

No drug use is safe use

Understanding, recognising and implementing zero tolerance for responding to alcohol and other drug (AOD) use

A guide for supporting young people in residential care

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Fairness
and Housing

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In this document, 'young person' refers to both a child and young person and 'young people' refers to both children and young people.

Unless otherwise noted, images in this document show models and illustrative settings only. The images may not depict actual services, facilities or recipients of services.

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Available at [No drug use is safe use - Practice approach | Child Protection Manual | CP Manual Victoria](http://www.cpmanual.vic.gov.au/advice-and-protocols/specialist-resources/out-home-care-resources)
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Policy Position

The Department of Families, Fairness and Housing (DFFH, the department) has always applied a zero tolerance policy to the use of alcohol and other drugs by young people residing in residential care. These guidelines do not change the department's policy position; they provide additional support and guidance for working with young people within residential care.

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About this guide

There are often many factors that underpin and interrelate with AOD use, meaning an integrated approach is required to effectively understand and respond to the needs of those who use AOD. This guide provides clarity, consistency, and direction on how the service system supports young people in residential care through understanding, recognising and continuing to implement zero tolerance for responding to AOD use.

This guide is informed by current research evidence and is reflective of the:

- broader Australian context and frameworks for service provision in residential care
- effectiveness of AOD interventions with young people
- experience of young people with lived experience of both AOD use and residential care.

This guide has been developed following extensive consultation with:

- Child Protection
- Community Service Organisations (CSOs) and Aboriginal Community Controlled Organisations (ACCOs) which provide residential care to young people in Victoria
- Youth-based AOD services
- Young people with lived experience.

'Understanding, recognising and implementing zero tolerance for responding to AOD use: A guide for supporting young people in residential care' has been built around one foundational concept: **'No Drug Use is Safe Use'**.

Aligned with current national and state alcohol and other drug strategies and policies, this guide is underpinned by the fact that drug use in Australia is illegal for young people aged under 18 (unless prescribed by a medical practitioner). It provides a *practice approach* for implementing zero tolerance with young people in residential care by those providing direct care and those in the broader care team including Child Protection. When applied, this guide will enable the following practice:

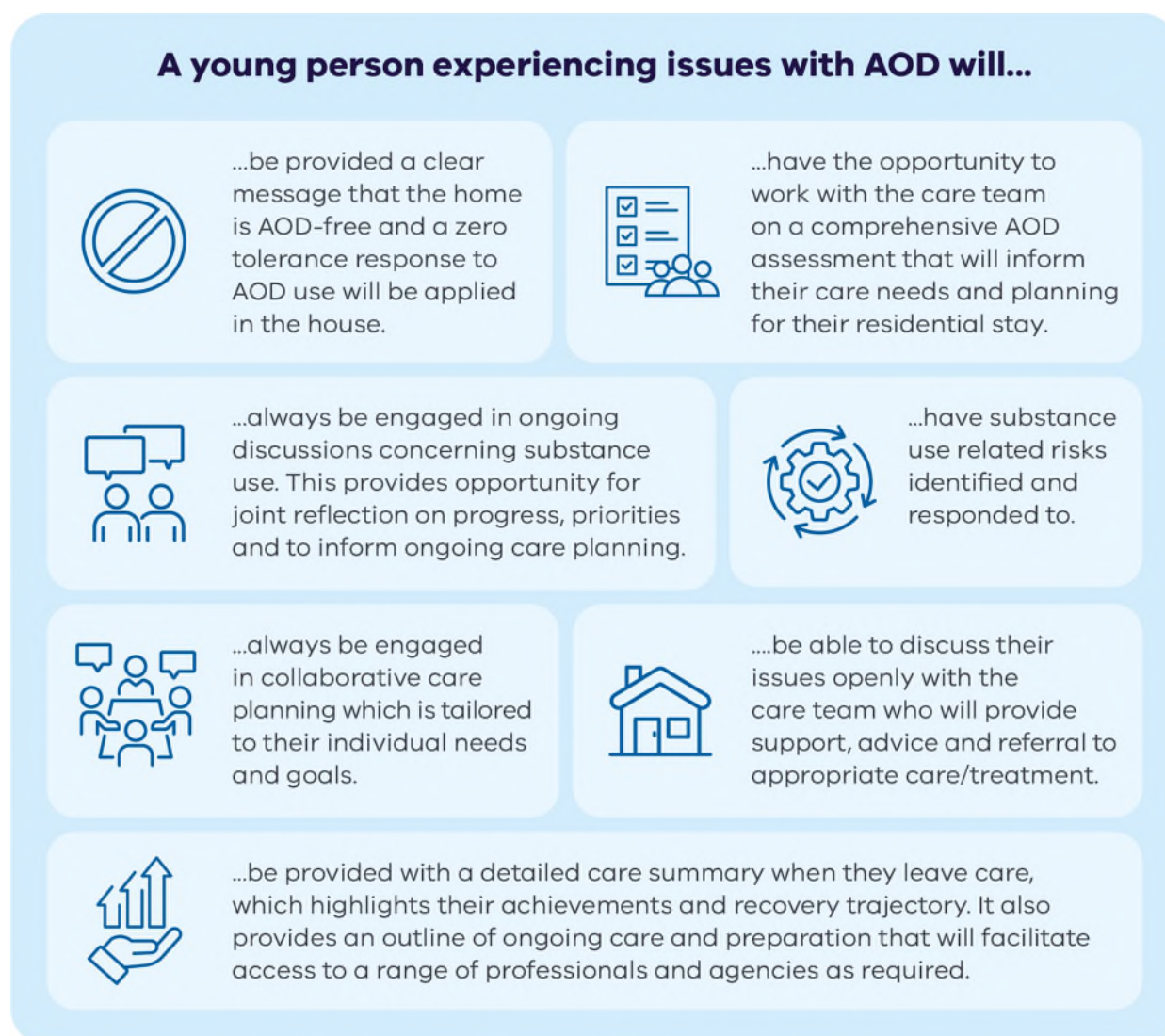


Figure 1. The practice approach in action

Context

Having faced severe “early adversity”, (Bath, 2015) young people in residential care are some of the most disadvantaged, disenfranchised, and vulnerable in our community. They often display highly complex behaviours and require therapeutic care and support (AIFS 2011).

Those providing residential care services to young people consistently express the importance of **recognising the young person’s lived experience *prior* to entry into residential care.**

Recognition of the young person’s lived *prior* experience includes their experience of:

- neglect
- abandonment
- physical, sexual, and emotional abuse
- poverty
- being witness to parental AOD use
- vulnerability to, or actual, AOD use.

Rapport and connection

For young people, the **importance of developing significant adult connections and relationships** with those responsible for their care is well understood. The building of rapport and connection relies on concerted effort by the adult to approach the young person with a genuine interest to get to know them. The initial period following a young person's entry into residential care is key to the building of rapport and connection. Through clear messaging the home is AOD free and a zero tolerance response to AOD use will be applied, the young person's initial connection to staff and the home is grounded in a clear, set expectation. Setting this expectation from the start will anchor future conversations and actions.

How this guide intersects with existing alcohol and other drug strategies, policies, and principles.

This guide aligns with existing Alcohol and Other Drug strategies and policies currently in place by the Victorian Government and the Federal Government. It closely aligns with the *National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–2029* (the national framework) which recognises that:

There is significant stigma and discrimination against people who experience problems because of their substance use. Stigma and discrimination against people exist in most settings: in the workplace, in healthcare services, in social welfare services, and in the broader community. It creates a serious barrier to seeking and receiving help. (Department of Health 2019, p. 4)

The Framework also emphasises that substance problems are health problems that can be treated, and treatment is generally more effective when initiated early.

In practice: No Drug Use is Safe Use

As drug use in Australia is illegal for young people aged under 18 (unless prescribed by a medical practitioner), for young people in residential care, the following applies:

- No Illicit drugs are allowed on premises.
- All young people with substance use issues must be referred to drug and alcohol treatment services.
- Young people are not permitted to have any non-prescribed inhalants in their possession or use such inhalants in residential care facilities. Items that are essential to the day-to-day operation of the residential care service and which clients could use as inhalants are to be securely stored.
- Strategies relying on passive observation of young people using substances are not permitted.
- Community service organisations are expected to do everything reasonable and consistent within safe work practices to stop young people from using AOD including non-prescribed inhalants, to remove drug and inhaling implements as soon as possible, and to reinforce that using AOD including non-prescribed inhalants is not permitted.
- In situations where young people present to the residential care facility in a substance affected state, our duty of care remains to ensure that they are appropriately assisted. This includes seeking medical intervention where required and monitoring the young person's wellbeing.
- Where necessary, police should be contacted for assistance under the provisions of the Drugs, Poisons and Controlled Substances (Volatile Substances) Act 2003.

To fulfill the duty of care to assist young people who return to residential care facilities substance affected, **those supporting the young person need to be informed about drugs and their impacts**. The table below sets out the action of different drug classes and their effect on a young person.

Table 1: Drugs and their common effects

Drug	Common effects
<p>Cannabis A depressant with hallucinogenic properties. Also known as weed, pot, dope, bud and green.</p>	<ul style="list-style-type: none"> • relaxed or euphoric mood • slowed reaction time • bloodshot eyes • dry mouth • increased appetite ("munchies") • anxiety, paranoia, or confusion (especially with high-strength strains).
<p>Methamphetamine A powerful stimulant that speeds up the body's systems. Comes as crystals, powder or a base.</p>	<ul style="list-style-type: none"> • increased energy, alertness • euphoria • talkativeness, hyperactivity • rapid heart rate • sweating • dry mouth • decreased appetite • difficulty sleeping
<p>Benzodiazepines Prescription sedatives used to treat anxiety, insomnia, and seizures.</p>	<ul style="list-style-type: none"> • calm, relaxed feeling • slowed thinking and movement • drowsiness or heavy sleep • reduced anxiety or fear • memory lapses, confusion
<p>Heroin & Prescription Opioids Central nervous system depressants, slowing down breathing and heart rate while producing strong pain relief and a sense of euphoria.</p>	<ul style="list-style-type: none"> • intense euphoria and feeling of warmth • heavy limbs • dry mouth • nodding off • slowed breathing and heart rate • confusion • nausea and vomiting
<p>Inhalants Common household products used to get a fast, short-lived high.</p>	<ul style="list-style-type: none"> • a short "rush" or high • dizziness • giggling or mood swings • hallucinations (seeing/hearing things) • slurred speech
<p>GHB A depressant drug young people may use to feel euphoric, relaxed, or sexually uninhibited.</p>	<ul style="list-style-type: none"> • deep sleep • unusual body movements • vomiting • seizures • unconsciousness

Drug	Common effects
<p>Ketamine A dissociative anaesthetic used medically for pain relief and sedation. It comes as a powder, liquid or as pressed pills.</p>	<ul style="list-style-type: none"> • floating or detached feeling (“K-hole”) • confusion • stumbling and poor coordination • difficulty speaking • numbness • hallucinations or paranoia • nausea and vomiting
<p>Alcohol A central nervous system depressant that slows brain and body functions.</p>	<ul style="list-style-type: none"> • slurred speech • impaired judgement • nausea and vomiting • aggression • blackouts or memory loss • slowed breathing and heart rate (in high doses)

For more information, access the Alcohol and Drug Foundation’s ‘What drug is that?’ poster.¹

¹ <https://alcohol-and-drug-foundation-shop.myshopify.com/products/what-drug-is-that-poster>

Principles of engagement with the young person to implement zero tolerance

For all young people in care, opportunity for growth and change centres on the building of trusting relationships with those who care for them, and those in their Care Team more broadly. Due to their prior traumatic experiences, for some young people, the building of relational trust takes time. However, through consistently experiencing being listened to, cared for, supported and respected, the foundations of trust will be set. For young people who use AOD, the building of a relational connection is crucial to enabling a pathway of recovery. In the words of those with lived experience, “the best workers were those that listened to my needs and acted on them”.²

Why we need to ask the question, implement and reiterate zero tolerance, and then continue to ask the question

From the outset of a young person's entry into residential care, we need to be clear on the set, zero tolerance expectation regarding AOD use in the home. We should seek to understand from the young person if they have engaged in AOD use historically and if there is any current AOD use. If this information is known prior to a young person's entry into care, it must be documented and shared with the care provider. The set, zero tolerance expectation applies to *all* young people. However, if a young person is entering care with an *existing* pattern of AOD use, an awareness of this will enable those caring for the young person to know from the outset that reiterating the set expectation will likely be necessary as will ensuring the young person has the necessary AOD treatment supports in place.

Understanding the reason *why* AOD use is occurring, informs how the young person can best be assisted. When asking the question, we need to be seeking as much information as possible, such as:

- when their AOD use started
- times they feel most inclined to use
- what happens when they do use
- how they feel, can they think of times when they have felt a lesser urge to use and why this may have been the case.

How to ask the question and implement a zero tolerance approach to AOD use

Open exploration of a young person's circumstances in relation to their AOD use needs to be approached with genuine care and concern. It should always be done in a manner whereby the young person has agency. Be curious, empathic, and non-judgmental whilst being clear the set expectation is AOD use is not permitted in the home

If the young person is less forthcoming, mention any behaviours or indicators you have noticed which align to possible AOD use, highlighting concerns about things you have noticed. Let them know that their best interests, safety, and wellbeing is your priority.

² Participant of Leaving Care AOD Focus Group with young people held at MacKillop Family Services South Melbourne on 1 May 2025.

If you don't elicit much information from the first conversation, try again, and importantly, keep trying. Continuously revisiting this topic with the young person demonstrates your interest in understanding their use, and them. Talking to a youth AOD clinician can also provide additional strategies you can use in initiation or continued discussion concerning drug use or issues associated with drug use.

Clear boundaries and expectations from the outset

Boundaries and expectations create safety. To implement a zero tolerance response there are **four primary expectations** relating to AOD use *in* the residential care home; they are:

- **No Illicit drugs including non-prescribed inhalants are allowed on premises.** Young people in residential care need to know that they are not allowed to have AOD including non-prescribed inhalants in the home. They also need to know that if they bring AOD including non-prescribed inhalants into the home, they will be supported to safely dispose of it. To reinforce this expectation, there should be a safe space outside of the home to dispose of AOD including non-prescribed inhalants or drug paraphernalia.
- **Children and young people are not permitted to have any non-prescribed inhalants** in their possession. This includes glues, hair spray, deodorants, insect spray, spray paint and cleaning fluids. Items that are essential to the day-to-day operation of the residential care service and which young people could use as inhalants are to be securely stored.
- Strategies relying on **passive observation of young people using substances is not permitted.** Young people in residential care need to know that those providing them with care will not standby when they are aware of AOD use. Carers have a duty to keep those in residential care safe; they must try to support young people to stop their AOD use and engage in an alternative behaviour. In situations where young people present to the residential care facility in a substance affected state, our duty of care remains to ensure they are appropriately assisted. This includes seeking medical intervention where required and monitoring the young person's wellbeing.
- **Everything reasonable and consistent with safe work practices will be employed to stop young people from using AOD, including non-prescribed inhalants.**

It is important that the young person understands the steps you will take to establish their safety.³

Safety comes first

In situations where children and young people present to the residential care facility in a substance-affected state, our duty of care remains to **ensure that they are appropriately assisted**. This means ensuring all measures are taken to dispose of any substances the young person has brought home with them, and importantly, undertaking all necessary actions to ensure the young person is physically, psychologically, and emotionally safe and supported and medical intervention is sought if required.

When to call an Ambulance

Call an ambulance when:

1. The person.
 - Is unconscious

³ Participants of Leaving Care AOD focus group with young people held at MacKillop Family Services, South Melbourne on 1 May 2025.

- Has difficulty breathing
 - Is not breathing
 - Has no pulse
2. The person has:
- Troubled breathing (audible wheeze/crackle)
 - Altered conscious state
 - Cyanosed.

Zero tolerance response approach for substance risk regulation

Regulating exposure to substance related harm and creating conditions for young people to work towards sustainable behaviour change is essential. **For young people in residential care, this includes the following:**

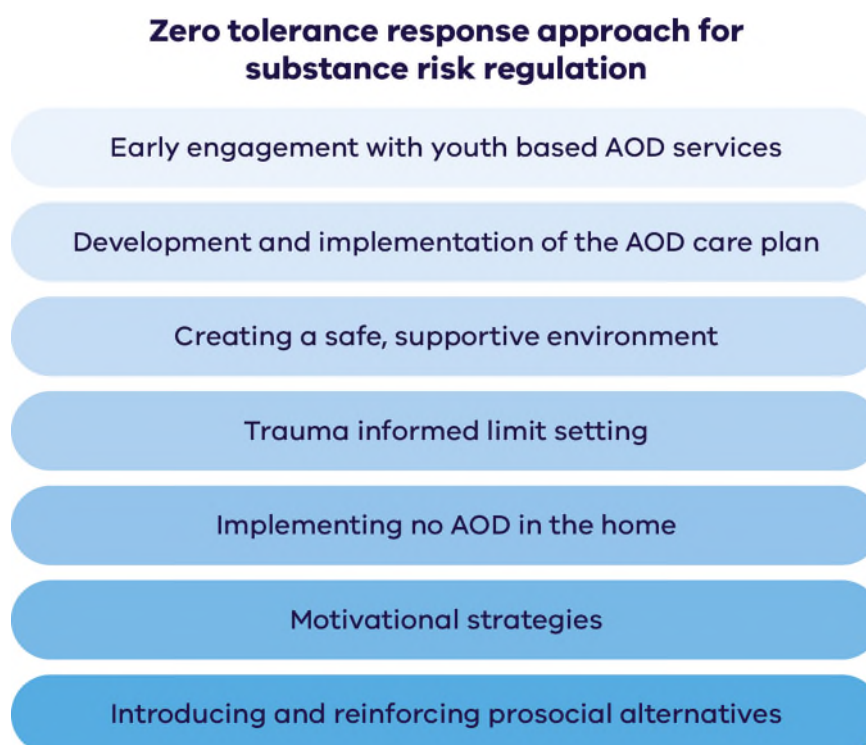


Figure 4. Zero tolerance response approach for substance risk regulation.

Early engagement with youth based AOD services

Early engagement with a youth based AOD clinician is imperative to a young person's care.

A discussion about the young person's AOD use should be organised soon after the young person's entry into residential care. This discussion should involve the young person, their Care Team, and their youth AOD clinician⁴. Young people may choose to include significant adults in this discussion and for Aboriginal and Torres Strait Islander children, the inclusion of family and community is a key consideration.

This meeting provides the young person the opportunity to engage in open discussions whilst supported by others. This helps to build a sense of connection between the young person and the adults who are committed to their ongoing wellbeing and development. Further, it allows the young person to hear from Child Protection and the care provider about the set, zero tolerance expectation regarding AOD use in the home whilst hearing from the AOD service about the supports available to them to address their AOD use.

⁴ If a youth AOD clinician is *not* available in Area, the local adult AOD service should be contacted to arrange supports for, and to meet with the young person and their care team. The Therapeutic Specialist should be engaged as part of any discussion with the young person.

Ideally, the discussion will encourage the young person to participate freely in a comprehensive AOD assessment. This means they will have a say in how their own AOD use is managed with them and for them. Readiness for change is an important aspect in a young person's substance use journey. If a young person appears reluctant to engage in discussions concerning their substance use or does not want to be involved in an AOD assessment, providing an empathic approach will keep open the opportunity to support the young person when they *are* ready. A young person's AOD recovery journey may not be linear. If they do not immediately engage in the process of an AOD assessment, efforts to promote their engagement should continue.

Consultation with a youth AOD clinician to explore strategies to engage the young person as well as ongoing visitations to the residential care home by the AOD clinician with offers to engage and support the young person and staff is highly recommended. This to occur alongside everything reasonable and consistent within safe work practices continuing to stop the young person from using AOD, including non-prescribed inhalants. This includes removing inhaling implements and any other drug paraphernalia as soon as possible and reinforcing the message that AOD use, including non-prescribed inhalant use, is not permitted.

Development and implementation of the AOD care plan

The information gleaned from the discussion with the young person, their Care Team, family, community, and their AOD clinician (as outlined above) is the foundation of the care plan developed for and with the young person.

AOD care plans are tailored to each young person. They are an important tool to establish consistency and transparency for the young person relating to any possible AOD use outside the home and in the community. The plan needs to reflect an in depth understanding of the young person, including past and current AOD use, their goals and interests, and world view. Importantly, the plan should reflect the role and responsibility of the Care Team and the young person in enacting the plan.

There is an overwhelming need to have an integrated approach to understanding, recognising and responding to young people who use AOD. Building and maintaining Care Team structures based on open and regular communication and centred on a common AOD care plan is critical to achieve a unified approach to supporting the young person.

For young people transitioning from residential care, it is particularly important to ensure their substance use care planning considers what specific ongoing AOD supports they require. Connection to these supports must be in place *before* they transition from care. Continuity of AOD support is crucial for what is often a process of ongoing recovery.

Creating a safe, supportive, zero tolerance environment

All young people thrive in a space they are comfortable in. There are several ways a care giver can create a calm, safe and supportive environment if a young person returns home and is affected by AOD.

- **Evoke empathy.** Move from a legal/punitive orientation to a function/meaning perspective, based on the understanding that AOD use is a symptom of a bigger problem. This creates empathy between the young person and yourself and paves the way for positive change.
- **Calm and non-invasive interactions.** Keeping your voice calm and body language relaxed is essential. Reacting with fear or control can further escalate tense situations.
- **Reduction of stimulation.** Lower the lights, turn off electronic devices and facilitate the reduction of contact with co-residents. Overstimulation can make the effects of being AOD affected worse.

- **Space to move.** If the young person is agitated or restless, offer safe ways to move around or self-regulate (walking, using a stress-ball, fidget toys).
- **Offer of hydration and nutrition.** Offer the young person water, hydrolyte, fruit or yoghurt, even if they don't appear to be hungry or thirsty and haven't said they are. Providing them something to eat and drink will help with recovery later.
- **No arguing with delusions.** If the young person is paranoid or hearing things, don't challenge the belief, just offer reassurance: "That sounds really intense, I am here if you need support."
- **Sleep support.** Crashes are common in young people who use AOD, so create space for rest and check in gently.
- **The provision of Naloxone.** For young people whose AOD presentation includes opiate-based drugs which suppress the central nervous system, there is serious risk associated with slowed breathing and heart rate. If young people are showing signs of a possible overdose, the provision of Naloxone can be lifesaving as it can reverse an overdose quickly by restoring breathing. As a routine measure, all residential homes should have Naloxone (Nyxoid® nasal spray) available. Having a Naloxone kit ready is like a seatbelt "we hope the young person doesn't need it, but it's there and it's lifesaving if they do⁵."

Trauma informed limit setting to enact a zero tolerance response

Setting limits and boundaries is an act of nurturing and care when done in the context of respectful, and attuned, relationships. Undertaken in the context of building a relationship with the young person, the setting of clear boundaries and expectations, from the outset, will ensure the impetus behind such boundaries is understood by the young person as keeping them well and safe. That is, the home is AOD free, there is a zero tolerance approach to AOD use, and actions taken will reflect this.

Implementing no AOD in the home

For young people in residential care, access to AOD can occur outside the home and in the community. For young people at risk of sexual exploitation, push and pull factors are the personal and situational factors that contribute to increased risk. Push factors are things that 'push' the young person away from safety and towards exploitation for example being unsettled in their placement or limited connection to positive adults. Pull factors are things that 'pull' or attract the young person towards exploitation -access to AOD is a well-known pull factor⁶. Unless the pathway via which young people are obtaining AOD is known, and can be disrupted, options for reducing supply can be limited. However, through the boundary and limit setting attached to their use, that is, no AOD or use in the home, accessibility and use *can* be reduced.

Motivational strategies

In AOD practice, motivational strategies focus on helping individuals develop the internal drive to change their substance use behaviours. Youth-based AOD services employ specific techniques to explore their clients' goals and motivation for change. To promote opportunity for change, the service system working with the young person, should focus on keeping the conversation open with

⁵ <https://adf.org.au/drug-facts/naloxone/>

⁶ <https://www.cpmanual.vic.gov.au/advice-and-protocols/advice/children-specific-circumstances/sexual-exploitation-advice>

the young person about their AOD use, engaging in reflective listening, and focusing on building rapport and connection.

Introducing and reinforcing prosocial alternatives

Once the reason(s) for AOD use has been identified, motivational and engaging alternatives need to be introduced. This could be through exploring:

- vocational interests
- engagement in education
- volunteer or even paid work.

Any alternative needs to promote a lifestyle that is incongruent with substance use and importantly, aligned to a vision for the future that is meaningful. Activities can be incorporated in a young person's day-to-day schedule which provide opportunity to engage in novelty seeking in ways that promote learning and competence. Connection to community and active engagement with supportive social networks are fundamental to changing AOD use. The connection between social and community support is recognised as important in providing young people with a sense of identity, acceptance, and belonging that they have otherwise attained from AOD use.

The practice approach in action

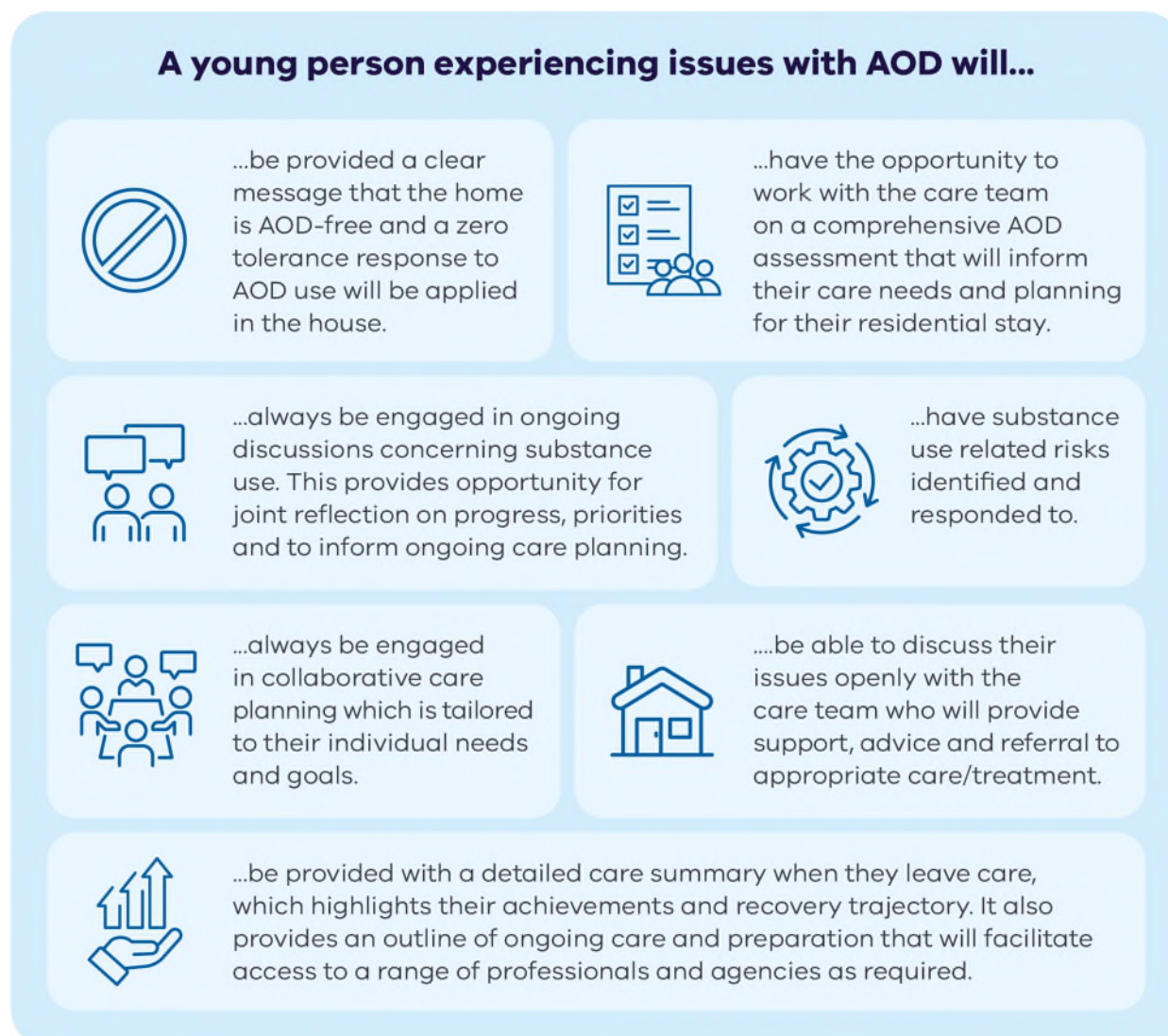


Figure 1. The practice approach in action

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