



A REVIEW OF EVIDENCE-BASED ALCOHOL AND OTHER DRUG (AOD) INTERVENTIONS SUITABLE FOR YOUNG PEOPLE IN A COMMUNITY SETTING

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Introduction

Coordinaire commissioned Lives Lived Well to complete a literature review that identifies evidence-based youth alcohol and other drug (AOD) interventions suitable for community settings. The literature review forms part of a larger project on models of youth AOD services. This report reviewed existing peer-reviewed and grey literature to examine models, and elements of, youth AOD services. It examined existing evidence for youth AOD services, as well as the headspace model of delivery of AOD services. The review does not include residential youth AOD service delivery.

Alcohol and other drugs (AOD) services for young people is an area that is still developing as is the evidence to support what works for young people. This report explores AOD service provision, settings for service delivery, outcomes, key elements of service delivery, infrastructure required for service provision, AOD workforce, and needs of specific population groups.

Young People

Adolescence is an important developmental stage and involves significant changes -physically, psychologically, emotionally, and socially. As young people transition through this stage to becoming independent adults, they ideally come to understand their identity, values, interests and relationships (Ellis & Australia 2010, p. 2).

Definition of young people

There are no universally accepted definitions of youth and young people. The definition changes in different circumstances and in different settings. The United Nations defines adolescents as persons aged 10-19 years, young people as persons aged 10 – 24 years, and youth as those between 15-24 years (UNDESA n.d). The Australian National Drug Strategy defines young people as 10 – 24 years of age (Department of Health 2017, p. 27) and the 2010 National Strategy for Young Australians defines young people as 12 to 24 years of age (Ellis & Australia 2010). Similarly, youth focused services like headspace define young people as 12 – 25-years-old. There is no consistent client age group for youth drug and alcohol services across NSW, however 12 to 25 years of age is the median age range (NADA, 2017). In this report we define young people as 12 to 25 years of age.

Young people's alcohol and drug use

Young people are a diverse group and similarly their substance use is on a spectrum. Adolescence is a time of transition as young people form their identify, values and



purpose and part of this process is experimentation (Tran & Bhar 2014). While daily alcohol and drug (AOD) use for young people is rare, a fifth to a quarter of young people engage in a risky level of substance use (NSW Ministry of Health 2014, p. 8).

Young people who experience problematic AOD use are often also experiencing other psychosocial problems, including mental illness, involvement with the justice system, homelessness, trauma, family disruption and limited opportunities in education and work (Mitchell 2012).

The National Drug Strategy Household Survey (NDSHS) 2016 records age groups as 12 - 17 years and 18 - 24 years. The NDSHS recording the following use of alcohol and illicit substance for young people:

- In 2016, 8.8% of young people aged 12-17 and 28.2% of people aged 18-24 engaged in recent¹ use of illicit substances² (AIWH 2017a)
- In 2016, 18.8% of people aged 12-17 and 81.4% of people aged 18-24 engaged in recent³ use of alcohol (AIWH 2017b)
- In 2016, 1.3% of people aged 12-17 and 18.5% of people aged 18-24 had lifetime risk⁴ of alcohol related harm (AIWH 2017b)

The number of young people with AOD problems is relatively low. However, problematic or risky AOD use is likely to be related to a range of other life challenges.

Age and type of drug influence young people's use of AOD services. A Victorian snapshot of young people engaged in youth AOD services in 2013 found that those who participated in counselling and residential rehabilitation on average are older than those engaged in other services, e.g. outreach or day programs. Forty-four per cent of clients engaged in counselling are 22 years and older. Those who are 15 years and under were significantly more likely to have alcohol or cannabis as their primary drug of concern, whereas methamphetamine and heroin or other opiates are more likely to be the primary drug of concern for people over the age of 19 (Kutin et al. 2014).

Youth AOD service delivery NSW

In NSW there are a limited number of youth specific community based AOD services, particularly in rural and regional areas. headspace is significant provider of youth mental health treatment and support services in Australia. In addition to mental

¹ Illicit use of at least 1 of 16 classes of drugs in the previous 12 months in 2016. The number and type of illicit drugs used has changed over time.

² illicit drugs: illegal drugs, drugs and volatile substances used illicitly, and pharmaceuticals used for nonmedical purposes.

³ Consumed at least a full serve of alcohol in the previous 12 months.

⁴ On average, had more than 2 standard drinks per day.



health, one of headspace's four key pillars of service delivery is alcohol and other drugs. There currently more than 100 headspace centres in Australia making it a significant youth service. For many young people headspace is the only source of AOD services⁵.

NSW alone has 36 headspace centres, 14 are based in Sydney and 22 are based in regional NSW⁶. In contrast there are 19 NGO AOD specific residential and community-based services for young people - 14 in Sydney and five in regional NSW. It is notable that of the five youth AOD specific services based in regional NSW, three are residential rehabilitation services that have specific inclusion criteria and the other two community services are in Newcastle and Gosford (NADA 2017).

Most AOD services in headspace centres are provided through in-kind support from co-located services and consortium partners (Rickwood, Telford et al. 2015). The regional NSW headspace centres provide limited information about the AOD services provided at each centre. However, most of the AOD services provided at regional NSW headspace centres are provided by clinicians from adult services. It is also notable that some regional headspace centres had as little as 4 hours a week of AOD services provided⁷.

Community youth AOD services in NSW

There are fourteen youth AOD services in NSW that provide community-based services to young people. The fourteen services provide a range of different treatment and support. Most of services provide a combination of;

- Counselling including casework,
- Group work,
- Family inclusive practice,
- Case management,
- Information and referral.

In additional to the main treatment and support, several services also provide outreach, life skills, drop in, practical support, and brief intervention (NADA 2017).

AOD Service Provision

There are number of common elements of service delivery that are provided within youth AOD services. Following is an overview of the key elements of service provision along with the spaces and locations where these are provided. The key types of

⁵ 'headspace network services' - <https://headspace.org.au/assets/Uploads/headspace-centre-network-map-September-2018.pdf>

⁶ Three services are opening between 2017-2019

⁷ 'Find a headspace centre' - <https://headspace.org.au/headspace-centres/>



services delivery for community based AOD treatment includes psychosocial counselling which is usually inclusive of casework and case management, group work, family work, and brief intervention.

Psychosocial Counselling (including case work and case management)

Psychosocial counselling is broad term that is used to capture a range of therapeutic interventions but can also be inclusive of case management/case work and other support services. The therapeutic approach and intensity of psychosocial counselling can vary depending on the client's needs or goals (Ministry of Health NSW 2017, p. 11). Generally counselling is provided to young people on a weekly basis (Bruun 2015).

Case management and case work are terms that are often used interchangeably to describe direct work with young people and families. Casework involves the professional working with the client (which could be an individual, couple or a family) to overcome a problem situation that is causing distress (Cardona-Cardona, Montaño-Moreno, & Campos-Vidal, 2017). Whereas case management focuses on care coordination. Case management is important for maintaining engagement with young people with complex issues as they are often not aware of services that might be available (Bruun & Mitchell 2012, p. 58; Crane, Francis, & Buckley 2013).

Common methods for psychosocial counselling are identified by the NSW and Queensland Governments in their AOD treatment frameworks. Based on those documents Lives Lived Well approves a number of approaches for treatment in the 'Evidence Based Practice Policy QLD & NSW'. These approaches are:

- Contingency Management
- Cognitive Behavioural Therapy (CBT)
- Mindfulness Based Relapse Prevention
- Motivational Enhancement / Motivational Interviewing
- Acceptance and Commitment Therapy (ACT)
- Dialectical Behaviour Therapy (DBT)
- Relapse Prevention
- Community Reinforcement Training
- Behavioural Couples and Family Treatments

Group work

Group work that has a client centred approach is believed to be an effective treatment for young people. Groups provide a safe space for young people to problem solve, practice new skills and receive feedback (Bailey & Baker 2009, p.18).



However, there is limited research about the efficacy of groups for young people (Wagner & Ingersoll 2013, p. 404).

One of the common group approaches for young people is DBT, which is generally conducted for a minimum of 12 weeks, however there are modified versions for young people running between 8 and 12 weeks. (Crane, Francis, & Buckley, 2013, p. 64). Motivational interviewing groups with young people is seen as a promising approach. It has the flexibility to engage young people in the process, explore youth ambivalence, and promote decision making about behaviour change (Wagner & Ingersoll 2013).

Family work

Youth AOD workers can adopt a family responsive approach with the focus on assisting families to develop family relationship strengths and securing family support for young people (Crane et al. 2016). Family interventions can be generally placed into three types; working with the family to promote entry or maintenance of treatment, involvement of the family and the client in the treatment, and interventions with family members (Lubman 2017). Some practical approaches to working with the family include providing information and education sessions, "informal conversations about how family members might support their adolescent through their drug treatment, modelling of communication skills, conflict resolution sessions, and support for family members in their own right" (Bruun & Mitchell 2012, p. 56).

The 5-step method of working with families has growing evidence that it can increase the coping skills for families and reduce the physical and psychological symptoms (Lubman 2017). The approach aims to "utilise existing resources available to family members, so that they are able to support themselves as well as the individual with problematic AOD use" (Lubman 2017, p. 34). The 5-steps in the method are (Copello, Templeton et al. 2010):

1. Listen, reassure and explore concerns,
2. Provide relevant, specific and targeted information,
3. Explore coping responses including current coping responses,
4. Discuss social support,
5. Discuss and explore further needs.

Brief Intervention

The defining characteristic of a brief intervention is brief contact time with a limited number of sessions. It generally as short as 5 minutes to an hour and between one and five sessions. It is typically delivered in an ad hoc manner based on a window of opportunity by a provider such as a physician, nurse, psychologist, counsellor, or



other community service professional. It is not supposed to provide full treatment, but provides information, resources, and motivation to access specialist treatment (Tanner-Smith & Lipsey 2015; Tait & Hulse 2003; Crane, Francis, & Buckley 2013, p. 52).

For example, Quik Fix is a brief intervention that has two 30-minute telephone sessions using motivational interviewing including cognitive-behavioural coping skills training to target mental health and substance use issues in young people (Hide, Wilson, Quinn & Sanders 2016. P. 55). Quik Fix has been shown to be effective as a brief intervention with young people who have presented to an emergency department with alcohol related injuries and illnesses (Hides, et al. 2014).

Settings

The key settings for youth AOD service delivery include outpatient, outreach, online, and telephone.

Outpatient

Outpatient treatment can be delivered in a range of locations, including community centres, a client's home, or office setting (Filges, Kowalski, Benjaminsen & Jørgensen 2015, p. 19). Outpatient treatments do not include those delivered in a "residential, inpatient, emergency room, recreational or foster care setting" (Hogue et al. 2014).

Outreach

Outreach is provided in a client's preferred setting. Outreach can be particularly important to engaging clients who have high needs but are difficult to reach. Outreach can be conducted in "out of office settings, including streets, homes and parks, rural and remote settings, within other organisations or agencies" (Crane, Francis, & Buckley 2013 p. 34). It can also be an effective intervention to coordinate activities across related services centres, e.g. education, mental health, and youth justice (Bruun 2015).

Online

Technology can be used for providing counselling for young people, for self-directed intervention, as an assessment tool, or to complement face-to-face counselling (Blanchard 2011). Using web-based and mobile modalities, such as online assessments and feedback, can assist to engage young people who might not turn up for formal counselling (Hides 2016, p. 54). There have been some positive results when using technology with young people, for example when using an



electronic assessment at headspace young people were more likely disclose personal information (Bradford & Rickwood 2015, p. 2). However, there are some barriers to the use of technology in AOD treatment, including poor technological infrastructure, lack of policies and guidelines to guide use, and a lack of knowledge of effective strategies to employ within the online approach (Blanchard 2011).

Telephone

Telephone counselling can be used on its own or in combination with face-to-face counselling (Patterson, McDonald, & Orchard 2014). Telephone counselling can improve the access and efficiency of the service system to support young people concerned about AOD use (YSAS 2018, p.20). In addition to telephone counselling, telephone contact can also be used for assertive engagement, contact between sessions to reinforce approaches and improve implementation of strategies (Bruun & Mitchell 2012).

Outcomes

Information on youth AOD treatment outcomes is scarce. There is no current research identified that compared the outcomes of different youth AOD treatments. There is limited data available that examines the success rates of youth AOD services in general. The age, complexity, and severity of substance use of the young people who engage in different types of treatments differs significantly making it challenging to make a direct comparison of effectiveness.

In the older treatment population, several factors have been identified that can influence the outcomes of AOD treatment (Lubman et al. 2017, p. 64-65):

- Dependence severity,
- Mental health history,
- Social stability, e.g. homelessness,
- Treatment duration,
- AOD treatment history,
- Therapeutic alliance,
- Continuity of care - different treatment streams occurring sequentially.

An example of these factors is that positive therapeutic alliance is one of the best predictors of treatment outcome with 10 - 50% of the variance in the outcome of AOD treatment attributed to the characteristics of the therapist. Additionally, people who have more severe AOD problems will get more benefit from inpatient treatment and clients with comorbid AOD and mental health problems benefit from psychosocial therapy (Lubman et al. 2017). It is reasonable to assume that these factors will also be relevant to treatment for young people.



A Victorian Youth Cohort Study (2012), which sought to identify the profile of young people in youth AOD treatment, identified that most young people who engaged with specialist youth AOD services experienced positive changes regarding their substance use and other domains of their life. However, 1 in 8 did not improve, or their problems escalated. It is also noted that young people built up strong meaningful relationships with their clinicians and were dissatisfied if the clinician ended the relationship (Bruun 2015).

Key elements informing a model of youth AOD service delivery

A model defines the way that a service is delivered. It helps to ensure that all professionals are working towards a set of common goals and assists to evaluate the service delivered. In relation to the delivery of services the model should contain several key features including the treatment approach and intervention types, the professionals involved in delivering the service, the policies, resources, and other infrastructure required in the delivery of the service. The next section explores the key elements involved in developing a model for youth AOD service delivery.

Treatment Approach

Adolescent drug users differ from adult users. Young people are developmentally different to adults, have shorter histories of use, are more likely to be poly-drug users, and more likely to have external pressures to undertake treatment. As a result, it cannot be assumed that adult programs can be directly transferrable to adolescents (Wilson, Siggers, & Wildy 2013).

A key element that is recurring in youth AOD service reports is recommendation for using a client-centred approach. The client-centred approach focuses on creating a therapeutic relationship, with the counsellor providing empathy, genuineness, and unconditional positive regard allowing the client to work through their issues and identify their own solutions. This approach has received strong support in several studies (Crisp 2011; Harris & White 2013).

There is limited or insufficient evidence for the efficacy of any specific AOD intervention for young people. A review of 43 systematic reviews on the efficacy of youth substance treatment found that most studies are of poor quality. Those of reasonable quality (n=6) reported no significant effect of any particular type of treatment and that any small effects had dissipated after 12 months (Allan et al. 2018). In summary, six of the 43 systematic reviews/meta-analyses were assessed as methodologically sound and found limited evidence for any specific approach:



- Lindstrøm et. al. (2015) found no firm evidence to support of efficacy of family behavioural therapy (FBT) in reducing substance use in young people compared to other treatment approaches.
- Filges, Andersen and Jørgensen (2015) found that given the methodological flaws in the primary studies, there is no firm evidence to support the efficacy of functional family therapy (FFT).
- Filges and Jørgensen (2015) concluded that there was insufficient evidence to ascertain if CBT was more effective than a range of other alternative interventions, e.g. adolescent community reinforcement approach (ACRA), FFT, psycho-education and multidimensional family therapy (MDFT).
- Foxcroft, Coombes, Wood, Allen, & Almeida Santimano (2014) determined that there was no substantial evidence in support of the effectiveness of motivational interviewing in addressing alcohol misuse in young people.
- Lindstrøm, Rasmussen, Kowalski, Filges, and Jørgensen (2013) conducted a meta-analysis into brief strategic family therapy (BSFT) and found inconclusive evidence in support of the effectiveness of BSFT over other treatment types.
- Filges, Rasmussen, Andersen, and Jørgensen (2015) found evidence that MDFT was the most effective treatment in addressing substance abuse in young people when compared to other therapies, such as CBT, treatment as usual, ACRA, CBT, and motivational enhancement therapy. However, the authors found that the effect size of MDFT at 12 months follow-up was not significant.

A systematic review of the effectiveness of prevention, early intervention, harm reduction and treatment of substance use in young people for tobacco, alcohol and illicit drugs identified that availability of evidence for intervention for problematic substance use is scarce and made it difficult to identify the efficacy of the interventions. The systematic review analysed several treatment approaches including Motivational Enhancement Treatment (MET), cognitive behavioural therapy (CBT), family-based interventions, self-help interventions (with and without peers) (Stockings et al. 2016).

Instead of using a specific type of intervention or counselling method, a youth focused delivery approach or model is recommended. In 'A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services', Youth Support and Advocacy Service (YSAS) outline a list of characteristics for effective services and programs (Bruun & Mitchell 2012). YSAS note that not every characteristic is necessarily relevant for each service and program; and some may be best applied at a service level. The characteristics include:

- **Client-centred /socio-culturally relevant** – this should involve assessment and treatment matching, which involves tailoring interventions to the individual needs of the client.

- **Relationship-based /focus on relationships** - the client relationship is vital to positive outcomes, the quality of the relationship may be more important than specific interventions, and essential in keeping young people engaged in the process.
- **Developmentally appropriate** - Young people with AOD and other psychosocial difficulties are best served by services that are designed specifically for them. The services and programs need to be customised to developmental stage the young people are in. For example, being aware that young people learn more from direct experiences than through vicarious experiences or counselling.
- **Comprehensive, holistic, ecological, multi-systemic and integrative** - Most adolescents with AOD problems tend to experience other issues, such as offending behaviour, homelessness, unemployment, and exclusion from school, but no one of these issues applies to every single adolescent with AOD problems. The treatment should integrate other issues the young person may experience rather than addressing AOD use alone.
- **Family involvement** – There is some evidence that involving families in adolescent AOD treatment has a significant protective influence.
- **Sufficient duration and intensity** – the service needs to be an appropriate length for treatment to have an impact and ensure that change can last a over time. Three months has been identified as a minimum for effective AOD treatment, but for young people who have complex needs longer treatment is needed. Further, abstinence is unlikely therefore a harm reduction approach is more useful.
- **Engagement and retention strategies** – several factors enhance access and engagement, including reliability, respectful attitude, enthusiasm, and genuine listening.
- **Behavioural, experiential and skill focused**- Adolescent AOD treatment should include experiential and hands-on approaches such as role-playing and systematic encouragement to assist in learning and practicing new behaviours.
- **Building on strengths** – treatment should identify, reinforce and build upon the strengths of the client.

Importantly, evidence-based adult interventions that have not been tested with young people and should not be transplanted into a youth service and expected to work. Instead trials of approaches and strategies should be conducted (Stocking et al. 2016).

Harm Reduction

Relapse to substance use for young people is likely to occur within 2-3 months after treatment and approximately 80% will relapse within a year (Cornelius 2003). This is



supported by the Victorian Youth Cohort study that found that 72% of young people in the 'most at risk' category (highest level of substance use and highest complexity) are considerably more likely to return to treatment as a result of relapse and more likely to have previously been in youth AOD treatment (Kutin et al. 2014).

Many young people are not ready to abstain from substance use therefore harm reduction is an appropriate and effective approach. A harm reduction approach includes focusing on health education, reduction or cessation strategies, developing and improving social and coping skills (Bailey & Baker 2009. P. 15).

There is a growing acknowledgement that any treatment should be underpinned by the client's preferred outcomes and goals, as opposed to the focus on delivering a particular intervention. Within the therapeutic relationship the practitioner should utilise eclecticism to work towards the goals and outcomes of their clients (Crane, Buckley, & Francis 2012, p.43). In order to meet the diverse and changing needs of young people, a single therapeutic intervention is not enough. Eclecticism (also known as intentional eclecticism) involves drawing on a "variety of different therapeutic models and traditions" (Bruun & Mitchell 2012, p. 76).

Effective treatment for youth substance use should focus on (Lives Lived Well 2018):

- Motivational enhancement,
- Relapse prevention,
- Problem solving,
- Coping strategies,
- Case management,
- Family support,
- Working with adolescents' concerned others to change their environments.

Community Settings

Community based AOD treatment can be delivered in a range of community settings, such as agencies, schools, and the client's home (UNODC 2006). Community based AOD treatment is ideally provided in an office or spaces that are preferred by the client. Services delivered in a community setting include counselling, assessment, support and case management, group work, and family work (Australian Institute of Health and Welfare 2018, p. 48; NSW Ministry of Health, 2017).

headspace

headspace centres aim to be highly accessible, youth integrated service hubs (Rickwood, et al. 2015). Headspace is a key youth health service in rural and



regional Australia. Each centre is overseen by a lead agency on behalf of a consortium of local agencies. headspace Centres deliver mental health, alcohol and other drugs, primary health care, and vocational services (Rickwood et al. 2014).

headspace uses a unique hybrid funding model. Lead agencies receive funding from headspace National Office to hire administration, management and a small number of clinical staff, along with infrastructure and operating costs. This is complemented by other staff co-locating or integrating their services with headspace, such as GP's, psychologists in private practice, and other consortium member services (Carbone, Rickwood, & Tanti 2011). This model means that headspace centres engage in a diverse range of activities funded from a range of sources, which can potentially be a strength as each centre can adapt to address specific needs of the local community (Rickwood, Van Dyke & Telford 2015).

headspace AOD service delivery

Alcohol and other drugs is one of the four key service areas that are covered by headspace Centres. However, despite being one of the four key pillars of headspace service delivery, drug and alcohol services only accounts for a very small percentage of young peoples' primary presenting issues. A study of centre-based services between 1 January and 30 June 2013 found that 1.7% of clients self-reported that AOD was the main reason for attending headspace with this being more common for males (Rickwood et al. 2014). Another study, which took a census of headspace clients commencing an episode of care between 1 April 2013 and 31 March 2014 found only 3.1% of clients identified AOD as their main presenting issue, in comparison 72.7% of clients identified mental health as a problem. This potentially results in AOD problems being underreported as only primary presenting issues are recorded and it does not consider co-morbid conditions (Hilferty et al. 2015, p. 68).

More than half of the AOD services at headspace Centres were provided through in-kind support by co-located services or consortium partners. This arrangement shows some strengths in the local partnership model used by headspace. However, there is a need within the headspace model to build greater capacity for headspace Centres to respond to young people who present with AOD concerns (Rickwood, Telford et al. 2015).

Client satisfaction is shown to be high at headspace with the staff rated particularly highly. It is notable that compared to clients who present with mental health, behavioural, and vocational issues, clients who presented for substance use had the lowest satisfaction along with males, homeless, and those presenting for physical health (Rickwood et al. 2017).



Challenges in headspace AOD service delivery

As a result of staff shortages, it is a challenge for headspace Centres located in rural and regional areas to recruit professional staff. Adding to the challenge is that not all professionals are comfortable or enjoy working with young people including those with complex needs, such as mental illness and substance use issues (Carbone, Rickwood, & Tanti 2011). The rural adult AOD sector experiences recruitment difficulties and are likely to experience difficulties providing headspace with services.

Engaging marginalised and at-risk groups

headspace has been successful at engaging the most marginalised and at-risk groups of young people through its services. headspace has been able to engage young people from Aboriginal and Torres Strait Islander backgrounds, LGBTI young people, and young people from rural and regional areas. headspace has found that young people in rural and regional areas are largely engaged with headspace by attending a centre. However, notably most young people who attend a headspace Centre live within 10 kilometres of it (Hilferty et al. 2015, p. 38). In addition, young people from culturally and linguistically diverse backgrounds are underrepresented in headspace services (Hilferty et al. 2015).

Family members and AOD services

Family inclusive practice "recognises that individuals influence other members in their environment, especially family, and that family members in turn have an impact on these individuals" (NSW Ministry of Health 2014, p. 29).

It is important to include families in young people's AOD treatment whenever possible because family can be an important support. Interventions with families often focus on communication, relationships, and the developmental needs of the young person. (Rickwood et al. 2018, p. 3; NSW Ministry of Health 2014, p. 29). Involving family and friends should be negotiated with young people, looking at key factors such as confidentiality and privacy (Rickwood et al. 2018, p. 3).

Families can also play a key factor in young people engaging in treatment. A study of outpatient, harm reduction focussed AOD treatment found that young people living with family were more likely to stay engaged in treatment (Christie, Bavin, & Wills 2018).

Who are services delivered by?

Youth AOD treatment services need to be provided by people who are skilled and qualified. The Australian AOD workforce is made up of two groups, AOD Specialist



Workers and mainstream generic workers. AOD Specialist Workers' main role is working with AOD problems within a specialist AOD service or AOD program within a mainstream service. Mainstream generic workers are not employed within a specific AOD service or program but deal with AOD issues as part of their usual work (NCETA, ND).

In Australia there is no national professional accreditation for AOD specialist work (Roche & Pidd 2010, 64). AOD specialist work consists of multiple occupations in a range of roles. This includes occupations such as social workers, youth workers, counsellors, psychologists, Indigenous workers, nurses and allied health workers (Roche & Pidd 2010, p.24). In addition to consisting of a wide range of occupations, "a large proportion of AOD specialist workers have no accredited AOD specific qualifications" (Roche & Pidd 2010, p. 52).

The mainstream generic workforce is well placed to implement prevention and intervention strategies as a result of their contact with the wider community. Despite this key role, only a small proportion of mainstream generic workers have the required skills and knowledge to respond adequately to AOD issues (Roche & Pidd 2010, p. 46).

Roche & Pidd (2010) note in 'Alcohol and Other Drugs Workforce Development Issues and Imperatives: Setting the Scene' that there are several additional challenges for rural and regional agencies. These include recruiting and retaining qualified staff, lack of access to professional development and training opportunities, and less access to supervision.

However, there is an expectation of AOD informed service delivery. For example, headspace identify that any of their services, including AOD, should be delivered by appropriately qualified and experienced staff, such as psychologists, social workers, youth workers, nurses, and AOD workers (Rickwood et al. 2018). Given the workforce barriers, AOD service delivery may be limited.

What supports, policy and infrastructure are required to deliver youth AOD services

Youth AOD services require policy, resources, and infrastructure to help guide and support the treatment that is provided.

Youth Friendly

A service environment does not have to be youth specific to be youth friendly, but it does need to be carefully tuned to be experienced as friendly by young people. Some services explicitly aim to be both youth and family friendly (Crane, Francis, & Buckley 2013).



The World Health Organisation (WHO) has identified a framework for implementing youth friendly services. This framework emphasises accessibility, acceptability and appropriateness (AAA) as being critical in delivering youth friendly services (Muir, Powell, & McDermott 2012).

Some of the aspects that demonstrate youth friendly service delivery include:

- easy referral processes,
- prompt screening and assessment,
- short waiting lists,
- physical location that is easy to access and close to public transport
- affordability,
- being able to access multidisciplinary services at one site, and strong linkages to other services,
- Guaranteed confidentiality,
- Services should not be withheld from a young person in the absence of parental consent.

(Baker, Lee & Jenner 2004; Muir, Powell, & McDermott 2012).

The headspace model follows the World Health Organisation model for youth-friendly services (Rickwood et al. 2018). headspace centres are seen as successful at youth friendly service delivery. Despite this there are several practical barriers that have been highlighted across headspace service delivery. These include standard opening hours, lack of transportation, centre waiting lists, and "cultural appropriateness of service provided by some centres" (Hilferty et al. 2015, p. 3).

Infrastructure

There are program operating costs that need to be considered in program delivery. These include administration (payroll, HR etc.), stationery, telephone, car, information technology, client management system, staff professional development and supervision, evaluation and all costs associated with an office (e.g. rent, electricity, gas and heating) (NSW Ministry of Health 2013, p. 119).

As noted in an independent evaluation into headspace most young people who access headspace centres live within 10km of the centre (Hilferty et al. 2015, p. 38). This is something that could apply to any youth service. As a result, it is important that any offices/centres that need to be accessed by young people are centrally located and close to public transport. Additionally, it supports the importance of providing outreach and having the required resources to support outreach.



Standards and accreditation

Organisations delivering AOD services are required to be accredited. Accreditation means that the organisation “meets acceptable standards of service delivery, management, staffing and organisational development” (NSW Ministry of Health 2017, p. 5). There is not a formal accreditation for AOD organisations, however there are a number of accreditation system that organisations can use, such as The Australian Council on Healthcare Standards (ACHS) and Quality Innovation Performance (QIP) (NSW Ministry of Health 2017).

Resources

When delivering outreach or community-based services many resources are required. These include vehicles, mobile phones, laptops, client forms such as consent and information/referral resources. If providing an outreach service, sharps disposal kit, identifiable clothing/staff name badge, and first aid kits are necessary (Crane, Francis, & Buckley 2013, p. 39).

Policies

There are several legal considerations that have to be taken into account when providing alcohol and other drugs treatment to young people. These include: duty of care, confidentiality, consent to service provision information sharing with other agencies, and child protection (NSW Ministry of Health 2014, p. 15).

Any inclusion or exclusion criteria for a community based AOD service should be applied flexibly and adapted to each individual circumstance, for example client should not be excluded based on client characteristics, e.g. homelessness (NSW Ministry of Health, 2017).

Specific Groups

Youth drug and alcohol services should look at ensuring that they have approaches and policies that meet the needs of specific groups, such as young people from CALD backgrounds, young offenders, Aboriginal and Torres Strait Islander Young People, and LGBTI young people (NSW Ministry of Health 2014, p. 8).

Aboriginal and Torres Strait Islander young people

Aboriginal and Torres Strait Islander people have a greater prevalence of and experience greater harm from, substance use. Reasons for this include “cultural deprivation and disconnection to cultural values and traditions, trauma, poverty,



discrimination and lack of adequate access to services" (Department of Health 2017, p. 26). Services for Aboriginal and Torres Strait Islander people should be culturally responsive, have strong community engagement, and reflect Indigenous social, cultural and wellbeing needs (Department of Health 2017, p. 26).

Lesbian, Gay, Bisexual, Transgender and/or Intersex (LGBTI) young people

People who identify as LGBTI are at greater risk of experiencing problems with substance use. This risk can be associated with greater levels of stigma, discrimination, familial issues and marginalisation (Department of Health 2017, p. 29).

Cultural and Linguistically Diverse (CALD) Young People

As a result of factors such as language barriers, lack of awareness of support services, and limited culturally appropriate programs, in addition to family stress, CALD young people can be susceptible to problems with substance use (Department of Health 2017, 29).

Rural and regional young people

Few studies have examined youth substance problems in rural and regional areas (Coomber et al 2011). Existing studies indicate that young people in rural and regional areas are more likely than metropolitan young people to drink at risky levels, use illicit substances, and smoke tobacco. The potential harm of this increased substance use is comparable to that of adult populations in rural and regional areas and higher than young people in metropolitan areas (Miller et al. 2010, p. 116). This suggests a greater need for youth focussed AOD services in rural and regional areas compared to urban areas.

Youth Justice

There are higher rates of substance use among people who have contact with the criminal justice system (Department of Health 2017, p. 28). Young people under youth justice supervision were 30 times as likely as the remainder of the young Australian population to receive an alcohol and other drug treatment service. One in three (33%) of young people who are under "youth justice supervision from 1 July 2012 to 30 June 2016, also received an AOD treatment service at some point during the same 4-year period, compared with just over 1% of the general Australian population of the same age" (Australian Institute of Health and Welfare 2018, p.vii). This suggests most youth AOD service provision is clustered in the criminal justice sector.



Conclusion

There is no specific evidence-based intervention that should be provided for young people with AOD problems. Instead a youth friendly model of service is recommended where therapeutic alliance is a focus and multiple service types are provided across a range of settings. AOD services for young people are limited, especially in rural and regional Australia. headspace is the most accessible service for young people and the most widely dispersed across the country unless young people are involved in the criminal justice system. Further, the headspace model incorporates the WHO guidelines for youth services. However, while AOD is a key pillar of headspace service delivery, AOD services are usually provided by consortium members resulting in limited availability and potentially adult oriented service delivery. There is a need for structured development and testing of online and other technology driven methods of service delivery as options to deliver services this way is rapidly growing. AOD workforce shortages are critical and limit service delivery especially in rural areas. To address the challenges of youth AOD service delivery a specific model is proposed that could stand alone or be delivered within headspace centres.

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