Integrated responses for vulnerable young people

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The transition from childhood and adolescence to adulthood is a crucial period for establishing positive health and social behaviours for young people [5]. They experience social and emotional changes including finding their own identity, becoming independent and looking for new experiences, including those that involve risk-taking [15]. Many factors can influence a young person's development during this time, including family and peer relationships, physical and mental health – including any experience of trauma – and the environment in which they live [1]. Social, economic, environmental and technological changes over recent decades mean that young people face a different future than previous generations [2], and access to drugs and patterns of use have changed across generations [21].

Aly and Omran et. al. (2020) suggest that knowledge of these factors is important in order to understand the pathways of engagement in high-risk behaviours, such as harmful use of alcohol and other drugs (AOD) [1]. The presence of risk factors and the absence of protective factors may affect susceptibility. Replacing risk factors with positive and protective influences strengthens connections in the brain that form the building blocks of self-regulation, impulse control and executive functioning – the ability to pay attention, organise and plan everyday tasks and regulate emotions [1]. Identifying the positive and protective influences that may buffer risks for young people is complex, however there is growing evidence that connectedness to school, bonding with family, and parental support or positive relationships with caring adults within or outside the family and supportive peers may reduce distress and coping difficulties that lead to substance use [12][10].

This consultation paper addresses how young people might be vulnerable to high-risk behaviours, with specific reference to use of harmful substances such as inhalants. The term 'substance use' refers here to risk-taking behaviours involving substances that result in intoxication and euphoria. Without excluding AOD, this paper references cannabis and inhalants as they are more often used by younger people [37][28] and are more readily available [27]. Cannabis use, even at low levels, has been associated with poorer outcomes across measures including depression/anxiety, school completion, income, employment and alcohol use in later life. Intervention strategies to prevent or delay uptake are highly recommended in early adolescence [52][60][36].

According to the Australian *National Drug Strategy Household survey*, the use of inhalants has increased over the past three years [8]. The recognition that substance use can be a response to untreated trauma and underlying psychological conditions is gaining momentum. Established population strategies for preventing substance use in young people may not address the key issues for groups with the highest risk [12][17].

Vulnerable young people

According to the Australian Institute of Family Studies (2017), it is estimated perhaps five- to 10 per cent of the Australian population have been subject to physical abuse in childhood [2]. In Queensland for 2018-2019, 12,147

children were on care and protection orders and over 10 000 children were in out of home care. [5]. The impact of trauma and neglect on child development, and the effects of issues such as mental illness, alcohol and drug use, behavioural concerns, parenting capacity, and domestic and family violence [13] are evident in child protection and youth justice settings. Families experiencing a high degree of vulnerability face barriers in accessing services and may need a 'soft entry' (low threshold) proactive outreach approach. These families often require case management across multiple care providers and stakeholders, and adequate funding for these specific targeted interventions or comprehensive community responses is often lacking [37].

Some young people face additional challenges in the transition to adulthood [46][38][2][22][28]. A 2019 Youth Needs Census on Substance Use in Queensland found just over 40 per cent of those accessing AOD services identified as Aboriginal and Torres Strait Islander, six per cent identified as being from a culturally and linguistically diverse (CALD) background and five per cent identified as lesbian, gay, bisexual, transgender, intersex and/or queer (LGBTIQ). Cannabis use was most common among these groups [29].

Early-childhood trauma and underlying mental health conditions are emerging as potential predictors of high-risk behaviours and can be linked to substance use and mental health problems later in life [12]. The Canadian Centre on Substance Abuse identified that First Nations people could face challenges responding to trauma, particularly due to experiences of grief and loss; exposure to physical and/or sexual abuse and other types of violence; stigma and racism; and underlying risks of psychological disorders and increased risk of victimisation. Young people may use substances as a method of managing such experiences, the physiological effects of chronic stress, and psychological outcomes of untreated trauma [12].

In terms of young people and potential harm, it is appropriate to focus on the immediate and long-term health effects of substance use for the individual. There are also flow-on effects of substance use and co-occurring psychological distress for families, communities, and emergency and health services. A 2016 report noted that the most common cause of injury/poisoning hospitalisation for females aged 15-24 was intentional self-harm [3]. Despite decreasing overall rates of injury admissions for people aged 13-17 in Western Australia, alcohol-related injuries increased significantly from 1990 to 2009 and violence-related harm increased for both males and females in that age group [44]. People under 15 were over-represented in ambulance attendances for inhalant use in Victoria, and there was a strong association with self-injury and aggressive behaviours for this age group with increasing ambulance attendances [18]. For Indigenous people aged 15-19, reasons for hospitalisation included mental health and behavioural disorders, suicide and self-inflicted injuries for males, and anxiety disorders for females [21]. Effective early intervention and prevention strategies reduce the resource requirements to respond to and support young people, including families, communities, police, and emergency and health services [14].

According to *Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2037*, one in three young Aboriginal and Torres Strait Islanders in Queensland experiences high or very high psychological distress [2] and is 8.5 times more likely than non-Indigenous children to be placed in out-of-home care.

Foetal alcohol spectrum disorder (FASD), an acquired brain injury as a result of prenatal alcohol exposure, affects the growth and development of the brain and/or central nervous systems, resulting in one or more developmental deficiencies [53]. A 2019 report of research into the prevalence of FASD among young people in youth detention in Western Australia found that 89 per cent had at least one area of severe impairment and 36 per cent were diagnosed with FASD, often not identified or diagnosed prior to detention [13]. A 2016 study identified that out-of-home care was associated with both higher inhalant use (lifetime and 30-day) and alcohol use (lifetime), with significant indirect effects of physical abuse on early substance use [34]. There is a need for greater understanding of the interplay between substance use in young people and other conditions such as FASD, mental illness, attention deficit disorder, attention deficit hyperactivity disorder, the effects of the social environment, and the role of victimisation [12].

In 2016–17, available data on the disability status of children in out-of-home care showed 15 per cent were reported as having a disability [7]. Studies have shown people with all forms of disabilities are disproportionally more likely to use substances and less likely to access care [53], and are often underrepresented in treatment programs [26].

Without coordinated care, vulnerable young people can fall through the cracks when transitioning across services. It is important to ensure integrated care for young people as they turn 18 and move between child and adult mental health and/or AOD services [9][39][46].

In a 2020 study, young people identifying as LGBTIQ reported high levels of family disfunction, physical and sexual abuse and accumulated trauma relative to a similar non-LGBTIQ group. Members of the LGBTIQ group demonstrated higher levels of substance use and greater non-suicidal self-harm. They also reported poorer quality of life and psychological health and were more likely to report a history of mental illness, indicating a need for more support for these young people at risk [58]. For young people identifying at LGBTIQ, it is the immediate and cumulative effects of discrimination, bullying, social rejection and familial relationship difficulties that increase vulnerability rather than sexuality or gender status being an isolated cause of the increased vulnerability [29][58].

Prevalence and patterns of use

Inhalant use is reported in every region of the world. Rates of use in some parts of Australia are second only to cannabis [38]. While significant numbers of young people across Australia may experiment with inhalant products, few go on to become regular or chronic users. Those who do are generally among the most disadvantaged and marginalised members of the community [5].

The links between childhood trauma, harmful alcohol and other drug use, offending behaviour, and education disengagement is established in evidence and in practice-based wisdom [32]. Practitioners responding to a review of interventions for substance use in Queensland reported linkages between inhalant use and grief, trauma (often inter-generational trauma), dislocation from family, and abuse [32]. This aligns with emerging evidence [12]. Young people in need of care and protection who are engaged in high-risk behaviours tend to be experiencing a range of underlying vulnerabilities [13]. *National Directions on Inhalant Use* (2006) identified inhalant users as over-represented across mental health, juvenile justice and protective service systems [41].

Inhalant use involves the deliberate breathing of the gas or fumes released from a solvent at room temperature for the purpose of intoxication [14]. The use of inhalants is mostly initiated during adolescence and is associated with diverse physical and psychological harms [19]. In the same way that people use AOD, people experiment with inhalants because they are curious or they enjoy the pleasant and euphoric feelings they produce [14][32].

In Australia, more than 250 products have been identified as potentially containing substances that, when inhaled, generate an intoxicated state [14]. Critically, these substances are the most readily available and affordable methods of intoxication [28]. They are available in retail outlets and in homes and are used for their intended purposes regularly by the broader population. They include household adhesives such as glues, solvents such as petrol, toxic markers, paint thinner, lighter fluid, cleaning agents, and aerosols such as spray paint, hair spray, air freshener and deodorant [14].

These readily-accessible products and their use as inhalants can easily be hidden where caregivers, parents and professionals may not have the knowledge and confidence to recognise and respond to symptoms of use [50]. Conversely, inhalant use can be obvious where young people are intoxicated in public spaces, committing property crime and acting violently and anti-socially. In remote communities, inhalant use can cause intense disruption to families and can increase friction, causing a significant impact on the wider community [38]. Opportunities for early intervention can be missed by services and agencies such as police and health care workers in the absence of the knowledge and experience to best respond [50][14].

Legislative frameworks across Australia vary widely in terms of AOD and inhalants. The use of alcohol in Australia is societally acceptable, although there are age restrictions on purchase and supply. Cannabis and other drugs are restricted, but it is not illegal to use inhalants. In Queensland, it is against the law for a retailer to sell a harmful product to a person if they know or believe on reasonable grounds that the person may use that product to inhale or ingest or to sell on to someone else for the purposes of inhalation or ingestion. It is also against the law to sell

spray paint to anyone under 18 [23][48]. Police in declared localities across Queensland may take a person affected by inhalants to a place of safety [49].

The *Youth Needs Census Queensland* (2019) identified alcohol, cannabis, tobacco and inhalants as the most-used substances among people aged from 12 to 25, with socio-economic status influencing access to substances. People working with young people who use inhalants describe a cycle moving across and within communities and localities, with the types of substances used and methods of use changing over time. Early intervention for young people and their communities includes a rapid, informed response toward reducing supply and harm, incorporating education and community response and support (per comm, 2019) [14]. Responding to inhalant use in communities benefits young people by reducing harm, limiting similar behaviours among peers and reducing the need for intervention by police and emergency services [14][20].

While the numbers of young people engaging in inhalants use may be small relative to the broader population, the resources needed to support them are intensive [32]. The cost of not intervening across the three pillars of demand reduction, harm reduction and supply reduction is also high. Petrol sniffing across Central Australia was estimated to have cost nearly $80 million in 2005, in a study that incorporated costs due to burden of disease, crime and justice processes, loss of productivity, health care, long-term care and rehabilitation [38]. A United Kingdom report identified the high cost of inhalant use across a relatively small proportion of the population as equivalent to $632 million a year [50].

Key themes for early intervention and prevention

There is a body of evidence contributing to available knowledge on community-based approaches to substance use in Queensland and nationally [38]. Building on this evidence base through evaluation and research is critical for effective programs targeting vulnerable young people [38][50].

A report on the social impact of inhalant use has identified that no one organisation or department can address substance use and a responsive ecosystem is needed to work holistically on the problem as described in Figure [50] *(adapted)*.

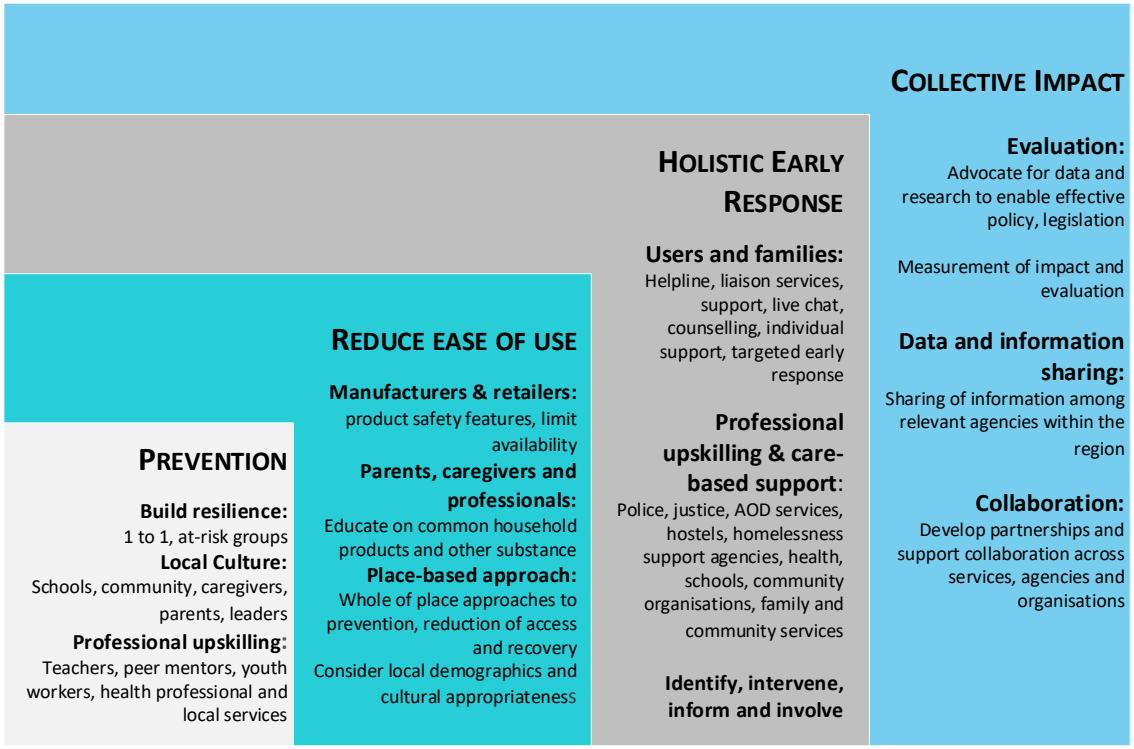

Figure 1 - Reducing the impact of inhalants

Key themes identified as important for early intervention and prevention strategies for substance use in young people include:

- The need to build the knowledge, capacity and awareness of people working with or coming into contact with young people, including retailers, parents and caregivers, teachers, youth workers, health professionals, allied professionals and police [50][12][41][56][25]. This extends beyond inhalants and AOD to include appropriate information on co-occurring trauma and mental health issues for vulnerable youth.
- Bringing together multiple services and agencies to provide wrap-around continuous care for vulnerable young people, including partnerships between both government and non-government agencies in areas such as education, treatment and services, primary health care, justice, child protection, social welfare, financial policy, trade, consumer policy, road safety and employment [50].
- Forming functional and effective partnerships with researchers, families and communities, peer educators, drug user organisations, Aboriginal and Torres Strait Islander communities, Aboriginal community-controlled health organisations and other groups [22][14]. Critical to partnerships and collaboration is the existence of, alignment and interoperability of agency policies and protocols to guide programs and responses [14][50].
- Providing the opportunity for young people to have an influence on what happens to them, especially in care, is important in terms of wellbeing and self-efficacy [31]. A strong sense of belonging reflects positively in adolescents' motivation, participation and ability to relate to their environment [31][43]. Youth (and family) participation and co-design at all levels, enabling youth-friendly, stigma-free cultures of care providing what young people and their families really need is important [39].
- Young people and people with lived experience should be involved in the planning, implementation and evaluation of programs [22][30]. Aspects to be considered include tailoring programs to gender and age groups, considering the influence of positive parenting and parental substance use on lifetime substance use risks [57], the need for culturally relevant interventions that help heal from trauma, build resilience and respond in healthy ways to stress and distress and staying connected with protective support resources in young people's lives [35][18][19][12].
- Key elements of effective programs preventing substance use in Indigenous adolescents across four countries have been identified as community involvement, cultural knowledge enhancement and the development of skills and education [56]. Access to appropriate, culturally validated and recommended assessment tools, including measuring outcomes for young people, is important when considering integrated responses [14][38].
- Investment in program evaluations that use alternate research designs to strengthen the evidence base of what works to prevent substance use, especially for vulnerable groups [56][25]. In South Australia, the fragmentation between mental health and AOD services for refugee youth, the stigma involved in accessing services, and a westernised therapeutic approach were barriers for CALD and refugee youth. Researchers suggested the services identified could potentially be adapted in a more flexible and culturally appropriate way.
- Finally, the organisation delivering integrated early intervention and preventative programs to young people may be an important part of the effectiveness and outcomes of that program [12]. The ability to be flexible in delivery and integrating services within established youth-centred organisations are aspects to be considered. The South Australian study found significant differences between government and non-government organisations to meet the needs of these vulnerable groups. Non-government organisations were shown to have more flexibility in delivery, improved staff training, and the availability of cultural liaison staff [47].

Integrated, effective responses

Inhalants directly depress the central nervous system, which controls most of the functions of the body and mind, with a rapid onset of intoxication. While inhalant use is a maladaptive coping strategy, it can play a functional role in how the nervous system processes and responds to sensory information and emotional regulation [32]. For community- based interventions to be effective, support from government agencies, community-controlled services and other local stakeholders is required [32]. Research has identified risks in providing young people services that are specific to inhalant use, suggesting that providing programs in public spaces to young people using inhalants can inadvertently contribute to the problem. Current advice is that great care needs to be taken when developing strategies and interventions that are not evaluated. Overly punitive responses can result in young people hiding and using inhalants in more dangerous places. Sudden sniffing death can occur when young people undertake physical exertion such as when they are startled and run. Education programs using shock tactics and sensationalist media reports have been shown to be ineffective and can inadvertently increase intentions to use substances or can show young people what to do [24]. Developmentally appropriate schools' programs based on evidence and facts have been effective in raising awareness and engaging young people in education on the potential social, psychological and physical harms of substance use.

Effective responses to inhalants and other drug use require coordination, with shared case management involving a range of stakeholders. This requires timely sharing of information, regularly updated case plans, and an ability to share information appropriately with all stakeholders [21]. Responses must align with the pillars of supply reduction, demand reduction and harm reduction. Coordinating service delivery responses to inhalants requires ongoing collaboration between stakeholders including youth AOD services, youth justice services, child safety services, residential care providers, QPS, Indigenous health services and other stakeholders [21]. Coordinated youth panels such as coordinated care for vulnerable young people (CCYP) are an effective mechanism by which this coordination can occur. Models of coordinated care panels allow for the development of a shared framework that directs decision making based on harm reduction and other shared approaches that lead to demonstrable outcomes [44]. Such models provide an opportunity for different disciplines and departments to share practice-based evidence and evidence-based practice, integrated with the specific needs of the young person.

Demand for youth treatment programs is increasing, and young people are a high need/priority population group in the *National Drug Strategy 2017-2026* and many state plans. There are gaps in services for families and women with children and discrete services for young people with multiple concerns, and there is a need for a holistic cross-agency approach between services for AOD, mental health, and justice. Demand for alcohol and other drug treatment far outweighs availability, with services unable to accept between 26 and 48 per cent of people seeking treatment. [51].

Meeting the needs of vulnerable young people involves addressing underlying disadvantage such as the access to food, shelter, youth work support and meaningful activity [33]. Evidence suggests benefits in adopting regional approaches that complement existing service provision and promote community capacity [20]. A place-based approach in regional areas supports the multi-agency and community involvement/collaboration that provides effective integrated responses, opportunities for early intervention, and coordinated care for young people.

Terminology

- AOD: Alcohol and other drugs
- CALD: Culturally and linguistically diverse
- LGBTIQ: lesbian, gay, bisexual, transgender, intersex and/or queer
- FASD: foetal alcohol spectrum disorder
- AIHW: Australian Institute of Health and Welfare
- CCYP: Coordinated care for vulnerable young people
- QPS: Queensland Police Service

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