ThYNC·Q

THE YOUTH NEEDS CENSUS - QUEENSLAND

Needs and Characteristics of Young People in Youth Alcohol and Other Drug Treatment in 2017.

Dr Karen Hallam, Cassandra Davis,
Ora Landmann and Jozica Kutin.

YSAS
YOUTH SUPPORT + ADVOCACY SERVICE

Dovetail
supporting the youth alcohol and drug sector in Queensland

Dovetail provides clinical advice and professional support to workers, services and communities across Queensland who engage with young people affected by alcohol and other drug use. Dovetail is an initiative of Queensland Health, hosted by Metro North Hospital and Health Service.

Written and Edited by
Dr Karen Hallam, Cassandra Davis, Ora Landmann and Jozica Kutin.

Designed by
Niall Steward

Published by
Dovetail
GPO Box 8161
Brisbane, Queensland, 4001
www.dovetail.org.au
June 2019
ISBN: 978-0-9873015-5-0

Suggested citation
Hallam, K. T., Davis, C., Landmann, O., & Kutin, J. (2019). ThYNC-Q, The Youth Needs Census - Queensland, Needs and Characteristics of Young People in Youth Alcohol and Other Drug Treatment in 2017. Brisbane: Dovetail.

Contents

Tables

Figures

Executive Summary

The Youth Needs Census - Queensland (ThYNC-Q) provides a state-wide snapshot of young people (aged 12-25) utilising youth alcohol and other drug (AOD) services on a nominal day in 2017. The outcomes of ThYNC-Q detail the AOD use patterns and psychosocial needs of these young people. The survey was undertaken by the Youth Support and Advocacy Service(YSAS) in conjunction with Dovetail.

ThYNC-Q was conducted across 12 Queensland youth AOD services, with data input by workers. The census date was 22nd May 2017. Young people were deemed eligible if they had commenced or were continuing treatment on this date. Each young person's key worker was asked to complete a 61-item quantitative online survey based on their current knowledge of that young person.

Workers completed the census on 508 young people. There were more males in treatment than females (62.4% and 36.9% respectively) and the average age was 19.3 years. 40.5% of young people identified as Aboriginal and/or Torres Strait Islander, 6.1% of young people identified from a culturally and linguistically diverse (CALD) background and 5.1% identified as lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ).

The results highlighted significant rates of cannabis use and dependence for the cohort. Alcohol was the second most frequently used substance, followed by tobacco. In terms of psychosocial outcomes, ThYNC-Q revealed high rates of family conflict, unemployment and school disengagement. Young people in this sample were reported to have high rates of trauma and concurrent mental health problems. Around 35% of young people had engaged in non-suicidal self-injury, with one in four of the young people attempting suicide at least once.

The results of ThYNC-Q can help to inform the development of improved treatment options for young people who are using AOD services by identifying the characteristics of young people presenting for treatment.

Acknowledgements

The Youth Needs Census - Queensland could not have been achieved without the support of workers across Queensland youth AOD services. I would like to thank each worker who took time out of already busy days to complete such a large-scale data collection exercise. Without the engagement of the sector and its workers, the census would not have been possible.

I would also like to acknowledge the huge effort from the Dovetail team for coordinating the ethical approval and supporting recruitment and to the Queensland Department of Health for funding support. In particular, ThYNC-Q could not have been achieved without the support of Cassandra Davis who drove the project for Queensland. The partnership between Dovetail and YSAS in Victoria is a true indicator of the strength and impact that state services can have when we collaborate to represent our often under-represented sector. Thank you also goes to the various Human Research Ethics Committees across the state that have allowed us to learn so much about the young people and their needs.

In Victoria, the census could not have been established and coordinated without the support of Ora Landmann and Dominic Ennis from the Strategy and Development team at YSAS; and the original census developed by Jozica Kutin in 2013. Through the collaboration between Dovetail and YSAS, we are voicing our own needs in the youth AOD field and advocating for the young people we support. We look forward to the next census across many states in 2020.

Thank you to all involved.

Sincerely,

Dr Karen Hallam

PhD(Melb.), MPsych(Clin.), BBSc(Hons.)

Senior Research Fellow

YSAS / Centre for Youth AOD Practice Development

Background

There is a lack of detailed information on the characteristics of young people in AOD treatment in Australia. The National Drug Strategy Household Survey (NDSHS) (AIHW, 2017) is Australia's primary source of data on population rates of substance use. The NDSHS offers an insight into a sample of young people aged 12 to 21 who are typically connected to education or have stable housing. However young people experiencing problems with substance use and accessing treatment are likely to be under-represented in this survey. The primary source of AOD treatment data, the "Alcohol and other drug treatment services National Minimum Data Set (NMDS)" provides information on AOD use and treatment, however, it does not include information on psychosocial characteristics of young people. ThYNC-Q aims to help correct this gap.

Aims of ThYNC-Q 2017

ThYNC-Q aims to describe the characteristics of young people aged 12 - 25 years who were accessing specialist youth AOD services across the state in late May 2017. Having information about young people currently in treatment is important because:

- it allows the development of improved treatment options for young people who are using AOD services
- it provides an insight into many different facets of young people's lives and the complexities they are facing
- it can be used to inform service system planning
- it can assist with workforce development by identifying the characteristics of young people presenting for treatment.

The Youth Needs Census - Queensland

Description of Methodology

ThYNC-Q was conducted across Queensland youth AOD services, with data input by youth AOD workers. The census provides a state-wide snapshot of young people utilising youth AOD services on a nominal day in 2017. The survey was undertaken by the Research Unit of the Youth Support and Advocacy Service (YSAS) in conjunction with Dovetail.

METHOD

Participating Alcohol and Other Drug Services

Youth AOD specialised services or youth AOD workers that are funded by Queensland Health were invited to participate in the study.

The census was completed by 12 services across a number of Hospital and Health Service (HHS) regions.

The government services that provided data included:

- Cairns Indigenous Youth AODS (Cairns and Hinterland HHS)
- Cherbourg AODS (Darling Downs HHS)
- Rockhampton Youth AODS (Central Queensland HHS)
- Hot House Biala and Redcliffe / Caboolture (Metro North HHS)
- Mount Isa Alcohol, Tobacco and Other Drugs Service (North West HHS)
- Townsville Alcohol, Tobacco and Other Drugs Youth Outreach Service (Townsville HHS)

Non-government services that provided data included:

- YETI (Youth Empowered Towards Independence) (Cairns and Hinterland HHS)
- Brisbane Youth Service (Metro North HHS)
- Noffs Queensland (Gold Coast HHS, Metro South HHS, Metro North HHS, Sunshine Coast HHS, West Moreton HHS)
- Lives Lived Well (Sunshine Coast HHS, Metro North HHS)
- YFS Shift Program (Metro South HHS)
- Clarence Street – Mater Hospital (Metro South HHS)

PROCEDURE

The census date was 22nd May 2017. Young people were deemed eligible if they had commenced or were continuing treatment on this date. Each young person's key worker was asked to complete an online survey based on their current knowledge of that young person. Surveys were completed by staff in a two-week collection period following the census date. Young people were not contacted or asked to complete survey questions and no identifiable information was collected.

Questionnaire

A 61-item online quantitative survey was developed utilising existing dataset items and questions developed by literature review, existing surveys and expert consultation. The survey was modelled on the 2013 Victorian Statewide Youth Needs Census (SYNC) (Kutin et al., 2014) for comparability, and some new items such as family violence and youth AOD worker role were added. Most items required a yes/no/don't know response, with adapted items from the Australian Treatment Outcome Profile (ATOP) rated on Likert scales. Timing trials with 48 trials over 8 workers indicated that each survey took an average of 13 minutes to complete (range 6-22 minutes).

The survey covered the following domains: demographics, program involvement, AOD use patterns, AOD use harms, involvement in employment, education or training, literacy and numeracy, housing, family conflict, mental health, suicide and non-suicidal self-injury, experience of neglect, physical, emotional and sexual abuse, or violence, child protection involvement, involvement in the criminal justice system and worker assessment of client AOD dependence. Workers were also asked to rate the client's level of physical health, psychological health and quality of life on 0 (poor) to 10 (good) Likert scales adapted from Section 2 of the ATOP (Ryan et al., 2013).

Data Analyses

Data were analysed using SPSS version 21. Descriptive data (AOD use and demographics) were reported for the sample group. For the age based comparisons, young people were divided into three groups: 12 to 15 years, 16 to 17 years and 18 years of age or over. Two clients were identified as gender diverse and one client's gender was identified as 'unknown'. These three clients were excluded from gender-based comparisons in the census to maintain their confidentiality. Continuous data was analysed using t-test, or one-way ANOVA where applicable and categorical data was analysed using Chi-Square analyses. Significance values were set at the probability value of 0.001 when graphs or tables presented ** or .05 when presenting one *.

Ethics Approval

The project was approved by the Royal Brisbane and Women's Hospital Human Research Ethics Committee HREC/17/QRBW/88 and endorsed by all applicable HHS regions.

1. Client characteristics

Demographics

Table 1.1 Age and gender demographics of total sample

	12-15 yrs	16-17 yrs	18-25 yrs	Female	Male	Gender diverse	Gender unknown
Frequency	49	117	340	188	317	2	1
Percentage	9.6	23.0	67.1	36.9	62.4	0.4	0.1

Youth AOD workers completed the census on 508 young people. Young men represented more than half of the census with 62.4% of the sample (n=317) being identified as male and 36.9% as female (n=188). Two clients were identified as gender diverse and one client's gender was identified as 'unknown'. Young people's ages ranged between 12 and 25 years of age with the average age being 19.3 years (SD = 3.1). In terms of age categories, 9.6% (n=49) were aged between 12-15 years, 23.0% (n=117) between 16-17 years and 67.1% (n=340) between 18-25 years.

Client Location

Table 1.2 Recruitment by Queensland Hospital and Health Service region

Hospital and Health Service Region	Frequency	Percent
Cairns & Hinterland HHS	135	26.6
Central QLD HHS	10	2.0
Darling Downs HHS	2	0.4
Gold Coast HHS	24	4.7
Metro North HHS	126	24.8
Metro South HHS	83	16.3
North West HHS	35	6.9
Sunshine Coast HHS	34	6.7
Townsville HHS	34	6.7
West Moreton HHS	25	4.9

Assessing the Needs of Specific Populations

Workers were asked to identify if each young person was a member of a specific population group. This included young people who identified as Aboriginal and/or Torres Strait Islander, young people who identified as culturally and linguistically diverse (CALD) and young people who identified as lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ).

Aboriginal and/or Torres Strait Islander

Youth AOD workers reported that 206 (40.5%) young people identified as Aboriginal and/or Torres Strait Islander. Of those, 128 (25.1%) identified as Aboriginal, 34 (6.7%) identified as Torres Strait Islander and 43 (8.4%) identified as both Aboriginal and Torres Strait Islander. In terms of gender, the Aboriginal and/or Torres Strait Islander group shows a similar skew as the broader ThYNC-Q sample towards more males within services (n=116) than females (n=90).

Culturally and Linguistically Diverse

Youth AOD workers reported that 31 (6.1%) young people identified as being from a CALD background. The following cultural backgrounds were reported: Maori (n=8), New Zealand (n=8), Papua New Guinea (n=3), Cook Islands (n=2), Cambodia (n=1), United Kingdom (n=1), Philippines (n=1), Italy (n=1), Samoa (n=1), South Africa (n=1), South Sudan (n=1) and Thailand (n=1). In terms of gender, there were more males (n=18) than females (n=12) in the CALD group.

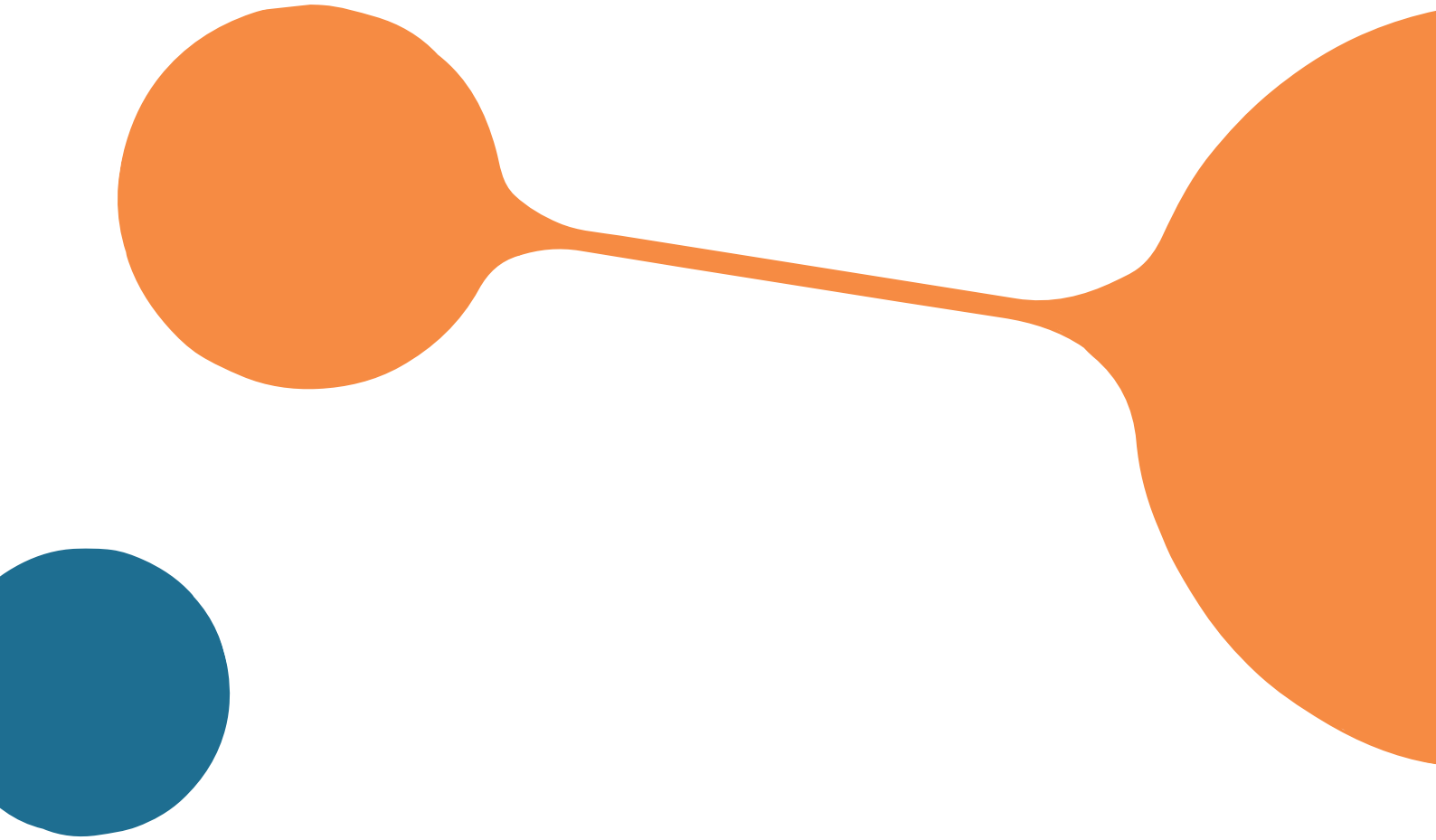
Lesbian, Gay, Bisexual, Transgender, Intersex and Queer

The census found a 5.1% (n=26) prevalence of individuals who identified as LGBTIQ. Within the LGBTIQ sample, 0.6% identified as gay (n=3), 0.8% (n=4) as lesbian, 2.9% (n=15) as bisexual and 0.8% as queer (n=4). Members of this group included more females than males (2.8% versus 2.2%) and two young people were identified as gender diverse (intersex or transgender).

2. Service and Program Utilisation

Understanding a young person's AOD support needs requires more than just information about the substances they are using. It requires the combined consideration of substance use severity and psychosocial vulnerability, that allows a more holistic approach to supporting young people.

The Queensland youth AOD treatment system is comprised of many individual services that can be grouped according to region. Each organisation provides slightly varied programs to young people based on their funding, therapeutic approach, staff skills, resources and local requirements. These range from outreach, through to day programs, individual counselling and other programs that services may offer for specific purposes linked to funding or particular local issues.



Program Utilisation Across Queensland Youth AOD Services

Most services offer a range of programs for young people such as counselling and outreach.

Figure 2.1 highlights the number of programs used by young people within a particular service. This flexibility in accessing multiple programs reflects the complexity of the cohort, with some individuals needing outreach, counselling, withdrawal and family supports while others requiring a more minimal intervention.

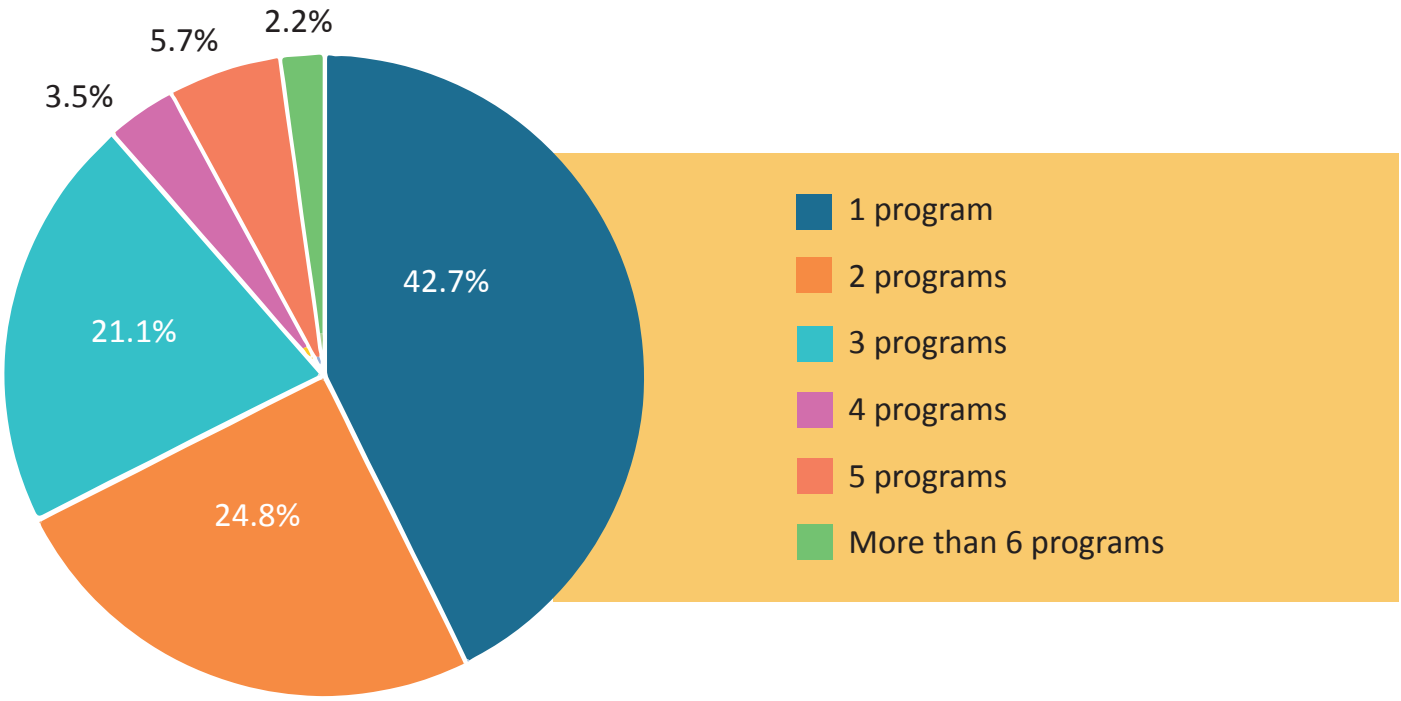
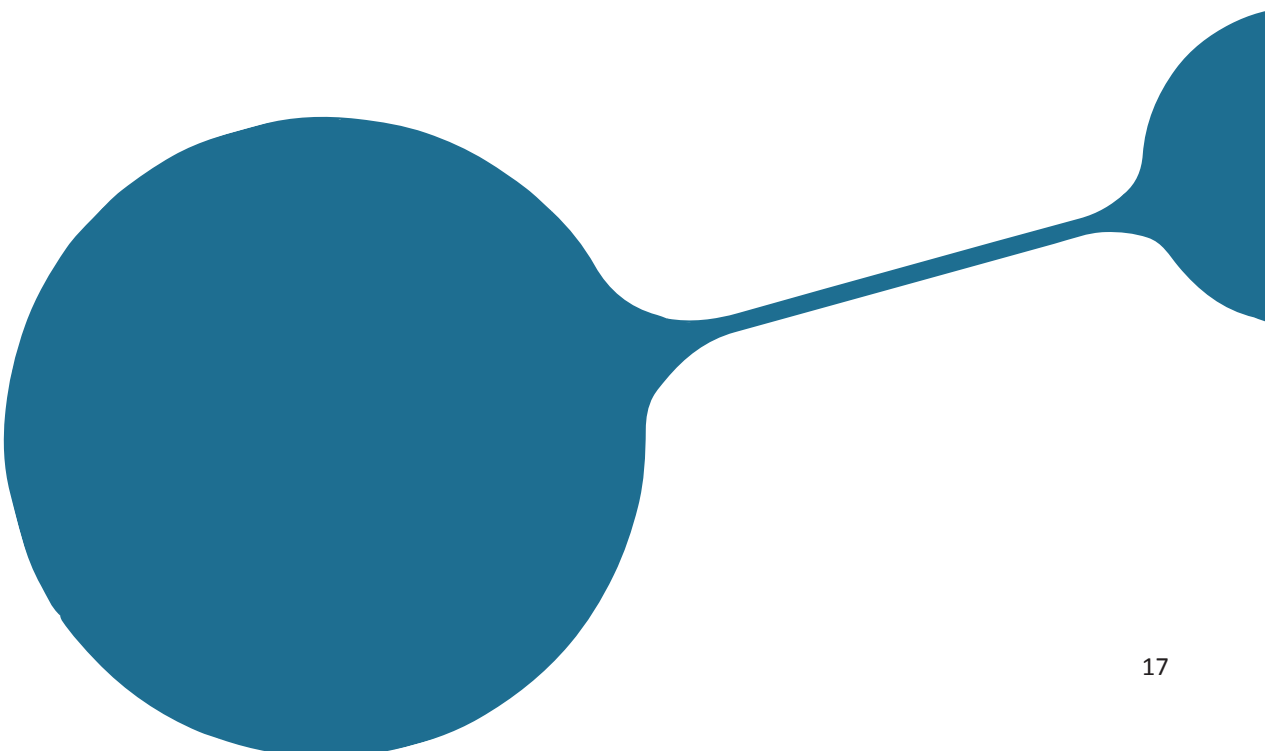


Figure 2.1 Number of programs young people in services attended

The results of the analysis indicated that most young people were engaged with one program at the time of the census, with a smaller number utilising two or three programs. Figure 2.1 also highlights that a smaller population of what may be more complex presentations utilise four, five or more than six programs within one service.

Table 2.1 Program utilisation across Queensland youth AOD services

Program	Primary	Secondary
Outreach	310	20
Counselling	299	65
Outpatient withdrawal	11	18
Home-based withdrawal	0	3
Day program	41	38
Residential withdrawal	7	8
Family therapy	6	15
Other (not specified)	30	27



Length of Involvement in Treatment

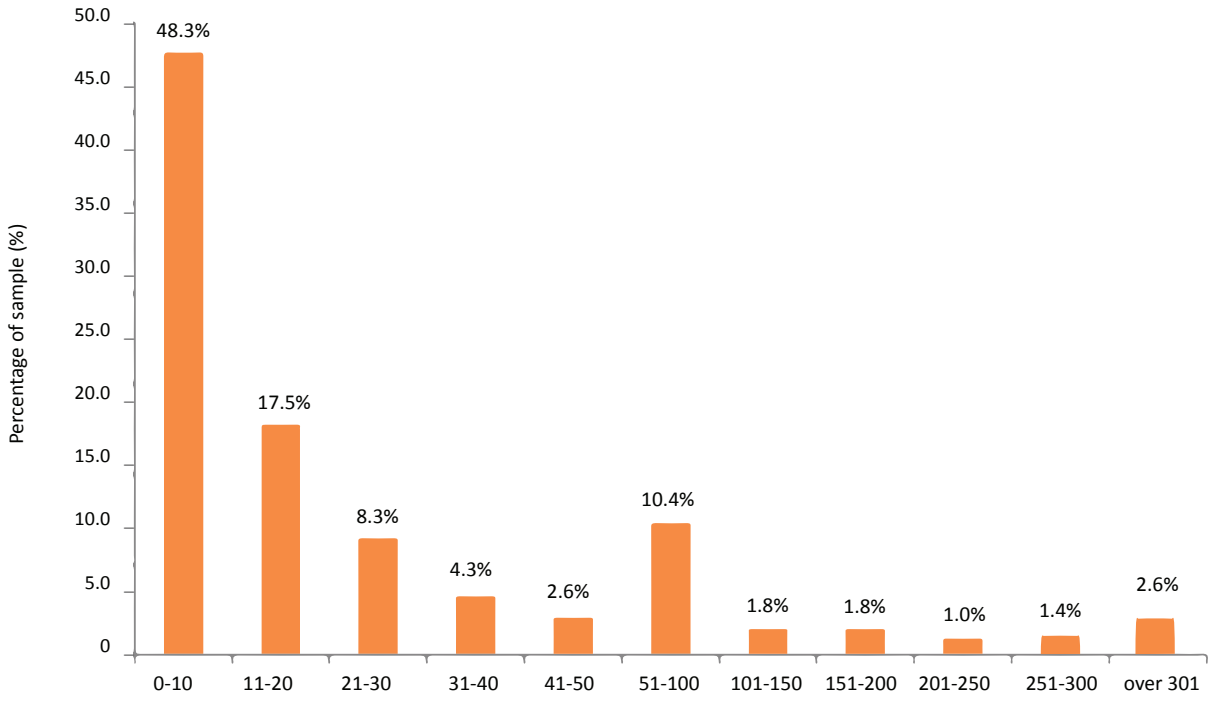


Figure 2.2 Length of treatment in weeks

Length of treatment data highlighted that most young people are engaged with youth AOD services for a period between 0-10 weeks. Following this time there is a gradual decrease, followed by a bimodal second peak between 51-100 weeks. In total, 18.7% of the cohort were engaged in treatment for a period over 51 weeks.

Young Person's Length of Involvement in Treatment by Gender

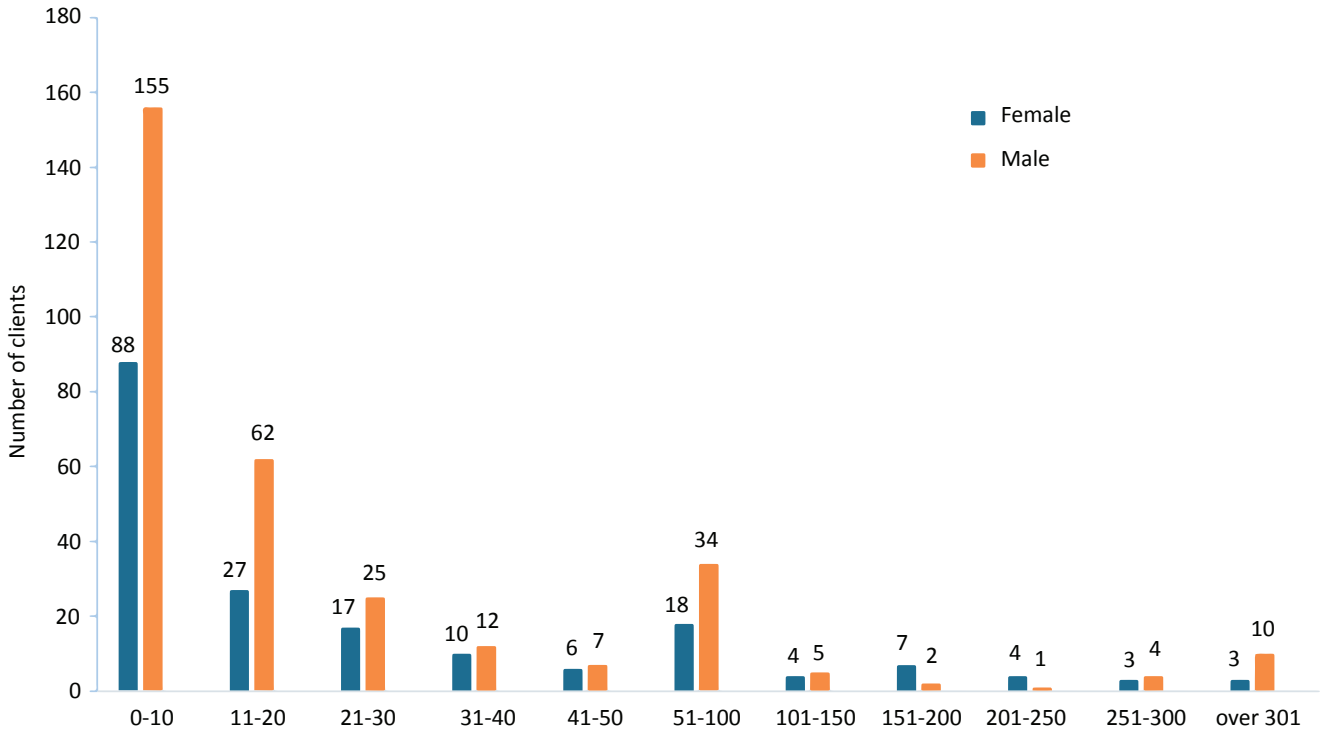


Figure 2.3 Length of treatment in weeks by gender

Data in Figure 2.3 highlighted the greater number of males within services than females. Further, the data showed a relatively consistent drop off every week for both males and females, with both genders exiting services within the first 10 weeks or shortly thereafter (up to 20 weeks).

Length of Treatment and Programs Utilised by Specific Populations

Table 2.2 Average (+SD) number of programs accessed and average length of treatment for Aboriginal and/or Torres Strait Islander young people, LGBTIQ young people and CALD young people compared with the general sample

		Sum of programs participated in	**Length of time engaged with service**
Identifies as Aboriginal and/or Torres Strait Islander	Yes	1.9 (1.3)	23.9 (65.2)
	No	2.5 (1.7)	57.7 (88.9)
Statistic		t(1,506)=-3.970, p<.001	t(1, 507)=-4.944, p<.001
		Sum of programs participated in	**Length of time engaged with service**
Identifies as LGBTIQ	Yes	2.1 (1.5)	29.0 (39.5)
	No	2.1 (1.5)	38.1 (78.9)
Statistic		t(1,507)=-.108, p=.914	t(1,507)=-.586, p=.558
		Sum of programs participated in	**Length of time engaged with service**
Identifies as CALD	Yes	1.8 (1.2)	40.5 (135.2)
	No	2.1 (1.4)	37.5 (72.5)
Statistic		t(1,506)=1.22, p=.223	t(1, 505)=-.209, p=.835

Table 2.2 demonstrates Aboriginal and/or Torres Strait Islander young people accessed on average, less programs and for a shorter duration than other young people in the sample. There were no statistical differences for LGBTIQ and CALD young people.

Length of Treatment for Long-Term Clients

Length of treatment data revealed a group of young people who were engaged in AOD treatment for a period over 52 weeks. These young people may represent a cohort with higher complexity and were analysed to further describe and understand this group.

There were 96 young people (18.8% of the total sample) who were reported to be engaged with the service provider for a period between 52 to 750 weeks. The average length of treatment for this group was 146.7 weeks (SD = 128.8). Ages ranged from 14 to 25 years with the average age being 20.2 years (SD = 2.9). Further demographic information for this cohort is described below.

Table 2.3 Demographics for long-term (52 weeks+) client group

	Female	Male	Identifies as Aboriginal and/or Torres Strait Islander	Identifies as LGBTIQ	Identifies as CALD
Frequency	40	56	63	5	4
Percentage	41.7	58.3	65.6	5.2	4.2

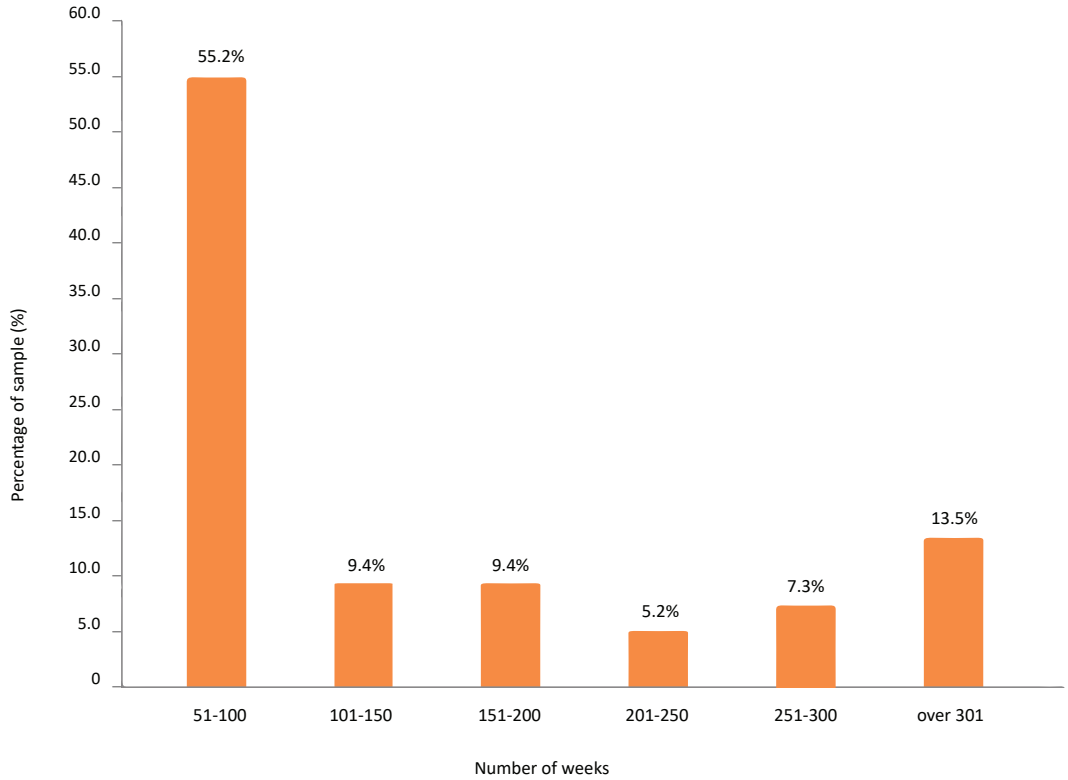


Figure 2.4 Length of treatment in weeks for long-term (52 weeks+) client group

3. Alcohol and Other Drug Use

Youth AOD workers were asked to provide information on self-reported substance use for each young person they were working with on the census date. This included substances used over the previous four weeks, substances used daily and clinician reported rates of substance dependence.

Substance dependence can be assessed using a range of diagnostic tools, such as the ICD-10 and DSM-V. Each service uses different tools to assess substance dependence and so caution is recommended when interpreting the rates of substance dependence in the cohort.

AOD Use Over Previous Four Weeks

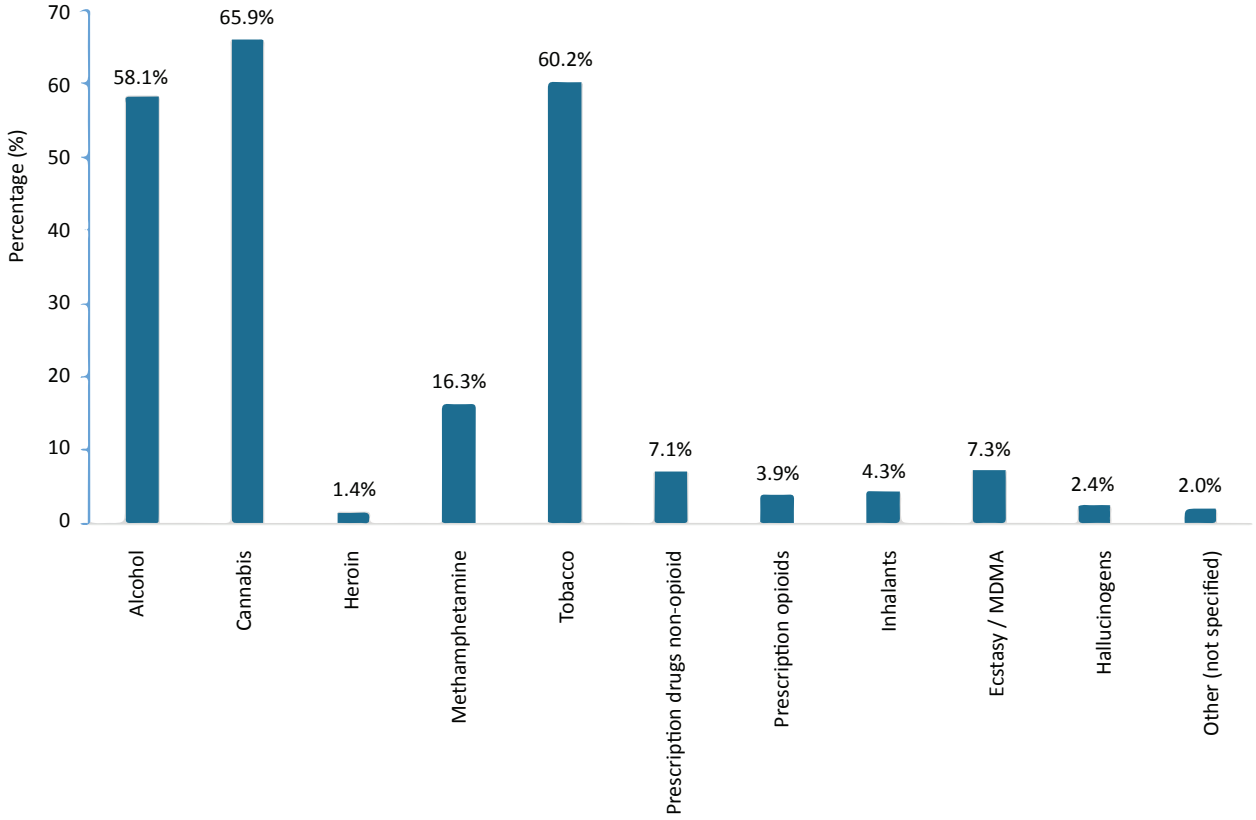


Figure 3.1 Percentage of young people that have used specific substances in the past four weeks

Figure 3.1 shows that cannabis was the most frequently reported substance used in the previous four weeks (66%). Tobacco was the second most frequent (60.3%) and alcohol was the third most frequently reported substance (58.2%). There is then a sharp decline to the next category which is methamphetamine (16%).

Table 3.1 Percentage of young people using AOD by age group and gender over previous four weeks

	12-15 years n=49	16-17 years n=117	18-25 years n=340	Female n=188	Male n=317
Alcohol	49.0	55.6	60.6	55.3	60.0
Cannabis	65.3	70.1	65.0	66.0	66.2
Heroin	0.0	0.0	2.1	2.1	0.9
Methamphetamine	10.2	8.5	20.0*	18.6	14.8
Tobacco	51.0	61.5	61.5	60.6	59.6
Prescription drugs non-opioid	0.0	6.0	8.5	6.9	7.2
Prescription opioids	0.0	2.6	5.0	3.7	4.1
Inhalants	30.6*	4.3	0.6	9.6*	1.3
Ecstasy / MDMA	0.0	6.0	8.8	6.4	7.9
Hallucinogens	0.0	0.9	3.2	2.1	2.5
Other (not specified)	4.2	0.8	2.9	2.1	1.6

*Note. * denotes significant difference using χ^2 at $p = < .05$.*

Gender and age analysis indicates that cannabis is the most widely used substance across these demographics. There are some statistically significant differences emerging in relation to the younger section of the cohort (12-15 years) using more inhalants than other young people and females being more likely to use inhalants than males. Methamphetamine was used significantly more by the older age group (18-25 years).

Table 3.2 Percentage of substances used over past four weeks by Aboriginal and/or Torres Strait Islander status, LGBTIQ status and CALD status

	Does not identify as Aboriginal and/or Torres Strait Islander n=302	Identifies as Aboriginal and/or Torres Strait Islander n=206	Does not identify as LGBTIQ n=482	Identifies as LGBTIQ n=26	Does not identify as CALD n=477	Identifies as CALD n=31
Alcohol	59.7	55.8	58.0	61.5	58.2	45.1
Cannabis	66.7	65.0	65.6	73.1	65.8	67.7
Heroin	2.0	0.5	1.4	0.0	1.4	0.0
Methamphetamine	19.8*	11.2	16.1	19.2	16.5	12.9
Tobacco	61.4	58.7	60.5	57.7	59.1	77.4*
Prescription drugs non-opioid	10.9*	1.5	6.0	26.9*	7.5	0.0
Prescription opioids	5.9*	1.0	3.3	15.4*	4.1	0.0
Inhalants	1.7	8.3*	4.6	0.0	4.4	3.2
Ecstasy / MDMA	10.2*	2.9	6.8	15.4	7.7	0.0
Hallucinogens	4.0*	0.0	2.1	7.7	2.5	0.0
Other (not specified)	3.3*	0.0	1.4	11.5*	4.7	0.0

*Note. * denotes significant difference using χ^2 at $p = < .05$.*

Table 3.2 indicates that Aboriginal and/or Torres Strait Islander young people were reported to have significantly lower levels of recent methamphetamine, prescription drug (opioid and non-opioid), ecstasy/MDMA, hallucinogen and 'other' (not specified) drug use. Young people from the Aboriginal and/or Torres Strait Islander cohort were reported to have significantly higher use of inhalants.

Workers reported that the LGBTIQ cohort were more likely to use prescription drugs, prescription opioids and 'other' (not specified) drugs in the previous four weeks. Young people from a CALD background were most commonly reported to be using tobacco, cannabis and alcohol in the previous four weeks. Recent use of tobacco was significantly higher for the CALD group.

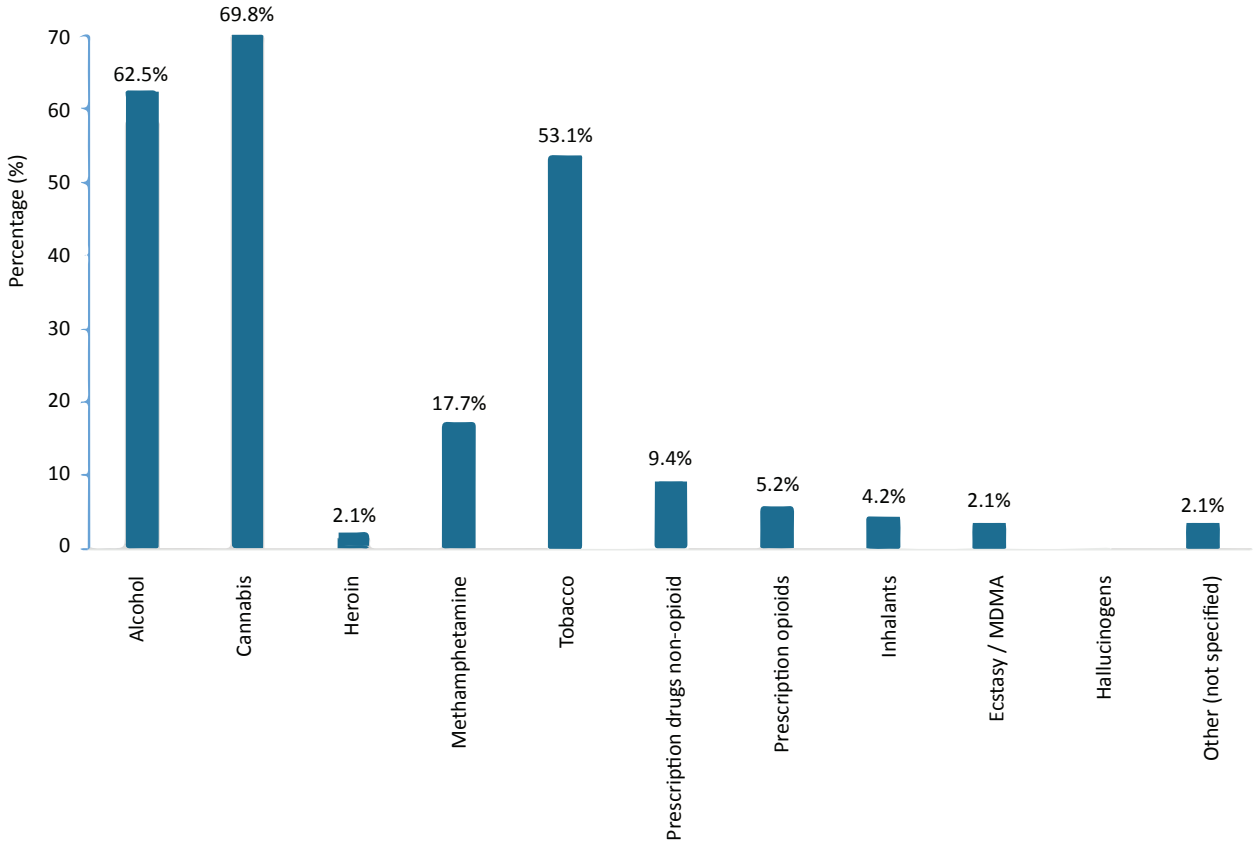


Figure 3.2 Percentage of young people that have used specific substances in the past four weeks for long-term (52 weeks+) client group

This figure shows that cannabis was the most frequently reported substance used in the previous four weeks for the long-term client group. Alcohol was the second most frequently reported substance. Alcohol use was higher for the long-term group compared to the overall census sample (62.5% versus 58.1% respectively). Interestingly, tobacco use was less likely to be reported by workers for young people in the long-term client group compared to the overall sample (53.1% versus 60.2% respectively).

Daily AOD Use

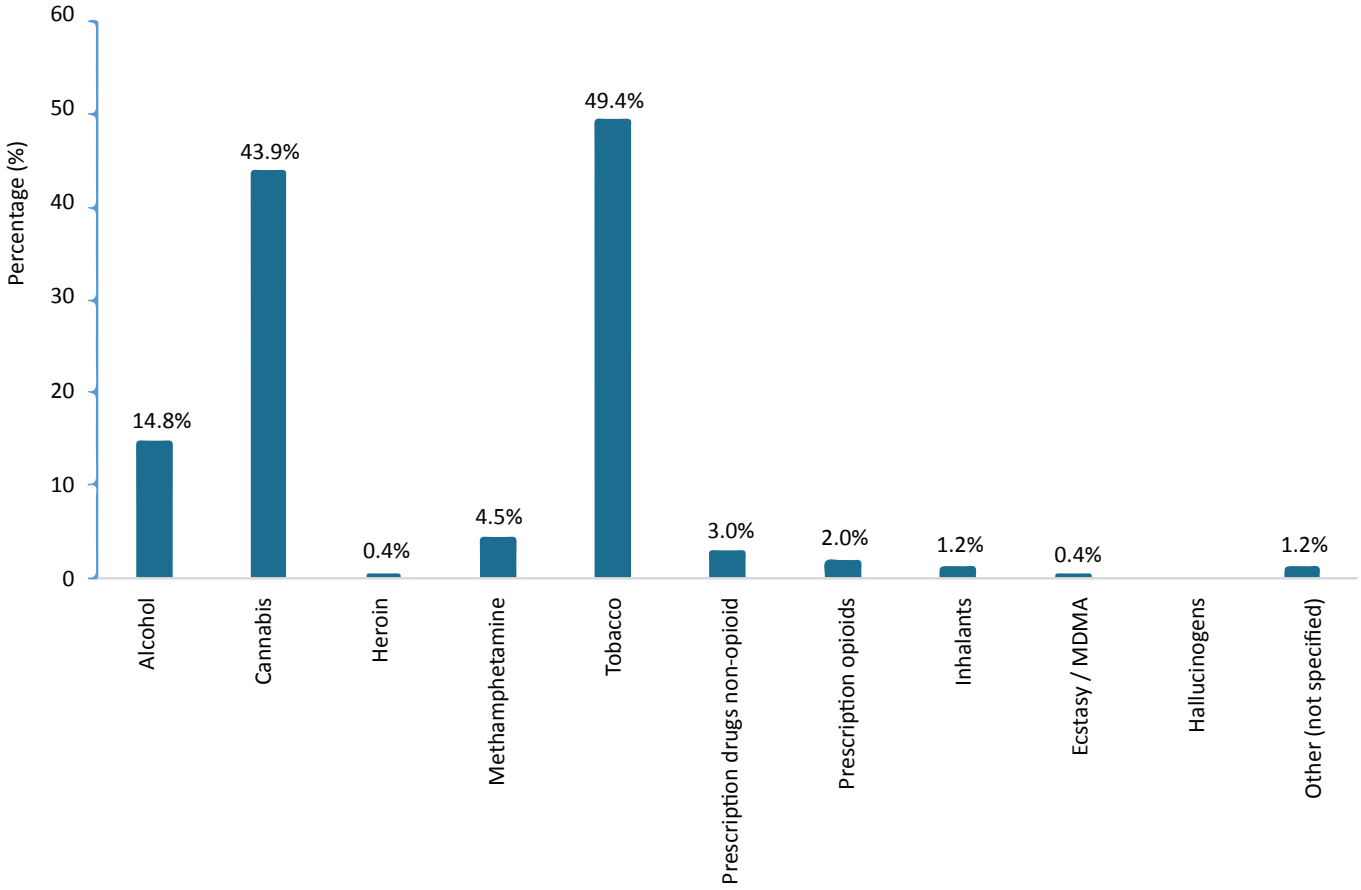


Figure 3.3 Percentage of young people that have used specific substances daily

This figure shows that workers identified tobacco as the substance most likely to be used daily by young people in the sample (49.5%). Cannabis was the second most frequent (44%) and alcohol was the third most frequently used daily substance (14.7%) reported by workers in the census.

Table 3.3 Percentage of young people using substances daily by gender and age

	12-15 years	16-17 years	18-25 years	Female	Male
	n=49	n=117	n=340	n=188	n=317
Alcohol	2.0	8.5	18.8*	13.8	15.1
Cannabis	32.6	47.8	44.4	45.2	43.5
Heroin	0	0	0.5	0.5	0.3
Methamphetamine	0	3.4	5.5	5.3	4.1
Tobacco	38.7	47.0	52.0	45.2	51.4
Prescription drugs non-opioid	0	1.7	3.8	1.0	4.1
Prescription opioids	0	0.8	2.6	2.1	1.8
Inhalants	4.0	3.4	0	2.1	0.6
Ecstasy / MDMA	0	0	0.5	0.5	0.3
Hallucinogens	0	0	0	0	0
Other (not specified)	4.0	0.8	0.8	1.5	0.6

*Note. * denotes significant difference using $\chi 2$ at $p = < .05$.*

Workers identified that tobacco was the substance most frequently used daily by males aged between 18-25 years. The second most frequently used substance was cannabis, and then alcohol, also predominantly used by 18-25 year olds. Methamphetamine, prescription drugs (opioid and non-opioid) were most frequently used by 18-25 year olds. Workers reported that daily inhalant use was most frequently undertaken by the younger age groups, particularly 12-15 year olds.

Table 3.4 Percentage of young people who use substances daily by Aboriginal and/or Torres Strait Islander status, LGBTIQ status and CALD status

	Does not identify as Aboriginal and/or Torres Strait Islander n=302	Identifies as Aboriginal and/or Torres Strait Islander n=206	Does not identify as LGBTIQ n=482	Identifies as LGBTIQ n=26	Does not identify as CALD n=477	Identifies as CALD n=31
Alcohol	14.2	15.5	14.3	23.1	15.0	9.6
Cannabis	53.5	59.7	56.5	46.2	43.3	51.6
Heroin	0.3	0.5	0.4	0.0	0.4	0.0
Methamphetamine	6.3*	1.9	4.6	3.8	4.4	6.4
Tobacco	51.2	47.1	49.3	53.8	48.0	70.9
Prescription drugs non-opioid	5.0*	0.0	2.5	11.5*	3.1	0.0
Prescription opioids	2.6	1.0	1.4	11.5*	2.0	0.0
Inhalants	1.3	1.0	1.2	0.0	1.2	0.0
Ecstasy / MDMA	0.7	0.0	0.0	0.4	0.4	0.0
Hallucinogens	0.0	0.0	0.0	0.0	0.0	0.0
Other (not specified)	1.3	1.0	0.8	7.7*	1.0	0.0

*Note. * denotes significant difference using $\chi 2$ at $p = < .05$.*

Data on daily AOD use reveals few differences between Aboriginal and/or Torres Strait Islander young people and non-indigenous young people. The only differences workers reported were significantly higher rates of methamphetamine and prescription (non-opioid) drug use in the non-indigenous population. In relation to the LGBTIQ group, the data revealed a significant trend for this group to be using prescription drugs (opioid and non-opioid) and 'other' (not specified) drugs daily, indicating a somewhat different AOD use pattern in this small cohort. Young people from a CALD background showed significantly higher daily tobacco use compared to the rest of the sample.

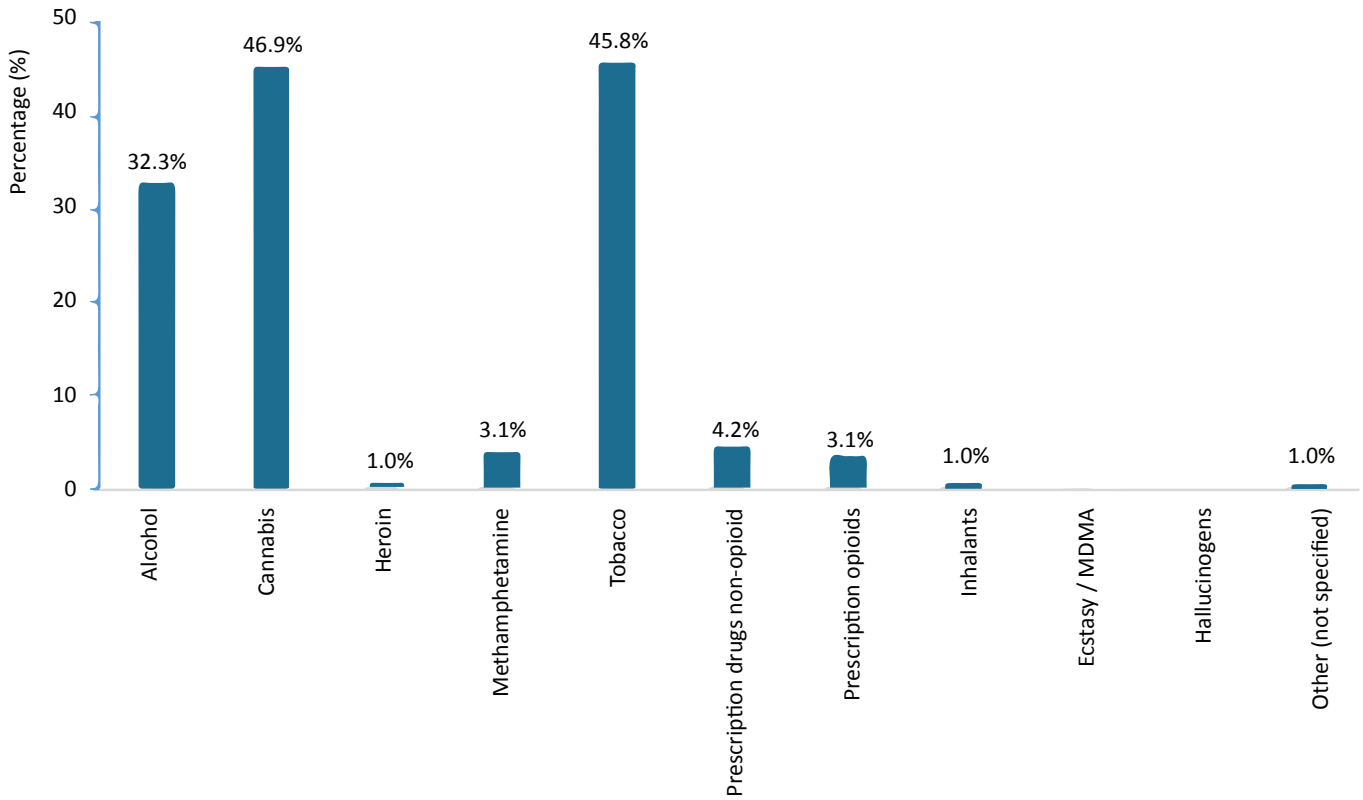


Figure 3.4 Percentage of young people that have used specific substances daily for long-term (52 weeks+) client group

This figure shows that workers identified cannabis as the substance young people in the long-term client group were most likely to be using daily. This was closely followed by daily tobacco use. Daily alcohol use was higher for the long-term client group compared to the overall sample (32.3% versus 14.8% respectively).

Substance Dependence

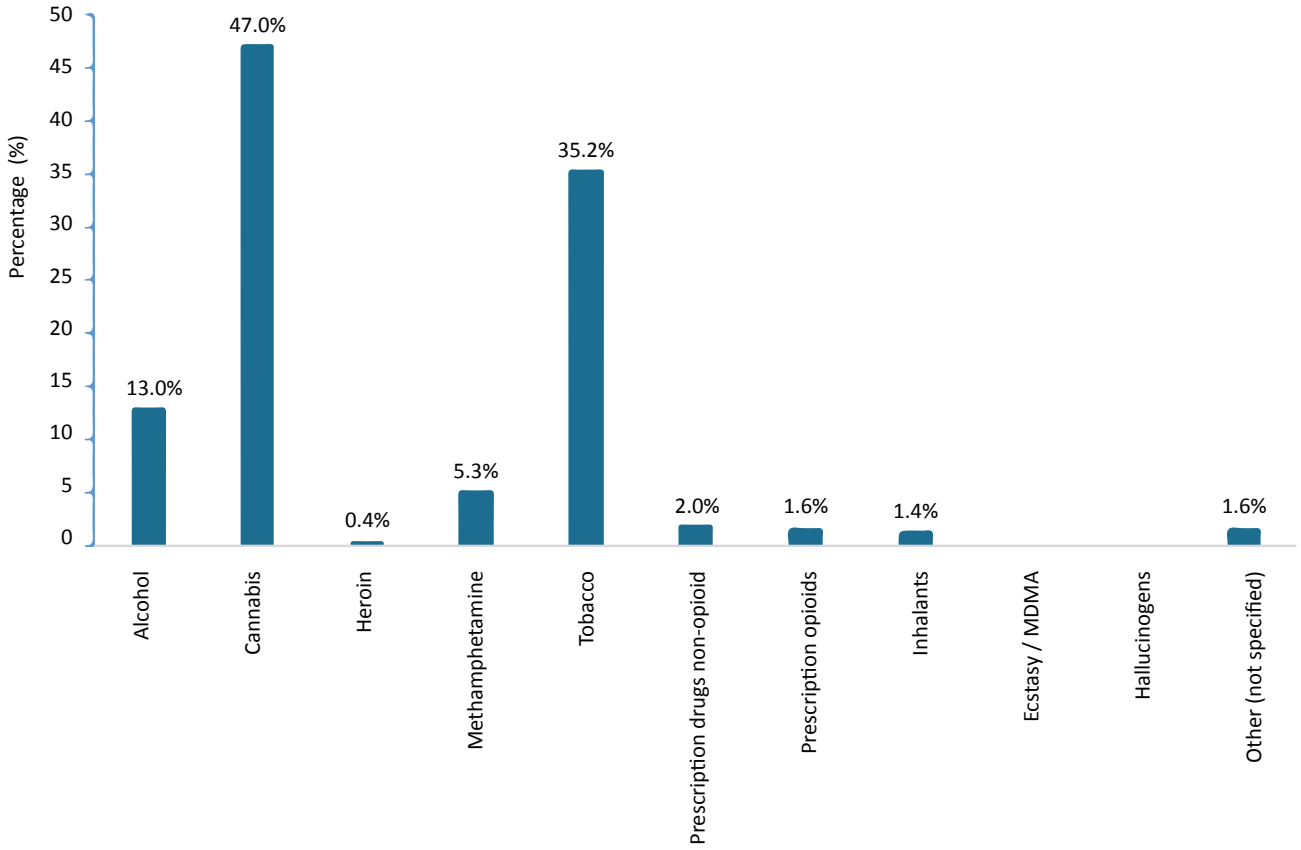


Figure 3.5 Rates of worker reported substance dependence (percentage) in young people

Workers identified cannabis as the most common substance of dependence in the sample, followed by tobacco. The lower rates of tobacco dependence identifed by workers is interesting given research highlights that most young people report mixing their cannabis with tobacco (Ramo, Liu & Prochaska, 2012) and daily tobacco use in the sample was identified at a much higher rate (49.4%).

There is then a decline to the next substance of dependence, being alcohol (13.0%) and then a sharper decline to methamphetamine dependence (5.3%).

Table 3.5 Rates of worker reported substance dependence (percentage) by gender and age

	12-15 years n=49	16-17 years n=117	18-25 years n=340	Female n=188	Male n=317
Alcohol	4.0	5.1	16.7**	10.1	14.5*
Cannabis	36.7	49.5	47.6	43.6	49.5
Heroin	0.0	0.0	0.5	0.5	0.0
Methamphetamine	0.0	3.4	1.7	5.8	5.0
Tobacco	28.5	33.3	37.0	31.9	36.9
Prescription drugs non-opioid	0.0	0.0	2.9	0.5	2.8
Prescription opioids	0.0	0.8	2.0	1.5	1.5
Inhalants	4.0	2.5	0.5	1.5	1.2
Ecstasy / MDMA	0.0	0.0	0.0	0.0	0.0
Hallucinogens	0.0	0.0	0.0	0.0	0.0
Other (not specified)	4.0	1.7	1.1	2.6	0.6

*Note. * denotes significant difference using $\chi 2$ at $p = < .05$.*

*Note. ** denotes significant difference using $\chi 2$ at $p = < .001$.*

Males aged 18 to 25 years were significantly more likely to be rated as dependent upon alcohol.

Table 3.6 Rates of worker reported substance dependence (percentage) by Aboriginal and/or Torres Strait Islander status, LGBTIQ status and CALD status

	Does not identify as Aboriginal and/or Torres Strait Islander n=302	Identifies as Aboriginal and/or Torres Strait Islander n=206	Does not identify as LGBTIQ n=482	Identifies as LGBTIQ n=26	Does not identify as CALD n=477	Identifies as CALD n=31
Alcohol	10.6	16.5	13.0	11.5	13.2	9.6
Cannabis	45.9	49.0	46.4	61.5	46.3	58.0
Heroin	0.3	0.5	0.4	0.0	0.4	0.0
Methamphetamine	7.3*	2.4	5.6	0.0	5.2	6.4
Tobacco	37.0	33.0	35.2	38.5	34.3	48.3
Prescription drugs non-opioid	3.3*	0.0	1.4	11.5*	2.0	0.0
Prescription opioids	2.3	0.5	1.0	11.5*	1.6	0.0
Inhalants	1.3	1.5	1.4	0.0	1.4	0.0
Ecstasy / MDMA	0.0	0.0	0.0	0.0	0.0	0.0
Hallucinogens	0.0	0.0	0.0	0.0	0.0	0.0
Other (not specified)	2.0	1.0	1.0	11.5*	1.4	0.0

*Note. * denotes significant difference using $\chi 2$ at $p = < .05$.*

Table 3.6 shows worker reported dependence rates across substances for Aboriginal and/or Torres Strait Islander young people, LGBTIQ young people and CALD young people. The data highlights that Aboriginal and/or Torres Strait Islander young people were significantly less likely to be dependent on methamphetamine and prescription drugs (non-opioid). The LGBTIQ group were significantly more likely to be dependent on prescription drugs (opioid and non-opioid) and 'other' drugs (not specified). No significant differences related to dependence were found for CALD young people in the sample.

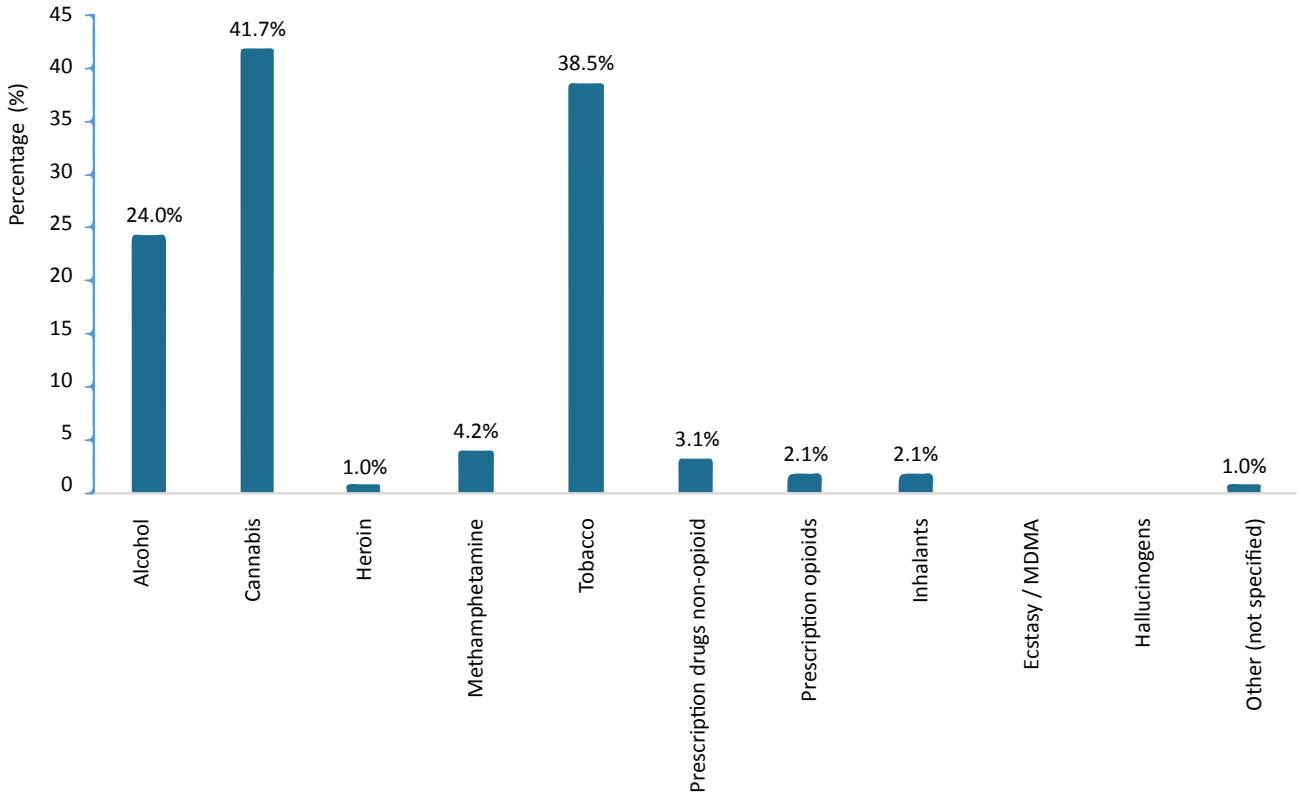


Figure 3.6 Rates of worker reported substance dependence (percentage) for long-term (52 weeks+) client group

This figure shows that workers identified cannabis as the substance young people in the long-term client group were most likely to be dependent upon (41.7%). This was followed by dependent tobacco use (38.5%) and dependent alcohol use (24.0%). Worker assessment of dependent alcohol use was higher for the long-term client group compared to the overall sample (24.0% versus 13.0% respectively).

Injecting Use and AOD Related Harm

History of injecting drug use and recent experience of serious AOD related harms are depicted below. AOD harms reported include:

- required a hospital admission or ambulance attendance
- suffered injuries or physical harm
- driven a vehicle when substance affected
- had unwanted sex when substance affected.

Table 3.7 Percentage of young people who have ever used a drug by injection

	12-15 years n=49	16-17 years n=117	18-25 years n=340	Female n=188	Male n=317	Total n=508
Drug use by injection	2.0	7.1	23.2*	17.0	17.4	17.7

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

In relation to injecting history, workers reported very similar rates for males and females. The main difference was seen by age grouping with young people aged 18-25 years being more likely to have reported ever injecting.

Table 3.8 Percentage of young people who reported serious AOD related harms in the last three months

	12-15 years n=49	16-17 years n=117	18-25 years n=340	Female n=188	Male n=317	Total n=508
Serious AOD related harm	30.6	22.2	35.6	37.8*	28.4	32.0

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

Table 3.8 demonstrates that females were significantly more likely to have reported experiencing AOD related harms in the previous three months. Further, there was a concerning risk for young people (12 to 15 years) reporting AOD related harms to their workers.

Table 3.9 Percentage of long-term (52 weeks+) clients who have ever used a drug by injection and who have ever reported serious AOD related harms

	Female n=40	Male n=56	Total n=96
Drug use by injection	17.5	25.0	22.9
Serious AOD related harm	50.0	28.5	38.5

Table 3.9 shows worker reported injection histories and recent experiences of AOD related harm for the long-term client group. Reports of injecting history was higher for the long-term client group compared to the overall sample (22.9% versus 17.7% respectively). Similarly, reporting of AOD related harm was higher for the long-term client group compared to the overall sample (38.5% versus 32.0% respectively).

4. Criminal Justice Involvement

The interplay between AOD use and criminal behaviour is complex. There has been a decrease in overall youth crime nationally over the past seven years (ABS, 2018). In Queensland, the number of youth offenders has moderately declined from 2012-13 to 2016-17 (ABS, 2018). A range of psychosocial factors contribute to offending. Factors include gender (males are more likely to offend than females) and age (12 -16 year old's are more likely to offend and with greater frequency, than those aged between 18-24 years) (ABS, 2018). Grieger and Hosser (2013) found that the top four predictive factors of criminal recidivism were family issues, school problems, lack of leisure/recreation and substance use. Further research by Shepherd and Purcell (2015) highlighted the impact of mental health issues and demonstrated that in young people with mental health concerns, being male, not engaging in education, employment or training, frequent drug use and/or multiple adverse events in life was positively related to police contact. These factors are notable, as ThYNC-Q highlights concerns in all of these areas for young people in the youth AOD treatment system.

Involvement in the Criminal Justice System

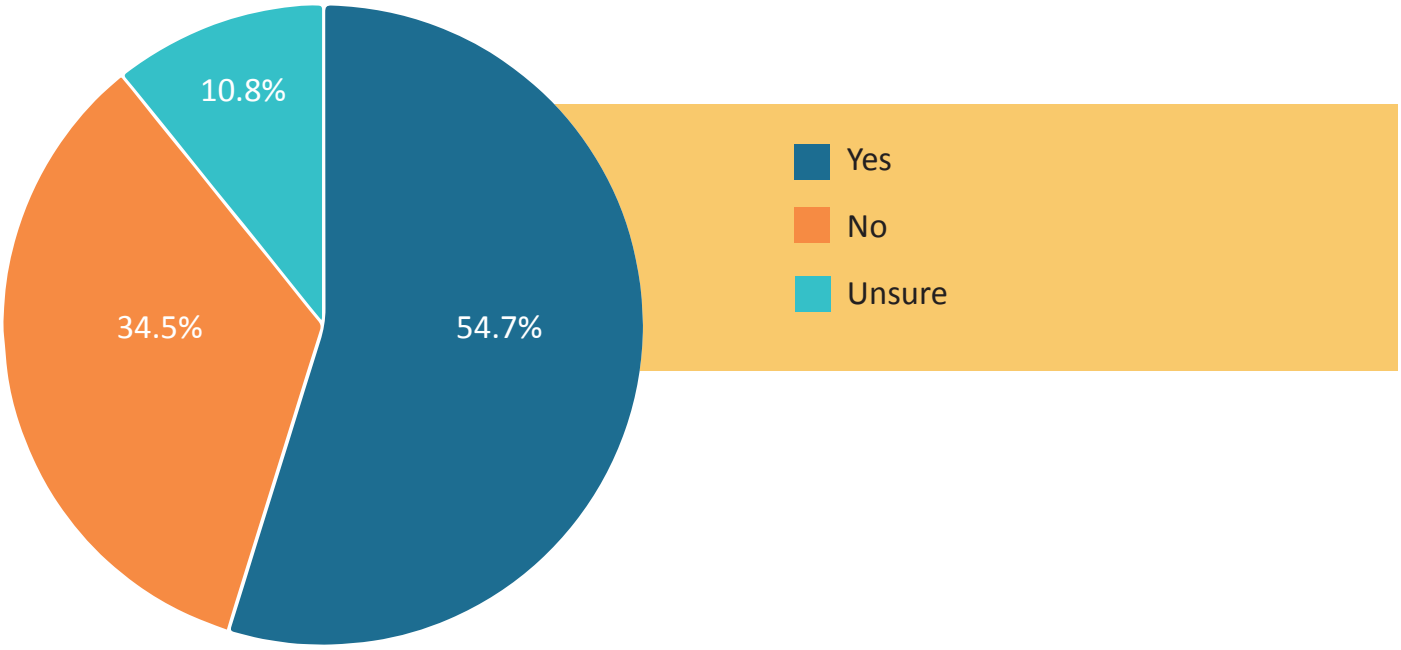


Figure 4.1 Percentage of young people that have ever been involved in the criminal justice system

Criminal Offending and Service Provision

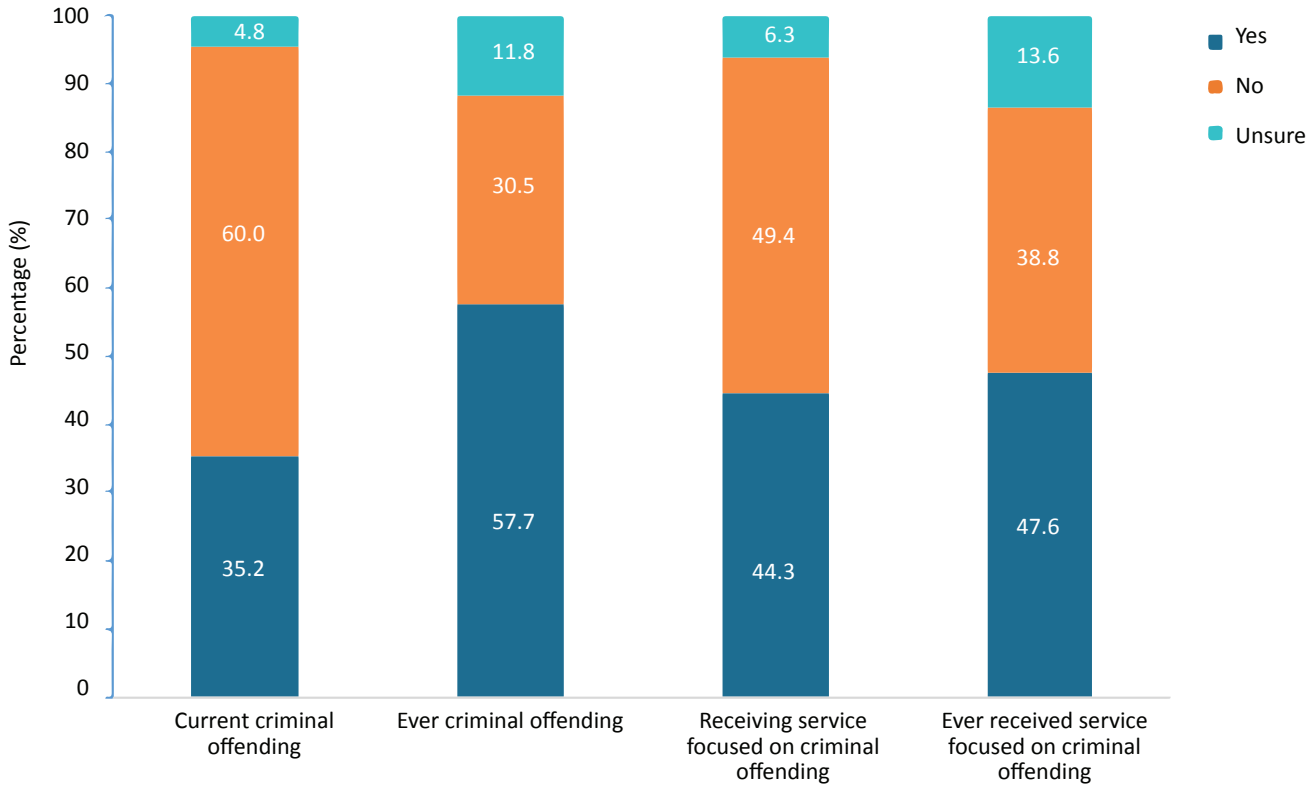


Figure 4.2 Percentage of criminal offending past and present with receipt of service past and present

Figure 4.2 highlights that around one third of young people were experiencing problems with criminal offending at the time of the census according to their worker. Service provision focused on criminal offending for this cohort was high, with 44.3% currently receiving support for this issue.

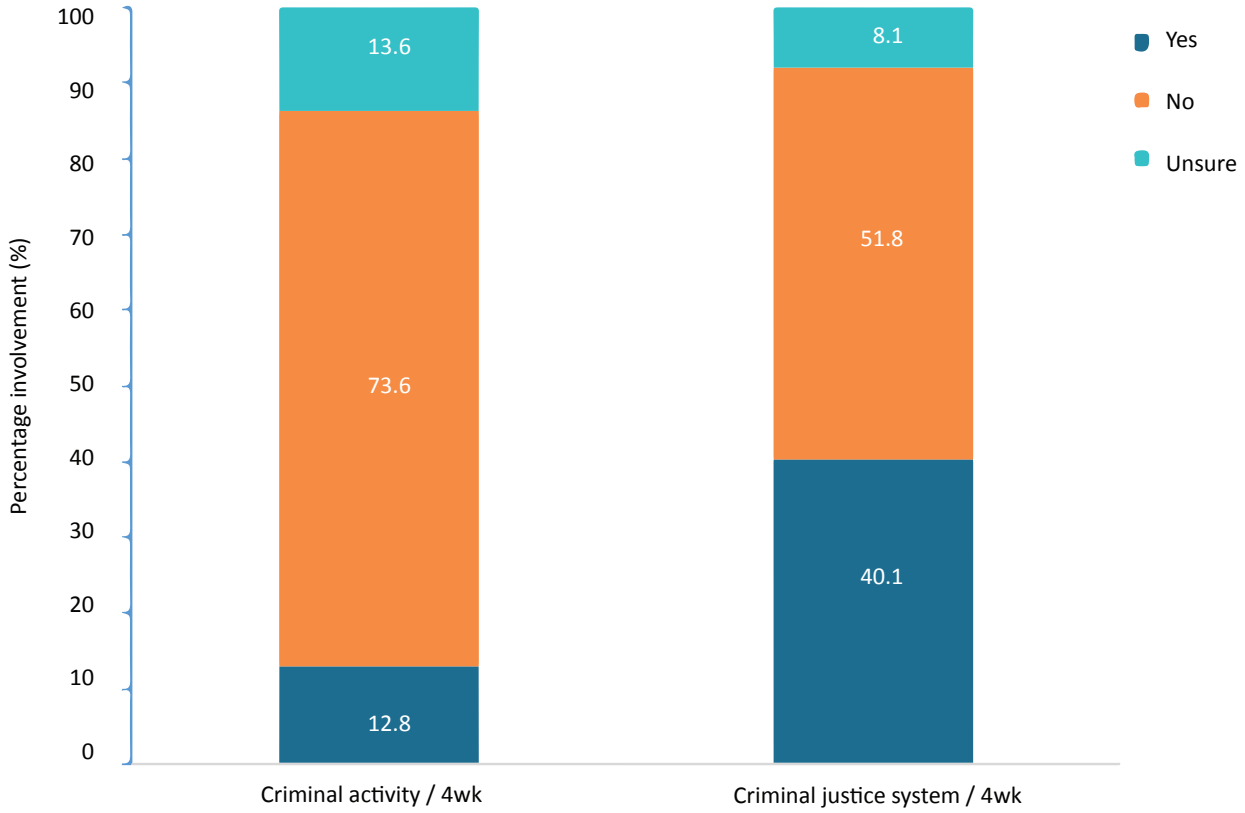


Figure 4.3 Excluding substance use, percentage of young people involved in criminal activity and criminal justice system over previous four weeks

Excluding substance use, workers reported that most young people (73.6%) had not been involved in criminal activity in the four weeks prior to the census and just over half of the sample had not interacted with the criminal justice system in the four weeks prior (51.8%).

Involvement in the Criminal Justice System by Demographics

Table 4.1 Percentage of young people that have ever been involved in the criminal justice system by age group and gender

Ever involved with criminal justice system	12-15 years n=49	16-17 years n=117	18-25 years n=340	Female n=188	Male n=317
Yes	42.8	41.0	60.9**	48.9	57.7
No	42.8	38.5	32.0	37.8	32.8
Unsure	14.4	20.5	7.1	13.3	9.5

*Note. ** denotes significant difference using $\chi 2$ at $p = < .001$.*

Table 4.1 shows that males in the sample were reported to be more likely engaged with the criminal justice system than females. Results also indicated that young people aged 18-25 years were significantly more likely to report criminal justice system involvement.

Criminal Offending in Specific Populations

Table 4.2 Percentage of young people reporting criminal offending and service provision focused on criminal offending by specific populations

	Criminal offending		Receiving service focued on criminal offending	
	Past	Current	Past	Current
Not identified as Aboriginal and/or Torres Strait Islander	52.9	32.4	42.3	41.7
Identifies as Aboriginal and/or Torres Strait Islander	64.5*	39.3*	55.3*	48.0*
Not identified as LGBTIQ	58.7*	35.6	48.1*	45.4*
Identifies as LGBTIQ	38.5	26.9	38.5	23.0
Not identified as CALD	57.4	34.5	47.5	43.3
Identifies as CALD	61.2	45.1	48.3	58.0

*Note. * denotes significant difference using $\chi 2$ at $p = < .05$.*

Table 4.2 highlights the significantly higher levels of offending (past and present) reported by workers for Aboriginal and/or Torres Strait Islander young people. Likewise, the data indicates that supports both past and present were significantly higher for Aboriginal and/or Torres Strait Islander young people.

In relation to young people from the LGBTIQ cohort, workers indicated that these individuals were less likely to have a current issue with offending than other young people in the census.

Table 4.2 also highlights the slightly higher levels of offending (past and present) reported by workers for young people who identified as being from a CALD background.

Table 4.3 Rates of young people reporting criminal offending and criminal justice involvement for long-term (52 weeks+) client group

	Frequency	Percentage
Current involvement with criminal justice system	42	43.8
Past involvement with criminal justice system	66	68.8
Criminal activity (past 4 weeks)	14	14.6

Nearly half of the long-term client group were involved with the criminal justice system at the time of the census. In addition, workers reported that nearly three quarters of young people from this cohort had a history of involvement with the criminal justice system.

5. Family and Relationships

Family relationships provide young people with a sense of belonging, support in negotiating challenges and connection to shared values, culture and history.

Youth AOD workers were asked to report if their clients had a current problem with family relationships and if their client was currently receiving a service focused on this issue. Workers were also asked to report on past problems with family relationships. Data on young people who were themselves parents was also collected.

Alongside family relationships, this section explores the prevalence of abuse, neglect and family violence within the sample. Workers were asked to report young people's history of abuse, neglect and family violence as well as involvement with the child protection system.

Table 5.1 Frequency and percentage of young people with family relationship problems past and present (last four weeks), and receiving service focused on this issue

	Frequency	Percent
Current problem	241	47.3
Past problem	349	68.6
Current service use	139	27.3
Past service use	166	32.6

Table 5.1 highlights that just under half of the population sampled were experiencing family problems. Notably, only around half of these young people were receiving any service to support them with these issues. In terms of past issues, the data highlights that two thirds of these young people experienced family problems, and one third received support.

Family Relationship Problems by Demographics

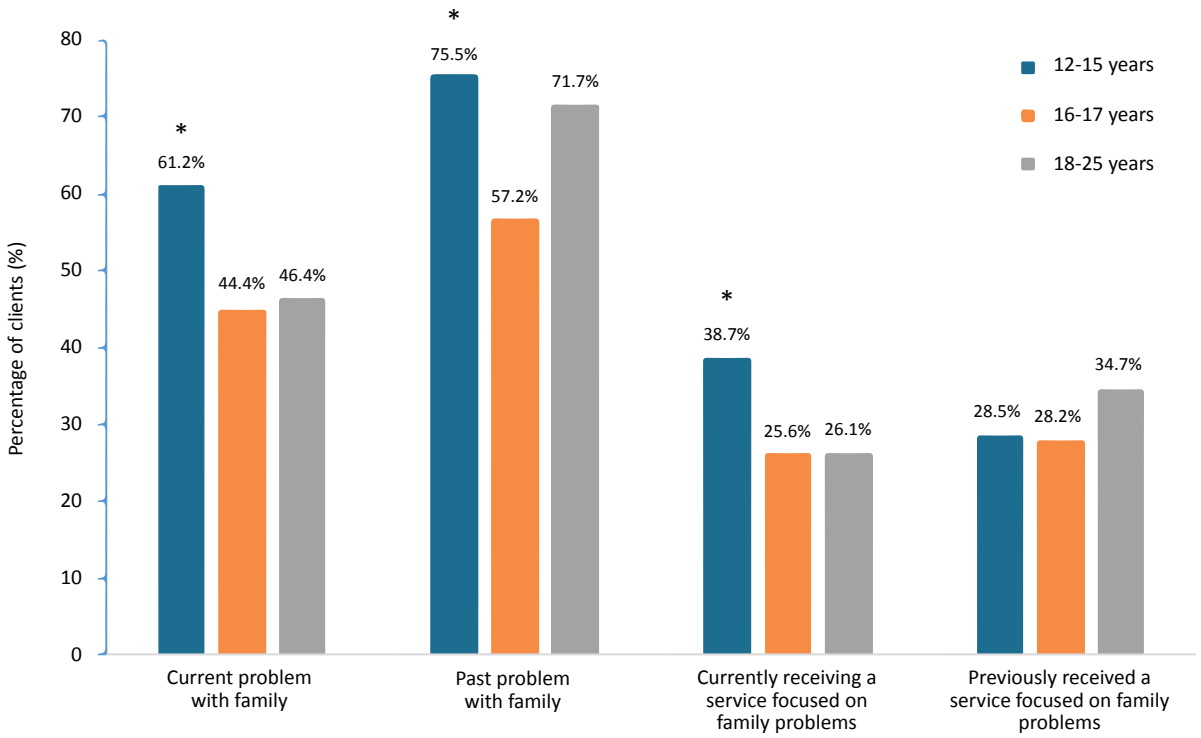


Figure 5.1 Percentage of young people with reported family relationship problems past and present (last four weeks), and receiving service focused on this issue by age

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

The data indicated that workers identified family issues as most significant for those in the youngest age range, both in the four weeks prior to the census and in their past. While this group reportedly received slightly more services at the time of the census on this issue, it was still only around half the amount of need identified. Even amongst the older groups there were marked differences in the services offered versus the need indicated as reported by their workers.

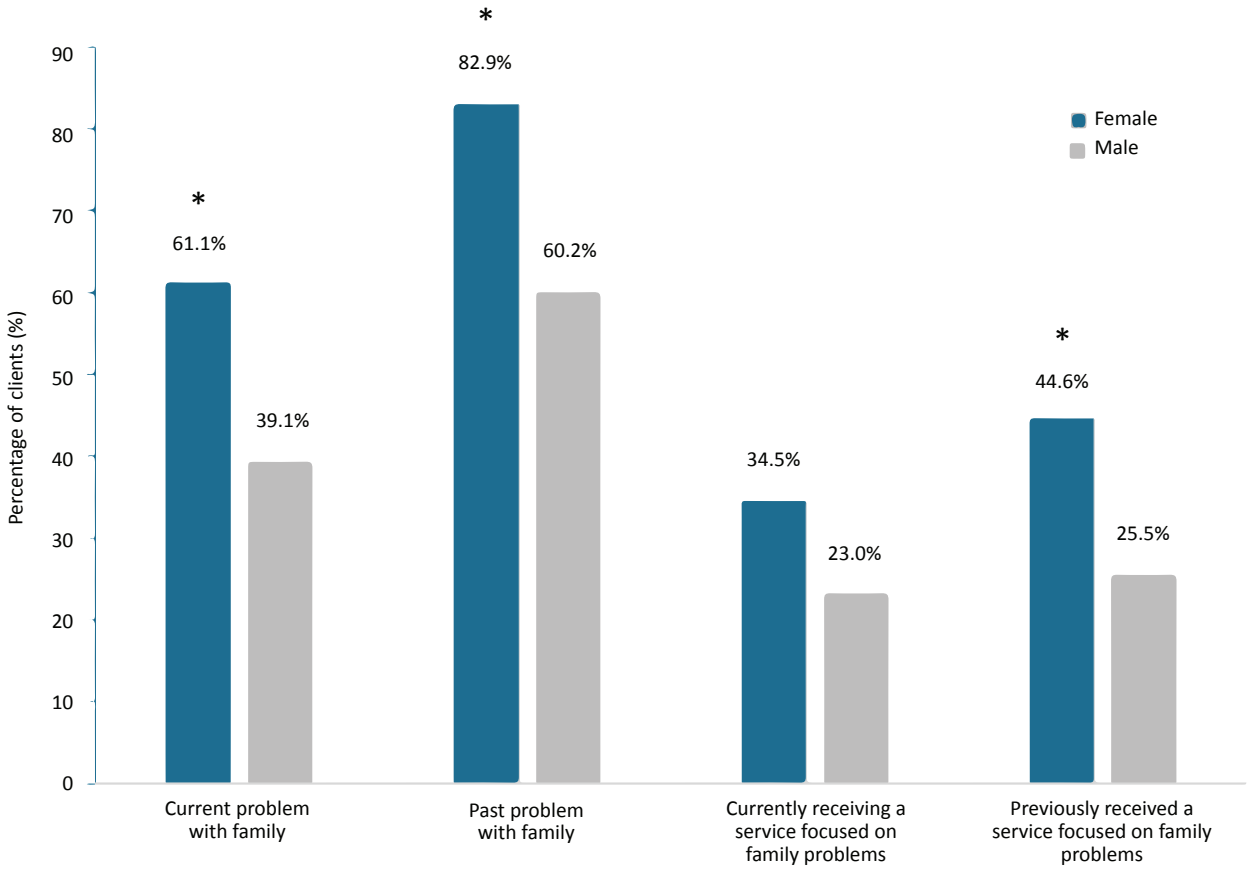


Figure 5.2 Percentage of young people with reported family relationship problems past and present (last four weeks), and receiving service focused on this issue by gender

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

Figure 5.2 highlights that workers identified females as significantly more likely to report current and past problems with family relationships.

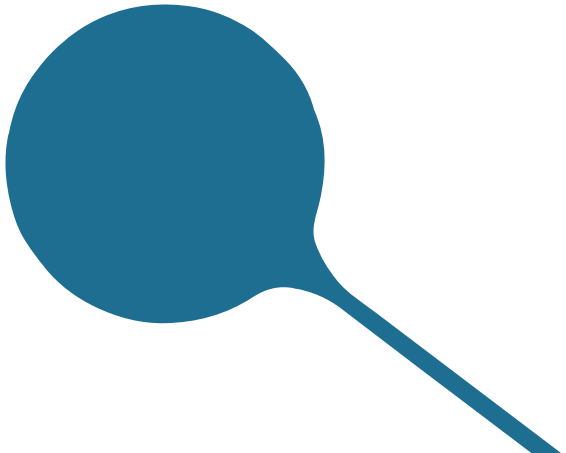
Family Relationship Problems in Specific Populations

Table 5.2 Percentage of young people with reported family relationship problems past and present (last four weeks), and receiving service focused on this issue by Aboriginal and/or Torres Strait Islander status, LGBTIQ status and CALD status

	Does not identify as Aboriginal and/or Torres Strait Islander n=302	Identifies as Aboriginal and/or Torres Strait Islander n=206	Does not identify as LGBTIQ n=482	Identifies as LGBTIQ n=26	Does not identify as CALD n=477	Identifies as CALD n=31
Current problem with family	46.9	48.1	45.5	80.8*	48.0	35.4
Currently receiving a service focused on family problems	25.4	30.1	25.5	61.5*	27.6	19.3
Past problem with family	71.0	65.0	67.1	92.6*	68.3	74.1
Previously received a service focused on family problems	25.4	43.2*	31.7	50.0	33.1	25.8

*Note. * denotes significant difference using $\chi 2$ at $p = < .05$.*

The data related to family problems in the Aboriginal and/or Torres Strait Islander cohort highlights that workers identified a slightly higher incidence of current family problems but no overall significant differences from the non-indigenous sample. In contrast, workers identified those from the LGBTIQ cohort as significantly more likely to have past and present family problems and have received support for this. Young people from a CALD background showed no significant differences in relation to family problems (past and present) according to their worker.



Family Conflict and Disconnection from Family

Table 5.3 Frequency and percentage of young people with reported conflict with family and family disconnection

Disconnected from family	Frequency	Percent
Yes	148	29.1
No	318	62.6
Unsure	42	8.3
Family conflict (past 4 weeks)	**Frequency**	**Percent**
Yes	217	42.6
No	207	40.7
Unsure	85	16.7

Youth AOD workers reported that 29% of young people in the sample were disconnected from their families, a very high number considering the cohort's age. Further to this, 42.6% of young people were reported to have experienced family conflict in the four weeks prior to the census date.

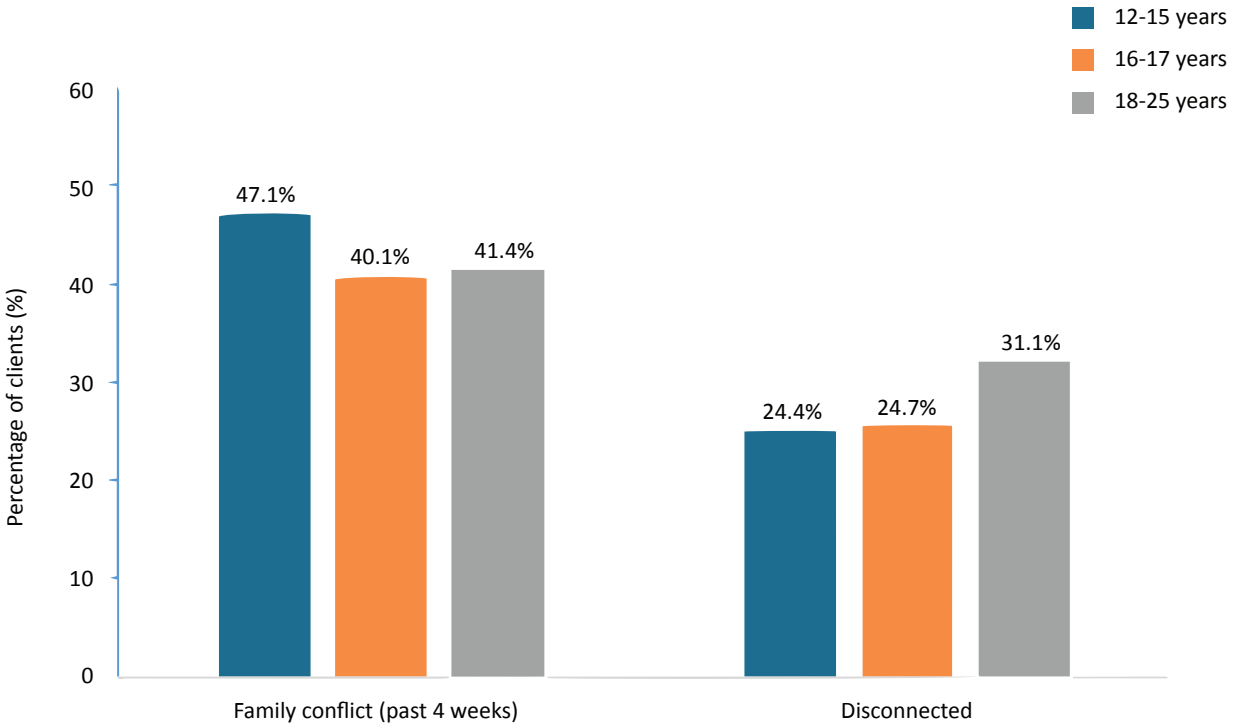


Figure 5.3 Percentage of young people with reported conflict with family, and family disconnection by age group

Figure 5.3 indicates that rates of family conflict was relatively consistent across age ranges, whilst disconnection from family was slightly elevated in the 18-25 year old age range.

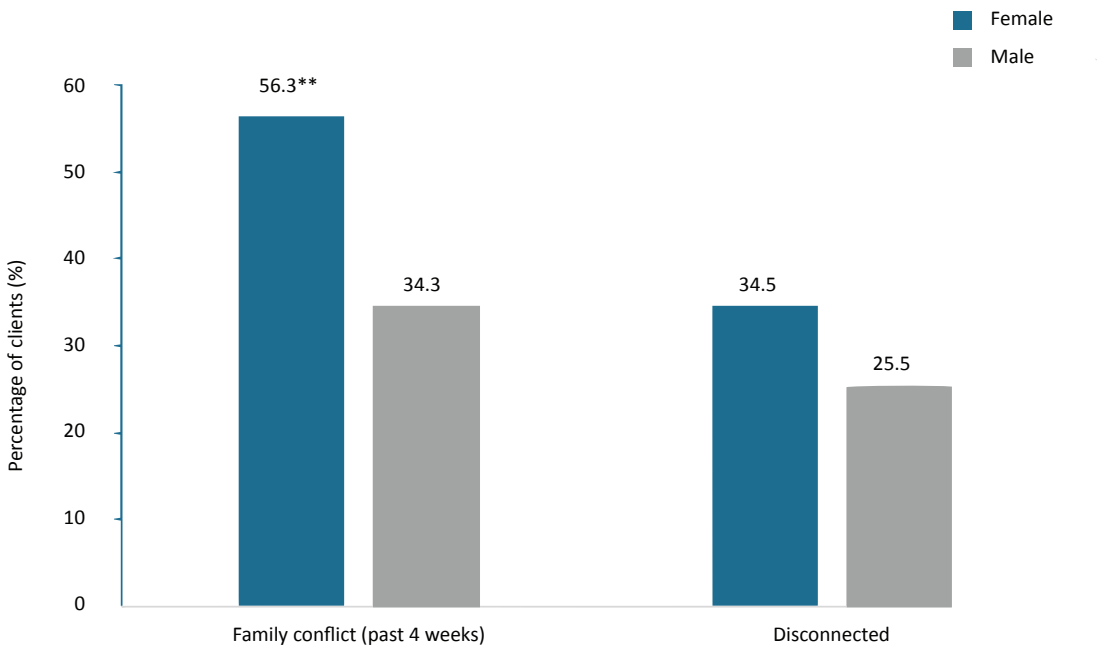


Figure 5.4 Percentage of young people with reported conflict with family and family disconnection by gender
*Note. ** denotes significant difference using χ2 at p = < .001.*

Figure 5.4 shows that females were significantly more likely to report recent family conflict to their workers. Females were also more likely to report being disconnected from family.

Table 5.4 Percentage of young people with reported conflict with family and family disconnection by Aboriginal and/or Torres Strait Islander status, LGBTIQ status and CALD status

	Does not identify as Aboriginal and/or Torres Strait Islander n=302	Identifies as Aboriginal and/or Torres Strait Islander n=206	Does not identify as LGBTIQ n=482	Identifies as LGBTIQ n=26	Does not identify as CALD n=477	Identifies as CALD n=31
Family conflict (past 4 weeks)	42.9	42.2	40.8	76.9*	29.3	25.8
Disconnection	27.1	32.0	28.2	46.2	43.6*	25.8

*Note. * denotes significant difference using $\chi 2$ at $p = < .05$.*

Table 5.4 highlighted no statistical differences in level of family conflict and disconnection in those from the Aboriginal and/or Torres Strait Islander cohort and those who were not. In contrast, there was a markedly higher level of family conflict and family disconnection reported in young people from the LGBTIQ cohort. The data shows significantly less reported family conflict and disconnection by young people from a CALD background compared to the rest of the sample.

Table 5.5 Rates of young people reporting current and past family relationship problems and disconnection from family for long-term (52 weeks+) client group

	Frequency	Percentage
Current problem with family	52	54.2
Past problem with family	82	85.4
Family conflict (past 4 weeks)	46	47.9
Disconnection	33	34.4

Abuse, Neglect and Family Violence

Table 5.6 Worker reported past rates of abuse, neglect, and family violence for the overall cohort

Neglect	Frequency	Percent
Yes	162	31.8
No	175	34.4
Unsure	172	33.8

Emotional Abuse	Frequency	Percent
Yes	202	39.8
No	137	26.9
Unsure	169	33.3

Physical Abuse	Frequency	Percent
Yes	147	28.9
No	161	31.7
Unsure	200	39.4

Sexual Abuse	Frequency	Percent
Yes	84	16.5
No	200	39.4
Unsure	224	44.1

Victim of Violent Crime	Frequency	Percent
Yes	75	14.8
No	216	42.5
Unsure	217	42.7

Family Violence Victim	Frequency	Percent
Yes	151	29.7
No	258	50.8
Unsure	99	19.5

Family Violence Witness	Frequency	Percent
Yes	168	33.1
No	240	47.2
Unsure	100	19.7

Family Violence Instigator	Frequency	Percent
Yes	68	13.4
No	331	65.1
Unsure	109	21.5

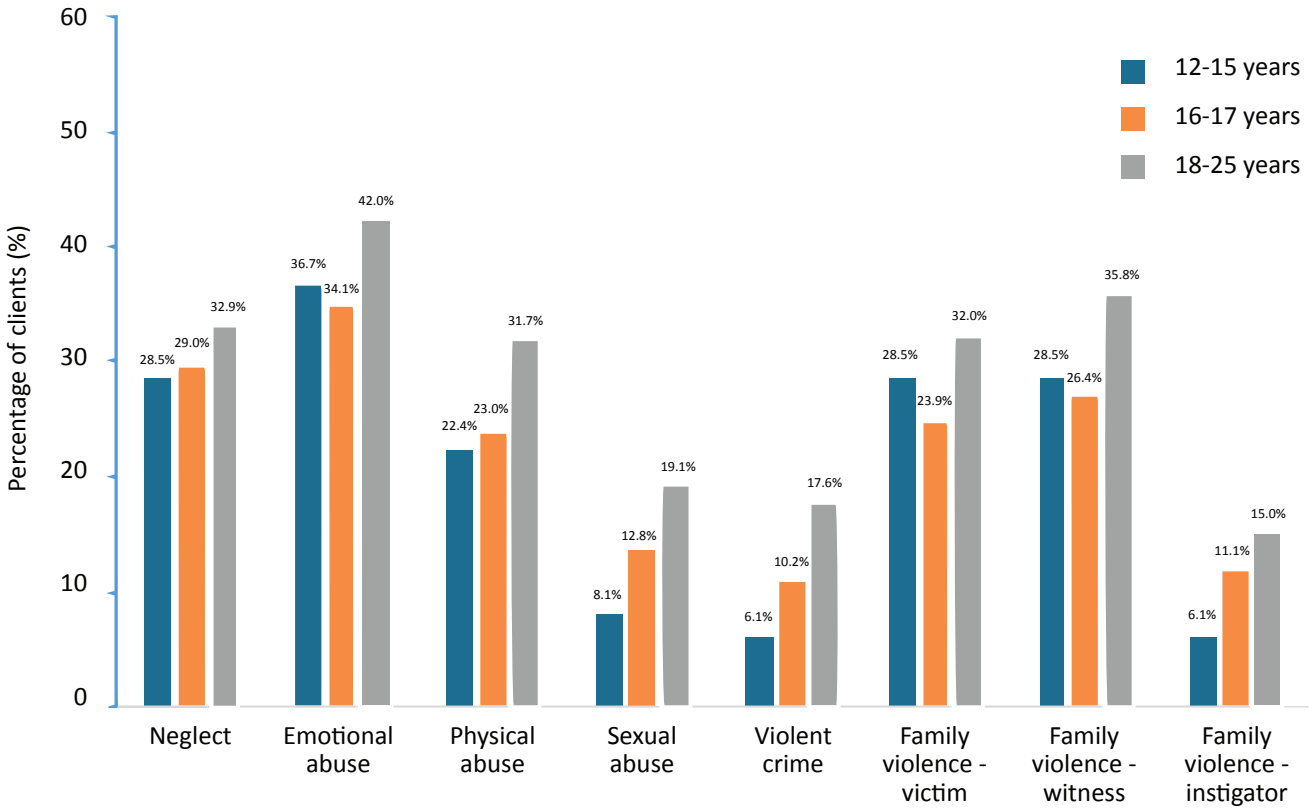


Figure 5.5 Percentage of young people reporting abuse, neglect and family violence to their worker by age group

Figure 5.5 represents "known" reports of abuse, neglect and/or family violence. As shown in the tables previous there were high rates of workers reporting that they did not know if their client had experienced abuse, neglect and/or family violence.

Young people in the 18-25 year old age group reported to their worker higher rates of abuse and higher rates of family violence, however there were no significant findings comparing age groups.

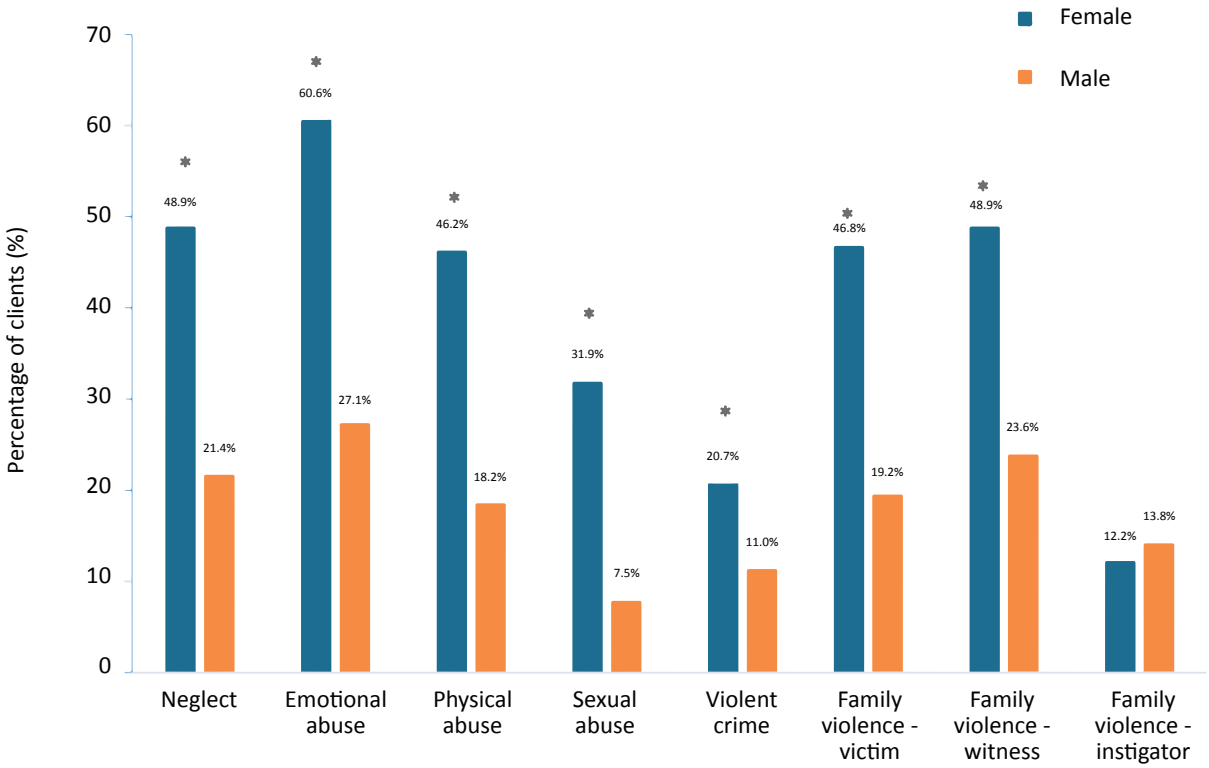


Figure 5.6 Percentage of young people reporting abuse, neglect and family violence to their worker by gender

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

The data related to "known" gender and family violence and abuse indicated that females were significantly more likely to report all forms of abuse and violence, with the greatest differential being the rates of sexual abuse. Females in the sample were also significantly more likely to report being a victim and a witness to family violence. No differences in the rates of being the instigator of family violence were found between genders.

Table 5.7 Percentage of young people reporting abuse and neglect to their worker by Aboriginal and/or Torres Strait Islander status, LGBTIQ status and CALD status

	Does not identify as Aboriginal and/or Torres Strait Islander n=302	Identifies as Aboriginal and/or Torres Strait Islander n=206	Does not identify as LGBTIQ n=482	Identifies as LGBTIQ n=26	Does not identify as CALD n=477	Identifies as CALD n=31
Victim of emotional abuse	34.8	47.1*	38.4	65.4*	39.8	38.7
Victim of physical abuse	21.5	39.8**	28.0	46.2*	28.7	32.3
Victim of sexual abuse	13.2	44.0*	15.1	42.3*	17.2	6.5
Victim of neglect	22.8	44.6**	31.3	38.5	31.7	32.3

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

*Note. ** denotes significant difference using χ2 at p = < .001.*

Table 5.7 highlights the significant "known" number of Aboriginal and/or Torres Strait Islander young people who reported ever experiencing neglect, emotional abuse, physical abuse and sexual abuse to their workers. The small sample of young people who identified as LGBTIQ also reported significant histories of neglect and abuse to their workers. There were no significant differences for young people who identified as CALD.

Table 5.8 Percentage of young people reporting family violence to their worker by Aboriginal and/or Torres Strait Islander status, LGBTIQ status and CALD status

	Does not identify as Aboriginal and/or Torres Strait Islander n=302	Identifies as Aboriginal and Torres Strait Islander n=206	Does not identify as LGBTIQ n=482	Identifies as LGBTIQ n=26	Does not identify as CALD n=477	Identifies as CALD n=31
Victim of violent crime	15.2	14.6	14.1	30.8*	13.8	29.0*
Family violence victim	25.8	35.4*	28.4	53.8*	29.3	35.4
Family violence witness	26.4	42.7**	32.7	38.4	33.1	32.2
Family violence instigator	13.2	13.5	13.2	15.3	13.6	9.6

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

*Note. ** denotes significant difference using χ2 at p = < .001.*

Table 5.8 indicated that workers reported a higher "known" rate of exposure to family violence (as a witness or a victim) for Aboriginal and/or Torres Strait Islander young people. In relation to the LGBTIQ group, workers identified an increased risk of being a victim of violent crime. CALD young people were reported to be significantly more likely to be a victim of violent crime. Notably, being the instigator of violence was low across the groups.

Child Protection System Involvement

Table 5.9 Frequency and percentage of young people with reported involvement with the child protection system (current and past)

Current Involvement	Frequency	Percent
Yes	71	13.9
No	363	71.5
Unsure	74	14.6
Past Involvement	**Frequency**	**Percent**
Yes	133	26.2
No	217	42.7
Unsure	158	31.1

Table 5.9 highlights that 13.9% of young people in the census were currently involved with the child protection system and 26.1% had prior involvement. Interestingly, a high proportion of workers reported that they did not know the child protection system involvement of their client.

Table 5.10 Percentage of young people with reported involvement with the child protection system by Aboriginal and/or Torres Strait Islander status, LGBTIQ status and CALD status

	Does not identify as Aboriginal and Torres Strait Islander	Identifies as Aboriginal and Torres Strait Islander	Does not identify as LGBTIQ	Identifies as LGBTIQ	Does not identify as CALD	Identifies as CALD
	n=302	n=206	n=482	n=26	n=477	n=31
Current involvement	9.2	20.8**	13.9	0.0	14.0	12.9
Past involvement	17.8	38.3**	25.7	34.6	26.4	22.5

*Note. ** denotes significant difference using χ2 at p = < .001.*

The results of the analysis of specific population groups indicated that young people who identified as Aboriginal and/or Torres Strait Islander were significantly more likely to have current and past involvement with the child protection system. This result is consistent with findings from the most recent Child Protection Australia 2016-17 report (AIHW, 2018) documenting the overrepresentation of Aboriginal and/or Torres Strait Islander young people engaged with child protection systems.

There were no statistical differences in the level of child protection system involvement for young people who identified as LGBTIQ or CALD.

Table 5.11 Worker reported rates of young people who are a parent, and of those, who have a child with a child protection order, and who reside with their children most of the time

Parental status	Frequency	Percentage
Young person is a parent	59	11.6
Parent of a child with a child protection order	31	49.2
Residing with children most of the time	73	45.8

Data indicated that around 1 in 10 young people in the census were a parent, and of these almost 50% had some form of child protection order in place. Despite this, almost half of the parents were residing with their children.

6. Mental and Physical Health

Research indicates adolescence and young adulthood can be a time of vulnerability in relation to mental health problems (Muir, et al., 2009). Early intervention is imperative to reduce the burden of disease associated with mental health (AIHW, 2011).

Current and Past Mental Health Problems and Current/Past Service Utilisation

Table 6.1 Frequency and percentage of young people with mental health problems past and present with service utilisation past and present

Current Mental Health Problem	Frequency	Percent
Yes	233	45.9
No	236	46.4
Unsure	39	7.7

Past Mental Health Problem	Frequency	Percent
Yes	289	56.9
No	156	30.7
Unsure	63	12.4

Currently Receiving Mental Health Service	Frequency	Percent
Yes	179	35.2
No	296	58.3
Unsure	33	6.5

Previously Received Mental Health Service	Frequency	Percent
Yes	222	43.7
No	206	40.6
Unsure	80	15.7

Current Formal Mental Health Diagnosis	Frequency	Percent
Yes	167	32.8
No	295	58.1
Unsure	46	9.1

Workers identified that nearly half of the sample were experiencing problems with their mental health at the time of the census (46.0%) and more than half in the past (57.0%). Workers identified that 33% of young people had a current formal mental health diagnosis.

Mental Health Problems by Demographics

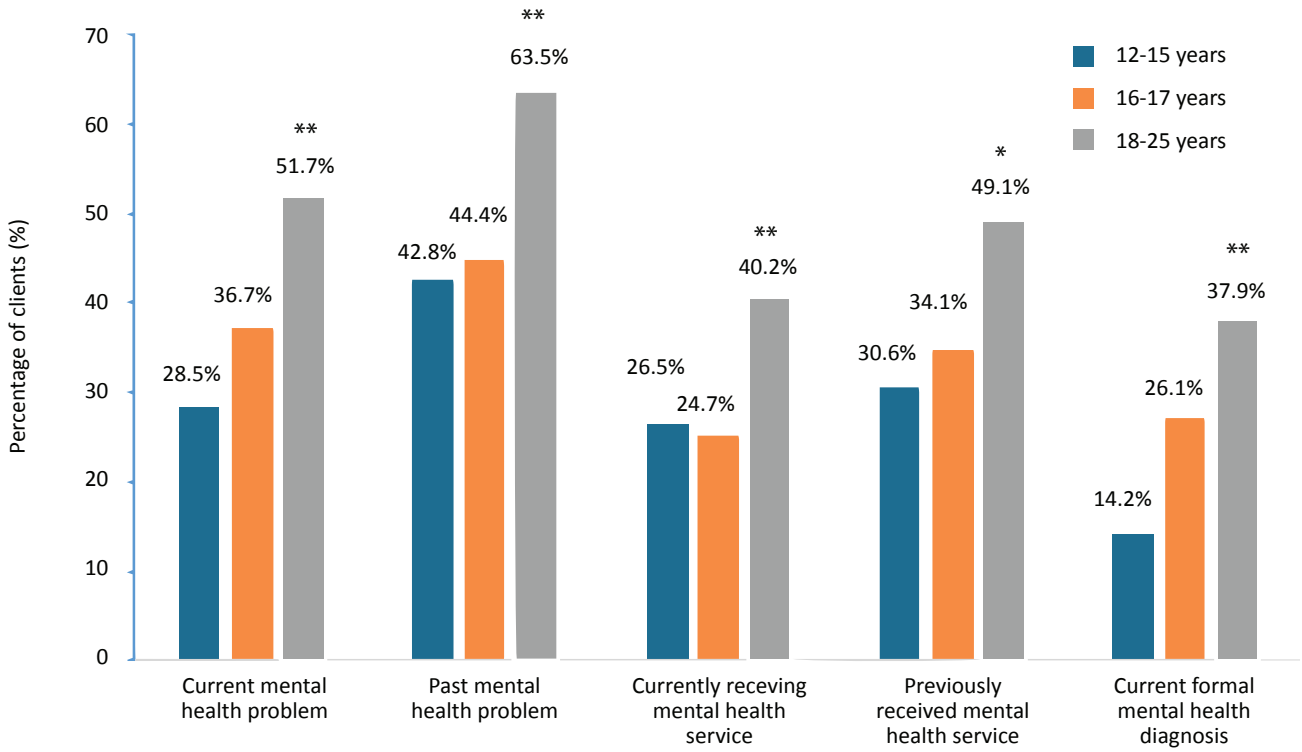


Figure 6.1 Percentage of mental health problems past and present with service utilisation past and present by age groups

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

*Note. ** denotes significant difference using χ2 at p = < .001.*

Young people in the older age groups (18-25 years) were more likely to have mental health problems identified by workers and were the group most likely to be accessing services.

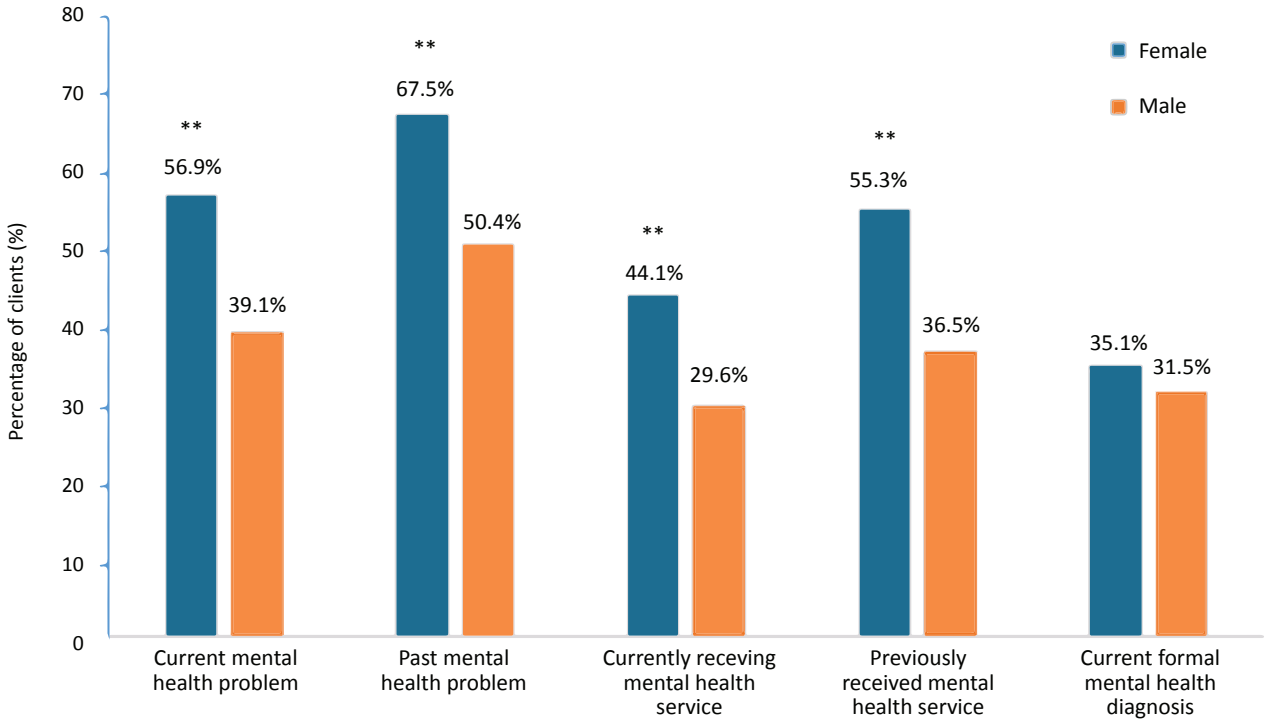


Figure 6.2 Percentage of mental health problems past and present with service utilisation past and present by gender
*Note. ** denotes significant difference using χ2 at p = < .001.*

Figure 6.2 highlights that workers identified more females than males currently or previously experiencing mental health problems. Females were more likely to have received services at the time of the census, and in the past. Interestingly, whilst workers identified females as more likely to have mental health problems, the diagnosis of formal mental health problems appears similar across the genders.

Mental Health Problems and Service Utilisation for Specific Populations

Table 6.2 Percentage of mental health problems past and present with service utilisation past and present by Aboriginal and/or Torres Strait Islander status, LGBTIQ status and CALD status

	Does not identify as Aboriginal and Torres Strait Islander n=302	Identifies as Aboriginal and Torres Strait Islander n=206	Does not identify as LGBTIQ n=482	Identifies as LGBTIQ n=26	Does not identify as CALD n=477	Identifies as CALD n=31
Current mental health problem	53.5*	35.0	43.9	84.6*	46.1	41.9
Currently receiving mental health service	63.4*	47.6	55.1	92.3*	35.6	29.0
Past mental health problem	41.6*	26.2	33.5	69.2*	57.2*	51.6
Previously received mental health service	48.8*	36.4	42.0	76.9*	43.8	41.9

*Note. * denotes significant difference using $\chi 2$ at $p = < .05$.*

Table 6.2 highlights patterns of mental health problems in specific populations. Young people from a CALD background were reported to have less problems with their mental health at the time of the census and significantly less problems in the past. Workers reported that Aboriginal and/or Torres Strait Islander young people had significantly lower rates of mental health problems than non-indigenous young people. Workers reported that the LGBTIQ cohort had significantly higher rates of mental health problems both in their past and at the time of the census.

Table 6.3 Rates of mental health problems past and present with service utilisation past and present for long-term (52 weeks+) client group

	Frequency	Percent
Current mental health problem	50	52.1
Past mental health problem	64	66.7
Current formal mental health diagnosis	29	30.2
Currently receiving mental health service	44	45.8
Previously received mental health service	54	56.3

Non-Suicidal Self-Injury and Suicide Attempts

Table 6.4 Prevalence of young people who reported to their worker non-suicidal self-injury and suicide attempts

Past non-suicidal self-injury	Frequency	Percent
Yes	168	33.1
No	281	55.3
Unsure	59	11.6

Past suicide attempt	Frequency	Percent
Yes	128	25.2
No	309	60.8
Unsure	71	14.0

Table 6.4 shows the high rates of non-suicidal self-injury and suicide attempts in young people in the sample. Workers identified that around one third and one quarter of young people engaged in these behaviours respectively.

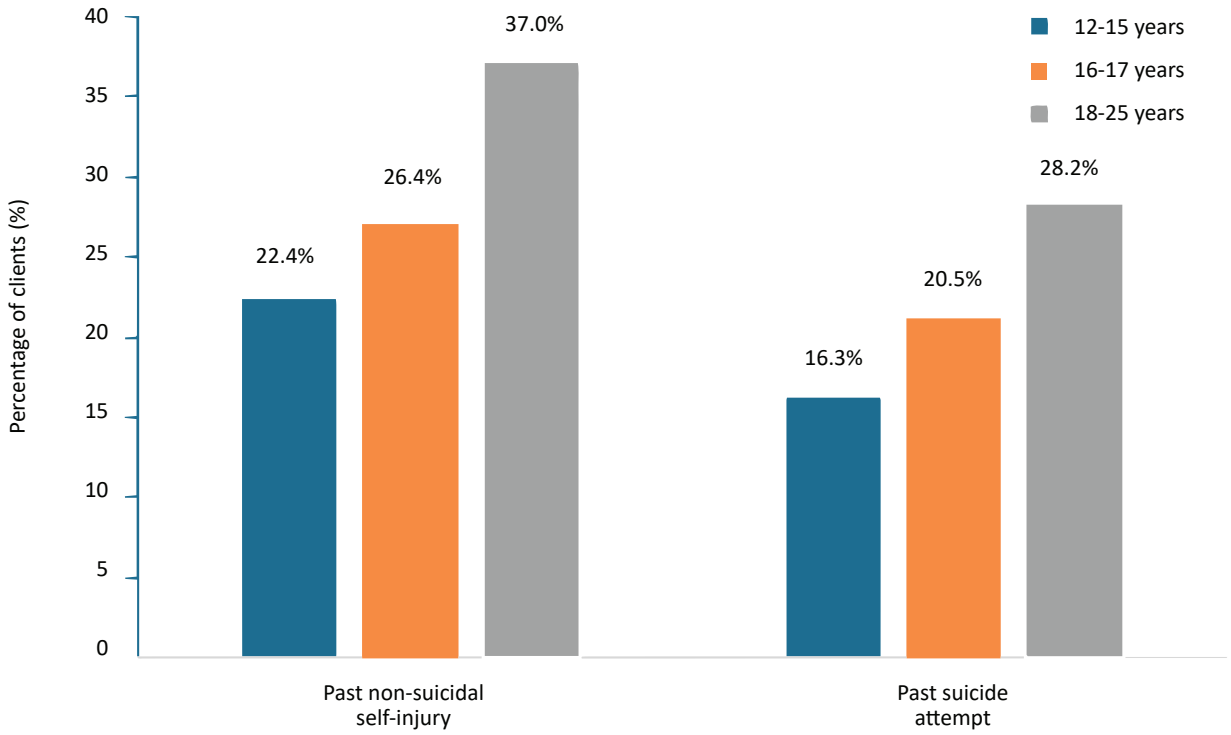


Figure 6.3 Percentage of reported non-suicidal self-injury and suicide attempts by age group

Figure 6.3 highlights the high rates of non-suicidal self-injury and suicide attempts across all age groups.

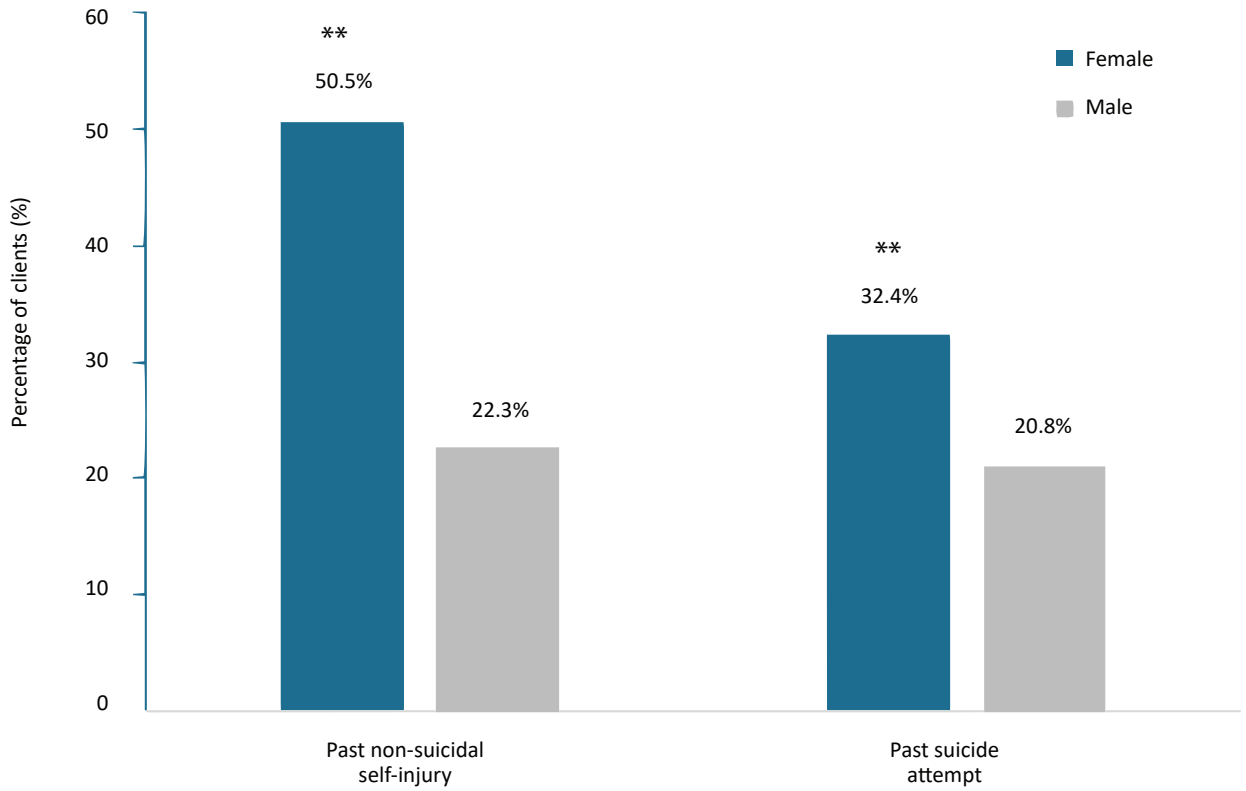


Figure 6.4 Percentage of reported non-suicidal self-injury and suicide attempts by gender
*Note. ** denotes significant difference using χ2 at p = < .001.*

Workers identified that young females were significantly more likely to have engaged in non-suicidal self-injury and have attempted suicide than males. While the rates in males were lower, the data still indicated that over 20% of men had engaged in non-suicidal self-injury and over 20% had attempted suicide.

Table 6.5 Percentage of formal mental health diagnosis, non-suicidal self-injury and suicide attempts by Aboriginal and/or Torres Strait Islander status, LGBTIQ status and CALD status

	Does not identify as Aboriginal and Torres Strait Islander n=302	Identifies as Aboriginal and Torres Strait Islander n=206	Does not identify as LGBTIQ n=482	Identifies as LGBTIQ n=26	Does not identify as CALD n=477	Identifies as CALD n=31
Current formal mental health diagnosis	41.9*	19.9	31.3	69.2*	3.1	29.0
Past non-suicidal self-injury	38.0*	26.2	30.8	76.9*	32.7	38.7
Unsure of past non-suicidal self-injury	3.6	14.5	12.0	3.8	12.3	0.0
Past suicide attempt	31.0	17.0	23.8	53.8*	24.5	35.4
Unsure of past suicide attempt	8.6	21.8	14.8	3.8	14.4	6.4

*Note. * denotes significant difference using $\chi 2$ at $p = < .05$.*

Young people who identified as LGBTIQ were reported to have significant rates of formal mental health diagnoses, previous suicide attempts and rates of non-suicidal self-injury.

For the Aboriginal and/or Torres Strait Islander cohort, there was a 14.5% and a 21.8% rate of workers reporting that they were unsure of Aboriginal and/or Torres Strait Islander clients past non-suicidal self-injury and past suicide attempts respectively.

Table 6.6 Rates of non-suicidal self-injury and suicide attempts for long-term (52 weeks+) client group

	Frequency	Percent
Past non-suicidal self-injury	40	41.7
Unsure of past non-suicidal self-injury	9	9.4
Past suicide attempt	18	18.8
Unsure of past suicide attempt	18	18.8

Table 6.7 Percentage of past suicide attempts requiring medical attention and/or attempts disclosed at the time it occured

		Required medical attention	Disclosed the attempt
	Overall (n=127)	15.9	14.8
Age	12-15 years	10.2	10.2
	16-17 years	15.3	13.6
	18-25 years	17.0	15.8
Gender	Female	23.9**	23.9**
	Male	11.3	9.4
Aboriginal and Torres Strait Islander status	Identified as Aboriginal and Torres Strait Islander	9.2	10.7
	Not identified as Aboriginal and Torres Strait Islander	20.5**	17.8*
LGBTIQ status	Identified as LGBTIQ	42.3**	34.6*
	Not LGBTIQ	14.5	13.9
CALD status	Identified as CALD	22.5	19.3
	Not CALD	15.5	14.4
Length of treatment	Long-term client group	13.5	10.4
	< 52 weeks client group	16.5	15.8

*Note. ** denotes significant difference using $\chi 2$ at $p = < .001$.*

Table 6.7 indicates that more females required medical care following a suicide attempt. In relation to other groups, those from the LGBTIQ population show increased risk and increased disclosure of attempts to others.

Australian Treatment Outcome Profile (ATOP)

Workers were asked to rate the client's level of physical health, psychological health and quality of life using the Australian Treatment Outcome Profile (ATOP) on a scale of 0 (poor) to 10 (good).

Table 6.8 Worker reported ATOP scores for psychological health, physical health and quality of life

		Psychological health	Physical health	Quality of life
Age	12-15 years	6.7 (2.0)	7.47 (2.0)	6.8 (2.1)
	16-17 years	6.7 (2.3)	7.31 (2.1)	7.0 (2.3)[C]
	18-25 years	6.3 (2.1)	6.9 (1.9)[B]	6.4 (2.1)
	ANOVA Statistic	N.S.	F(2, 504)=3.470, p=.032	F(2, 504)=3.038, p=.049
Gender	Female	5.9 (2.2)[A]	6.7 (2.0)[A]	6.0 (2.3)[A]
	Male	6.8 (2.0)	7.3 (1.9)	7.0 (2.0)
	ANOVA Statistic	t(1, 504)=-4.986, p<.001	t(1, 504)=-3.598, p<.001	t(1, 504)=-5.304, p<.001
Aboriginal and Torres Strait Islander status	Does not identify as Aboriginal and Torres Strait Islander	6.3 (2.1)	6.9 (1.9)	6.5 (2.1)
	Identifies as Aboriginal and Torres Strait Islander	6.7 (2.2)[D]	7.3 (2.0)[D]	6.7 (2.3)
	ANOVA Statistic	F(1, 507)=4.361, p=.037	F(1, 507)=5.1, p=.024	F(1, 507)=.680, p=.410
LGBTIQ status	Does not identify as LGBTIQ	6.5 (2.1)	7.1 (1.9)	6.7 (2.2)
	Identifies as LGBTIQ	5.3 (1.9)[E]	5.9 (1.8)[E]	5.4 (1.9)[E]
	ANOVA Statistic	F(1, 507)=9.035, p=.003	F(1, 507) =10.497, p=.001	F(1, 507)=8.119, p=.005
CALD status	Does not identify as CALD	6.4 (2.1)	7.0 (1.9)	6.5 (2.1)
	Identifies as CALD	6.7 (2.2)	7.3 (2.2)	6.8 (2.1)
	ANOVA Statistic	F(1, 507)=.729, p=.394	F(1, 507)=.969, p=.325	F(1, 507)=.291, p=.590

Notes. [A] denotes workers scored females significantly worse on psychological health than males.
[B] denotes workers scored 18-25 year olds significantly worse on physical health than those under 18.
[C] denotes workers scored 18-25 year olds significantly lower on quality of life than 16-17 year olds.
[D] denotes workers scored Aboriginal and/or Torres Strait Islander young people better on physical and psychological health than non-indigenous young people.
[E] denotes workers scored LGBTIQ young people significantly worse on all three ATOP measures.

7. Education and Employment

The Queensland Government follows a 'learning or earning' or compulsory participation approach, which means young people must be in school or an approved equivalent until Year 10 and after Year 10 must be in education, training or employment, or a combination, until turning seventeen (Department of Education, 2018).

Educational engagement is an integral part of a healthy developmental trajectory for children and young people. Problematic AOD use is known to significantly impact the ability of young people to attend, engage and excel in educational settings. Likewise, engagement in education is known to be protective (Loxley et. al., 2004). Increasing protective factors, such as engagement and connection to education or training may reduce the risks of a young person developing problematic AOD use as well as the long-term risks of chronic unemployment (Hancock & Zubrick, 2015).

Table 7.1 Education attendance by demographics and specific populations

Education Attendance

	Frequency	Percent
Attended high school	93	18.3
Attended TAFE / university	24	4.7
Attended other education (not specified)	64	12.6

Education Attendance by Demographics

	12-15 years	16-17 years	18-25 years	Female	Male
Attended high school	65.3	36.7	5.3	21.8	16.1
Attended TAFE / university	0.0	9.4	3.8	4.8	4.7
Attended other education (not specified)	12.2	6.8	11.5	16.5	11.7

Education Attendance by Specific Populations

	Identifies as Aboriginal and/ or Torres Strait Islander	Identifies as LGBTIQ	Identifies as CALD	Long term client group
Attended high school	19.9	3.8	9.7	13.5
Attended TAFE / university	5.3	19.2	9.7	3.1
Attended other education (not specified)	11.2	19.2	29.0	10.4

Behavioural and Learning Difficulties

Table 7.2 Behavioural and learning difficulties for young people in educational contexts

	Frequency	Percent
Expelled from school	91	17.9
Suspended from school	82	16.1
Disruptive behaviour	114	22.4
Learning difficulties or disabilities	111	21.9

Numeracy and Literacy

Youth AOD workers were asked to rate the young person's level of numeracy (mathematical skills) and literacy (reading and writing ability). These ratings reflect worker's pespectives and should be interpreted with caution.

Table 7.3 Percentage of worker's ratings of young people's numeracy and literacy ability

	Numeracy	Literacy
Excellent	8.3	10.6
Good	31.6	36.7
OK	29.3	28.9
Poor	10.6	10.4
Can't manage	1.6	2.2
Unsure	1.0	0.2

Rates of Employment

Table 7.4 Worker reported rates of employment

	Frequency	Percent
Current employment	100	19.6
Full time	32	6.3
Part time	26	5.1
Casual	42	8.3
Not employed	390	76.8

Overall, one in five young people were employed in any capacity. This was spread across casual, part time and full-time employment with 6.3% of the cohort employed full-time.

Table 7.5 Percentage of worker reported rates of employment by Aboriginal and/or Torres Strait Islander status, LGBTIQ status, CALD status and long-term client group

	Identifies as Aboriginal and/or Torres Strait Islander n=206	Identifies as LGBTIQ n=26	Identifies as CALD n=31	Long-term client group n=96
Current employment	6.3	26.9	16.1	9.4
Full time	0.0	7.7	12.9	2.1
Part time	3.4	7.7	0.0	3.1
Casual	2.9	11.5	3.2	4.2
Not employed	90.8	73.1	83.9	89.6

Table 7.6 Percentage of worker reported rates of employment by age and gender

	12-15 yrs	16-17 yrs	18-25 yrs	Female	Male
Current employment	0.0	15.4	24.1	16.0	22.1
Full time	0.0	1.7	8.8	5.6	6.9
Part time	0.0	2.6	6.8	4.8	5.4
Casual	0.0	11.1	8.5	5.9	9.8
Not employed	98.0	79.5	73.2	81.4	74.4

8. Housing

During adolescence and young adulthood, young people must learn to cope with a range of physical, emotional, and social changes. These challenges are much more difficult for young people experiencing housing instability or homelessness.

The risks for young people who experience homelessness are well documented. Homeless young people have been found to have poorer physical and mental health outcomes, including a higher incidence of non-suicidal self-injury and suicide attempts (MacKenzie et. al., 2016). Homeless young people are also more likely to disengage from education and employment and be exposed to risk factors, such as AOD use (Barker et al., 2012).

Understanding and addressing young people's housing situations are important when working with this cohort, as research has shown that individuals who experience homelessness at a young age are more likely to experience persistent homelessness into adulthood (Bevitt et al., 2015).

Housing Disposition

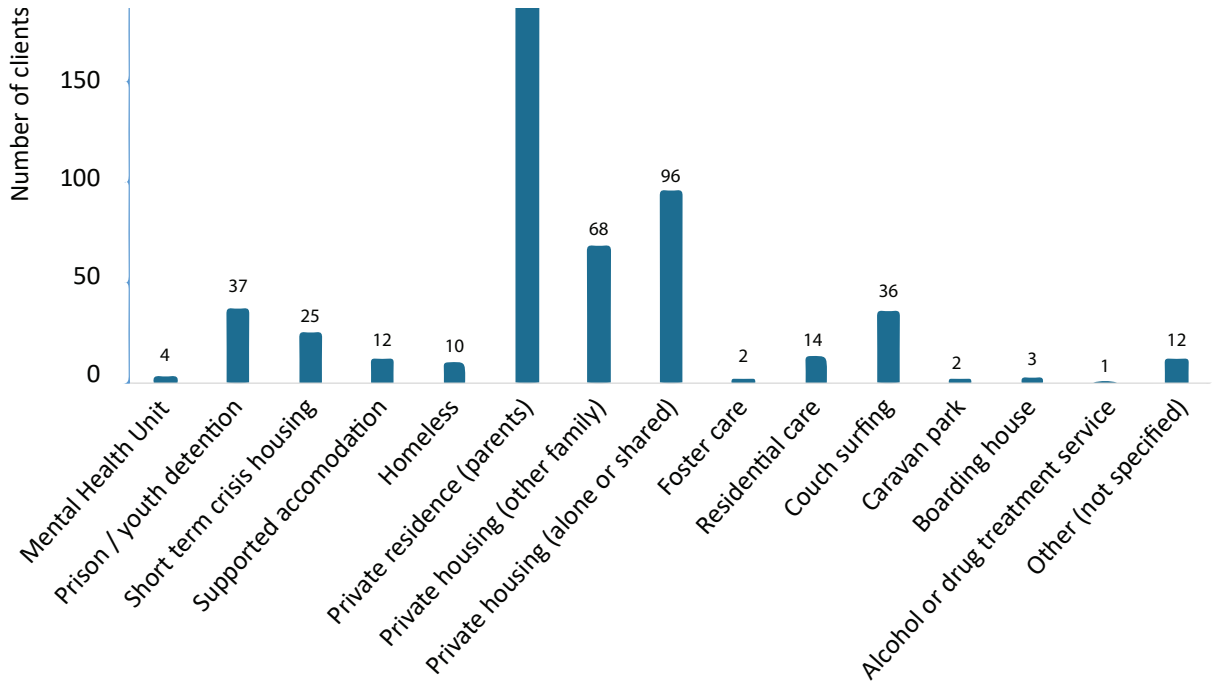


Figure 8.1 Worker reported housing disposition of total sample

Figure 8.1 shows that most clients lived in private residences, either with parents, other family or shared/ alone. Of all housing arrangements, living with parents in the family home was by far the most common.

Acute Housing Problems

Table 8.1 Percentage of young people who experienced acute housing problems in the last four weeks by age and gender

	12-15 years	16-17 years	18-25 years	Male	Female	Overall
Acute housing problems in the last four weeks	16.3	13.6	21.5	26.1	14.8	19.1

The breakdown by age and gender revealed that young people in the 18-25 year old group and males were more likely to report acute housing problems.

Table 8.2 Percentage of young people who experienced acute housing problems in the last four weeks by Aboriginal and/or Torres Strait Islander status, LGBTIQ status, CALD status and long-term (52 weeks+) client group

	Identifies as Aboriginal and/or Torres Strait Islander n=206	Identifies as LGBTIQ n=26	Identifies as CALD n=31	Long-term client group n=96
Acute housing problems in the last four weeks	21.3	15.3	12.9	33.3

Table 8.2 shows high rates of acute housing problems for the long-term client group (33.3%) and for young people in the sample who identified as Aboriginal and/or Torres Strait Islander (21.3%).

Conclusions

The Youth Need Census - Queensland (ThYNC-Q) provides the first comprehensive study of young people in AOD treatment across youth AOD services in Queensland. The results highlighted several interesting findings that may be used to help guide further investigation and development within the Queensland youth AOD sector.

1. Service and Program Utilisation

The census revealed that most young people were engaged in AOD treatment for a period of between zero to ten weeks. However, there was a group of young people identified in the data who were accessing AOD treatment for more than twelve months. This group of young people represent a cohort who present to treatment services with multiple and complex needs requiring longer periods of support.

Investigation of the unique characteristics of this long-term client group revealed that alcohol use and alcohol dependence was an issue of concern for these young people. Workers rated alcohol dependence higher for the long-term client group compared to the overall census sample. Workers also reported that this group of young people were more likely to report a history of injecting drug use and exposure to AOD related harms.

With regards to psychosocial concerns, workers reported that the long-term client group were experiencing very high rates of family relationship problems. Histories of trauma were prevalent for this cohort with workers identifying significant histories of abuse, neglect and family violence. These results were seen to translate into high levels of involvement with the child protection system.

Results revealed other concerns for the long-term client group around acute housing instability and high rates of unemployment.

2. Alcohol and Other Drug Use

Workers identified significant issues for young people regarding cannabis use and dependence. Across several questions exploring patterns and severity of AOD use, workers identified cannabis as the substance young people in treatment were using most frequently, as well as being the substance young people were most likely to be dependent on.

The results also highlighted high rates of daily tobacco use. Interestingly rates of reported tobacco dependence were lower to the rates of cannabis dependence. This finding was surprising given the high rates of daily tobacco use reported for the cohort and the likelihood that most young people were mixing cannabis and tobacco together when using cannabis (Ramo et. Al., 2012). Further investigation is warranted to determine if workers are not identifying tobacco related harms for young people using cannabis and are underreporting tobacco dependence.

3. Criminal Justice Involvement

The census demonstrated a high cross over between young people engaged in both the youth AOD treatment and the criminal justice system. According to their workers, over half of the sample had ever been involved with the criminal justice system at the time of the census. These results are not surprising as often (but not always) problematic AOD use is closely related to legal consequences. However, results need to be interpreted with caution, as it is common for youth AOD services to have established outreach clinics or close referral pathways with statutory services such as Youth Justice.

4. Family and Relationships

Workers reported significant rates of family relationship problems for young people. Specifically, workers reported high rates of current family relationship problems, family conflict within the previous month and family disconnection for young people aged 12 to 15 years. Furthermore, past rates of family relationship problems were significantly higher for the 12 to 15-year-old age group compared to young people aged 16 years and over, indicating that problems with family may span back into primary school years.

These findings highlight specific vulnerabilities and risks for the younger age groups as secure and supportive family relationships are an important protective factor for healthy adolescent development (Robinson, 2006). A breakdown in family relationships at a young age could increase risks of housing instability, education disengagement and disruptions to social and emotional development.

Experiences of trauma were prevalent in the census cohort. Workers reported high rates of "known" histories of neglect, physical, emotional and sexual abuse, and family violence.

There was a high number of "unsure" responses from workers in regards to histories of neglect, abuse and/or family violence. This could be due to underreporting based on the nature of the relationship the young person has with their worker.

The findings also demonstrated a higher than expected number of "unsure" ratings by workers regarding a young person's current and past involvement with the child protection system.

5. Mental Health

The census highlighted that workers described a high prevalence of mental health concerns for young people presenting to AOD treatment services. The rates of current mental health problems were high with mental health concerns reported for nearly half of the young people sampled. A significant finding was the number of young people who reported histories of non-suicidal self-injury and suicide attempts. Workers identified that around one third and one quarter of young people engaged in these behaviours respectively.

Data exploring mental health service provision demonstrated that despite the high rates of current mental health problems identified and the significant histories of suicide attempts and non-suicidal self-injury, only one third of the cohort were receiving a mental health service. There are several factors that could be contributing to this, for example, the provision of mental health interventions by AOD services, the lack of mental health services for young people living in rural and remote areas, or young people's (and their family's) reluctance to engage with mental health services due to stigma.

Further investigation is necessary to determine how mental health services are being provided and if there are any barriers for young people presenting with both mental health problems and AOD concerns.

6. Education and Employment

The results highlighted several important issues around participation in education and employment. For young people under eighteen years of age, around one third were not attending school at the time of the census. Disengagement from education has implications for life course trajectories. Young people who leave school early are at greater risk of unemployment, low income, social exclusion and risky health behaviours (Hancock & Zubrick, 2015).

In relation to employment, around one in five of the total sample were currently employed in some capacity. This finding also has several implications for unemployed young people in AOD treatment, as many may be at risk of persistent socioeconomic disadvantage (Hancock & Zubrick, 2015).

7. Housing

Most young people were reported to be living with their parents or other family members at the time of the census. This result is noteworthy considering the high levels of family conflict reported for this sample. Involving parents or other family members in a young person's AOD treatment, with the young person's consent and when safe and to do so, could help to mitigate the potential risks for housing instability. Acute housing problems were prevalent in the cohort with workers reporting that one in five young people were currently homeless or at risk of homelessness.

8. Specific population groups

Aboriginal and/or Torres Strait Islander Young People

In relation to AOD use, workers reported that Aboriginal and/or Torres Strait Islander young people were significantly less likely to be using methamphetamine and non-opioid prescription drugs compared to non-indigenous young people.

Workers reported that Aboriginal and/or Torres Strait Islander young people were significantly more likely to have histories of criminal offending, however there was a 25% improvement in offending behaviour from past to present. Whilst it is difficult to determine the causative reasons for the improvement reported in the data, the results did find significant service provision focused on this issue for the Aboriginal and/or Torres Strait Islander cohort.

Results indicated that worker reported rates of neglect, abuse and family violence were significantly higher for Aboriginal and/or Torres Strait Islander young people. There were also significantly higher rates of involvement with the child protection system for Aboriginal and/or Torres Strait Islander young people.

Workers reported that Aboriginal and/or Torres Strait Islander young people were significantly less likely to have mental health problems compared to non-indigenous young people. This finding is interesting considering the significant rates of neglect, abuse and/or family violence reported for the cohort. It is possible that mental health problems for Aboriginal and/or Torres Strait Islander young people are being underreported which may account for the high number of "unsure" responses to questions about non-suicidal self-injury and suicide attempts. Workers may be reluctant to label behaviours as mental health symptoms or may misinterpret underlying trauma presentations. Additionally, young people may not report symptoms due to feelings of shame or stigma.

Alternatively, Aboriginal and/or Torres Strait Islander young people presenting to AOD treatment may have learnt coping skills for mental health or trauma symptomology and be demonstrating mental health resilience to their workers. Future research investigating the mental status of Aboriginal and/or Torres Strait Islander young people in AOD treatment is needed to explore this in more detail.

Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) Young People

Despite the cohort being small, the findings indicated significantly poorer mental health for LGBTIQ identified young people. Workers identified that these young people had significant mental health issues both in their past and at the time of the census and significant rates of non-suicidal self-injury and suicide attempts.

For many LGBTIQ young people the cumulative and acute effects of discrimination, marginalisation, bullying, and rejection can lead to high levels of mental health issues. This highlights the importance of services being safe and inclusive for LGBTIQ young people and/or processes for supporting LGBTIQ young people to access safe and appropriate services.

It is worth noting that the small cohort in this study may not accurately reflect the number of young people accessing youth AOD services who identify as LGBTIQ. There are many factors for potential underrepresentation of LGBTIQ clients at an individual and service level. For example, workers may not know the young person's LGBTIQ identity or the young person themselves may still be exploring their LGBTIQ identity.

Culturally and Linguistically Diverse (CALD) Young People

There were few statistically significant differences found for CALD young people in the sample. Tobacco smoking was highlighted as a specific substance of concern for CALD young people. CALD young people were significantly less likely to report family conflict and family disconnection.

Like the LGBTIQ group, the small cohort of CALD young people identified in this study may not accurately reflect the number of young people accessing youth AOD services who identify from a CALD background.

The NMDS requires services to collect information on a client's country of birth and preferred language. Additional questions such as, "main language spoken at home" and "family ancestry" may provide a broader understanding of a young person's cultural background.

Limitations

The youth service system includes a range of agencies who may provide services that assist young people with AOD concerns, however some of this work may not be identified as "AOD treatment." For example, some youth work services address young people's concerns in an holistic manner. Given that problematic AOD use can be closely linked with other psychosocial vulnerability, it is difficult to assume that the cohort included in ThYNC-Q is representative of all young people with AOD concerns in Queensland.

There were several limitations identified in this study. Firstly, the study relied solely on worker report. Variables such as the quality of the therapeutic relationship, worker skill/experience and the ongoing nature of the assessment process all influence a worker's knowledge of a young person's experiences.

Secondly, age was broken into three different groups to examine differences, however the group age ranges that were determined by the researchers resulted in there being a larger number of 18-25 year old clients represented in the analyses that compared age.

Thirdly, the questions asking about AOD related harms and "other" substances used did not allow for the worker to enter any additional information. Without specific AOD related harms or "other" substances detailed, it is not possible to determine which substance or harm (or combination thereof) in the data is eliciting the result.

Lastly, in relation to the specific population groups, (Aboriginal and Torres Strait Islander, LGBTIQ and CALD young people) the heterogeneity of the sub-groups and the diversity of identities and cultures represented, makes interpreting and comparing results difficult.

Future research which seeks to address these limitations is warranted as the information collected can help guide workers and services to improve AOD service provision for young people in Queensland.

References

Australian Bureau of Statistics (ABS). 2018. Recorded Crime - Offenders, 2016-17. [Accessed December 4, 2018] http://www.abs.gov.au/ausstats/abs@.nsf/mf/4519.0

Australian Institute of Health and Welfare (2018). *Child protection Australia 2016-17.* Child welfare series no. 68. Cat. no. CWS 63. Canberra: AIHW.

Australian Institute of Health and Welfare (2017). N*ational Drug Strategy Household Survey 2016: detailed findings.* Drug Statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW.

Australian Institute of Health and Welfare (2011). *Young Australians: their health and wellbeing 2011.* Cat. no. PHE 140 Canberra: AIHW.

Barker, J., Humphries, P., McArthur, M., & Thomson, L. (2012). *Literature Review: Effective interventions for working with young people who are homeless or at risk of homelessness*. Canberra: Department of Families, Housing, Community Services and Indigenous Affairs.

Bevitt, A., Chigavazira, A., Herault, N., Johnson, G., Moschion, J., Schutella, R., Tseng, Y., Wooden, M., & Kalb, G. (2015). *Journeys Home Research Report No. 6: Complete Findings from Waves 1 to 6.* Canberra: Australian Government Department of Social Services.

Department of Education (2018, November 27). *Compulsory participation phase.* Retrieved from https://education.qld.gov.au/schools-educators/other-education/home-education/senior-secondary

Grieger, L., & Hosser, D. (2013). Which Risk Factors are Really Predictive?: An Analysis of Andrews and Bonta's "Central Eight" Risk Factors for Recidivism in German Youth Correctional Facility Inmates. *Criminal Justice and Behavior,* 41(5), 613-634. DOI: 10.1177/0093854813511432.

Hancock, K. J., & Zubrick, S. R. (2015). *Children and young people at risk of disengagement from school.* Western Australia: Telethon Kids Institute and University of Western Australia for the Commissioner for Children and Young People WA.

Kutin, J., Bruun, A., Mitchell, P., Daley, K., & Best, D. (2014). *Snapshot: SYNC Results: Young people in AOD services in Victoria. Summary Data and Key Findings.* Youth Support and Advocacy Service: Melbourne, Australia.

Loxley, W., Toumbourou, J.W., Stockwell, T., Haines, B., Scott, K., Godfrey, C., …Williams, J. (2004). *The prevention of substance use risk and harm in Australia: A review of the evidence.* Canberra: The National Drug Research Centre and the Centre for Adolescent Health.

MacKenzie, D., Flatau, P., Steen, A., & Thielking, M. (2016). *The Cost of Youth Homelessness in Australia: Research Briefing* (Hawthorn, VIC: Swinburne University of Technology, 2016), accessed February 2019: http://www.csi.edu.au/media/uploads/CYHA_FINAL_REPORT_18April2016_v0dqGpT.pdf

Muir, K., Mullan, K., Powell, A., Flaxman, S., Thompson, D., & Griffiths, M. (2009). *State of Australia's young people: a report on the social, economic, health and family lives of young people.* Canberra: Department of Education, Employment and Workplace Relations and the Social Policy Research Centre, University of New South Wales.

Ramo, D. E., Liu, H., and Prochaska, J. J. (2012). Tobacco and marijuana use among adolescents and young adults: A systematic review of their co-use. *Clinical Psychology Review,* 32(2): 105–121.

Robinson, E. (2006). Young people and their parents: Supporting families through changes that occur in adolescence. Australian Family Relationships Briefing, 1 1-7.

Ryan A, Holmes J, Hunt V, Dunlop A, Mammen K, Holland R, Sutton Y, Sindhusake D, Rivas G & Lintzeris N. (2013). "Validation and implementation of the Australian Treatment Outcomes Profile in specialist drug and alcohol settings". *Drug Alcohol Review.* 33(1) · November 2013

Shepherd, S. M., & Purcell, R. (2015). What are the factors associated with criminal behaviour for young people with mental health problems?, *Psychiatry, Psychology and Law,* 22(6), 869-879. DOI: 10.1080/13218719.2015.1015399.

YSAS
YOUTH SUPPORT + ADVOCACY SERVICE

Dovetail
supporting the youth alcohol
and drug sector in Queensland