Drug and alcohol treatment services for young people in Sydney

Research Report

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Executive Summary

Introduction

Providing effective treatment and support for young people experiencing drug and alcohol problems is challenging. Young people face unique barriers accessing and using services, which deter early interventions and treatment. The treatment programs that are in place for adults, are often not suitable for young people and can actively discourage young people from treatment. Health services have generally moved to youth-centred service models to improve engagement with services. However, implementing youth-friendly healthcare into adult-orientated health spaces remains a challenge and identifying what is effective for young drug and alcohol clients specifically is not well understood.

Methods

This project examined the range of services provided to young people within the public health system in Sydney Local Health District (SLHD). Specifically, it aimed to:

i) explore local staff's experience of providing healthcare to young people involved with drugs and/or alcohol,
ii) identify pathways and barriers to providing care for young people in targeted services and for generalist services within SLHD,
iii) examine the experience of service provision before and after COVID-19 restrictions were in place.

Qualitative methodologies, specifically interviews with Sydney Local Health District staff, were used. Participants were staff providing services to young people seeking and receiving drug and alcohol treatment such as nurses, nurse practitioners, social workers, counsellors, and unit managers. Nine interviews were conducted. Results were analysed thematically in NVivo.

Findings

Overall participants felt the services they provided were effective for young people, however, there were significant barriers and gaps that reduced their ability to deliver treatment. Participants described young people presenting to services and the avenues they utilised to attend as distinct from adults with substance use issues. Adult services when provided young people struggled to be flexible or to provide developmentally appropriate interventions. Staff reported young people benefited from targeted, specialist services for young people with a flexible, confidential, and community-based approach to treatment.

Some staff believed services were able to provide effective and supportive treatment to many young people, but almost all participants identified some young people still missed out on otherwise beneficial treatment due to service gaps. Improving the transition between adult and paediatric care was an ongoing issue as well as improving inclusion criteria for services. Young people with mild but still problematic substance use often failed to meet adult thresholds for treatment and were unable to attend certain services. Alternatively, some young people presented with co-occurring mental health and substance use disorders which excluded them from some specialist services, although many participants acknowledged young people commonly presented with both.

Community-based care with outreach and relationship building were important cornerstones of effective treatment programs with young people. COVID-19 fractured these programs. Participants reflected that COVID-19 increased service wait times and decreased service availability but also brought new and different clients into services due to increased financial and/or social stressors. The full effect of COVID-19's disruptions to services and young people's lives will likely have long term consequences.

Conclusion

Improving services for young people in the public health sector is an ongoing concern across many health districts and within departments. Our results suggests that health staff are receptive and positive about the interventions and processes currently in place; however, working within the wider adult-focused health network can be frustrating. Improving access to services and building confidence in the management of young people with drug and alcohol problems would be beneficial in improving outcomes for young people.

Background

Providing effective treatment and support for young people experiencing drug and alcohol problems is challenging. Young people face unique barriers accessing and using services, which deters early intervention and treatment (Christiani et al., 2008; Horsfield et al., 2014; Knight et al., 2017; Russell et al., 2019). Early treatment of harmful drug and alcohol use can reduce use in the long term and can improve employment, housing, and health (Cairns et al., 2018; Guo & Slesnick, 2017). However, the treatment programs that are in place for adults, are often unsuitable for young people. Adult services have been found to discourage engagement and expose young people to more risky drug use behaviours (Barker et al., 2015; Philbin et al., 2017). Young people often use drugs differently than older adults and are less familiar with treatment services available (Indig et al., 2010; Philbin et al., 2017). Health services have generally moved to youth-centred service model to attempt to improve access to confidential, culturally sensitive, and community-based services. However, implementing youth-friendly healthcare into adult-orientated health spaces remains a challenge and our understanding of what effective youth-friendly healthcare looks like is still largely under researched.

The definition of a young person, youth or young adult varies between treatment service, state and country and are often used interchangeably (Degenhardt et al., 2019) and the quality of the data concerning substance use and service provision can vary considerably between service, location and context of data collection (Australian Institute of Health and Welfare, 2020; Degenhardt et al., 2019). In Australia, the Australia Burden of Disease data refers to youth as 15-24 year olds (Australian Institute of Health and Welfare, 2019b), Australian Secondary Student's Alcohol and Drug Survey reports it as 12-17 (Department of Health, 2018), the Alcohol and other Drugs Treatment Services National Minimum Data Set have the widest range of 10-29 (Australian Institute of Health and Welfare, 2019a). In this report, young person will refer to people between 13-18 unless otherwise specified as this is the usual age cut off for services treating young people and the age limits not included in paediatric and adult services.

Adult services models can struggle to provide suitable treatment interventions that meet the development needs for a young person presenting with substance use (Holmbeck et al., 2006). Young people have been found to have different attitudes, treatment goals and behaviours related to their substance use compared to adults (Vander Laenen, 2011). In adult services, primary treatment outcomes would include abstinence achieved through a combination of pharmacotherapy, detoxification and rehabilitation (NSW Health). However, many young people presenting to treatment services do not wish to completely cease using substances (Vander Laenen, 2011). They may instead seek to reduce their use, or learn more about their drug use to make more informed choices (Russell et al., 2019). As a result, there is a growing trend of providing harm minimisation and other specific services for young people until they are willing to engage in health related interventions (Paterson & Panessa, 2008).

Further, even with services in place, engaging and motivating young people is considerably more difficult than adults. Engagement with services is important for young people with substance issues as it allows them to access effective and appropriate treatment. However, achieving engagement with young people can be difficult as they have different barriers and priorities compared to adults (Barker et al., 2015; Robards et al., 2019). Lower levels of motivation to engage in treatment for young people is largely attributed to an absence of children, a reduced risk of chronic health conditions and being less aware of the risks of certain harmful behaviours (Russell et al., 2019). As a

consequence, interest in treatment can be very sporadic (Russell et al., 2019). Young people may also experience barriers such as cost and reduced ability to travel due to a lack of income or support (Russell et al., 2019), as well as low confidence navigating the health system due to a lower exposure to it compared to adults (Robards et al., 2019). These issues are compounded by long wait times and procedural barriers in public health services which may delay service connection. As a result, these services can miss the opportunity to provide an intervention and capture a young person when they are interested (Christiani et al., 2008; Digiusto & Treloar, 2007; Guo & Slesnick, 2017; Hoffman et al., 2011; Rice et al., 2017). As adults and young people generally have different exposure to the health systems and face different barriers to treatment, research suggest that the provision of flexible and age-specific treatments can be of value (Barker et al., 2015; Bekaert, 2003; Rickwood et al., 2019).

There are few documented effective methods of how to deliver drug and alcohol services for young people (McDonagh et al., 2018), and they are rarely independently evaluated. Evaluation of youth services is complex and traditional measures of success such as treatment retention or abstinence may not be the best measure of an intervention. Interventions put into place now may not see an effect until later in life and similarly, measuring attendance to appointments may fail to capture a young person's ongoing communications with a service over social media or text messaging with clinicians, social or peer workers. Studies in other healthcare environments with young people, suggest that positive youth-friendly services require an inclusive culture and confidentiality (Bekaert, 2003; Crossen, 2017; Islam et al., 2017; Pitts & Forman, 2020). Although some aspects of similar health environments can be used in youth drug and alcohol services, sometimes they are contraindicated. For example, in many health services the utilization of family, friends, peer workers and cultural representatives can improve overall engagement with a service (Horyniak et al., 2014; Hughes et al., 2020; Lindstrøm, Filges & Jørgensen, 2015). In drug health, however, there is limited and somewhat conflicting evidence of its value due to the stigma of alcohol and drug issues and problems ensuring confidentiality, particularly in small communities like minorities populations, rural towns and school groups (Christiani et al., 2008; Kilian & Williamson, 2018; Rickwood et al., 2019; Snowdon et al., 2019; Stathis et al., 2006; Vander Laenen, 2011).

One strategy used by mental health and drug health services to combat this issue is integrated services. Integrated services, if privacy can be assured, can mask a person's involvement with drug and alcohol services and reduce the real and perceived stigma of attending (Christiani et al., 2008; Newton et al., 2016). Integrated systems can also reduce the burden of transport and referral requirements that young people in particular struggle with (Rickwood et al., 2019; Russell et al., 2019). By providing a range of services like food, social groups, lawyers, employment, and health all situated together they reduce the health literacy requirements and the cost of attending (Christiani et al., 2008; Newton et al., 2016; Smith et al., 2019). What is most effective for young people with substance use issues is currently not well understood. Similarly, the availability of services and their intersection with other services and adult services for substance use has not been well-described. In this project we describe drug health services provided to young people by Sydney Local Health District (SLHD), one of the most diverse health districts in Australia which services over 700,000 residents, 44% of which were born overseas, 55% do not speak English at home and 1.1% are Aboriginal(Sydney Local Health District, 2021). This project examines the experience of staff providing these services, the procedures in place and the network they operate within to improve our understanding of what works for young people in this sector.

Aims

This project examined the drug and alcohol health care providers experience of providing assistance to young people within the public health system. Specifically, it aimed to:

i) explore local staff's experience of providing healthcare to young people involved with drugs and or alcohol,
ii) identify pathways and barriers to providing care for young people in targeted services and for generalist services within SLHD,
iii) examine service provision before and after COVID-19 restrictions were in place.

Methods

This study used qualitative methodologies. Specifically, in-depth interviews with Sydney Local Health District staff were conducted face-to-face at a location convenient to the staff member. Some interviewers were undertaken during the 2020 COVID-19 restrictions in which case, interviews were conducted via video call. Participants were staff providing services to young people seeking drug and alcohol treatment and included nurses, nurse practitioners, social workers, counsellors, and unit managers. Nine interviews were conducted, averaging 56mins minutes in length, and ranging from 42 to 69 minutes. The interview guide began with broad contextual themes of delivering services to young people with subsequent questions focused on the challenges and barrier involved with their roles. Results were analysed thematically in NVivo. The study was reviewed and approved by Sydney Local Health District Review Committee (RPA zone). All participants provided written informed consent.

Setting

Within the catchment of Sydney Local Health District (SLHD), youth drug and mental health services were available in hospital wards, emergency departments, public and private clinicians, community health-aligned services and non-government organisations (NGO)(NSW Ministry of Health, 2014). Depending on the service, referrals could be required to access treatment, whilst others could be accessed through outreach programs or self-referral. Except for the emergency department, each service had an inclusion and/or exclusion criteria for those attending a service, these generally included criteria related to age, mental health diagnoses, school attendance or drop out, concerning drug use or abstinence. Wait times for services could be extensive, particularly in public health facilities due to high demand and/or limited places. Except for some private health such as private counselling/psychology and private doctors' appointments, programs for drug related issues and mental health were usually free. In community programs, outreach used a nurse practitioner or social worker as a common referral pathway to services, but self-referral was also an option. However, in hospital-based services recruitment was made through emergency department presentations, GP or school referrals with formal referral requirements more commonly utilized.

Within the SLHD catchment, the main services for young people experiencing drug related issues included Youthblock, Weave, Headspace and Camperdown Community Mental Health Service.

Youthblock is a health aligned outreach clinic for young people providing a range of counselling and health services with a focus on drug related problems, chronic illness and disability, nutrition and physical activity, mental health, harm and injury, oral health, and sexual health (Sydney Local Health District, 2016). To be eligible, a young person needs to be aged 12-25 years and live, work or study in within the Sydney Local District catchment area (largely within Sydney's Inner-West Local Government Area). Youthblock also targets young people that have experienced some level of marginalisation including homelessness (or risk of homelessness), Aboriginal or Torres Strait Islander, sexually or gender diverse, have a physical or mental disability, had contact with the justice system, in out of home care, come from a rural or remote area, come from economic disadvantage, a young parent/carer. Youthblock has an outreach program with a nurse practitioner and set programs with a flexible appointment schedule and no/limited referral requirements.

Weave is an NGO focused on practical skill development, health promotion and community building. Its services includes tutoring, driving licence acquirement, prison release programs (WEAVE Youth and Community Services, 2021). Weave's priority focus is Aboriginal and Torres Strait islander people, culturally or linguistically diverse people, refugees, migrants or asylum seekers, people living in social housing, single parent families, low income earning families, parents/carer with a Centrelink health card or pension. As Weave focuses more on community development there is no set age limit for many of their programs, however, there was a location limit – generally restricted to the district nearby.

Headspace provides community-based mental health support for young people within the SLHD district. Headspace sees young people aged 12-25 with a focus on non-acute cases with a 'one stop shop' model for other healthcare interventions (Headspace, 2021; Rickwood et al., 2019). Appointments and referrals are required for Headspace, however, there are some 'drop-in' options. Headspace provides limited substance related interventions with a focus on mental health interventions instead and provides only public health information about general drug use.

Camperdown Community Mental Health Service is a hospital-based outpatient mental health service. Within this service the Community Adolescent Outreach Service (CAOS) team provides youth mental health treatment and support (Sydney Local Health District, 2020). CAOS focuses on trauma, family therapy, and cognitive behavioural therapy, however, it is only accessible to young people still attending school. CAOS has a counsellor treatment model and includes a medical consultant role which requires appointments, although the model is flexible. The CAOS team provides care for adolescents aged up to 18 years but generally does not provide services for young people with significant drug-related issues.

Other facilities like schools, NGOs and PCYC (police citizens youth club) also provide interventions and referrals to the health network (NSW Ministry of Health, 2014). Within SLHD services, Drug Health services and the gastroenterology ward provide adult and some limited adolescent health care within the hospital. Most of the hospital-based programs are categorised as paediatric or adult, with limited delineation to adolescent care, whereas community-based services have significant separation of 'mainstream adult' services and adolescent services.

COVID-19

The interviews were conducted during 2020 COVID-19 restrictions in New South Wales. As part of the interviews participating staff discussed their experience of COVID-19 and its effect on their service. During the 2020 COVID-19 restrictions, many health services across NSW were required to change or cease their programs. This included reducing admissions to hospital, ceasing group therapy and community/social activities, reduced face-to-face programs and reduced external supports like community transport (NSW Government, 2020). The few services that did continue, made use of video chat, which in some cases was facilitated by the service providing tablet devices and phones, and/or face masks and glass barriers. The flow on affect for wait times, emergency presentations and health outcomes are yet to be determined. Early research suggests for young people, isolation increased, income became more unstable and there was a lack of peer support (Fisher et al., 2020; Glowacz & Schmits, 2020) which may have impacted treatment presentations and outcomes.

Findings

Overall, health and community staff were confident that the services they provided were positive interventions for most clients and addressed their treatment needs. Building a respectful, flexible, patient driven service was important for engaging young people and participants saw this enacted in most youth-specific services. Adult or more generalist services, however, struggled to adapt to the needs of their younger patients, and were frustrated at the less flexible service models of adult healthcare. Some young people struggled to engage in services due to barriers or strict eligibility criteria with the result that some young people were still "falling through the cracks" and missing out on important interventions altogether.

How do young people differ from adults when presenting to health services?

The presentation of a young person to a health service for drug or alcohol related issues was described by participants as distinct from adult presentations. A typical adult presentation was characterised by a treatment seeking adult with chronic drug or alcohol use, calling the intake line at drug health services, and being referred into detoxification, counselling, medical appointments, or other treatments. The occasional adult would present to the emergency department (ED) or through their doctor and be referred internally. The adults who attended services, often sought abstinence or pharmacological treatment for chronic, long -term use of substances. Treatment seeking was generally for the substance itself with the recognition that other life aspects may improve if treatment was successful. Participants believed that adults who presented to services were often more comfortable in medical settings:

> *"With adults I think that they're a bit more concrete, a bit more prescriptive, and … will turn up to appointments… And I think they really feel like they're getting treated because it's in a medical setting."* Participant 2

By comparison, young people were less familiar with healthcare services and responded negatively to clinical spaces:

> *"We always prioritise young people because for some it's their first contact with healthcare and providing some kind of quick [response for] where they're at…is really what they're often after and helping them understand how healthcare systems work."*- Participant 4

> *"I've got clients that I consider to be pretty sophisticated but would really struggle to enter a hospital building to do something. It's intimidating and yet they do things I could never do, like in terms of their street smarts. But when you translate that to the other environments, they really kind of get stuck and just need some support to do those things..."* Participant 7

Young people were described as having less health literacy and confidence navigating the health system compared to adults, a finding reiterated in the literature (Bekaert, 2003). This was largely attributed to their developmental stage, education, and exposure. Staff reflected that low health literacy could manifest as an underutilization of certain healthcare services such as the intake telephone line, GPs, or specialist clinics. A young person was instead more likely to presented to ED following an acute event at school or home and would be seen by a specialist nurse. The nurse would then refer them into a particular service like counselling or a short stay unit or simply de-escalate the issue and discharge them. Alternatively, a young person could be referred through a school, local doctor or see an outreach nurse at a community centre to a particular health service like a drug and alcohol nurse practitioner, social worker, or counselling team. Self-referral in young people was also common and alternative and flexible pathways were generally required compared to adult service users.

The ways in which young people presented to services and the issues that they commonly presented with were reported as different to that of adult clients. Substance use in young people when they presented to health services were highlighted by participants as particular to young people i.e., drug use was generally not yet a chronic issue and use was more sporadic compared to a typical adult seeking treatment. One nurse described youth substance use presentations to hospital as:

> *"Episodic use, hazardous use, harmful use, occasional use, used in the context of relationships and the context of sexual encounters. We see quite a lot of young people using with other people or misadventure. When I say misadventure, maybe have gone out with friends, combined multiple substances, perhaps some alcohol, perhaps some benzos, perhaps some cannabis, perhaps some MDMA." Participant 4*

Participants reported that young people presenting to services, however, often described the issues they were most concerned about not as drug use but as an exacerbation of an adjacent issue such as worsening mental health, poor relationships, or school trouble with underlying drug use. Many young people did not acknowledge, or possibly did not recognise, that drug use could be the cause or a significant factor for the issues they were attempting to address. Staff often were required to use these interactions as a pathway to eventual drug health treatment rather than as a first step. Even when young people did recognise their drug use as problematic, participants identified that drug use in young people often required alternative methods of treatment. Whilst some staff described drug use in young people as a social network or part of a community culture, many highlighted the role drugs played in helping disadvantaged young people cope with life situations. A social worker from a community centre reflected that drug use for the young people was often a form of self-medication:

> *"I think it's to ease symptoms of mental health, and that's the biggest thing I've seen amongst all our cohort…they're using cannabis to sleep, to lift their mood, to numb, to escape…."* Participant 7

Due to the role of drugs in self-medicating, abstinence was not generally the treatment outcome a young person desired. Clinical services provided to young people were therefore aimed at harm minimisation rather than cessation. Staff described young people as "not ready" for abstinent treatment and that redirection was an important part of providing a positive health response instead:

> *"They're not prepared to give it up, so it's about weaning, harm minimisation, one day giving it up but when you're young, this is your only mechanism. It's trying to convert people to prescription medicine, anti-depressants, try and sell the benefits of switching over to something legal."* Participant 7

> *"There's a few that come in quite regularly with a lot of distress and we try and come up with, what's some ways that we can redirect this? … doing this drug is the only thing…they're just like, "No, I need to have a glass of wine. I need a bottle of wine. I need a beer or something." That's the only way I can relax." They've got no other way. That's the only way that they've been shown. It's all they know so they can't even – even though we try other things like self-soothing and just mindfulness activities and everything as well, they just can't focus on it. It's just purely that. I need it, I need it, I need it- so it's very hard for them."* Participant 8

Desired treatment outcomes for young people were generally those that were flexible, and patient driven. Often these included reengagement in activities they once enjoyed, discovering new hobbies and other social activities. Pharmacotherapy was not a major part of treatment (and only has limited research supporting their use in this age group (Squeglia et al., 2019)), with counselling used primarily in acute cases unless the young person could afford private practitioners. A youth worker described their flexible approach:

> *"A lot of the therapy that we use and that I advocate for isn't "let's sit down and have a talk for 45 minutes", it's "they're really interested in this and so I think that we should go with it". It doesn't have anything to do with their drugs, but it could be something that engages them enough that that becomes more powerful than taking the drugs kind of thing." Participant 3*

Adult outcomes by comparison were directed more at long term goals such as abstinence or pharmacotherapy. Staff generally acknowledged that young people required different interventions and required different models of care to those employed in adult treatment models. As a result, treating young people in adult services is described as more difficult.

What are the difficulties of treating young people in adult services?

As described above, adult treatment goals and treatments differ from those of a young person. Many young people do not have substance use that would reach the clinical threshold for dependence and generally describe sporadic use. As a result they may fail to recognise the benefit of an intervention or treatment, or may not acknowledge the potential damage the substance may have on their long term health and life(Cheung, 2015; Goldberg, Halpern-Felsher & Millstein, 2002; Small, Silverberg & Kerns, 1993). And even when young people can see the effect of drug or alcohol use on their life, unlike most adults, they may not be able to pursue goals and aspirations they wish to, due to circumstantial barriers and lack of motivation (Christiani et al., 2008; Moensted, 2018). A nurse from

an adult hospital ward described one of the key differences between treating adults compared to young people was motivation:

> *"With the older adults it's, they want to be there for their kids. Their partner is threatening to break-up with them or they're going to lose their job or they're going to go to jail or something. They have some reason to be here but for the younger adults quite often they don't have a reason to be here. It's not for a partner. It's not for kids. It's not for a job or anything. We don't have a carrot that we can dangle in front of them."* Participant 8

> *"I think it's quite hard that they see some of our older adults that are admitted under the same team, especially being in a four-bed bay where you can hear everything and you're hearing their stories…You're just constantly hearing those reinforcing messages of, "I was an alcoholic, drinking an X amount until I was age 24 and then I went and did this but then I relapsed and all that." They're just getting that reinforcing message that, you're going to relapse at some point so what's the point in trying type thing."* Participant 8

Staff described adult treatment settings as frustrating environments to look after young people in. This encompassed everything from rigid appointment schedules where flexibility was required, to unwelcoming clinic spaces, poor food options for young people and limited access to specialist staff.

> *"The biggest challenge I think is that young people have so much complexity that they don't always fit. Like when they come to hospital they may not fit in a basket, they may not fit under the gastro team, under the neuro team… so they may not always hit the threshold for if you like some space for an admission."* Participant 4

> *"Things like the space isn't set-up, like we're in a siege mentality jail with glass, doors and locks because hospitals can look a lot like that and sometimes. Perspex, and you can only speak to us through this little bit. That can be – that's in ED, that's in mental health, that's in drug health. Sometimes there's a lot of physical architectural barriers…That can be a bit confronting for our young people too…And they can be overstimulated by our environment."* Participant 4

Staff that worked in adult services that provided care to young people were frustrated by the barriers clinical environments brought about and the cold culture. Methods to circumvent or improve aspects of the adult treatment setting were employed by staff when young people presented but there was frustration at the low resources and options available to treat young people in these settings. Stigma was also a significant issue for young people trying to access drug and alcohol treatment. This was an issue for all services but was particularly highlighted in mainstream/adult services where young people were visibly receiving treatment for substance use. Stigma was described as an issue both in the staff interacting with some young people, and with the other patients on the ward:

> *"I think it's quite hard to change the attitudes of certain staff who just see it that these patients [young people] are here taking up a bed, taking up their time …because it's not that we're rushing them to a CT scan or…doing all these intense investigations."* Participant 8

Hospital staff reflected that this stigma sometimes effected whether a young person felt comfortable presenting to ED. Perceived or real disrespect effected whether a young person would present or stay for treatment.

> *"If they do come in frequently, they get that level of disrespect from ED, or a perceived level of disrespect and they'll just want to discharge. We always want to try and see it as a possibility that we can change things but you do have to try and move quick with some of them to get them up and get them up to the ward so that they get that reinforcement that, "Yes, this is a really good thing that you'd come in, that you're trying to get help, that you're trying to fix things a bit.""* Participant 8

Although delivering care in adult settings was a challenge, some small actions had been implemented to improve the culture and experience of young people. Staff described having a 50/50 gender of nursing and health staff to ensure young people had role models of both genders available. Within outpatient settings and community centre, the distinction between adult services and youth services was also able to be muted through a patient-centred model of care. Referring patients out of rigid hospital-based services was generally observed as the ideal pathway for treating young people.

How do services effectively support young people?

Multifaceted and responsive engagement strategies were described by staff as the key components of successful service for young people. Ongoing contact and engagement were important in the treatment journey of young people even if they were not seeking drug and alcohol treatment specifically. Many alternative avenues of support were utilized by staff to keep young people involved in adjacent health services to build health literacy and skills, for when, or if, a young person sought treatment. A worker from a community outreach facility articulated the different methods used to engage young people:

> *"I know that family therapy (…) if you were going to engage in it, is going to be a gold standard, but let's work down a line to get you there and maybe the first part is a transactional relationship. We have food that gets delivered from Oz Harvest…We have a brokerage service with one of the local youth places where we can give out grocery cards. So, if we can get somebody coming back in on that transactional basis, we will, until one day they come in and they go actually "I'm having this problem as well", and then we capitalise on that."* – Participant 3

Building relationships and trust with services was an important part of service engagement and treatment. Relationships were often built through provision of basic necessities for young people such as food, transport, and community. As well as immediate and physical supports, building resilience and confidence in young people was an alternative avenue for supporting a young person when they were faced with significant external pressures. It recognised the value of autonomy in healthcare as well as the varied attitudes to drug use in young people.

> *"Young people don't always want counselling…sometimes they want groups and other people that understand where they're at."* Participant 4

> *"Their confidence in their ability to be able to change and (…) it's building up that self-efficacy that they can change, and they can do things. And then also keeping it realistic as well. Not, "yeah, you can be the prime minister or anything like that," but might be - like, for example, the boy who wants to be a social worker: 'What are the steps we need to take in order for you to do that?'"* Participant 2

Providing a safe space for a young person to build their autonomy and resilience was commonly described by services as a pathway towards addressing underlying problems. Simple activities such as calling Medicare could be facilitated and encouraged but were not enforced. This method allowed for client-led decision making and control in health spaces that were traditionally overly paternalistic. Motivation and peer support helped to facilitate goal building and achievements such as the acquisition of a drivers' licences or TAFE/University admission. These activities were part of a broader treatment goal of building young people's independence and relationships with the service. Broader issues such as mental health and substance use could be treated alongside or further down the track if social and personal goals were addressed. Diversity in treatment pathways and options reflected the flexible culture of services for young people and enabled clinicians to tailor their service to the young person they were treating. This diversity was also seen in the approach a clinician could take when trying to engage a young person in the service.

> *"My appointment scheduling is a little bit flexible and a little bit fluid…if they're late or they're intoxicated, I don't turn them away. I will always try and see them no matter if they're late, and that forms part of that engagement and trust that you kind of care enough that you will see them."* Participant 2

Where other services described strict rules and referral pathways, some youth specific services were able to provide a model of care that suited the young person. Staff described this model as key to engaging young people effectively. A similar model was able to be used in the community centre where client advocates were used as a method to improve the navigation of health processes with the patient and improve their patient's treatment experience generally to build confidence and skills using healthcare. A social worker described the benefits of this support:

> *We were at the RMS [roads and maritime] this morning, standing there with my young fellows, like what is he, 18, and yeah, the lady just kept asking, "Where's your letter? Where's your letter?" …if I wasn't standing there, he would not walk out with his licence, I can promise you that. I just said, "No, I've called ahead. He's due to get his licence back today. I've called." She's like "Where's your letter?" I said, "We don't have a letter. I called." So, she got her boss and figured it all out but no, he would have walked out ten minutes before. I've got a million of those [examples]. I've got too many."* Participant 7

Being able to provide the service a young person needs and responding to their treatment needs allowed staff to provide interventions and build relationships with young people. To effectively address the needs of young people presenting to health services, specific adolescent environments and programs should be available. Measures of attendance and traditional treatment outcomes were not helpful measures of successful engagement for these services but rather successful connections and interventions over time that may one day provide and avenue to more traditional outcomes.

What was the effect of COVID?

Early research suggests that young people were affected by COVID potentially disproportionately compared to adults due to interruption in education, employment, life events such as graduations, achievements in school or sport, employment, and social activities (Glowacz & Schmits, 2020). Staff reflected that these disruptions had an effect on the presentations to ED in particular:

> "*We're seeing people with anxiety and dissociative disorders pretty much go through the roof. Initially with COVID, we were seeing a very quiet period when no one was turning up, and then no one was scared of COVID anymore and all the anxieties were amplified. Everything's just got too much for a lot of people, I think."* Participant 1

> *"I'm finding there's probably quite a bit of anger and distress about COVID from some of our young people feeling really shut out of things they're used to; groups, clubs, music, bars, some of the avenues or places that they really spend time with their friends…I think we're starting to see some more spill into the hospital. I had quite a lot of young people overdosing too."* Participant 4

Staff also described COVID as bringing out a group of young people that often did not present to services such as international students. The combination of reduced supervision and boredom was considered a strong factor for the increase in presentations and drug use.

> *"We've had quite a few young Asian students as well who have been experimenting with different drugs and different things now…They all tend to be 20 to 22 and it's their first time away from home. All of a sudden mum and dad aren't easily able to come out and collect them…"* Participant 8

As well as ED presentations, COVID-19 lockdowns and interruptions impacted more basic things such as aspirations and goal setting for many young people. Tertiary education, travel, employment, and work placements were harder to achieve and for some became unviable options.

> *"A lot of people have been left feeling that they've got no future and a lot of other things and have turned to drugs and alcohol. They haven't been able to go to uni, haven't been able to interact. Even some of them with jobs, we've had a lot of young people that are in that early-20 range that have lost jobs or not been able to get jobs, not been able to move out of home and just continue along the usual journey into adulthood type stuff."* - Participant 8

Staff identified COVID-19 as a significant influence on presentations to hospital and the types of issues presented particularly for young people. This issue was likely further compounded by the impact of service reductions, cessation, or drastic alterations to allow for social distancing, mask wearing and other infection controls. Some services were able to continue virtually, however, for many the external supports like outreach, transport support and group activities they relied on to engage young people had to cease. Most staff reported an influx of young people to their services with the result that wait times and referrals were increased significantly beyond pre-COVID levels. The fluctuating nature of COVID has meant that the full impact of these disruptions will be fully

measured for some time, however it is likely the ripple effect of these issues will be seen in the future for this generation.

What are the gaps in services specific to young people?

Although drug and alcohol services for young people were considered positive interventions on the whole, frustration was expressed with how these services functioned within the greater health network. Referrals are a common and often the only method for gaining treatment in hospital-based services and private clinics. Without referrals young people are often not eligible to access certain clinics or treatment, may not be able to claim Medicare (for a reduced rate or for no-cost to the client), or cannot contact a clinic/treatment group. The community-based staff described the difficulty the referral process can present to otherwise effective services:

> *"I think we have some great services, but I don't think it's necessarily the easiest thing in the world for people to get linked in with. It's not as simple as you're using drugs and alcohol, here why don't you turn up to [Health Service] and someone will see you? Because it doesn't work that way. We do have some good services, but I don't think there's necessarily an ease of access to it."* Participant 1

> *"It's just really hard when you're someone who's already got a lot of issues to campaign for the beds, and it is a campaign. There's no other word for it. It's got to be on the ball, calling at the right times, present well but not too well, have a criminal record that isn't too bad but bad enough. I mean it's just – I know if I'm that stressed in trying to get someone, what are they feeling?"* Participant 7

As well as difficulty referring clients into services, gaps were identified where clients were missing out on treatment due to the way young people presented to services seeking treatment. Young people that missed out on treatment were described as those without the "typical" presentation of a "full blown addiction", that is, not having chronic, harmful use as seen in adult presentations. Admissions and treatment were complicated as a result because certain thresholds would not be met even though these may be reflective of adult addiction rather than a young person's. Engagement strategies that would work for those with more significant use may not be as effective to those with lower levels but still harmful use. As a result, even though early intervention is known to be an effective treatment to improve outcomes for young people using substances (Cairns et al., 2018; Guo & Slesnick, 2017), many who may benefit missed out.

> *"I think the difficult ones are the ones that are stuck in that middle ground where …they're not risky enough basically to refer onto services, but they're not really travelling so well either." Participant 1.*

As well as 'medium risk' clients who often failed to meet any service inclusion criteria, 'high risk' clients like those with polydrug use or suicide ideation particularly in acute situations were considered exclusion criteria on almost all youth-specific services. Some participants found this excluded clients from treatment that otherwise would have been considered beneficial and could result in clients falling through the gaps of service coverage.

"We don't really have much success referring people to Headspace. Their threshold is very – quite - you do have to be reasonably well to an extent for Headspace to take you on." Participant 1

"I mean, if somebody got anxiety and depression and they're using a large amount of cannabis, isn't it about looking at what's going on? Why have they started? Let's have a look at that. Explain to them about that and not just immediately referring somebody [to drug health]…and if somebody is psychotic because of their use of methamphetamine or cannabis, well, don't we look at reducing that and then making a decision and stuff like that? I don't think you just immediately [refer someone] - they're so intertwined, the two. It's really hard to separate it." Participant 2

Some hesitancy around taking on these 'higher risk' clients was due to a services inability to take on acute cases, which had to be referred instead to emergency or healthcare hotlines. However, some participants acknowledged a lack of confidence in navigating the overlap between mental health and substance use services for themselves and their colleagues which effected the referrals they received and which services they were confident in sending their clients to.

"Sometimes [its] tricky to treat the mental health, say, even if they need medication, because the medication's not going to be often that helpful if they're taking heaps of drugs. So that's hard. And then there's the consultants. One consultant probably would still sometimes try and treat the depression with an anti-depressant, whereas the other psychiatrist was like, "Well no, if you're using drugs" was a bit more strict with his boundaries around, "Well I'm not going to prescribe you medication." Participant 9

Building the confidence of staff and the capacity of services to cater to these more vulnerable clients was a central gap to fill for services catering to young people. Multidisciplinary teams and interdepartmental skill sharing were suggested to build up the network and skills of both mental health and drug health staff. This relied on close connections, time and co-ordination between NGOs, health departments or community groups that in resource tight sector felt restricted. Although many recognised interdisciplinary co-ordination, smooth transitions were not always achieved.

Even when young people could be engaged in treatment services, as they moved from adolescence to adulthood, transitional care was often lacking, again, due to a lack of multidisciplinary cohesion. As young people became too old for youth-specific facilities, not all were ready for the harsher mainstream adult services, particularly as adulthood can be a transitionary period for issues such as housing, education, and employment. In other health facilities like cancer and chronic illness, a care-plan would habitually be put in place enabling the young person to slowly transition across to adult facilities with the support of the clinicians. Although most clinicians recognised substance use as a chronic relapsing condition which takes considerable time to change and/or recover from, chronic health care plans were not in place in services for young people with substance use.

"[Chronic care plans are important] so that at the time when they transition, it's not a huge breach of attachment or a sense of calamity; I've lost my home, I've lost my friends, I've lost my support people. And it's not like they were my parents and it's hard enough leaving my

parents, but these were people who were doing their best for me in a situation where it wasn't ideal, I've lost even that." Participant 5

As the transition to adult services were considered a difficult stage for young people, some services extended their age of provision to better cover service gaps and needs. In generalist services the age cut off is generally under 17years , whilst some specialist services have extended the cut off to age 25 years. A newer model of service up to age 30 years was advocated for by some participants for more disadvantaged young people. Whether due to involvement in the foster system, juvenile justice or other roadblocks, some people had not been able to access the services needed or did not feel comfortable in adult services due to heavy institutionalisation. Youth-friendly services were considered generally easier to navigate and better supported for those who had poor health literacy, not just adolescents. A social worker described how raising the age limit provided benefit to clients that otherwise would have struggled to navigate the adult health network:

"We work with young people in the criminal justice system as a criteria [sic]. We're a little bit older – our age range is 18 to 30. Accounting for the fact that people might have spent some time in custody and that knocks years out of their lives. And in fact, one fellow that I just talked to [the health worker] today about seeing, she saw him here at Weave when he was like 23 – maybe 24. He went to jail for two years. He's just gotten out. He's 26. So, it's like he's missed those years and the chance to see [the healthcare worker]. Now he wants to see her, but we'll work that out." Participant 7

Providing support for young people in practical ways has benefit for their overall engagement and their treatment outcomes. As described previously, staff who were strong advocates significantly impacted those around them and helped their client navigate the system better. However, staff struggled in areas with limited resources or capacity such as school leavers and those from cultural and linguistically diverse groups. The need for advocates from a client's own community and outreach was raised as beneficial even if it was a consultation role to protect a young person's confidentiality.

"With some of the Aboriginal kids with their families, to be able to have an Aboriginal support worker who could support the family while I'm trying to work with the young person as well, because there's often lots of issues, and I don't have the capacity to be able to manage all of that." -Participant 2

"One of our roles would have been around trying to help that person get back to school, but we just don't have the capacity to do that anymore. So that's something I used to think was worthwhile but can't do that anymore." – Participant 9

Although no single service was able to meet every gap in their clients' needs some were better equipped than others, particularly in the co-ordination between services and disciplines across departments. Advocates and outreach helped to bridge these gaps and afforded these services extra flexibility in how they saw clients for appointments and how they approached treatment goals.

Ultimately, prevention was highlighted by all staff as the ideal target of services. Acute issues like suicide and dangerous substance use (i.e., overdose or intoxication), were difficult to prevent and

difficult to treat. Clients presenting with mental health and drug related issues to emergency or acute counselling services were raised as an area of particular concern as emergency was the 'only option' for many of these young people due to the restrictions in place for community and outpatient services.

"*I think that's why a lot of them wind up in the emergency department because they don't really have a service looking out for them…I think what's not working."* - Participant 6

The broader health network is not always well equipped to address acute and complex needs of young people. However, by addressing service gaps through flexibly and proactive key staff members, drug and alcohol services found ways to improve client experience and treatment pathways. Boosting resources and capacity to address the needs for the most disadvantaged young people was crucial. Implementing youth-friendly spaces, reducing barriers such as admission requirements and reducing referral criteria were key areas that staff highlighted may improve the experience of young people presenting to services and to improve engagement. Whilst staff were confident that many young people were looked after, it was those in the most vulnerable positions that generally missed out on services.

Discussion

Improving services for young people in the public health sector is an ongoing concern across many health districts and departments. Our results suggest that health staff are receptive and positive about the interventions and processes they implement on the whole, however working within the wider adult-focused health network can be frustrating. Within these settings, it continues to be challenging to engage with vulnerable young people, with some young people still unable to access the services they need due to eligibility and resource restraints.

Staff from specialist or targeted services for young people generally reported better ability to address the needs of their young clients compared to generalist facilities. Previous research suggests that services for young people in generalist settings can fail to exercise the required flexibility and welcoming environment for young people to engage (Leukefeld & Gullotta, 2018; Rickwood et al., 2019). This was echoed by some participants who reflected the harsh clinic walls, furniture and even the food were not conducive to looking after young people in generalist settings. Specific services for young people described modifying their model of care and treatment pathways to address the individual, a method well described in literature on person centred care (Heffernan et al., 2017; Leukefeld & Gullotta, 2018; Rickwood et al., 2019). Limited resources and strict eligibility were recurrent themes for generalist services who described their main priority as redirecting young people out of the system, particularly the hospital environment. Multiple participants, and previous research reflected that there is not a place for all young people who need treatment in the public health network (Barker et al., 2015; Digiusto & Treloar, 2007; Farrugia, Smyth & Harrison). School leavers, homeless and young people from diverse cultural and linguistic backgrounds had fewer options and could be left behind (Abdel-Baki et al., 2019; Barker et al., 2015; Bryant et al., 2016; Farrugia, Smyth & Harrison; Guo & Slesnick, 2017; Wu et al., 2002). Therefore, our findings are consistent with literature in that, providing targeted services for young people is more effective at engaging them in treatment than generalist or adult services.

Services that employed proactive health approaches and adaptive models of care were those that health staff described as most effective in engaging young people. The need to capture young people for short interventions or during a period of receptivity to change was emphasised by staff and well supported by previous research (Abdel-Baki et al., 2019; Barker et al., 2015), but identified as an area the public health system struggled to address particularly during COVID-19 restrictions where options were further restricted. For those seeking drug and alcohol treatment or advice, key staff appeared to be the driving force behind why patient outcomes were positive, not necessarily the processes in place. Key staff were described as important patient advocates that pushed for ongoing engagement, resources, and referrals for their patients. Staff described visiting young clients, rather than requiring the client to come to them whether this was in the community or on the wards. Client advocates sought services and resources for their clients, particularly issues like getting onto waitlists for rehabilitation beds, detoxification admission and psychologists required ongoing attention and pursual. Client advocates in this area were particularly important in achieving good outcomes for young people experiencing disadvantage (Magwood et al., 2019; Robards et al., 2018). These advocates employed encouragement and support roles that were usually taken on by family or peer-support which in a stigmatised area such as drug health, or with marginalised groups, were less likely to be available (Corrigan, Watson & Miller, 2006; Herz et al., 2018; Robards et al., 2018; SmithBattle, 2013). Services that provided client advocates built trust in services through relationships and improved client outcomes and should therefore be a focus of services proving care to young people.

Drug and alcohol services reflect an ongoing issue across many health districts relating to effective and ongoing engagement and improved outcomes for the most vulnerable. Basic needs like food, healthcare and transport were common incentives combined with flexible and forgiving referral pathways enabled staff to build relationships with their clients. Improving access to services and building confidence in healthcare workers and in their clients in the treatment options and management of young people with drug and alcohol problems would be of benefit.

Limitations

The recommendations and generalisation of the results are limited due to the small sample size. COVID-19 restrictions and limited study resources reduced the recruitment and study period.
This study only interviewed staff members from within Sydney Local Health District and its associated partners, and therefore may not represent the views or experiences of young people using the services and staff of private services or other health networks.

Recommendations

Participants provided a range of recommendations on how to improve engagement and client outcomes. Some suggestions focused on improving the culture of existing services. This included the addition of peer workers from marginalised communities or client advocates, as well as increasing resources within the hospital to provide food, decoration, and electronic devices to foster a youth-friendly environment in an otherwise clinical space. This has precedent in paediatrics but is missing from adolescent spaces.

Improving the process of youth specific services was also important as it enhanced the engagement and long-term outcomes for young people. In particular, having flexible staff roles was a design benefit which improved responsiveness of services and allowed them to cater to the unique needs of the young people presenting to their services. Similarly, embedding a drug health nurse or support worker into existing services appeared to be a highly effective way to engage young people and improve the knowledge of drug and alcohol staff in those services. As well as improving the availability of staff, better process and support are needed to streamline the process of transition between adult and adolescent services. Age limits and eligibility criteria excluded young people who could potentially benefit from existing services, therefore building capacity to broaden eligibility criteria and target vulnerable groups was a significant recommendation.

Conclusion

Improving services for young people in the public health sector is an ongoing concern across many health districts and within departments. Our results suggests that health staff are receptive and positive about the interventions and processes currently in place; however, working within the wider adult-focused health network can be frustrating. Staff from specialist or targeted services for young people generally reported better ability to address the needs of their young clients compared to generalist facilities. Age limits, referral processes and resources were ongoing barriers in services which hindered engagement by young people. Improving access to services and building confidence in the management of young people with drug and alcohol problems would be beneficial in improving outcomes for young people.

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