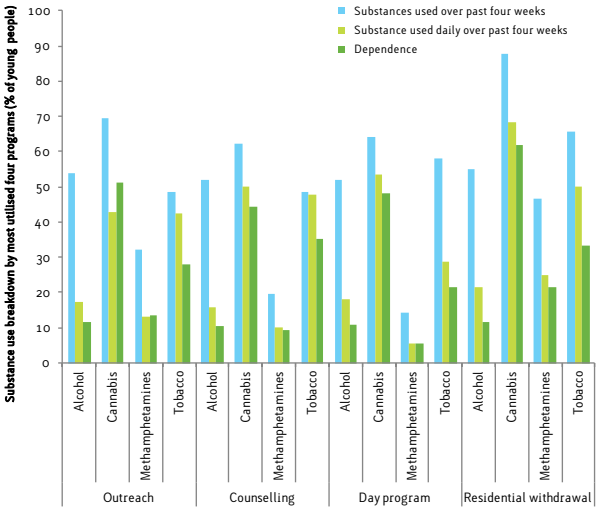

Figure 2.2. Substance use, regular use and dependence by service type.

Figure 6.2 highlights the high rates of cannabis use, regular use and dependence across all service types. Methamphetamines become more of a concern within the residential withdrawal context whilst alcohol appears to be used but not particularly regularly across the services.

Level of severity by four most common service types

Level of severity data indicated that most people attending the main four service types showed most young people attending were within the moderate and high severity range. The highest percentage of young people with severe substance use concerns attended the day program and residential withdrawal units. These data are presented in Figure 2.3.

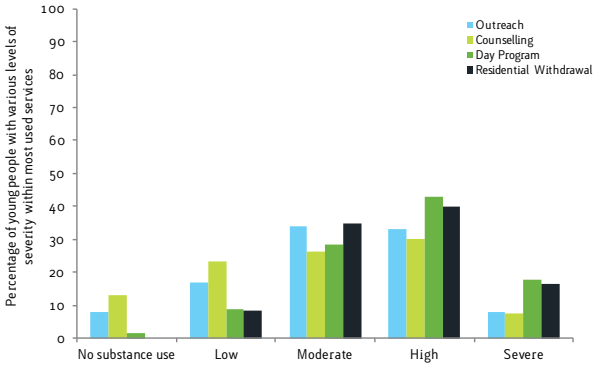

Figure 2.3. Severity of substance use concern for young people in most used programs (presents data for the primary program used).

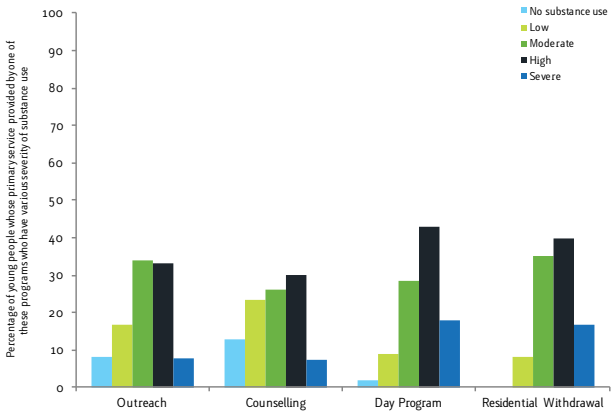

Figure 2.4. Severity of substance use concern within programs.

Polysubstance use by service type

Young people engaged with outreach services were the least likely to be using multiple substances, with an average number of multiple substances falling at 2.06 (S.D. 1.39). Young people engaged with counselling were likely to be using more multiple substances at the time of the census, with average scores around 2.45 (S.D. 1.39). Young people engaged with day programs were on average using 2.41 (S.D. 1.52) substances at the census time. Polysubstance averages for those in the residential withdrawal programs were on average 3.1 (S.D. 1.73) different substances. These data highlight that those engaged with an outreach worker had less difficulty with multiple substances used at one time and those in residential withdrawal had the greatest issue with polysubstance use.

Drug use harms by service type

The data on drug use harms by service type reveal that 37% of young people engaged primarily with outreach have experienced significant drug related harms over the three months prior to the census. This compares with 33.3% of those primarily engaged with counselling-focused services, 35.7% with day program users and 48.3% of residential withdrawal service users. Overall, these data highlight that only those engaged with withdrawal services have notably higher levels of substance-related harms leading up to the census.

Psychosocial needs and service delivery across most used services

The psychosocial needs associated with substance use in young people engaged with services was assessed by four standard questions. These were utilised across the range of psychosocial needs including education and employment, housing, family issues and conflict, criminal activity and mental health. The results on these measures for those primarily attending outreach services is presented in table 2.5.

Table 2.5: Identified psychosocial need (past and present) and service delivery (past and present) for those primarily using outreach services (percentages).

Counselling	Has a current problem	Has a past problem	Has current assistance	Has had past assistance
Education/ training	56.9	77.7	35.4	43.6
Employment	51.9	55.6	23.3	25.4
Housing	24.8	54.2	29.6	36.8
Family Issues	58.4	79.6	29.7	39.1
Criminal Activity	22.8	39.8	21.6	28.1
Mental Health	63.2	68.5	38.1	48.2

Table 2.5 highlights that young people utilising outreach have significant issues around employment and education, and also indicates a high level of unmet need in this area. A past history of family issues was marked and associated with a large discrepancy between need and service provision. The needs and service delivery levels within counselling as the primary program are presented in table 2.6.

Table 2.6: Identified psychosocial need (past and present) and service delivery (past and present) for those primarily using counselling services (percentages).

Counselling	Has a current problem	Has a past problem	Has current assistance	Has had past assistance
Education/ training	49.6	70	28.8	32.9
Employment	47.5	52.9	23.3	21.3
Housing	17.9	44.6	19.2	28.8
Family Issues	62.1	80	27.9	36.3
Criminal Activity	36.4	57.2	40.1	46.5
Mental Health	20.9	75	47.5	52.1

Three quarters of those who primarily use counselling had past mental health issues, with just over half of this cohort receiving support for this issue. Other measures were similar to those observed in the outreach group.

Table 2.7: Identified psychosocial need (past and present) and service delivery (past and present) for those primarily using day programs (percentages).

Day Program	Has a current problem	Has a past problem	Has current assistance	Has had past assistance
Education/training	64.3	78.6	37.5	32.1
Employment	62.5	75	46.4	37.5
Housing	48.2	73.2	62.5	46.4
Family Issues	62.5	73.2	41.1	42.9
Criminal Activity	32.9	55.3	37.8	43.5
Mental Health	64.3	71.4	53.6	53.6

Individuals using the day program services had the highest overall complexity and concerns of the program utilizers. Of particular note were the elevations in occurrence of housing, education, and employment concerns that were more often than not also needs that were unmet.

Table 2.8: Identified psychosocial need (past and present) and service delivery (past and present) for those primarily using residential withdrawal services (percentages).

Residential Withdrawal	Has a current problem	Has a past problem	Has current assistance	Has had past assistance
Education/training	60	71.7	31.7	38.3
Employment	60	58.3	20	43.3
Housing	33.3	60	35	50
Family Issues	68.3	78.3	25	43.3
Criminal Activity	31.2	53.9	36.7	42.5
Mental Health	85	85	53.3	70

Table 2.8 shows the high levels of psychological distress in those engaging with residential withdrawals that may be associated with the care itself or co-occurring. Notably, the rates of psychological concerns are constant over time. The mismatch between psychological needs and services being provided highlights a potential import role for these units in collaborating or funding mental health input from allied and medical staff.

3. CRIMINAL ACTIVITY

EXECUTIVE SUMMARY

For some young people, there is a complex and negative interplay between substance use and offending. The drivers of both substance use and offending are complex and multifactorial, and often represent social disengagement and complex histories.

BACKGROUND

Over the last three years, there has been a decrease in overall youth crime across Australia. The state of Victoria shows the most significant decrease in youth offending (ABS, 2016). While these data show promising, declining trends in crime within this group, 21% of offender populations are still youth offenders, higher than would be expected based on population statistics (ABS, 2016). Criminal offending in youth has a range of psychosocial precipitants and contributors including gender (males more likely to offend than females) and age (12-16 year olds more likely to offend more frequently than those between 18 and 24) (Crime Statistics Agency, 2016). Grieger and Hosser (2013) show that the top four predictive factors of criminal recidivism were family issues, school problems, lack of leisure/recreation, and substance abuse. Further research by Shephard and Purcell (2015) highlights the impact of mental health issues as positively linked to police contact, as do the following factors: being male, not engaging in education, employment or training, frequent drug use, and/or multiple adverse events in life. These factors are notable as the Youth Needs Census highlights concerns in all of these areas for young people in the youth AOD system.

Rates of criminal offending, past and present

The data indicated that criminal offending over the past four weeks prior to the census was significantly higher in males (37.4%) than females (23.5%), $\chi2(6, 823) = 18.956$, $p=.004$. Workers were unsure of the criminal behaviour of a further 7.3% of males and 6.8% of females.

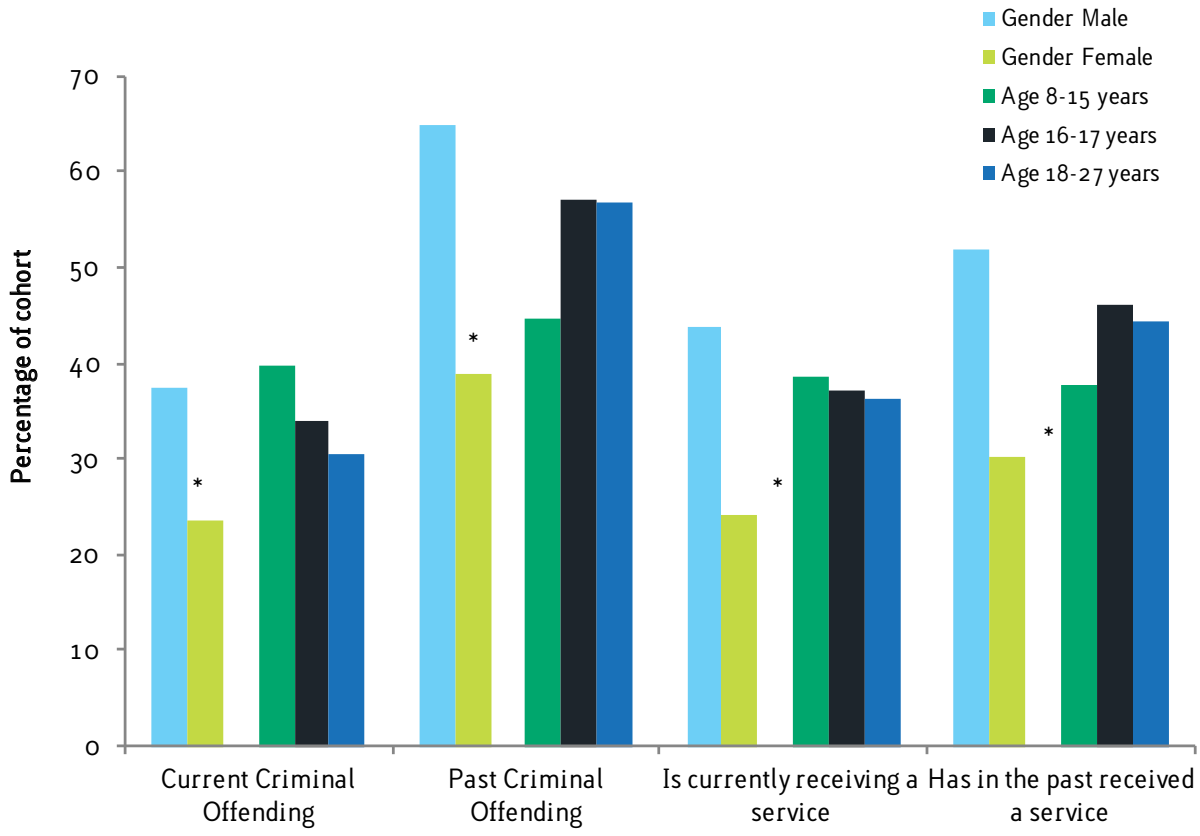

Figure 3.1. Criminal offending past and present and receipt of service past and present.

Figure 3.1 highlights that males are more likely than females to both offend and receive services relating to offending. This finding is consistent with youth offending profiles in Victoria[1] where males are typically more engaged in criminal activity and the criminal justice system. It was notable that offending and receiving services rates were not markedly impacted by age. This indicates that true early intervention of an offending cohort should have commenced between the ages of 8-15 as offending continues at similar levels after throughout young people in the youth AOD system.

1 https://www.crimestatistics.vic.gov.au/research-and-evaluation/publications/patterns-of-recorded-offending-behaviour-amongst-young

Criminal activity and service utilisation in specific populations

Data on service utilisation and criminal activity within the specific focus populations were recorded for each young person registered with services on the census date. These data are summarised in Figure 3.2.

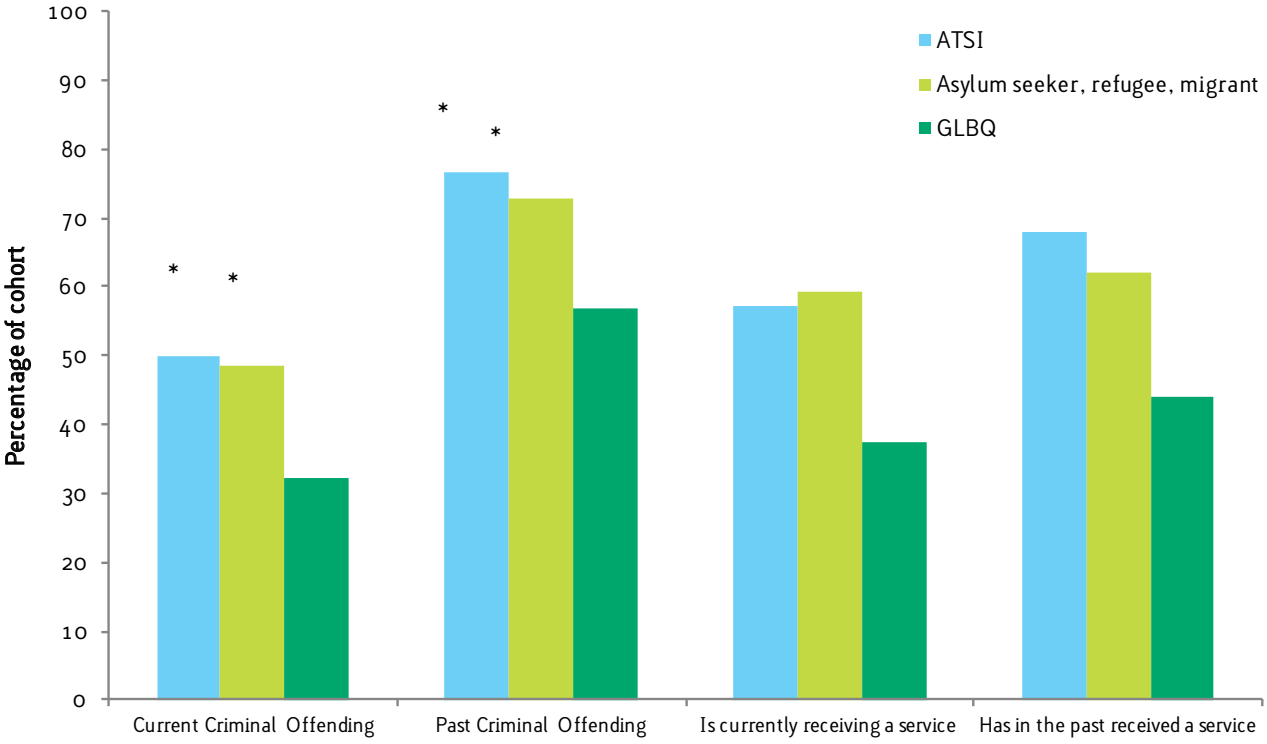

Figure 3.2. Current and past criminal offending and service utilisation.

Figure 3.2 highlights the significantly increased risk of past and current offending in both ABORIGINAL AND TORRES STRAIT ISLANDER and asylum seeker, refugee and migrant groups. In contrast, the GLBQ young people were no more likely to offend in the past and present than the overall group of young people recorded.

Changes in criminal offending and service utilisation statistics 2013-2016

Offending past and present and service utilisation were contrasted to assess changes in trend over time between the 2013 census. The results are depicted in Figure 3.3.

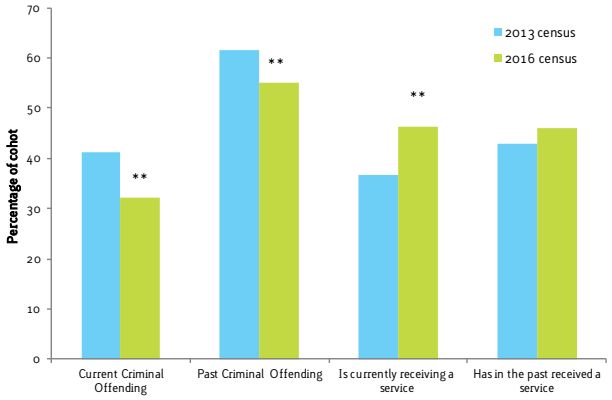

Figure 3.3: Offending and service utilisation past and present in the 2013 and 2016 census.

The 2013 and 2016 data highlight a decrease in engagement in criminal activity past and present between census years. It further highlights an increased exposure to current services related to offending showing an improved service and potentially system level response. Overall, the data show that there is a decrease in criminal behaviour and a better service response to current criminal behaviour needs by services.

Four week engagement in criminal activity significantly reduced from the 2013 (18.7%) to 2016 (15.3%) census, an 18% decrease that was statistically significant, ($\chi 2[2,1820] = 12.36$, $p=.002$. Similar findings were reported in relation to being involved in the criminal justice system in the four weeks preceding the census. In the case of criminal justice system involvement, the data again showed a significant ($\chi 2[2,1820] = 18.20$, $p<.001$) drop from 41.7% in 2013 to 32.1% in 2016.

Intervention Insight: Specialist ACSO/ COATS Services

The Victorian youth AOD system is a complex and responsive mix of organisations, tailored to respond to the complexity of young people's needs. Many of these services provide support to young people referred under the Australia Community Support Organisation's (ACSO) Forensic drug treatment (COATS) program. COATS provides a range of programs for over 2,500 Victorians each year, including withdrawal programs, residential drug treatment programs, pharmacotherapy programs, and counselling/outreach. As 30.4% of the young people in the census (n = 250) were referred through this system, this subgroup are critically assessed versus the wider census population.

Substance Use Data in ACSO /COATS referrals

Figure 3.4 highlights a number of substance use characteristics that differentiate the COATS referred young people versus other young people assessed in the census.

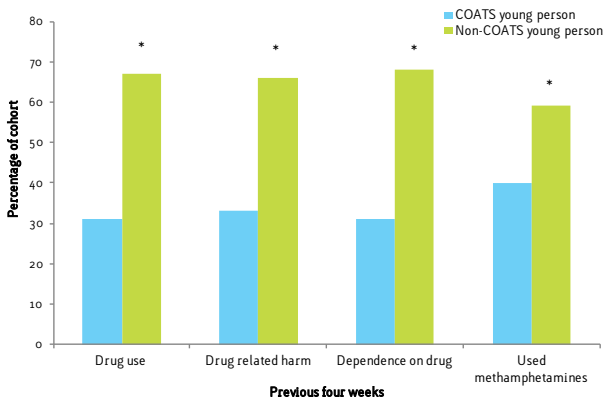

Figure 3.4. COATS and non-COATS referred young people and substance use.

Note * denotes significant difference between groups on χ2 at p=.05.

Figure 3.4 indicates that across a number of substance use parameters, young people referred to services through the ACSO-COATS program were significantly better off in terms of substance use, substance-related harm, dependence on a substance, and use of methamphetamines than other people presenting to youth AOD services. This may reflect a number of factors, but one important factor might include the level of severity and substance use issue that might pre-exist in a young person before they ask for assistance, versus the potential that forensic assessments deliberately screen for substance related issues. Hence they may present at services earlier.

Education and employment in COATS referrals

The data indicated that despite COATS referrals being less engaged with substance use, this cohort had significantly worse educational and employment profiles. In relation to education, 20% of COATS young people attended school, TAFE, training, or University compared to 38% in other young people. This rate of attendance was significantly worse. Further, significantly more (60%) COATS clients were disengaged from education than other young people (52%). In relation to employment, COATS referrals both had significantly more employment problems (62% versus 50%) and were significantly less likely to be employed (24% versus 27%).

Family Relationships and Housing

In terms of these contextual issues, COATS clients again had less disruption overall than other young people attending youth AOD services. COATS clients experienced significantly less family relationship difficulties (53%) than other young people (61%). Over the four weeks prior to the census, they again had significantly less family conflict (45%) than other young people (53%). In relation to housing, COATS clients have significantly less housing issues than other YSAS clients (21% versus 26%).

Offending

As would be predicted, COATS referrals were significantly more likely to have offended in the four weeks prior to the census (27% versus 10%), and were more likely to have a current problem with offending (62% versus 18%) and to be involved in the criminal justice system in the four weeks prior to the census (68% versus 16%)

Health

COATS clients had better overall psychological and physical wellbeing than other clients of youth AOD services. These significant differences included better psychological health (6.5 versus 6.2 on ATOP), physical health (7.2 versus 6.9 on ATOP), and quality of life (6.8 versus 6.5 on ATOP). In relation to self-injury and suicide, the COATS clients are significantly less likely to engage in either behaviour (self-injury history 26% versus 46% for other young people; suicide history 16% versus 23% for other young people). Finally, COATS clients are less likely to have received a psychiatric diagnosis than other young people (23% versus 37% respectively).

4. SUBSTANCE USE

Young people don't use substances without a good reason, for many young people there is a positive function that their substance use initially serves. Young people often report that their substance use makes it easier for them in social situations or it provides an enjoyable feeling. There are young people who are able to identify that their substance use provides relief from a physical or psychological pain or anxiety, or the feeling that their mind is always in action.

A young person's substance use can have varying impacts of their life depending on the trajectory of their use. Many young people experiment with substance use during their adolescence and do not end up with substance use issues. Their use can evolve and change over time. There are a number of determining factors that affect a young person's use, such as finances, access to substances, access to services, and engagement with community and/or education. Young people's connections to family and their family's views on substances significantly impact a young person's substance use.

Some young people consume substance on a casual basis, while others use on a regular basis (daily, weekly, monthly etc). Young people's substance use can vary from using one substances at a time to using multiple substance at a time, this is called poly substance use. The range of substances used by young people accessing Youth AOD services range from tobacco, cannabis, alcohol to methamphetamine, MDMA, heroin and non-prescribed (opiates) prescription medication. In this section, we are able to see what substances young people in Youth AOD Services have been using in the previous four weeks, the age of the young people, and their daily substance use.

At census, youth workers were asked to profile the substance use of each young person that they worked with on the date, and were also asked about past substance use issues for that same group of young people. Overall, the data obtained provided data on substance use in the last four weeks, daily (or almost daily) substance use, substances the youth worker believed the young person was dependent on, and the primary substance of concern according to the worker. Results on each of these measures are presented.

Substance Use over Previous Four Weeks

Substance use within the past month was measured to assess the range of substances used whether on a casual or regular basis (Figure 4.1). Previous data indicates polysubstance use is common and occasional substance use of some substances is common, whilst other substances are more frequently used on a regular basis. The substances used by the cohort over the previous four weeks are presented. Note that due to stage of treatment differences, some individuals may no longer be using substances whilst others may be using multiple substances. This is associated with greater overall numbers than in the sample.

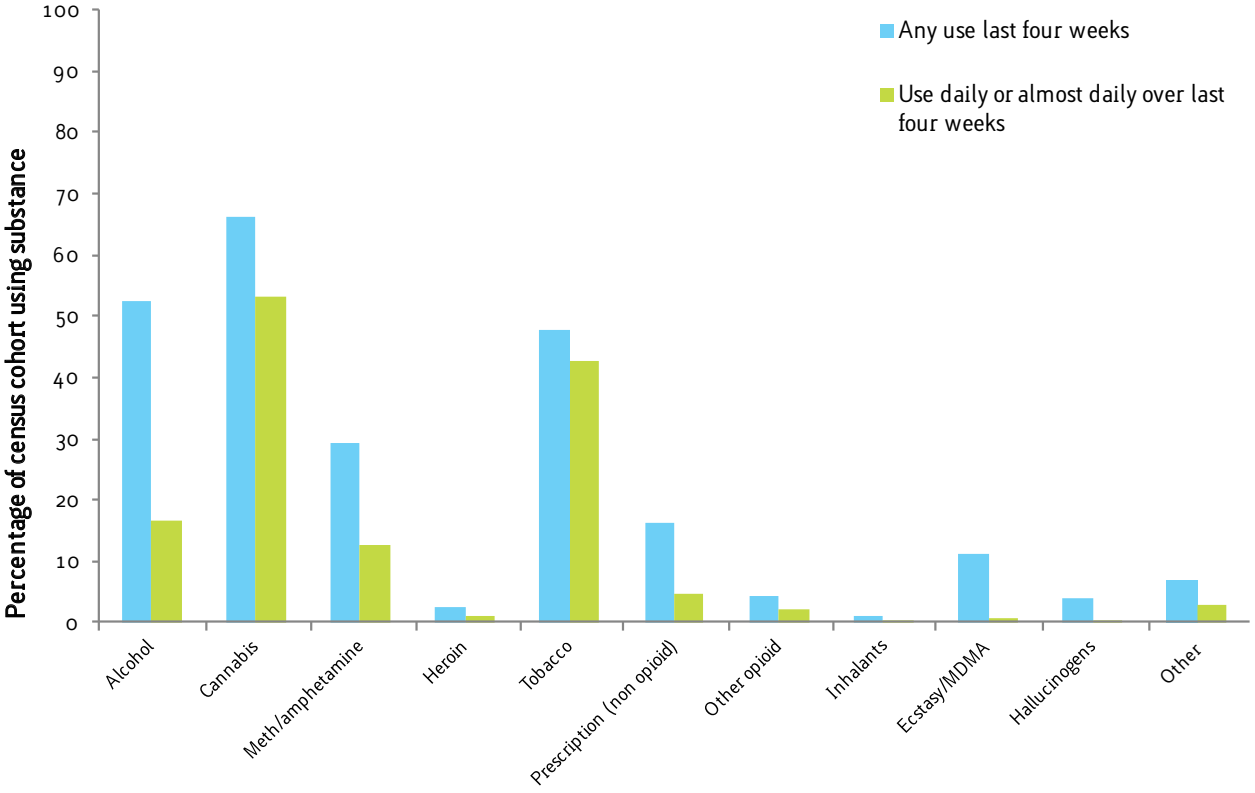

Figure 4.1. Prevalence of Substances Used and Substances Used Daily (or almost daily) Over Previous Four Weeks.

The data in Figure 4.1 indicate that the most prevalent substance used in the youth AOD cohort is cannabis with over 60% of the cohort using this substance in the month leading up t the census. The next most used substances are tobacco and alcohol. There is then a sharp decline to the next category which is meth/amphetamines. The data on daily (or almost daily use) indicates that young people in the youth AOD system show a similar profile in terms of habitual use. Namely, most use cannabis daily followed by tobacco and alcohol followed by smaller levels of chronic meth/amphetamine and other drug use.

Breakdown of substance use over four weeks by gender and age

Assessment was conducted to better understand gender and age differences in substance use over the four weeks prior to the census. The results again highlighted the general trend for males to use more substances than females in all categories, and indicated a positive correlation between increasing usage of substances as age increases. These results are depicted in Table 4.1.

Table 4.1: Prevalence of Substance Use in Four Weeks Prior to Census by Gender and Age.

	Gender		Age		
Substance	Male	Female	8-15	16-17	18 and over
Alcohol	288	146	50	66	268
Cannabis	358	185	77	117	351
Heroin	13	7	3	2	15
Methamphetamines	154	86	25	42	176
Tobacco	273	148	42	69	285
Prescription (non opioid)	59	25	8	14	63
Opioids (e.g. codeine)	25	11	3	5	28
Inhalants	4	5	4	3	2
Ecstasy/MDMA	68	26	12	19	62
Hallucinogens	27	5	4	8	20
Other	34	24	7	9	42

Table 4.1 highlights again that cannabis (illicit) and alcohol (licit over 18) are the most widely used substances in this sample in both males and females. These are followed by tobacco (licit over 18) and methamphetamine (illicit), again in both males and females. In terms of ages, the data indicated a marked increase in alcohol use at 18 years of age, the time when usage becomes legal. Likewise, other substances jump markedly from adolescence to young adulthood including methamphetamines and tobacco.

Daily substance use by gender and age

Daily substance use by gender and age was recorded and displayed in Table 4.2.

Table 4.2: Daily Substance Use by Gender and Age Group

	Gender		Age		
Substance	Male	Female	8-15	16-17	18 and over
Alcohol	89	49	9	24	105
Cannabis	286	157	57	100	287
Heroin	3	5	52	21	78
Methamphetamines	62	40	325	21	78
Tobacco	128	223	132	63	257
Prescription (non opioid)	25	12	1	7	30
Opioids (eg codeine)	13	5	0	4	13
Inhalants	0	2	0	2	0
Ecstasy/MDMA	6	1	0	2	5
Hallucinogens	0	2	0	1	1
Other	11	14	3	5	17

Table 4.2 highlights the relative increase in substance use across adolescence to early adulthood. In addition, males were more frequently using substances occasionally than females in all substance categories.

Dependence on substance profile

Youth workers were asked to rate their impression of whether young people were dependent on a substance, and which substance this included. The results are presented in Figure 4.3.

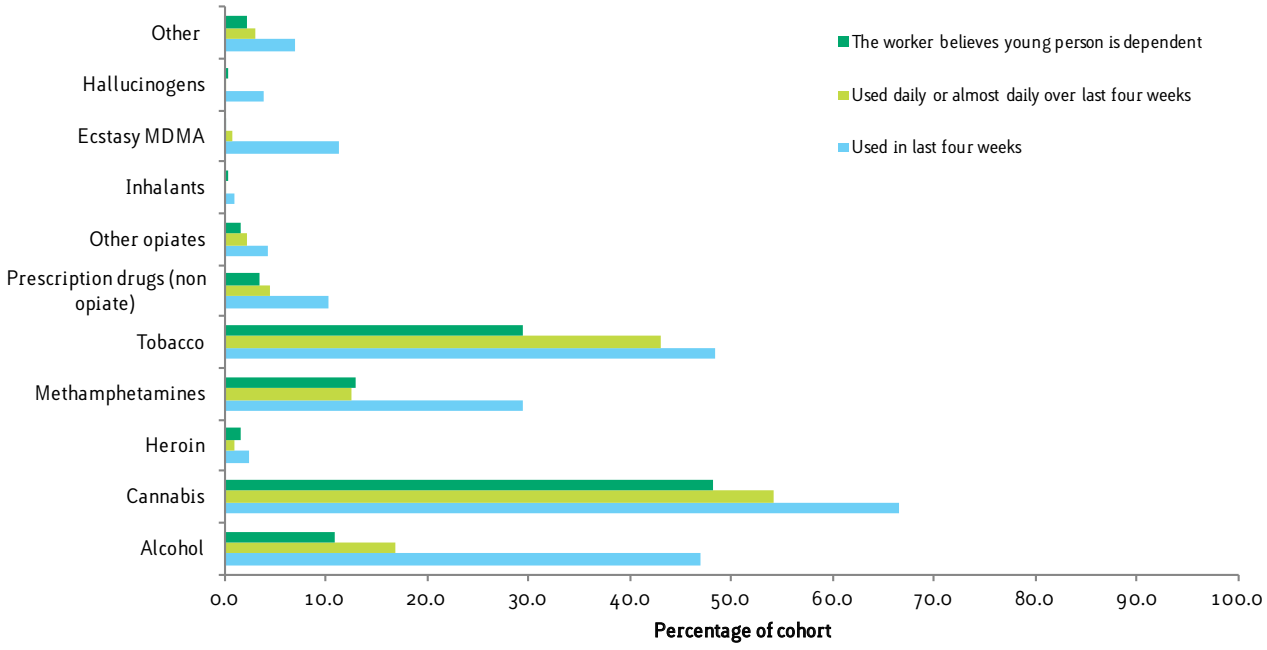

Figure 4.2. Percentage of Cohort Identified as Substance Dependent by Substance.

Figure 4.2 again shows the substances on which young people in the cohort were the most dependent. Notably, cannabis is the highest level of dependence, according to workers. The second most dependent category is tobacco, followed by methamphetamines and alcohol.

Table 4.3: Prevalence of Substance Dependence by Age and Gender.

	Gender		Age		
Substance	Male	Female	8-15	16-17	18 and over
Alcohol	37	52	3	10	77
Cannabis	143	250	48	84	263
Heroin	7	6	2	1	10
Methamphetamines	47	58	6	19	82
Tobacco	92	149	20	39	182
Prescription (non opioid)	9	19	1	6	22
Opioids (eg codeine)	2	11	0	3	10
Inhalants	3	0	1	2	0
Ecstasy/MDMA	0	2	0	0	2
Hallucinogens	0	3	1	0	2
Other	8	11	4	2	13

Age and gender data indicates that substance dependence continues to follow the typical course of cannabis being the main substance of concern. Notably, alcohol and tobacco are replaced by meth/amphetamines as the second leading substance of concern to workers in the young people. This may reflect increased acuity of symptoms and psychosocial complexity with this substance use.

Primary Substance of Concern

While workers were asked to identify the substances used and the frequency of severity of use, the primary drug of concern category reflected their own impression of drug-related harms. Workers were asked to indicate a primary drug of concern that was the target of their work over other substances used. Notably, substances dependent on and the primary drug of concern may differ based on the risk profiles and formulation of the worker. The primary substances of concern for the 2016 Youth Needs Census are depicted in Table 4.4.

Table 4.4: Primary Substance of Concern.

Substance Class	Frequency	Percent
Alcohol	114	13.9
Cannabis	361	43.9
Heroin	12	1.5
Meth/amphetamine	215	26.1
Tobacco products	22	2.7
Prescription drugs – non-opiate (e.g. benzos)	18	2.2
Other opiates (e.g. morphine, codeine, oxycontin)	9	1.1
Inhalants (e.g. nitrous oxide, petrol, solvents, glue)	6	0.7
Ecstasy, MDMA	13	1.6
Hallucinogens (e.g. LSD, mushrooms)	8	1.0
Other. Please state	24	2.9

Table 4.4 highlights that most youth workers identify cannabis as the primary substance of concern. This correlates with the data also highlighting it is the most commonly used substance over both the month-long period and on a daily basis. The second most concerning substance to youth workers was methamphetamine over alcohol, possibly indicating the severity with which methamphetamine use is viewed. It is notable that alcohol is less likely to be a substance of concern, despite more general population data indicating significant youth issues with this substance. This may indicate some substantive different between the youth AOD population and the more general statistics n young people and the community at large (AIHW, 2016).

Unmet Needs

Figure 4.3 shows the substance use unmet needs for the 2016 Youth Needs Census. Youth Workers reported that 75% of their clients had a current problem with substance abuse. 94% of clients were currently receiving a service focused on this problem. The 75% did not include clients who were currently in residential services. Workers reported that 92% of clients had a problem with substance use in the past. 58% of clients had received a service focused on this problem in the past.

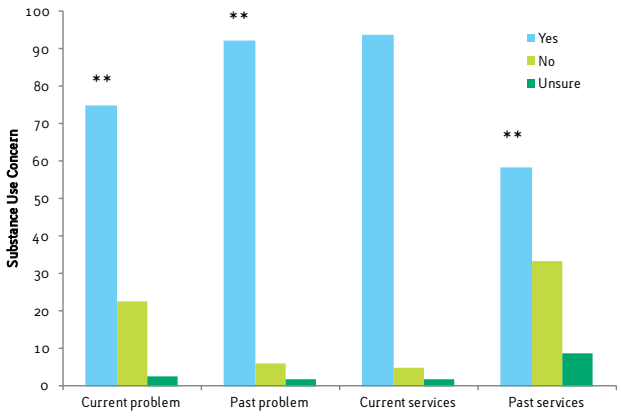

Figure 4.3. Prevalence of Substance Use Past and Present and Service Provision Past and Present in 2016 Youth Needs Census.

Note ** denotes significant difference on x2 at p=.01.

Drug Use by Injection

Analysis of drug use by injection statistics indicated that 95 (11.5%) of the surveyed young people had used drugs by injection, compared to 586 (71.2%) of young people who had not used drugs by injection. Workers were unsure of the injecting drug use status of a further 142 (17.3%) of young people included in the census. Contrasting the 2013 and 2016 census shows that the rate of injecting drug use has remained relatively constant between recording periods (10% in 2013 and 11.5% in 2016).

Drug Related Harm

Serious drug related harm was defined by a hospital admission or ambulance attendance, suffering injuries or physical harm, driving a vehicle while substance affected, or engaging in unwanted sexual activity while substance affected. Youth Workers reported that 302 (37%) of clients had experience drug related harm compared to 407 (49.5%) of clients who had not experienced drug related harm. Workers were unsure of the drug related harms status of 114 clients. This high rate of young people not necessarily experiencing drug related harms was notable, as it is difficult to elicit behavioural change if a person does not see a need to alter their behaviour. This highlights the need for workers to focus on a wide range of the impacts and effects of substance use (that may be less catastrophic and more insidious) when working to increase motivation to change if a young person wants to reduce their substance use.

5. FAMILY AND RELATIONSHIPS

BACKGROUND

The youth alcohol and other drug (AOD) sector typically use a socio-ecological perspective. This perspective views youth alcohol and other drug use as a complex interplay between the individual, their systems (especially family and social systems), and the wider community. Family experiences and environments are one of the most important predictors of young people who are resilient, attached to other important figures in their lives and are able to access help and support when needed. When family and social systems are not working well (such as in the case of families where violence and neglect exist) there is an increased risk of cognitive, mental health and social functioning issues, and reduced engagement in education and employment. These same experiences also predispose young people to engage in more criminal behaviour including violence against peers and partners (Morgan & Chadwick, 2009) and also directly increases the risk of substance abuse (Wright, Fagan & Pinchevsky, 2013) and mental ill health (Schiff et al., 2014).The impact of substance use on a young person also extends beyond the direct relationship with parents and siblings to other trusted relationships in their lives. Notably, social systems outside the immediate family have significant impacts on substance use, including the protective role of other trusted adults and youth workers.

Youth workers were asked to report if their clients had a current problem with family relationships and if their client was currently receiving a service based on this issue. Youth workers were asked to report whether their client has had a past problem with family relationships and if their client had in the past received services for their problems with family relationships.

Problems with family functioning past and present and provision of services around these needs past and present

The prevalence of past and current family issues and corresponding utilisation of services is depicted in Figure 5.1.

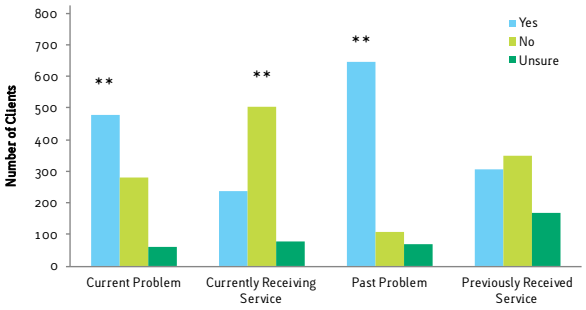

Figure 5.1: Prevalence of family issues past and present (last four weeks) and whether young person has received service based on this issue (past and present).

Note ** denotes significant difference on x2 at p=.01.

These results highlight that over half of the young people engaged with youth services have had difficulty with family issues in the four weeks leading up to the census. Moreover, most young people have had significant family issues in their past. Family issues can cover a gamut of concerns from typical friction related to normal adolescent and young adult development, through to significant family dysfunction including family violence, neglect, parental mental illness, or substance use or similar difficulties with siblings. The inverse relationship between the amount of need and the amount of support provided around this important issue highlights a significant gap in care provided to young people.

Family Conflict and Disconnection

A further analysis of the rates of family conflict (versus family discord that may contribute to Figure 5.1) showed rates of conflict and disconnection from family on the more severe end of the family issues spectrum. These results appear in Figure 5.2.

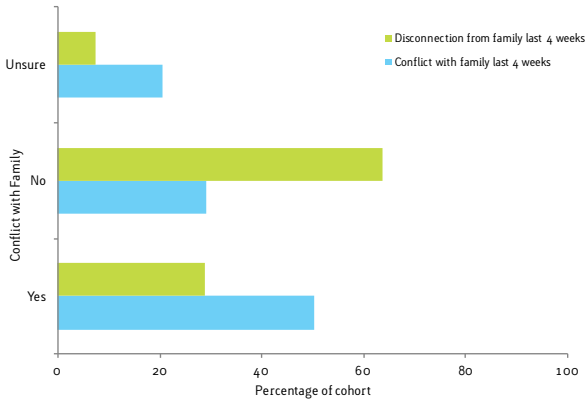

Figure 5.2: Conflict with family and family disconnection.

Figure 5.2 shows that half of the young people included in the Youth Needs Census had experienced family conflict over the four weeks preceding the census. At greater risk of poor psychosocial outcomes were the 29% of young people who were disconnected from their families. Knowing that family connection (or created family connection with meaningful others) is a significant predictor of substance use outcomes, this sub group are particularly vulnerable.

Connection outside of the family

Many individuals create family and support networks where they may have previously had negative experiences or no relationship with family of origin. In many cases, individuals seek out their own supportive adults with whom to establish a safe connection. Youth workers were asked whether the young person they were working with had a safe connection with a trusted adult outside their family that they could turn to for help if required. The results were positive, showing that 66% of young people had a trusted person to turn to in life outside their family. A follow up question asked whether the worker was the main trusted adult outside of the immediate family, or if they could identify other supports. This gave some indicator of the bond between workers and young people, and trust in that relationship on the part of the young person. The results further showed that while the youth worker was not the primary support person for 16% of young people, the worker was considered one of those supports in young people's lives in 41% of cases. Most notably, youth workers were estimated to be the most trusted adult in the lives of 10% of young people.

Engagement with Human Services as Client or Parent of Client

When difficult family relationships occur, young people may become involved with human services or child protection as either a direct client themselves, or the parent of a client of DHHS. The census demonstrated that 39.4% of the young people recorded had previous engagement with child protection services. An additional 16.8% of the cohort was engaged with child protection at the time of the census. In terms of parenting, 10.8% of the young people in the census were a parent. All but five of the parents resided with their children and 5.7% of parents with a child had that child engaged with child protective services.

Prevalence of violence and abuse experiences in young people

When considering the impact of childhood and early adulthood trauma, evidence indicates that abuse and violence in the family context as well as violence and abuse outside the family unit (ie societal level) plays a significant role in the development of substance abuse issues. Experience of forms of violence in this sample of young people in the four weeks leading up to the census (Table 5.1) and in their past (Table 5.2) are presented.

Table 5.1: Proximal Experiences of Abuse over Previous Four Weeks (number and percentage)

The young person experienced the following during the previous four weeks	Yes	No	Unsure
Neglect	56(6.8%)	579(70.4%)	188(22.8%)
Emotional Abuse	176(21.4%)	425(51.6%)	222(27.0%)
Physical Abuse	70(8.5%)	519(63.0%)	234(28.4%)
Sexual Abuse	18(2.2%)	565(68.7%)	240(29.2%)
Violent Crime	29(3.5%)	555(67.4%)	239(29.0%)

Recent experiences of abuse or violence indicated that emotional abuse was more commonly reported about this group of young people followed by physical abuse and neglect. The unsure scores were notable as they indicate that youth workers are not aware of the young person's experience of abuse in around one quarter of young people.

Table 5.2: Distal Experiences of Abuse (over lifetime)

The young person experienced the following during their lifetime	Yes	No	Unsure
Neglect	298 (36.2%)	290(35.2%)	235(28.5%)
Emotional Abuse	418 (50.8%)	187(22.7%)	218(26.4%)
Physical Abuse	319 (38.8%)	240(29.2%)	264(32.0%)
Sexual Abuse	139 (16.9%)	311(37.8%)	373(45.3%)
Violent Crime	184 (22.3%)	296(36.0%)	343(41.6%)

The lifetime prevalence of abuse and violence highlighted high levels of identified emotional abuse, physical abuse, and neglect in the young people engaged with youth AOD services. Lower levels of sexual abuse and violent crime were reported for these young people, which may reflect on both the difficulty discussing these topics and varying levels of prevalence.

To better understand the relationship between the high levels of experiencing violence and young people's experience of family violence, workers were asked to further identify the violence occurring in the family context and what role (if any) young people had within the situation. The results indicated that 32.8% of young people were reported as being victims of family violence, 33.3% as a witness and 15.8% as the instigator of family violence. Some young people may have been all three, two, or just one whilst others had not experienced family violence.

Abuse, neglect and family violence by gender

The gender breakdown of family issues and family violence is depicted in Figure 5.3.

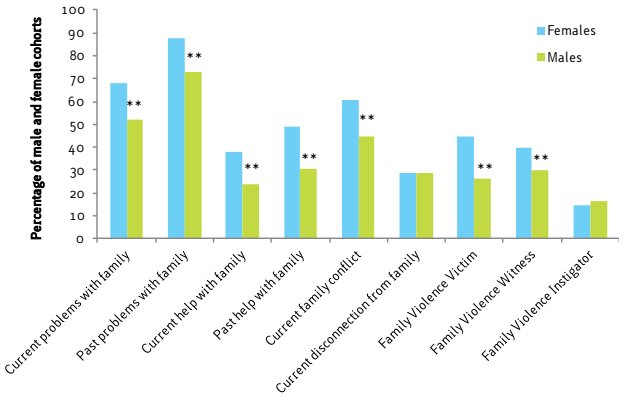

Figure 5.3. Abuse, neglect and family violence by gender.

Note ** denotes significant difference on χ2 at p=.01.

The analysis of gender data highlighted a clear gap between the experiences of young females and young males facing family difficulties and experiencing and witnessing violence in the home, according to youth workers. The largest difference indicated that females were significantly more likely than their male counterparts to experience and /or be the victims of family violence.

Abuse, neglect and family violence by age

Family issues, service utilisation, abuse and neglect in the three age groups selected are presented in figure 5.4.

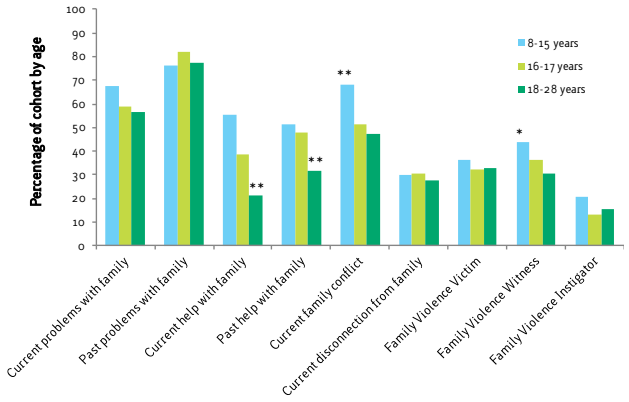

Figure 5.4. Abuse, neglect and family violence by age category.

Note ** denotes significant difference on χ2 at p=.01.

The analysis of age breakdowns reveals less variability than observed with gender. Some differences arose in relation to individuals in the older age category receiving less assistance with family issues in both the past and present than the other groups. This finding makes some sense in terms of maturation and reaching legal adulthood, where the family context might be less important than for younger adolescents. There is a cautionary element to this however, as strong family relationships continue to be an important predictor of good outcomes well into adulthood. The data also highlights the peak time for family conflict occurs from childhood to mid-adolescence, a time that corresponds with the most significant boundary testing and individuation attempts from the family – these are well-known precipitants of family conflict. This time may be an ideal opportunity to intervene and utilise distress management and affect control techniques in young people to assist in maintaining strong family bonds into the future and avoiding familial relationship ruptures.

Abuse, neglect and family violence in specific groups

Family issues, service utilisation, abuse and neglect in the three age groups selected are presented in Figure 5.5.

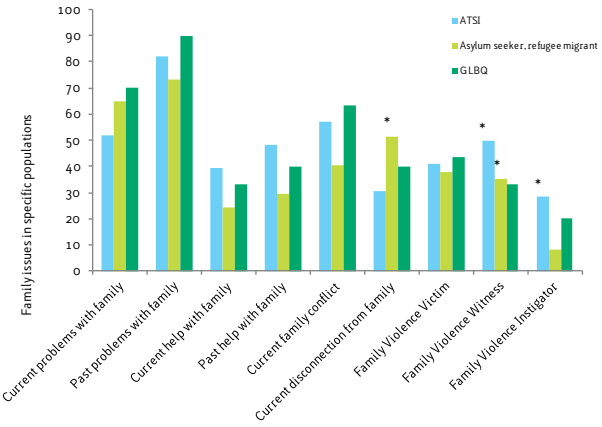

Figure 5.5. Abuse, neglect and family violence by specific interest groups.

Note * denotes significant difference on □2 at p=.05.

The results of the analysis of specific interest groups indicated that young people from an ATSI background were more likely to witness and instigate family violence than other young people and those from asylum seeker, refugee, or migrant communities were more likely to be disengaged with their families.

6. MENTAL AND PHYSICAL HEALTH

BACKGROUND

Youth mental health has become an increasingly important topic as a growing body of research increasingly indicates adolescence and young adulthood as times of particular vulnerability in relation to the development of mental ill health. In line with this knowledge, services and programs are increasingly recognising that early intervention in youth mental health is imperative to reduce the later burden of disease and psychosocial impairment associated with chronic mental illness. Different services and sectors have different approaches to the use of substances in teenagers and young adults. Some sectors regard substance dependence or abuse as a mental disorder in its own right (see DSM-52). Others consider substance use and misuse as coping mechanisms and socially determined behaviours that may indicate disadvantage/psychosocial complexity, or simply experimentation and individuation activities in adolescence. It is likely that as with all complex behavioural and health issues, substance use and misuse in adolescence and early adulthood is a combination of these factors. Many young people will experiment or habitually use substances and have no significant tolerance or withdrawal issues if they stop use (particularly for substances like cannabis). Others with a high genetic load for substance use disorders, who use heavily, who have fewer supports to change or to help them to better understand their behaviours, as well as those who may not be coping in other elements of life, will struggle considerably to reduce or cease their substance use. These are the individuals who often concern workers and services in relation to the mental and physical health impacts of substance use.

2 https://www.psychiatry.org/psychiatrists/practice/dsm

While more young men use substances, an established phenomenon of adolescence is that more females tend to develop mental health issues, particularly around mood and anxiety concerns. A similar, well-known finding notes that the rates of mental health issues tend to increase across adolescence as this is the biological time period during which many psychiatric disorders first emerge. Table 6.1 highlights the gender and age data from the 2016 census in terms of past and present mental health issues and the receipt of services based on these factors.

Current and past mental health concerns and current/ past service provision

Youth workers were asked to report if their clients had a current problem with mental health and if they were receiving a service based on this issue at the time of the census. Youth workers were also asked to report if their client has had a past problem with mental health and if their client had in the past received services for their problems with mental health.

Gender and age factors in relation to current and past mental health issue and service provision

Table 6.1: Current and past mental health issues and current and past service utilisation for mental health issues

	Current mental health issue	Past mental health issue	Current mental health services	Past mental health services
Male	60.9%	64.0%	38.3%	43.9%
Female	73.8%*	80.6%*	45.2%	58.2%*
8-15 years old	55.4%	61.4%	29.7%	34.7%
16-17 years old	62.2%	65.4%	34.0%	44.2%
18-27 years old	68.7%*	73.4%*	45.1%*	53.3%*

Note * denotes significant difference on $\chi 2$ at α=.05.

As highlighted in table 6.1, females had more mental health issues in the four week period prior to the census, as well as a stronger past history of mental health issues. Associated with this, females also had significantly more mental health service support in the past than males. Notably, the relative provision of mental health services in the four weeks leading up to the census was not significantly different. The age data continues to demonstrate the rates of mental health issues and histories of mental health issues increase with age, as do the utilisation of past and current mental health services. This supports data from the mental health field indicating the importance of early intervention for biological, psychological, social and developmental reasons.

In relation to mental illness diagnoses, the responses indicate that significantly more females (at a significance level of .05) disclosed to workers a diagnosed mental illness than males (44.6% versus 29.3% of males). It must be noted that youth workers do not directly diagnose mental ill health so this diagnostic information is based on the clients or other informants understanding of diagnoses. In terms of the age breakdown, the same data indicated statistically significant differences based on age (, $\chi 2(4, 820) = 41.322$, p←.001) with 14.9% of 8-15 year olds, 24.4% of 16-17 year olds and 42.1% of 18-27 year olds having a current mental health diagnosis at the time of the census. This again highlights the increasing prevalence of formal mental illnesses across middle to late adolescence.

Non-Suicidal Self-Injury and Suicide

Alongside measuring mental illness, workers were asked to indicate if the young people had disclosed self-injury or suicide attempts over their lifetime. The prevalence of these behaviours in young people enrolled with youth AOD services is depicted in figure 6.1.

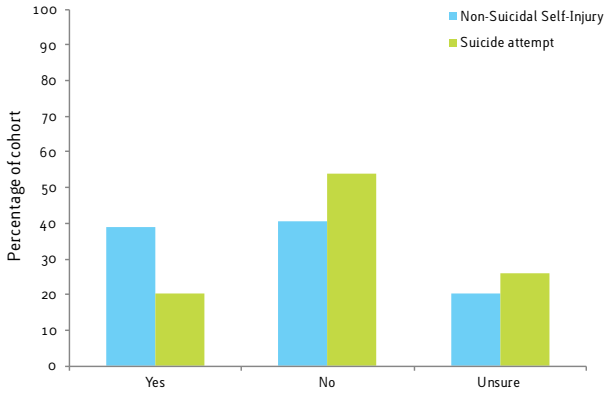

Figure 6.1. Prevalence of self-injury and suicide attempts in the population of young people within Victorian youth AOD services.

Of the clients who had attempted suicide in the past, 100 individuals required medical attention, 42 did not, and workers were unsure of whether medical attention was needed in 21 further cases. Youth workers reported that 102 clients disclosed the suicide attempt at the time it occurred, 32 did not disclose, and workers were unsure of whether the event was disclosed by 30 clients.

Specific populations and service utilisation and self-injury/suicide attempt history.

Data related to the ATSI, asylum seeker, refugee and migrant and GLBQ groups are presented in Figure 6.2.

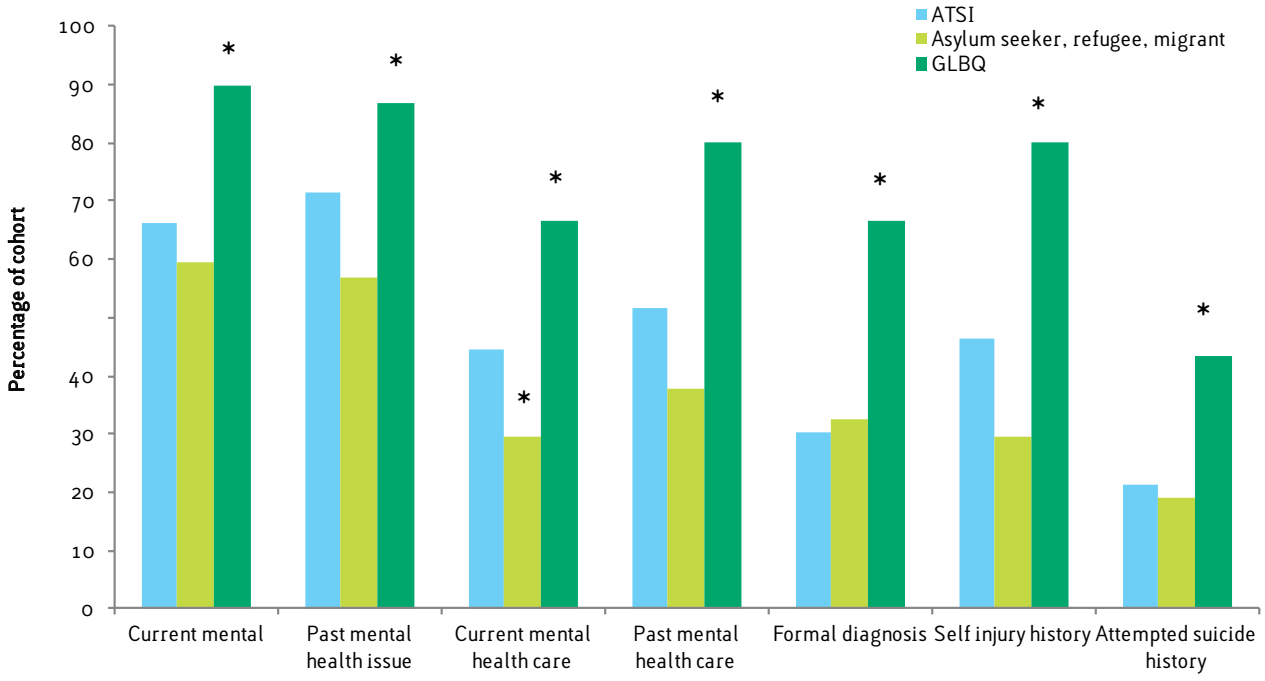

Figure 6.2. Mental health and service utilisation past and present, diagnosis and self-injury and suicide attempt prevalence.

Note * denotes siginficant difference on $\chi 2$ at p=.05.

The data from figure 6.2 highlight the vulnerability of the GLBQ group in terms of most mental health issues. This category of young people is clearly more vulnerable to mental health issues, diagnosis, and behaviours related with distress (self-injury and suicide attempts) than the other two vulnerable populations. This group is also the most likely to have used mental health services in the past and present, indicating a high cost of their mental health concerns on the population, and an implied need for providing timely and early intervention focused work to reduce the long-term impacts of mental illness. This risk is one of the clearest differentiations of the census.

Wellbeing measures from the Australian Treatment Outcome Profile

Three structured scales from the Australian Treatment Outcome Profile (ATOP) were included in the Youth Needs Census. These items asked workers to describe the psychological health, physical health and overall quality of life of each young person. These items are scaled on a 1-10 axis with ten associated with the strongest functioning and one as the most difficulty in that domain.

The sum of the different substances used in the four weeks preceding the census was correlated with the outcomes of the three ATOP subscales. The results of the Pearson Product Moment Correlation Coefficient and significance test appear in Table 6.2.

Table 6.2: Correlation between ATOP subscales by number of different substances used over four weeks prior to census.

Number of different substances (4 weeks)	Psychological Health (4 weeks)	Physical health (4 weeks)	Quality of life (4 weeks)
Correlation	-.263**	-.277**	-.261**
p-value	<.001	<.001	<.001

Note * denotes siginficant difference on χ2 at p=.01.

The outcomes of the correlations indicate all sub scales of the ATOP show significant relationships between number of different substances used and impacts on health. The data show this as a conservative, negative correlation, meaning the greater the number of different substances used, the poorer the psychological and physical health of the individuals and the lower the quality of life. Essentially, this highlights that polysubstance use has a significant association with poorer outcomes on all three formal measures of health and wellbeing included in the census.

Comparison of ATOP subscales between 2013 and 2016 census

The ATOP psychological and physical health scales and quality of life scores were contrasted over the two census collection periods to assess change in formal scale outcomes over time that may reflect changes in the cohort characteristics. The results of this comparison are presented in table 6.3.

Table 6.3: Changes in ATOP Psychological, Physical and Quality of Life Scales over time.

ATOP Subscale	2013 Census	2016 Census	Statistic
Psychological Health	4.80(2.26)	6.21(2.00)	$t(1, 1807)=13.857$, $p<.001$
Physical Health	5.66(2.19)	6.93(2.03)	$t(1, 1807)=12.701$, $p<.001$
Quality of Life	5.13(2.21)	6.53(2.01)	$t(1, 1807)=3.160$, $p<.001$

The results of the ATOP analysis over time highlight that across all three measures of health and wellbeing, the young people surveyed in 2016 were significantly more healthy or had higher levels of quality of life than those included in the 2013 census. As the statistical analysis by design largely accounts for this variation arising by chance, this implies something qualitatively different between census periods. The nature of this difference cannot be determined by the data available from the census but implies something positive is occurring to improve health and wellbeing. The breakdown of the ATOP data for psychological health, physical health and quality of life for specific group comparisons are presented in Tables 6.4, 6.5 and 6.6. Table 6.4 highlights that while there were some differences between groups in predicted directions (i.e. females had more psychological distress than males), none of these factors reached significant levels on the ATOP subscale on statistical analysis. Of all groups, the GLBQ and asylum seeker, refugee or migrant groups had the lowest psychological health scores.

Table 6.4: Psychological Health by Specific Group From the ATOP Subscale

Factor	Group	Mean (S.D.)	Statistic
Gender	Male	6.3(2.0)	t(1,814)=-1.461, p=.144
	Female	6.1(2.0)	
Age	8-15 years	6.2(1.9)	F(2,817)=.632, p=.532
	16-17 years	6.0(1.9)	
	18-28 years	6.3(2.1)	
Specific group	ATSI	6.2(2.1)	t(1,821)=.133, p=.910
	Non ATSI	6.2(2.0)	
	Asylum seeker, refugee or migrant	6.0(2.5)	t(1,821)=..561, p=.575
	Non Asylum seeker, refugee or migrant	6.2(2.0)	
	GLBQ	6.0(2.1)	t(1,821)=-.578, p=.563
	Non GLBQ	6.2(2.0)	

The physical health results also showed similar scores across groups on the outcomes of the physical subscale of the ATOP. Young males who didn't come from a specific population had the best health scores, whilst being female was a predictor of the lowest physical health scores. While results were evident, they did not reach significance at an alpha level of .05.

Table 6.5: Physical Health by Specific Group From the ATOP Subscale

Factor	Group	Mean (S.D.)	Statistic
Gender	Male	7.1(2.0)	t(1,814)=-1.461, p=.144
	Female	6.6(2.0)	
Age	8-15 years	7.1(1.9)	F(2,817)=.328, p=.721
	16-17 years	6.8(1.9)	
	18-28 years	6.9(2.1)	
Specific group	ATSI	6.8(2.2)	t(1,821)=.541, p=..589
	Non ATSI	6.9(2.0)	
	Asylum seeker, refugee or migrant	6.9(2.0)	t(1,814)=.274, p=..784
	Non asylum seeker, refugee or migrant	6.8(2.6)	
	GLBQ	6.8(2.0)	t(1,821)=-.258, p=.796
	Non GLBQ	6.9(2.0)	

Table 6.6: Quality of Life by Specific Group From the ATOP Subscale

Factor	Group	Mean (S.D.)	Statistic
Gender	Male	6.6(2.0)	t(1,814)=-1.898, p=.058
	Female	6.4(2.0)	
Age	8-15 years	6.5(2.0)	F(2,817)=.588, p=.556
	16-17 years	6.4(1.9)	
	18-28 years	6.6(2.0)	
Specific group	ATSI	6.5(2.0)	t(1,821)=.198, p=.843
	Non ATSI	6.5(2.0)	
	Asylum seeker, refugee or migrant	6.3(2.6)	t(1,821)=.816, p=.415
	Non asylum seeker, refugee or migrant	6.6(2.0)	
	GLBQ	6.2(2.0)	t(1,814)=-1.020, p=.308
	Non GLBQ	6.6(2.0)	

7. EDUCATIONAL OUTCOMES

BACKGROUND

Educational engagement is an integral part of a healthy developmental trajectory for children and adolescents. Substance use is known to significantly impact the ability of young people to attend, engage, and excel in educational settings. The Youth Needs Census surveyed a range of educational elements in the young people engaged with services. These elements are described below with the results of the survey.

Youth workers understand that having a sense of connection to self, community, and family increases protective factors that help to build resilience in young people. Community can have a variety of meanings for different young people. Community can mean the wider community of family and friends and it can also mean being involved in education, sports teams, groups, and/or clubs.

For many of the young people who are attending Youth AOD services, there has been a disruption in their educational pathways. Keeping a young person linked in with educational settings can increase their protective factors by offering them a supportive/ trusted adult who is willing to guide them through the hard times. Educational environments also create a sense of stability to those young people who may have never experienced that feeling before.

Teachers are often the adults in a young person's life who witness them starting to withdraw or act differently and are able to help identify when substance use develops from recreational to problematic. It is important for young people to feel as if they have access to a trusted adult outside the family unit with whom they are able to talk about what is happening in their lives.

Young people who leave school early or are forced out of mainstream education can have their development compromised in many different ways. These young people can feel isolated and alienated from their peers who are attending school, from education opportunities, and from those who are acting as support systems. These feelings often result in a young person withdrawing from family, community, and self, thereby increasing the risk factors in their life which in turn may lead to risk taking behaviours, such as substance use.

There is no single cause for or prevention measures against problematic substances use, however increasing a young person's protective factors, such as engagement and connection to education, will make them less at risk of developing problematic substance use behaviours.

Education Attendance, engagement and type of studies being undertaken

The Victorian Youth AOD census indicated low overall educational attendance. 270 of the 823 young people reviewed by workers were engaged with some form of education, whilst 514 young people were not engaged and the engagement was

unknown for 39 young people. Of the engaged students, n=110 were in secondary education, n=56 in VET, n=14 in TAFE or University and n=88 in other forms of training (n=2 unknown) over the four weeks prior to the census.

The ThYNC results showed that in the four weeks leading up to the census, of those young people who attended education, 140 were fully engaged, with 170 having precarious engagement. This highlighted the risks of non-attendance and future disengagement in 55% of those young people who were attending education at the census date.

Educational Needs, Service Reception and Unmet Needs

Workers were asked to indicate if there was an unmet educational need in the prior four weeks to the census date, and/or in the young person's past that has impacted on their ability to engage in educational pursuits. Based on these findings, a calculated unmet need was provided in Table 4.1 in Section 4 above.

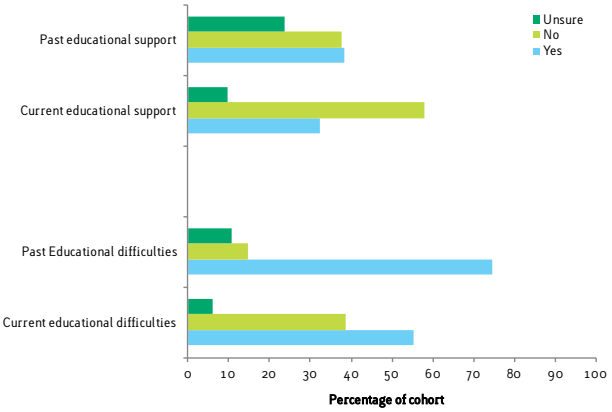

Figure 7.1. Educational Problems and Related Services in the Overall Sample

In relation to education, Figure 7.1 highlights young people with a significant past history of academic concerns that have largely gone unmet in terms of service response. This coupling is likely to be associated with the high overall level of educational disengagement in the young people included in the Youth Needs Census. Notably, the present data indicates a continued need for services in many young people, but a lack of services designated to respond to this need.

Educational and Behavioural Difficulties at School

Youth workers were asked to report if their clients had educational-related difficulties. 39.9% (n = 328) of youth workers reported that their clients did not have educational-related difficulties. Workers were able to endorse a range of behavioural and educational-related difficulties that impact young people. The results of these questions are highlighted in Figure 7.2.

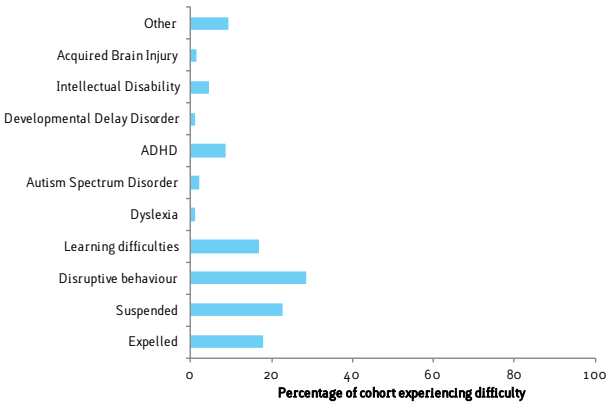

Figure 7.2. Percentage of Behavioural and Educational Difficulties of Young people in Educational Contexts.

Figure 7.2 highlights the high incidence of behavioural difficulties in this cohort of young people, namely disruptive behaviour in class, being suspended, and being expelled from school. In terms of learning difficulty with a lower number indicating the young person had discussed ADHD, or some other form of learning difficulty. This indicates that for many of the young people, engagement with education may be particularly difficult because of either behavioural and/or learning difficulties.

Sum of educational related difficulties

Youth workers were asked to report the sum of education related difficulties each client had experienced with 0 = no reported learning difficulties and 10 = 10 reported learning difficulties. Results are shown below in Figure 4.3. These difficulties include suspension, expulsion, disruptive behaviour, learning difficulties, dyslexia, autism spectrum disorders, ADHD, developmental delay disorder, intellectual disability, acquired brain injury, and "other".

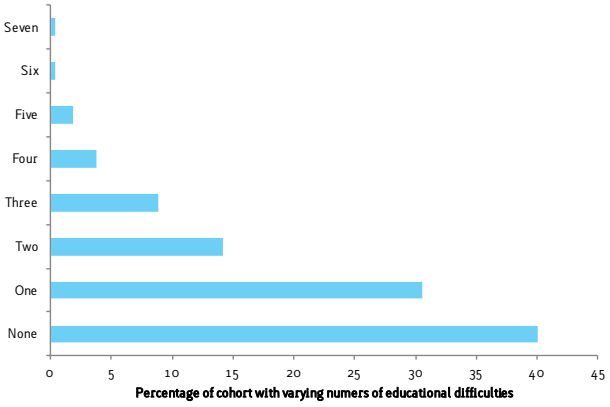

Figure 7.3. Percentage of Cohort with Education Related Difficulties.

Figure 7.3 demonstrates that 60% of our cohort of young people are suspected to have behavioural and/or learning difficulties by their youth workers. There is a steady decrease in the number of clients with multiple issues learning issues with a small minority having multiple concurrent learning difficulties.

Education related difficulties in specific populations

In relation to specific populations, the results of a series of chi square analysis indicated that young people from Aboriginal and Torres Strait Islander backgrounds were significantly more likely to be expelled from school (35.7% versus 16.8%). Males were also significantly more likely to be suspended (21.5% versus 12.2%), as were clients referred through the COATS program (31.6% versus 12.0%). In terms of suspensions, males were again significantly more likely to be suspended from school than females (26.2% versus 16.7). Finally, clients referred through the COATS program showed significantly more educational difficulties than other young people (25.2 versus 20.7).

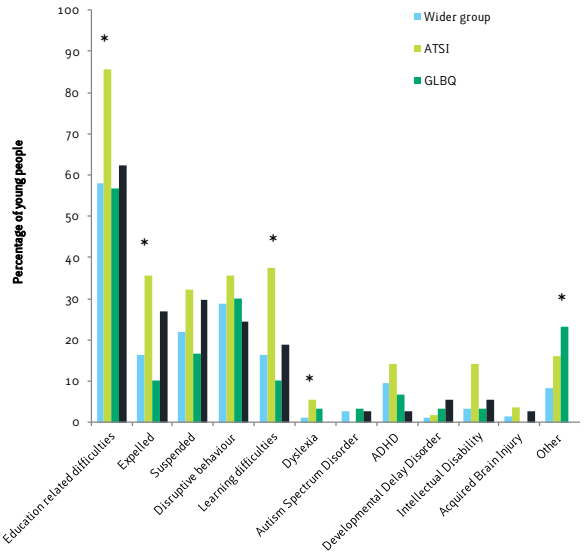

Figure 7.4. Percentage of young people from specific populations who have educational difficulties.

Note * denotes significant difference on χ2 test with p=.05.

Figure 7.4 highlights the increased risk of educational difficulties in young people from an ATSI background. Further, these young people are at a higher risk of being expelled, learning difficulties, dyslexia, and acquired brain injuries as reported by youth workers. It is notable to report that these potential learning difficulties are as reported by youth workers who have this information from the young person and not from health professionals directly. The notable increase in the incidence of 'other' issues at school in the GLBQ group may represent a range of external schooling factors that are impacting their learning, with previous research indicating some increased risk of bullying may fall into this category.

Numeracy and Literacy

Youth workers were asked to rate their client's level of numeracy (mathematical skills) and literacy (reading ability). The levels of each of these in the 2013 census and the 2016 census are presented in table 7.1. It is notable that this task asked workers to go outside their expertise in identifying these issues. Because of this, the data reflect an estimate rather than tested measure of literacy and numeracy.

Table 7.1: Numeracy and Literacy Rates in Young People Engaged with Youth AOD services in 2013 and 2016.

	Numeracy		Literacy	
Year	2013	2016	2013	2016
Excellent	11.8	10.9	14.1	13.4
Good	28.9	31.6	31.5	33.4
OK	31.4	27.2	31.5	27.9
Poor	13	13.2	13.3	12.2
Can't do mathematics/ read	1	1.7	0.8	2.2
Unsure	11.8	10.9	8.7	10.9

The numeracy and literacy data reveals few changes between census dates which likely reflects the relatively short interval between studies. Notably, the data highlights that young people are likely to have between poor and good levels of both numeracy and literacy. This indicates that for many of the young people who use services, their literacy and numeracy skills are sufficient for daily life, but are not conducive to completing education at a strong level, or to pursuing continuing/higher education.. This data may link to the high rates of educational drop out seen in this cohort.

Numeracy and literacy issues by gender and age group

Data were categorised by gender and ages to further investigate literacy and numeracy. The results are presented in table 7.2 and 7.3.

Table 7.2: Numeracy by Gender and Age (percentage)

	Level of Numeracy			
	Good	OK	Poor	Unsure
Female	0	4.2	91.7	4.2
Male	1.3	5.3	90.7	2.7
8-15 year olds	0.0	0.0	95.5	4.5
16-17 year olds	6.3	0.0	87.5	6.3
18-27 year olds	1.0	5.0	91.0	3.0

Analysis of numeracy highlights that both males and female young people in services are often assumed to have low numeracy scores and that this difficulty is relatively independent of the young person's age.

Table 7.3: Literacy by Gender and Age (percentage)

	Level of Literacy					
	Excellent	Good	OK	Poor	Can't manage	Unsure
Female	17.7	34.7	27.6	8.2	1.0	10.9
Male	10.2	33.1	28.4	14.4	2.9	11.1
8-15 year olds	5.9	21.8	38.6	21.8	0.0	11.9
16-17 year olds	9.0	35.3	30.1	10.3	1.9	13.5
18-27 year olds	16.0	35.0	25.2	11.0	2.7	10.1

Literacy measures indicate that youth workers typically endorse excellent to good literacy levels in around half of their clients and this is independent of gender and age. One notable exception to this was the literacy issues identified in the youngest of the cohorts. This level likely reflects their educational level and the importance of early intervention and support in youth AOD services to facilitate these young people developing their literacy further over time.

Literacy and numeracy skills in specific populations

The literacy and numeracy levels for ATSI, asylum seeker, refugee, and migrant and those from the GLBQ populations were scored independently to observe if there are any specific risks associated with membership of these groups. The results are depicted in table 4.2.

Table 7.4: Numeracy and Literacy Scores for Young People from Specific Populations of Interest

	Percentage of cohort					
	ATSI		Asylum seeker/refugee/migrant		GLBQ	
	Literacy	Numeracy	Literacy	Numeracy	Literacy	Numeracy
Excellent	14*	11.5*	13.6	10.9	33.3*	30*
Good	34.7	32.6	33.6	31.9	33.3	36.7
OK	27.5	27	27.6	27.1	23.3	20
Poor	10.7	11.9	12	12.8	3.3	6.7
Can't manage	2.1	1.6	2	1.7	0	0
Unknown	11.1	15.5	11.2	15.5	6.7	6.7

Note: * denotes a significant difference in the x2 analysis between the reference group and the normal population.

Note: Because of low sample size in the asylum seeker/refugee/migrant group data were lower but not statistically significant.

The data on the specific group breakdowns indicate that those from an Aboriginal or Torres Strait Islander background had significantly lower numeracy and literacy scores than other young people attending Victorian Youth AOD services. In contrast, those from a GLBQ background had significantly better numeracy and literacy. Note that because of low sample size in the asylum seeker/refugee/migrant group data were lower but not statistically significant.

Expulsions, suspensions and behavioural issues at school: Changes over time

The census data indicated that 18% of the young people receiving support in Youth AOD services in November 2016 had been suspended from schooling. This is slightly lower than the 2013 levels of 23% expulsions. In terms of suspensions, 22.7% of young people had been suspended from school, again, down on the 2013 data of 34%. Finally, 28.6% of young people had been identified by their worker as reporting that they display disruptive behaviour at school. This contrasts with the 37% rate seen in the 2013 census. Overall these data point to a modest albeit consistent improvement in school retention and behaviour amongst young people.

8. EMPLOYMENT

BACKGROUND

Similarly to young people having connection to education, young people having access to employment is incredibly important. A young person who has a connection to employment outside their family unit or educational setting tends to have a greater sense of purpose.

Some young people choose to exit educational settings early, others are asked to leave due to behavioural issues. For young people who do not finish school and who are from non-English speaking backgrounds, obtaining employment can be incredibly difficult. If they are unable to find something meaningful to fill their time, they may begin to feel isolated, begin to doubt themselves, and become bored. Young people who have a lack of purpose through education or employment and have excess free time tend to partake in risk-taking behaviours such as substance use.

Creating opportunities in which young people have access to employment helps to create crucial skills to improve a young person's economic and social prospects. [3]

SECTION SUMMARY

Youth workers were asked to report on their clients' employment status in the last four weeks. The results demonstrated that 25.4% (n = 209) of clients were employed either full time, part-time, or casually in the last four weeks. Of these individuals, 66 were employed full time (8%), 45 part time (5.4%), and 97 (11.7%) casually. Finally, workers were unsure of the vocational engagement of 4.6% of the cohort (n=38). Because many young people were engaged with education and others engaged with employment, a further calculation was made to assess the numbers of young people engaged in meaningful activity (education and/or employment). These data are presented in section 9 of the report.

Of the young people engaged with employment, the survey asked workers to report on their level of engagement. This included the young person being fully engaged (i.e. attending and intending to continue), precariously engaged (sporadic attendance and intent to disengage) and disengaged. The data revealed that the majority of young people who were engaged in employment were fully engaged (73%), indicating some security in desire to be employed. A further 23.9% of the employed cohort were precariously engaged, indicating some risk of employment instability.

Employment issues and service response past and present

Youth workers were asked to report if their clients had a current problem with employment and if their client was currently receiving a service based on this issue. Youth workers were then asked to report whether their client has had a past problem with employment, and whether their client had in the past received services for their problems with employment.

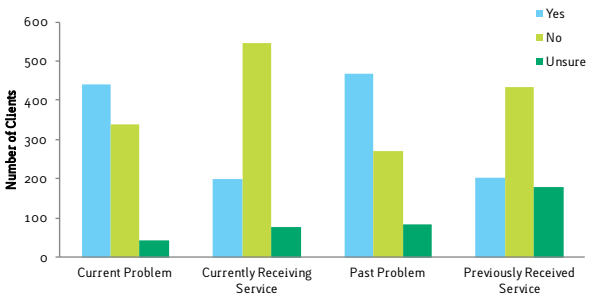

Figure 8.1. Needs and Responses around Employment

The data in figure 8.1 highlight that a significant number of workers identify both past and present issues with employment in a significant number of young people. It is notable that the graph also highlights that young people engaged with AOD Youth work are infrequently receiving assistance with employment issues and that they have also struggled to receive assistance with this issue in the past highlighting a significant unmet need as a target for intervention.

Employment outcomes by specific population groups

As with all measures, employment outcomes were inspected for members of the Aboriginal and Torres Strait Islander community within Victorian Youth AOD services, those from asylum seeker, refugee, and migrant communities and those from the LLGBQ community. The respective outcomes are presented for each group below.

Aboriginal and Torres Strait Islander employment outcomes

The Youth Needs Census revealed that 87.5% of young Aboriginal and Torres Strait Islanders within the Youth AOD system were not engaged with any form of employment (compared to 74.1% for non ATSI young people). Of those who were engaged, 7.1% were fully engaged (compared to 19.4%) with a further 5.4% precariously engaged with employment. Of the young ATSI clients engaged in employment, none were employed full time, 5.4% employed part-time and 7.1% employed casually.

3 http://yfoundations.org.au/explore-and-learn/publications/the-foundations/education-and-employment/

Asylum seeker, refugee and migrant young person employment outcomes

Seventy three percent of asylum seekers, refugees or migrant young people in services were not engaged with employment. Of those who were engaged, 21.6% were fully engaged (slightly above the average for all young people of 18.4%) and 5.4% were precariously engaged. In terms of time fractions, 2.7% of these young people were employed full time, 5.4% part time and 18.9% casually. Overall, these data indicate that for this population, those engaged in employment were likely to be fully engaged and also to be working casually.

Lesbian, gay, bisexual and queer young person employment outcomes

The data indicated that members of the GLBQ population were less likely to be engaged in employment than other young people (86.7% versus 74.5%), yet those who were engaged in employment were exclusively fully engaged (13.3%). Those in employment were spread between full time work (3.3%), part-time (6.7%) and casual roles (3.3%).

9. MEANINGFUL ACTIVITY

Engagement in education and engagement in employment (full time, part time, casual or voluntary) were combined to provide a measure of engagement in meaningful activities. Engagement in meaningful activities are a significant protective factor in adolescent and young adult development. This measure also acknowledged that some young people might be more engaged in education or workplace activities and that both tend to predispose young people to better outcomes.

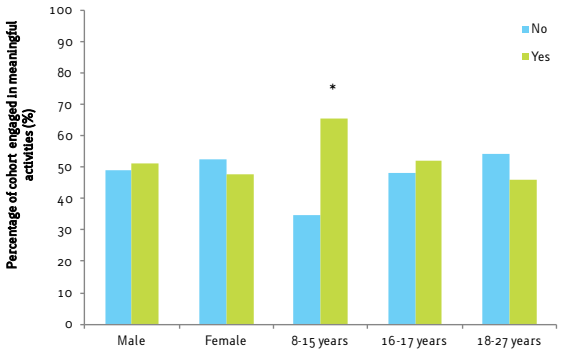

Figure 9.1: Meaningful activity engagement rates by gender and age category.

Note that * denotes significant difference in x2 test at p=.05.

The most notably result from Figure 9.1 is that the youngest cohort of people were also the most likely to be engaged in meaningful activity. This is most likely to be schooling as younger adolescents and children are required to attend schooling. The data show the significant drop off as young people reach 16 to 17 years old and beyond, with the older category showing a reversal where more people are disengaged from meaningful activities. This highlights a risk for social drift to accompany a lack of continuing education and employment.

Meaningful activity in specific populations

Data for the three specific populations were assessed against the meaningful activity criteria. The results of this analysis are highlighted in Figure 9.2.

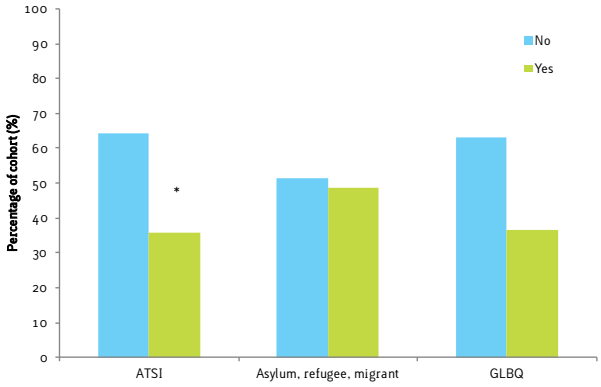

Figure 9.2. Meaningful Activity Engagement for Young People in Specific Populations.

Note that * denotes significant difference in $\chi 2$ test at $p=.05$.

The data on specific populations demonstrates that significantly more ATSI young people are disengaged from meaningful activity. The GLBQ population was small, hence effects were not statistically significant but also showed greater disengagement than engagement from meaningful activities.

10. HOUSING

BACKGROUND

Maslow's hierarchy of needs states that if a person is able to satisfy their need for shelter, warmth, food and security, their higher level needs such as personal development and meaningful relationships are able to be addressed (Maslow, 1987). Feeling safe and having food and shelter are the basic needs that a human must have to enable them to try to strive for more.

Youth Workers often find that young people who have unstable housing, those living in out of home care or those who are homeless tend to have more chaotic lives and choose to participate in risk-taking behaviours such as substance use. It is often seen that young people who come from single-parent homes, dysfunctional homes, and / or homes in which there is abuse or substance use may experience a significant disruption to their psychological, and at times physical, development.

When a young person is exposed to large communities of people who are not in work, working for minimum wages, and struggling to access education and health care, there tends to be a flow on effect within these communities. This flow on effect can be detrimental to a young person's emotional and behaviour learning outcomes. Youth workers see many young people from migrant and/ or refugee communities struggling with many of these issues. Homes in which young people feel safe, are well fed, have a caregiver who is living with them and to whom they are able to develop a healthy attachment are all protective housing factors that help meet psycho-social needs and foster resilience.

Needs and services provided: Past and present

Youth workers were asked to report if their clients had a current problem with housing and if their client was currently receiving a service based on this issue. Workers were also asked if their clients had this issue and/or service for a housing issue in the past. Figure 10.1 provides the breakdown of housing needs and services received.

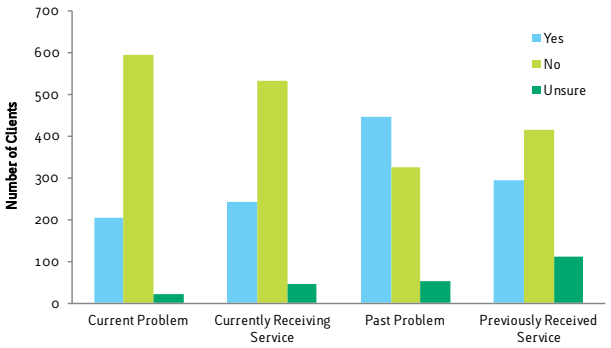

Figure 10.1. Housing Needs and Services Received for Young People.

Figure 10.1 highlights that a number of young people had housing issues in their past with fewer experiencing current housing issues in the four weeks leading up to the census. Further, the differential between needs and services provided are smaller leading up to the census than in the past, indicating efforts of services to remediate young people's housing issues.

Accommodation Types

Type of accommodation for the cohort was recorded and highlighted in table 10.1. This data highlights that most of the young people lived at home with parents, other family, or in private residence alone or with others (74%). The remaining young people's accommodation was distributed amongst a variety of settings.

Table 10.1: Accommodation dispositions for young people

Living arrangements over last 4 weeks	Yes	%
Parents in private residence	393	47.8
Other family members in private residence	93	11.3
With others or alone in private residence	123	14.9
Out of home care-Kinship Foster care	4	0.5
Out of home care-Non-Kinship Foster care	4	0.5
Out of home care-Residential unit	38	4.6
Couch Surfing	62	7.5
Caravan Park	8	1.0
Boarding house or private hostel	8	1.0
AOD treatment service	23	2.8
Institutional setting	4	0.5
Prison, remand centre, youth training centre	15	1.8
Short term crisis, emergency or transitional housing	51	6.2
Supported accommodation	51	6.2
Public place, temporary shelter, homeless	13	1.6
Other	20	2.4

Secure and Insecure Housing

Accommodation options were broken down into secure (living with parents, living with family, living alone or with others in private accommodation, in out of home care [OoHC] kinship care, non-kinship care, and residential care) and unsecure (all other accommodation) housing. The results of this breakdown in terms of gender, age and specific groups under investigation are presented in figure 10.2.

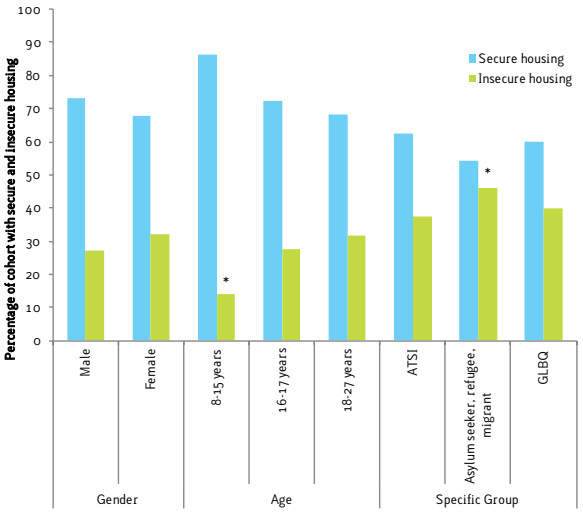

Figure 10.2. Young People in Secure and Unsecure Housing across Gender, Age and Specific Groups.

Note * denotes significant difference using χ2 at p=.05.

The cohort of young people least likely to be in secure accommodation were those from an asylum seeker, refugee, or migrant background. This group may be particularly vulnerable as there may be fewer established social and support networks for those newer to Australia than those who have generational roots in the country. For workers assisting this group of young people, housing may prove to be an area of particular need, and focus.

Housing disposition by age

The results of the secure and unsecure housing based on ages showed that younger individuals were the most likely to be in secure housing overall, a positive trend when considering the increasing emphasis on early intervention in youth AOD. The full housing by age data are presented in figure 10.3.

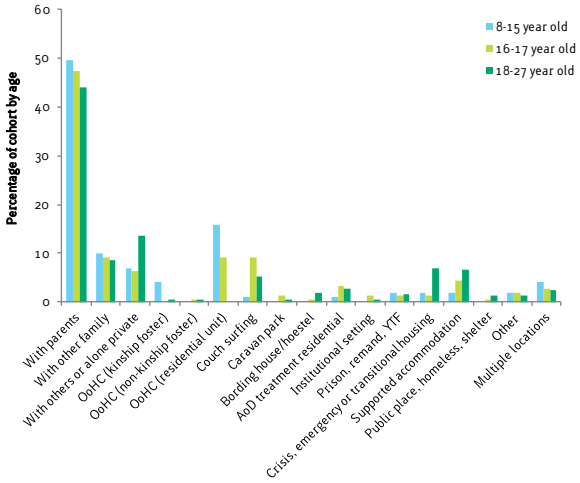

Figure 10.3. Disposition of Accommodation for Young People Based on Age Category.

The further analysis of age data highlights that the increased likelihood for younger people (8-15 years) to be in secure housing relates to a greater likelihood of living with parents (as would be expected), other family, and in residential out of home care settings. It is notable that a number of young people between 8-15 years are living in independent accommodation with or without others in private accommodation.

CONCLUSIONS AND FUTURE DIRECTIONS

The youth needs census highlights the complex psychosocial context that young people utilising youth alcohol and other drug services face that are both precipitating and possibly influenced by substance use behaviours. A number of imperative findings of the census are evident in policy and research domains.

Early intervention

Early intervention should continue to be a priority in service development as there is a progression from cannabis and alcohol to more impactful substances. There is also evidence that at earlier ages schooling and employment opportunities have not yet dropped off and these factors are considered seminal in reducing the long term psychosocial impacts of substance use. When coupled with evidence that there are neuropsychological as well as structural and functional changes in the brain of young people who use substances, it is clear that primary prevention and then early intervention are imperative.

Specific groups have specific needs.

Not all young people share the same needs and just as those with more casual substance use differ from those with more chronic concerns, many other vulnerabilities and relative strengths exist between members of this cohort.

- The psychosocial burden of substance use on women is greater than men on many measures and their increased risk of violence and childhood sexual abuse.
- Young men are at a greater risk of assault and physical abuse backgrounds.
- Those from a GLBQ background have significantly greater risks of mental health issues, suicide and non-suicidal self-injury than other young people
- Those from an ATSI community showed greater difficulties engaging with education and employment.

Cannabis is the most common substance used, used frequently and of concern

The majority of young people engaged with youth AOD services have cannabis as the primary substance of concern. While a portion of substance users engage in polysubstance use, most do not. Cannabis use was most often considered to be of moderate or high severity. Cannabis use increases in frequency across age with younger teens having the lowest amount of use (albeit the highest of any substance). This increases for those in late adolescence with a strong peak in young adults. This highlights the ideal opportunity for intervention for cannabis as the most common illicit substance used is early adolescence, further reinforcing the need for early intervention.

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APPENDIX A.

PAPER VERSION OF THE 2016 YOUTH NEEDS CENSUS (V2)

Introduction

Organisations across Victoria and Queensland are participating in a Youth Needs Census looking at the characteristics and treatment needs of young people in these states. The research is led by YSAS in Victoria and Dovetail in Queensland with the support of the Queensland Department of Health. We are asking each worker to complete one survey per client. Thank you for participating in this important exercise. If you have any questions, please do not hesitate to contact...

Section 1: Background Information

This section asks you questions about the background of yourself and your client

Q1. Your initials

Q2. Your client's postcode

Q3. What is your client's year of birth

Q4. What is your client's gender?

- ☐ Male (1)
- ☐ Female (2)
- ☐ Transgender or intersex (3)

Q5. Does your client identify as (or are) a member of any of the following populations?

- ☐ Aboriginal or Torres Strait Islander (1)
- ☐ Asylum seeker, Refugee or Migrant (2)
- ☐ Gay, Lesbian, Bisexual or Queer (3)
- ☐ Specific cultural group/ ethnicity (other than Caucasian/White/Australian) (4)

Answer If Does your client identify (or are) as a member of any of the following populations? Aboriginal or Torres Strait Islander Is Selected

Q6. What is the ATSIC status of your client?

- ☐ Identifies as Aboriginal (1)
- ☐ Identifies as Torres Strait Islander (2)
- ☐ Identifies as both Aboriginal and Torres Strait Islander (3)

Answer If Does your client identify (or are) as a member of any of the following populations? Asylum seeker, Refugee or Migrant Is Selected

Q7. What is the asylum seeker/ refugee/ migrant status of your client?

- ☐ Asylum seeker (has not yet obtained refugee status) (1)
- ☐ Refugee (2)
- ☐ Migrant (moved to Australia during own life) (3)

Answer If Does your client identify (or are) as a member of any of the following populations? Gay, Lesbian, Bisexual or Queer Is Selected

Q8. What is the GLBQ status of your client?

- ☐ Gay (1)
- ☐ Lesbian (2)
- ☐ Bisexual, pansexual (3)
- ☐ Queer (not yet defined but does not identify as heterosexual) (4)

Answer If Does your client identify (or are) as a member of any of the following populations? Specific cultural group/ ethnicity (other than Caucasian/White/Australian) Is Selected

Q9. What is the cultural background/ethnicity (country) of your client?

Section 2: Treatment

This section asks you questions about your client's treatment

Q10. What programs does this young person participate in within your service?

	Primary program/s used (1)	Secondary program/s used (2)
Outreach (1)	☐	☐
Counselling (2)	☐	☐
Outpatient Withdrawal (3)	☐	☐
Home-based Withdrawal (4)	☐	☐
Rural Withdrawal (5)	☐	☐
Day Program (6)	☐	☐
Parent Support Program (7)	☐	☐
Residential Withdrawal (8)	☐	☐
AOD Supported Accommmodation (9)	☐	☐
Mental Health Nurse Program (10)	☐	☐
Family Therapy (11)	☐	☐
Other (12)	☐	☐

Q11. Length of current treatment in your organisation (in weeks)

Q12. Is this client a current COATES client?

☐ Yes (1)

☐ No (2)

☐ Unsure (3)

Q13. Is this client participating in a youth AOD program at another/other services?

☐ Yes (1)

☐ No (2)

☐ Unsure (3)

Section 3: Substance Use

This section asks you questions about your client's substance use

Q14. In relation to substance use, this client (please answer each question):

	Yes (1)	No (2)	Unsure (3)
Has a current problem (1)	☐	☐	☐
Has had a problem in the past (2)	☐	☐	☐
Is currently receiving a service focussed on this issue (3)	☐	☐	☐
Has ever received services in the past related to this issue (4)	☐	☐	☐

Q15. In the past 4 weeks, how frequently has your client used any of the following drugs? (please tick all that apply)

	Daily or almost daily (1)	In the last 4 weeks (2)	Please indicate the primary drug of concern (3)
Alcohol (1)	☐	☐	☐
Cannabis (2)	☐	☐	☐
Heroin (3)	☐	☐	☐
Meth/amphetamine (4)	☐	☐	☐
Tobacco products (5)	☐	☐	☐
Prescription drugs - non opiate (e.g. benzos) (6)	☐	☐	☐
Other opiates (e.g. morphine, codeine, buprenorphine, oxycontin) (7)	☐	☐	☐
Inhalants (e.g. nitrous oxide, petrol, solvents, glue) (8)	☐	☐	☐
Ecstasy, MDMA (9)	☐	☐	☐
Hallucinogens (e.g. LSD, mushrooms) (10)	☐	☐	☐
Other. Please state (11)	☐	☐	☐

Q16. From your perspective, is your client DEPENDENT on any of the drugs used in the past four weeks (excluding tobacco)?

- ☐ Yes - client is dependent on at least one drug (1)
- ☐ No (2)
- ☐ Unsure (3)

Answer If From your perspective, is your client DEPENDENT on any of the drugs used in the past four weeks (excluding tobacco)? Yes - client is dependent on at least one drug Is Selected

Q17. Which drug is it?

Q18. From your perspective, please rate your client's overall SEVERITY of substance use (excluding tobacco)

- ☐ No substance use (1)
- ☐ Low (2)
- ☐ Moderate (3)
- ☐ High (4)
- ☐ Severe (5)

Q19. Has your client EVER used any drug by injection (non medical use)?

- ☐ Yes (1)
- ☐ No (2)
- ☐ Don't know (3)

Q20. Has your client experienced serious drug use related harms in the last 3 MONTHS?For example: Required hospital admission or ambulance attendance, suffered injuries or physical harm, driven a vehicle when substance affected, had unwanted sex when substance affected, been a victim or perpetrator of violence.

- ☐ Yes (1)
- ☐ No (2)
- ☐ Unsure (3)

Section 4: Education & Training

This section asks you questions about your client's education and training

Q21. In relation to academic achievement or disconnection from education, this client:

	Yes (1)	No (2)	Unsure (3)
Has a CURRENT problem (1)	☐	☐	☐
Has EVER had a problem with this issue in the past (2)	☐	☐	☐
Is currently receiving a service based on this issue (3)	☐	☐	☐
Has ever received a service based on this issue (4)	☐	☐	☐

Q22. In the past four weeks, has your client attended school, TAFE, University or a training program?

- ☐ Yes (1)
- ☐ No (2)
- ☐ Unsure (3)

Answer If In the past four weeks, has your client attended school, TAFE, University or a training program Yes Is Selected

Q23. This training was at...

- ☐ Secondary school (1)
- ☐ VET (2)
- ☐ University (3)
- ☐ Other training program (4)

Q24. For the past four weeks, please rate your client's level of engagement with education or training

- ☐ Fully engaged (1)
- ☐ Precarious engagement (2)
- ☐ Disengaged (3)
- ☐ Not engaged (this feels like a double up) (4)

Q25. Does your client have any of the following education related difficulties?

- ☐ Expelled from school (1)
- ☐ Suspended from school (2)
- ☐ Disruptive behaviour (no diagnosis) (3)
- ☐ Learning difficulties or disability (4)
- ☐ Dyslexia (5)
- ☐ Autism, Asperger's or Autism Spectrum disorder (6)
- ☐ Attention Deficit disorder (with or without hyperactivity) (7)
- ☐ Developmental delay disorder (8)
- ☐ Intellectual disability (9)
- ☐ Acquired brain injury (10)
- ☐ Other (please specify) (11) _____

Q26. How would you rate this clients level of...

	Excellent (1)	Good (2)	OK (3)	Poor (4)	Can't manage (5)	Unsure (6)
Reading ability (literacy) (1)	☐	☐	☐	☐	☐	☐
Numeracy ability (2)	☐	☐	☐	☐	☐	☐

Section 5: Employment

This section ask you questions regarding your client's employment

Q27. In relation to EMPLOYMENT, this client (please answer all questions)

	Yes (1)	No (2)	Unsure (3)
Has a CURRENT problem (1)	☐	☐	☐
Has EVER had a problem in past (2)	☐	☐	☐
Is CURRENTLY receiving a service focused on this issue (3)	☐	☐	☐
Has EVER received a service focused on this issue (4)	☐	☐	☐

Q28. In the last FOUR weeks, was your client employed (full time, part time or casually)?

☐ Yes (1)

☐ No (2)

☐ Unsure (3)

Answer If In the last FOUR weeks, was your client employed (full time, part time or casually)? Yes Is Selected

Q29. This employment was...

☐ Full time (1)

☐ Part time (2)

☐ Casual (3)

Answer If In the last FOUR weeks, was your client employed (full time, part time or casually)? Yes Is Selected

Q30. For the last 4 weeks, please rate your clients level of engagement with their employment

☐ Fully engaged (1)

☐ Precarious engagement (2)

☐ Disengaged (3)

Section 6: Housing

This section asks you questions regarding the housing of your client

Q31. In relation to HOUSING, this client (please answer each question)

	Yes (1)	No (2)	Unsure (3)
Has a current problem (1)	☐	☐	☐
Has had a problem with housing in the past (2)	☐	☐	☐
Is currently receiving a service focused on this issue (3)	☐	☐	☐
Has ever received a serviced focused on this issue (4)	☐	☐	☐

Q32. In the last 4 weeks, has your client experienced acute housing problems?

- ☐ Yes (1)
- ☐ No (2)
- ☐ Unsure (3)

Q33. Where has this client mostly lived over the last 4 weeks?

- ☐ At home with parents in private residence (private owned or rented, public rental) (1)
- ☐ With other family members in a private residence (private owned or rented, public rental) (2)
- ☐ With other people or alone in a private residence (private owned or rented, public rental) (3)
- ☐ Out of home care- Kinship Foster Care (4)
- ☐ Out of home care- Non-kinship foster care (5)
- ☐ Out of home care- Residential unit (6)
- ☐ "Couch Surfing" (staying with others on short term, temporary basis) (7)
- ☐ Caravan Park (8)
- ☐ Boarding house or private hostel (9)
- ☐ Alcohol and Other Drug Treatment Service (10)
- ☐ Institutional setting (includes pscyhiatric mental health settings) (11)
- ☐ Prison, remand centre, youth training centre (12)
- ☐ Short term crisis, emergency or transitional housing (13)
- ☐ Supported accommodation (14)
- ☐ Public place, temporary shelter, homeless (15)
- ☐ Other (16) _____

Section 7: Family Issues

This section asks you questions regarding your client's family issues

Q34. In relation to FAMILY RELATIONSHIPS, this client (please answer all questions);

	Yes (1)	No (2)	Unsure (3)
Has a current problem (1)	☐	☐	☐
Has ever had a problem with this in the past (2)	☐	☐	☐
Is currently receiving a service focused on this issue (3)	☐	☐	☐
Has ever received services in the past focused on this issue (4)	☐	☐	☐

Q35. In the past 4 weeks, has your client had conflict with their family or relatives?

- ☐ Yes (1)
- ☐ No (2)
- ☐ Unsure (3)

Q36. Is your client currently disconnected from their family?

- ☐ Yes (1)
- ☐ No (2)
- ☐ Unsure (3)

Q37. Does your client have a trusted adult outside their immediate family that he or she can go to for help?

- ☐ Yes (1)
- ☐ No (2)
- ☐ Unsure (3)

Answer If Does your client have a trusted adult outside their immediate family that he or she can go to for help? Yes Is Selected

Q38. Is this trusted adult you (the young person's worker)?

- ☐ Yes (1)
- ☐ No (2)
- ☐ Both myself and at least one other trusted adult (3)

Q39. Is/has your client involved in child protection

	Yes (1)	No (2)	Unsure (3)
CURRENTLY (1)	☐	☐	☐
EVER (2)	☐	☐	☐

Q40. Is your client...

	Yes (1)	No (2)	Unsure (3)
A parent (1)	☐	☐	☐
A parent of a child under a child protection order (2)	☐	☐	☐
Residing with children most of the time (3)	☐	☐	☐

Section 8: Mental Health

This section asks you questions about the mental health of your client

Q41. In relation to MENTAL HEALTH, this client (please answer all of the questions)

	Yes (1)	No (2)	Unsure (3)
Has a current problem (1)	☐	☐	☐
Has had a problem with this issue in the past (2)	☐	☐	☐
Is currently using a service focused on this issue (3)	☐	☐	☐
Has ever received services in the past focused on this issue (4)	☐	☐	☐

Q42. Does your client have a CURRENT formal diagnosis of a mental health condition?

☐ Yes (1)

☐ No (2)

☐ Unsure (3)

Answer If Does your client hasve a CURRENT formal diagnosis of a mental health condition? Yes Is Selected

Q43. Please list CURRENT diagnoses you are aware of

Q44. Has your client EVER intentionally...

	Yes (1)	No (2)	Unsure (3)
Injured themself in past (1)	☐	☐	☐
Attempted suicide in past (2)	☐	☐	☐

Answer If Has your client EVER intentionally... attempted suicide in past - Yes Is Selected

Q45. If this client has attempted suicide in the past did they...

	Yes (1)	No (2)	Unsure (3)
Require medical attention (1)	☐	☐	☐
Disclose the attempt at the time it occurred (2)	☐	☐	☐

Answer If Has your client EVER intentionally... attempted suicide in past - Yes Is Selected

Q46. If you know, please state how this young person attempted suicide (or multiple attempts)

Q47. In the last 4 weeks, has your client been a victim of abuse or neglect?

	Yes (1)	No (2)	Unsure (3)
Neglect (1)	☐	☐	☐
Emotional abuse (2)	☐	☐	☐
Physical abuse (3)	☐	☐	☐
Sexual abuse (4)	☐	☐	☐
Violent crime (5)	☐	☐	☐

Q48. Has your client EVER been a victim of abuse or neglect?

	Yes (1)	No (2)	Unsure (3)
Neglect (1)	☐	☐	☐
Emotional abuse (2)	☐	☐	☐
Physical abuse (3)	☐	☐	☐
Sexual abuse (4)	☐	☐	☐
Violent crime (5)	☐	☐	☐

Q49. Has your client EVER reported experiencing family violence?

	Yes (1)	No (2)	Unsure (3)
Yes- as victim of family violence (1)	☐	☐	☐
Yes- as witness of family violence (2)	☐	☐	☐
Yes-as instigator of family violence (3)	☐	☐	☐

Section 9: Australian Treatment Outcome Profile (ATOP)

The following questions are about your client's physical and mental health and overall quality of life. Please tick the response that best describes your client where 0 is the worst, 10 is the best and 5 is feeling average.

Q50. How would you rate your client's....

	0 (1)	1 (2)	2 (3)	3 (4)	4 (5)	5 (6)	6 (7)	7 (8)	8 (9)	9 (10)	10 (11)
Psychological health status in the past 4 weeks (e.g. anxiety, depression and problem emotions and feelings) (1)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Physical health status in the past 4 weeks (e.g. extent of physical symptoms and bothered by illness) (2)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Overall quality of life in the past 4 weeks (e.g. able to enjoy life, gets on well with family and partner etc) (3)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Section 10: Justice and Crime

This section asks you questions about the criminal history of your client

Q51. In relation to CRIMINAL OFFENDING (excluding drug use), this client (please answer each question):

	Yes (1)	No (2)	Unsure (3)
Has a current problem (1)			
Has ever had a problem with this issue in the past (2)			
Is currently receiving a service focused on this issue (3)			
Has ever received a service in the past focused on this issue (4)			

Q52. Apart from illegal substance use, has your client...

	Yes (1)	No (2)	Unsure (3)
Been involved in criminal activity in the past 4 weeks (1)			
Been involved in the criminal justice system in the past 4 weeks (2)			
Ever been involved in the criminal justice system (3)			

Q53. VulnerabilityFrom your perspective, please rate your client's overall level of vulnerability

- ☐ Not vulnerable (1)
- ☐ Low (2)
- ☐ Moderate (3)
- ☐ High (4)
- ☐ Severe (5)

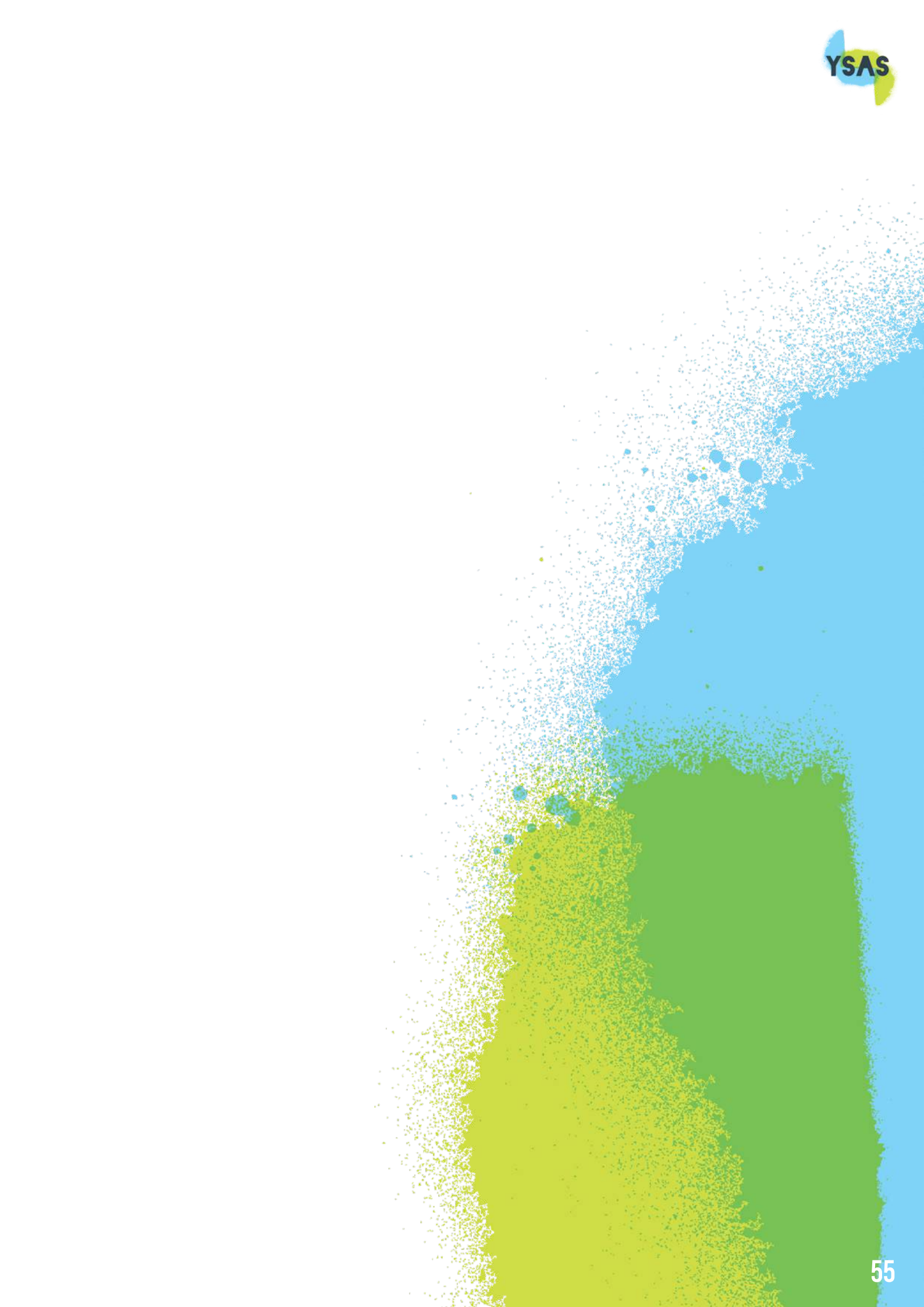
Q54. Which of the following words would you use to describe this young person overall? (tick all that apply)

- ☐ Self sufficient (1)
- ☐ Hopeful (2)
- ☐ Flexible (3)
- ☐ Strong (4)
- ☐ Adaptable (5)
- ☐ Compassionate (6)
- ☐ Resourceful (7)
- ☐ Resilient (8)
- ☐ Responsible (9)
- ☐ Caring/kind (10)
- ☐ Confident (11)
- ☐ Authentic (12)
- ☐ Motivated (13)
- ☐ Loyal (14)

- ☐ Positive (15)
- ☐ Humerous (16)
- ☐ Dynamic (17)
- ☐ Honest (18)
- ☐ Creative (19)
- ☐ Empathic (20)
- ☐ Brave (21)

Q55. You have just completed this survey for this young person born on ${q://QID4/ChoiceTextEntryValue}. If you need to provide any comments for the administrators, please type this in the box below

Q56. Thank you for your time in providing this valuable feedback! It will inform our planning and responsiveness to young people's needs. If you would like to go in the draw to receive 1 of 20 $50 Coles/Myer vouchers, please provide your email address in the box provided.



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CONTACT INFORMATION

YSAS Reception:
Ph. 03 9415 8881
Email: reception@ysas.org.au
www.ysas.org.au