SVA PERSPECTIVE PAPER

AOD use and the risk of entrenched disadvantage in Australia

June 2024

Social Ventures Australia acknowledges Traditional Owners of Country throughout Australia. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present, and emerging.

This report has been prepared by Social Ventures Australia (SVA) Consulting

Social Ventures Australia (SVA) is a not-for-profit organisation that works with partners to alleviate disadvantage – towards an Australia where all people and communities thrive.

We influence systems to deliver better social outcomes for people by learning about what works in communities, helping organisations be more effective, sharing our perspectives and advocating for change.

SVA Consulting is one of Australia's leading not-for-profit consultancies. We focus solely on social impact and work with partners to increase their capacity to create positive change. Thanks to more than 15 years of working with not-for-profits, government and funders, we have developed a deep understanding of the sector and 'what works.

Our team is passionate about what they do and use their diverse experience to work together to solve Australia's most pressing challenges.

This Paper has been authored by SVA Consulting and Policy and Advocacy team members.

For more information, please contact us: **consulting@socialventures.org.au**

Legal disclosure statement

Glossary of terms, acronyms and abbreviations

Term	Description
AOD	Alcohol and Other Drugs – used in reference to the range of alcohol and drug use throughout this Paper.
Criminalisation	Criminalisation is the formal recognition by the legal system that certain behaviours are considered harmful or socially unacceptable and should be punished through the criminal justice system[1].
Crisis accommodation	Supported refuge accommodation
Disadvantage	Defined as lack of access to material and social resources, that limits ability to participate in society[2]
Entrenched disadvantage	As above but experienced over an extended period (more than 2 years) and often over family generations. The Department of Social Services describes as: "... a segment of the population where disadvantage is entrenched and multigenerational, and manifests itself across a range of activities and areas of policy..."[3]
Early intervention	Service provision prior to indication of harm relating to AOD use. Can include resources and education
Harm minimisation/ reduction	A range of approaches that aim to prevent and reduce AOD related issues, and to support people experiencing harms (including dependence) to address these harms
Harm prevention	Also known as 'primary prevention. Harm prevention aims to proactively address AOD use by focusing on helping people to delay, avoid, reduce, or modify their use, including through information and awareness building around specific drug types and risk factors.
Harms relating to AOD use	Used throughout to refer to where AOD results in harms (health, social and financial) for the user or for others as a result of AOD use by someone else.
Licit and illicit drugs	Illicit drug use in Australia is the recreational use of prohibited drugs in Australia. Illicit drugs include illegal drugs (such as cannabis, heroin, and certain types of stimulants), pharmaceutical drugs (such as pain-killers and tranquillisers) when used for non-medical purposes, and other substances used inappropriately (such as inhalants). Licit drug use refers to the use of drugs that are legal but that can come with restrictions, such as age and quantity or amount for consumption, around that use. This includes alcohol and medical pharmaceuticals.
Protective factors	Protective factors are characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact.[5]
Risk factors	Risk factors are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes[6].
Social exclusion	Occurs when someone experiences multiple, overlapping problems, such as unemployment, poor health and inadequate education, which stop them fully participating in society
Stigma	The disapproval of or discrimination against an individual or group based on perceived characteristics that distinguish them from other members of a society.
SVA	Social Ventures Australia

1. *Criminalisation Research in Australia: Building a Foundation for Normative Theorising and Principled Law Reform.* McNamara L et al. Criminalisation and Criminal Responsibility in Australia, Oxford University Press, 33. 2015..
2. Socio-economic advantage and disadvantage. Australian Bureau of Statistics. 2016. https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Socio-Economic%20Advantage%20and%20Disadvantage~123
3. *Productivity Commission, Rising Inequality: A Stocktake of the Evidence, Productivity Commission Research Paper*, August 2018, Canberra, pp. 4-5. AND Department of Social Services (DSS) described as part of the *Select Committee on Intergenerational Welfare Dependence*, 2018.
4. Socio-Economic Indexes for Areas (SEIFA), Australia. Australia Bureau of Statistics. 2021. https://www.abs.gov.au/statistics/people/people-and-communities/socio-economic-indexes-areas-seifa-australia/latest-release
5. *Risk and Protective Factors.* Substance Abuse and mental Health Services Administration. 2019. https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf
6. As above.
7. Socio-Economic Indexes for Areas (SEIFA), Australia. Australia Bureau of Statistics. 2021. https://www.abs.gov.au/statistics/people/people-and-communities/socio-economic-indexes-areas-seifa-australia/latest-release

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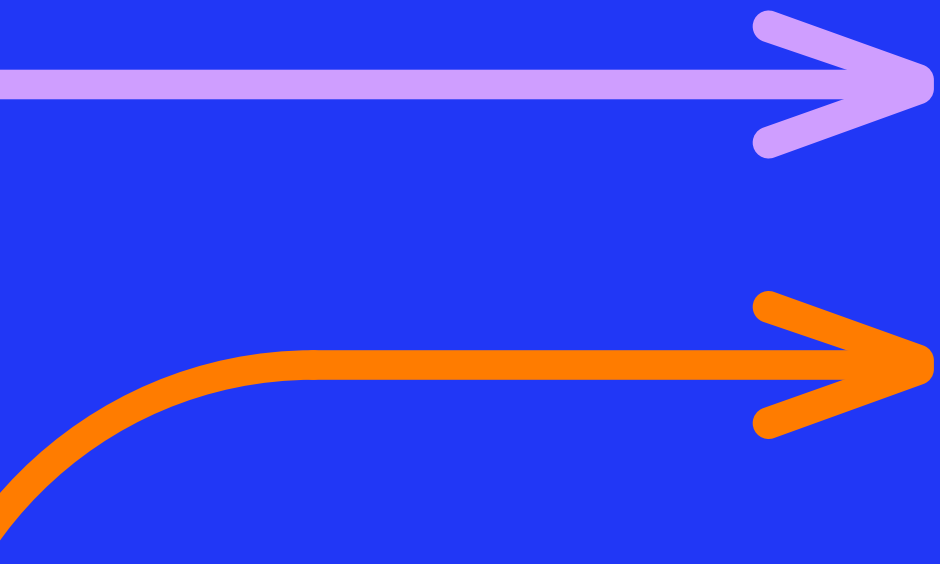


Introduction (CEO's foreword)

SVA is one of Australia's leading social impact organisations, dedicated for over 20 years to finding innovative solutions to entrenched social issues and accelerating positive change. We challenge institutions to think differently, redesign systems, and work hand-in-hand with passionate partners and communities to drive meaningful social change. We leverage our broad perspective, transformational mindset, and trusted voice to combat inequality.

As part of our approach to drive systemic change in Australia, SVA distils insights that combine learnings from our practical experience reducing disadvantage, with publicly available data and research to present our perspective. We have previously published insights in the areas of education, employment, housing, disability and mental health.

In this paper we take a different approach. The paper focuses specifically on the intersection between alcohol and drug use and disadvantage and asks the question of whether alcohol and drug use entrenches disadvantage in Australia. It takes a systems lens to identify evidence-based levers to drive improved outcomes for individuals and communities experiencing harms from AOD use.

Many people who use AOD do not experience negative consequences. AOD use does not inevitably lead to disadvantage or other adverse impacts. However, focusing on where experiences of disadvantage and AOD use intersect, allows the identification of opportunities to influence positive outcomes most effectively.

The paper draws on SVA's experience working across sectors to support all people and communities to thrive, including working with a range of organisations that operate within and alongside the AOD support sectors.

The paper aims to spark debate, innovation and collaboration among practitioners, community members, funders and policy makers.

Executive summary

Alcohol and other drugs (AOD) are part of many people's lives. A significant number of Australians consume substances regularly, including alcohol, cannabis and other drugs. Three in four people consumed alcohol in the past year and 1 in 2 have used illicit drugs in their lifetime.

Many people navigate their consumption with minimal impact to their immediate or longer term wellbeing. Yet the broader effects on individual and public health, safety, and economic stability can be substantial. High levels of AOD consumption are linked to serious harms not just to users, but also to their families and communities. These risks manifest through health problems, increased violence, economic strain, and significant burdens on health, social and justice systems.

The harms resulting from AOD use don't hit everyone equally. People who are disadvantaged and who live in disadvantaged communities are disproportionately impacted, worsening their circumstances and making recovery and advancement even harder. For example, harmful alcohol use is an outcome connected to post-traumatic stress disorder, a mental health condition many individuals develop after experiencing violence, including women who have been subject to family violence. AOD use exacerbates a cycle of disadvantage which can continue for generations, affecting children's development and overall community health and wellbeing. This interrelationship emphasises the importance of approaches that address disadvantage and AOD use holistically.

At Social Ventures Australia (SVA), we focus on creating an Australia where all people and communities thrive. By mitigating the harms associated with AOD use, those facing deep-seated disadvantage are better supported to live healthy and fulfilling lives.

This is a complex issue without a simple solution. In this paper we identify the need for approaches that span systems, communities, and individual actions. Our insights are informed by hands-on experience, data, and research – with a particular lens to responses that better address the intersection between AOD use and disadvantage. They are not intended to be exhaustive but represent our perspective on some of the essential systemic changes required to improve outcomes.

1. **Responses to individuals, families and communities with complex needs are integrated and holistic** to recognise the complex social determinants of health, and mitigate harmful AOD use.
2. Governments adopt an 'investment approach' with the aim to **rebalance expenditure away from crisis responses** and towards evidence-informed prevention, early intervention and health-led responses.
3. Governments fund the **true cost of delivering AOD treatment and response services**, including adequate funding to meet demand.
4. Governments facilitate improved cross-sector collaboration between police, the justice system and health services **to prioritise health and harm reduction** in response to AOD.
5. Organisations advocating for change create a coalition to foster **collaborative and inclusive advocacy** at a national level to create momentum for policy and system changes
6. Governments and service providers improve the **collection and use of data to better understand and respond to AOD-related needs** across various service systems.
7. Governments, academics, service providers, and users should **partner to strengthen the evidence base** and understanding of effective AOD treatments and responses.
8. Government and philanthropy support and empower more **place-based initiatives to respond to community needs**.
9. Governments, businesses, and philanthropic organisations **invest in comprehensive awareness and education campaigns to tackle stigma**.

As is critical to affect change in all complex issues, SVA is committed to working collaboratively with the broader sector to drive these changes, aligning our efforts and support with community-led strategies, evidence-based practices and the rich knowledge of people with lived experience. Through these collaborative efforts, we aim to create a more inclusive, supportive environment that uplifts the most vulnerable, setting a course for healthier, more fulfilling lives across all Australian communities.

Vision

SVA has a vision for an Australia where all people and communities thrive.

Many people in Australia use AOD without causing harm to themselves or others. However for some, AOD use can lead to significant negative effects as one of the many elements of the complex, interconnected factors associated with disadvantage and social exclusion, resulting in poorer long term outcomes.

The individuals and communities SVA supports include those who experience harms relating to AOD use. AOD use and entrenched disadvantage can amplify one another, making it difficult for those affected to escape a cycle of harm due to lack of financial and social leverage.

We believe that by working to minimise harms relating to AOD use, Australians who are at risk of entrenched disadvantage are better supported and empowered to live healthy and fulfilling lives.

Evidence shows that the harmful impacts of AOD are not solely due to individual choices. Our framework for better outcomes examines how an individual's experiences are shaped by their environment — their home, community, and the systems they interact with (see Figure 1. 'Drivers of Better Outcomes'). This approach is based on Bronfenbrenner's ecological model, recognising that people are influenced by their surroundings.

Achieving our vision requires:

- Systems that prioritise and support the well-being, safety, and recovery of everyone.
- Inclusive communities that promote connections and fair access to support.
- Individual and family environments that encourage healthy behaviours and positive norms.

Drivers of better outcomes

Figure 1. Drivers of better outcomes

Vision: By working to minimise harms relating to AOD use, Australians who are at risk of entrenched disadvantage are better supported and empowered to live healthy and fulfilling lives.

1. Systems prioritise and support population wellbeing, safety and recovery

1.1. Early intervention and prevention approaches for AOD are prioritised, with universal & targeted elements

1.2. Evidence-based, holistic policies, programs and funding to minimise AOD harms, that are integrated within and across sectors

1.3. Commitment to integrated data and continuous improvement of AOD policies.

1.4. Responses to AOD use and harms prioritise health and safety, over punitive, justice system-led responses

1.5. Policy and regulation recognises commercial drivers of use

2. Inclusive communities and services that support connection and equitable access to support

2.1. Safe and socially inclusive communities that foster a sense of belonging

2.2. Community ownership, self-determination and accountability to address AOD harms

2.3. Employment, education and training pathways

2.4. Positive Policing

2.5. AOD services are strengths-based and respond to individual needs

3. Individual and family environment that promotes positive norms around healthy behaviours

3.1. Positive role modelling, mentoring and practical pathways are available to all

3.2. Environment free from experiencing/ witnessing trauma, abuse, violence, neglect and chronic stress

3.3. Positive and nurturing relationships are maintained within the household

3.4. Kinship and social connection inside and outside of the home is strengthened

3.5. Individuals have a sense of purpose

3.6. Individuals are supported to develop responsibility & accountability, including for meeting health & wellbeing needs

3.7. Parents and caregivers are adequately skilled and supported

Enablers:

1. Systems and responses to AOD use are i) trauma informed and culturally appropriate; ii) free from stigma; iii) supportive of healthy norms and behaviours; iv) shaped by people with lived experience, who participate in decision-making at all levels

2. Material needs of individuals and communities are met, including housing, food security, financial resources and local infrastructure

About this Paper

Scope

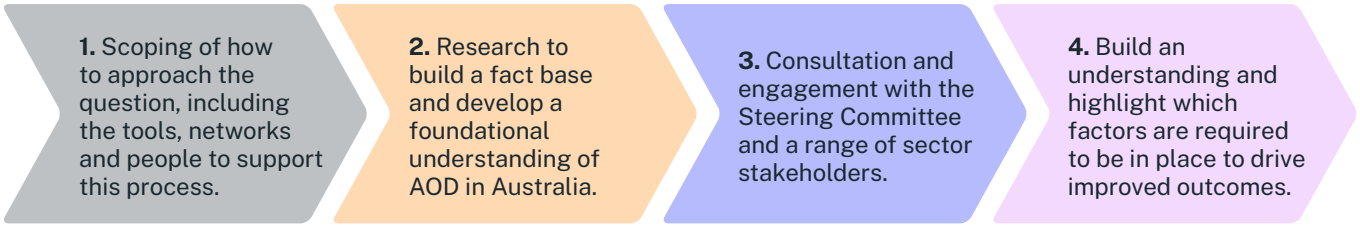
This Paper offers an overview of the complexities surrounding AOD use in Australia, with a focus on opportunities to reduce harms associated with AOD use for people experiencing disadvantage from a systems perspective. Disadvantage can be measured and understood through a range of lenses, such as financial, housing, education, family and community. An individual may experience disadvantage across several or all of these areas, just one, or none. Indicators of disadvantage intersect with and contribute to negative outcomes in relation to AOD use; this paper is shaped around these intersections.

It is not within the scope of this paper to capture the full diversity of experiences of AOD use, including the nuance of experience as it relates to different substances and the full spectrum of interventions for AOD use.

Methodology

SVA conducted a desktop literature review and consulted with various individuals and organisations within and related to the AOD sector, including those involved in service delivery, research, advocacy, education, and harm prevention and minimisation.

Figure 2. Perspective Paper development steps



Our research found that AOD use is influenced by societal decisions and actions, including social, commercial, and cultural norms, as well as regulatory frameworks, the justice system, service delivery, local resources, and family environments. Disadvantages such as discrimination based on gender, race, colour, or sexual identity, and experiences of trauma also play a significant role.

Steering Committee

SVA collaborated with a Steering Committee for guidance on the approach and to develop, test, and refine a framework identifying the drivers of better outcomes. The committee included key sector representatives, such as leaders from peak bodies, treatment and support service providers, advocacy groups, harm prevention and minimisation organisations, and SVA representatives. They highlighted critical challenges within Australia's AOD systems and their interactions.

The Steering Committee assisted in navigating language, key topics, and discussion approaches, including concepts of AOD 'use' and 'misuse', impacts of stigma, criminalisation, legal and illegal drug classifications, and models used across Australia to prevent, minimise, treat, and punish AOD use.

The Committee's recommendations, expertise, and insights were vital for framing and crafting this paper, significantly enhancing SVA's understanding of the complexities associated with AOD use, its prevalence, and outcomes in Australia.

The issue

AOD use in Australia is widespread

AOD use is common in our society and Australians use AOD at some of the highest rates in the world. A national survey in 2022-23 found three in four people in Australia aged 14 years and older consumed alcohol in the past year and almost 1 in 2 (47%) have used illicit drugs in their lifetime[8]. Cannabis was the most commonly used illicit drug - by 41% of people across their lifetimes[9].

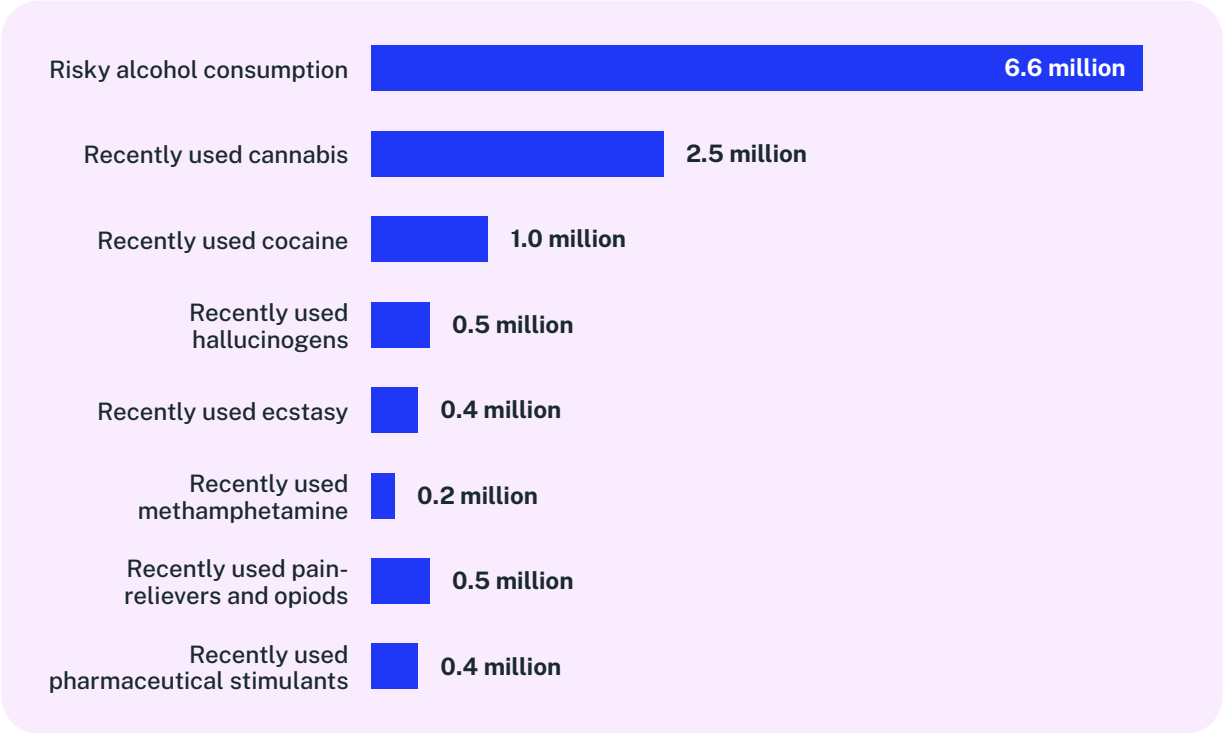
Alcohol, cannabis and other drugs are used for various reasons, such as socialising, relaxing, or enhancing creativity. Consumption of alcohol in particular is closely entwined with social and cultural activities. Some Australians use AOD to cope with physical or psychological pain. Common reasons young people give for AOD use include peer influence, curiosity, seeking new sensations, feeling good, boosting confidence, or escaping problems at school or home.

Some Australians use AOD at higher levels and use more harmful substances. In 2022-23, around 1 in 3 people (31%) or 6.6 million people – recorded use of alcohol in ways that put their health at risk[10]. 1 in 4 people reported consuming more than 10 standard drinks per week on average.

Illicit use of drugs includes use of illegal drugs, misuse or non-medical use of pharmaceutical drugs or inappropriate use of other substances (such as inhalants).

AOD use is influenced by factors beyond individual choice or morality, such as adverse childhood experiences, lack of parental support, drug availability, high-stress environments, and limited access to healthcare, social support, education, and employment. The availability, price, and purity of drugs also affect their use.

Figure 3. Summary of alcohol and illicit drug use, people aged 14 and over, 2022–2023



8. *National Drug Strategy Household Survey 2022–2023.* Australian Institute of Health and Welfare (AIHW). 2023.
9. *National Drug Strategy Household Survey 2022–2023.* Australian Institute of Health and Welfare (AIHW). 2023.
10. The National Health and Medical Research Council Guidelines state that healthy men and women should drink no more than 10 standard drinks a week and no more than 4 standard drinks on any one day: https://www.nhmrc.gov.au/health-advice/alcohol. Consumption above this level increases the risk of alcohol-related harm and is classified as 'risky drinking.

Individual harms vary; societal harms from AOD use are significant

The ways in which people use AOD and the extent of the harms associated with that use vary greatly. Many people experience limited harms from AOD use. However, the impacts for some individuals, their families and communities and for society as a whole are significant.

Patterns of drug use and associated harms are complex – from experimental use to dependence. AOD dependency involves chronic substance use characterised by compulsive seeking and use despite harmful consequences. Repeated use can lead to physiological changes, making it difficult to limit further use, and these changes can persist, making dependency an ongoing and relapsing condition. Individuals in recovery remain at increased risk of relapse, even after years of abstinence.

Heavy use and dependency can result in an individual choosing to prioritise income expenditure on an AOD substance ahead of their/their family's day to day needs. In 2020, the average Australian household spent around $1,900 on alcohol ($32 per week), with lower income households spending proportionally more that higher income households[11].

The Australian Association of Social Workers has noted the interrelated nature of harms surrounding AOD dependency, with the cost of maintaining ongoing use sometimes resulting in insufficient funds to pay for a range of goods and services. Further they suggest that irregular employment or unreliability at work frequently accompanies heavy substance misuse, impacting payment of regular bills, including rent or mortgage, food and clothing, and other purchases that are the staples for survival[12].

The impacts of AOD use for individuals, communities and society include:

- Health impacts such as burden of disease, hospitalisations, overdose and death
- Social impacts such as violence, crime and trauma
- Economic impacts such as the cost of health care and law enforcement.

11. The Alcohol and Drug Foundation. https://adf.org.au/insights/up-when-alcohol-goes-down/
12. House Standing Committee on Family and Human Services, 'The winnable war on drugs
The impact of illicit drug use on families'. https://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=fhs/illicitdrugs/report/chapter9.htm#fin

Figure 4. Health, social, economic impacts of alcohol use in Australia

HEALTH

- Alcohol-related deaths were at a 10 year high in 2022 – at 1,742
- Drug-induced deaths totalled 1,693, exceeding deaths from road accidents (1,267)
- Alcohol use contributed to 4.5% of the total burden of disease in Australia in 2018; illicit drug use contributed 3.0%
- 42% of treatment episodes were for alcohol in 2021-22, followed by amphetamines (21%)
- QLD Child Death Review Board found 39.2% of child deaths in QLD involved methamphetamine use

SOCIAL

- Alcohol has been identified as a trigger of increased aggressive behaviour in both men and women, though the effect is more pronounced in men (50%) compared to women (13%)
- In 2022-23, more people reported experiences of harmful behaviour because of others' alcohol use than in the past.
- 'Illicit drug offences' (52,315 offenders) were the second most common principal offence nationally, behind 'acts intended to cause injury' (83,926 offenders).

ECONOMIC

- Alcohol-related harms were found to have a social and economic cost of $66.8 billion, with a further $12.9 billion for harms relating to other drugs in 2017–2018. For alcohol-related harm, this total combines: **Tangible costs** – of $18.1 billion from alcohol-attributable premature death, health costs, increased absenteeism and injuries at work, alcohol-attributed justice system costs and road traffic accidents **Intangible costs** – premature mortality, lost quality of life and harms attributed to child abuse.
- The proportion of household expenditure on alcohol in 2015–16 was 2.2%, down from 3.4% in 1984.

The Australian Burden of Disease Study 2018, https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/impacts/health-impacts#death-alcohol
https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/impacts/health-impacts#death-alcohol

Australian Bureau of Statistics, Causes of Death, Australia, 2022. https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#potentially-avoidable-mortality-and-selected-external-causes-of-death

Examining the Social and Economic Costs of Alcohol Use in Australia: 2017/18. Whetton S. et al. National Drug Research Institute: Curtin University; 2021.

The nature of the harms varies with substance type and patterns of use. For example:

- 1 in 5 people (21%) were verbally abused, physically abused or put into a state of fear by someone under the influence of alcohol in the previous 12 months in 2022-23.
- Violent behaviour is more than 6 times more likely to occur among methamphetamine dependent people when they are using the drug, compared to when they are not.
- Cannabis dependence among young adults is correlated with, and can contribute to mental health disorders such as psychosis.
- Opioids including heroin are associated with higher risk of infectious disease transmission and death from overdose.

Alcohol use is associated with family violence

Several studies have found a strong and ongoing link between alcohol use and partner violence, although there is limited evidence to show that alcohol directly causes violence against women.

- **Alcohol was involved in 23% to 65% of all family violence cases** reported to police in Australia.
- Half of the men in programs designed to help perpetrators of violence have had issues with alcohol, and about half of the men in programs for AOD treatment have been violent towards their partners.
- **Men entering programs for violent behaviour were 8 times more likely to be violent** towards women on days they drank alcohol. On days they drank, they were also **11 times more likely to engage in severe violence**.
- Analysis of data from 13 different countries found a **strong and consistent link between drinking alcohol and more severe partner violence**.

Analysis from ANROWS has revealed that alcohol is commonly used as a coping strategy by women who have been subjected to violence.

According to the Australian Institute of Health and Welfare, Indigenous women are 35 times more likely to be hospitalised for family violence-related assaults than other Australian women.

Alcohol use has also been linked to the impacts of post-traumatic stress disorder, a condition many women develop after experiencing violence . Both childhood and adult experiences of sexual assault are linked to harmful AOD use, and women who were sexually abused as children are at a higher risk of these problems than men who experienced similar abuse.

Harms relating to AOD use is a significant intersecting mental health issue for women who have faced sexual violence, often serving as a way to cope with the negative feelings related to traumatic experiences.

13,14,15,16,17,18

13. National Drug Strategy Household Survey 2022–2023, web report. Australian Institute of Health and Welfare (AIHW) 2024. https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey/contents/about
14. Risks for children caused by Methamphetamine use by parents. Queensland Child Death Review Board, Queensland Family & Child Commission.
15. The Australian Burden of Disease Study 2018, https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/impacts/health-impacts#death-alcohol
16. Australian Bureau of Statistics, Causes of Death, Australia, 2022. https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#potentially-avoidable-mortality-and-selected-external-causes-of-death
17. Examining the Social and Economic Costs of Alcohol Use in Australia: 2017/18. Whetton S. et al. National Drug Research Institute: Curtin University; 2021.
18. Deaths due to harmful alcohol consumption. Alcohol, tobacco & other drugs in Australia. Taken from the AIHW webpage - https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/impacts/health-impacts#death-alcohol

Harms related to AOD use disproportionately affect population groups and communities at risk of disadvantage

The National Drug Strategy identifies specific priority population groups who have higher risk of experiencing disproportionate harms associated with AOD use. These include:

- First Nations people – compared to other Australians, First Nations people suffer more harm from alcohol, tobacco and other drug use[19].
- People with co-morbid mental health conditions – illicit drug use is more common among people with a mental health condition (28.9 per cent compared to 15.9 percent of people without a mental health condition)[20].
- People in contact with the criminal justice system and who have high underlying rates of alcohol and drug problems[21].
- Culturally and linguistically diverse populations – some groups have higher rates of, or are at higher risk of harms relating to AOD use[22].

While some of these groups consume AOD at higher rates than the population as a whole, the disproportionate impacts reflect that the relationship between use and harm is complex.

Some groups are more likely to experience deep social exclusion as well as increased risk of harms related to AOD use:

- Around **15% of First Nations Australians experience deep social exclusion**, versus 6% non-First Nations people
- **People living in regional and remote populations are more likely to experience deep social exclusion** across a range of indicators including access to services, education and employment
- **13% of single parents experience deep social exclusion**

19. (Department of Health and Aged Care 2017).
20. https://www.aihw.gov.au/reports/mental-health/mental-health-alcohol-drugs
21. https://www.health.gov.au/sites/default/files/national-drug-strategy-2017-2026.pdf p.28
22. https://www.health.gov.au/sites/default/files/national-drug-strategy-2017-2026.pdf ,29

First Nations use and related harms

Rates of risky drinking among First Nations people are similar to rates for non-Indigenous people. Drinking behaviours, however, differ between the two groups.

According to the Australian Institute of Health and Welfare and after adjusting for differences in age in 2022–2023:

- First Nations people were 1.2 times as likely as non-Indigenous people to have consumed no alcohol in the previous year. Abstinence among First Nations people has increased from 25% in 2010 to 28% in 2022–2023.
- First Nations people were 1.2 times as likely to have consumed more than 4 standard drinks in a single day at least once a month.
- Non-Indigenous people were 1.1 times as likely to have consumed more than 10 standard drinks per week on average.

The largest difference was for occasions of very high alcohol consumption.

- First Nations people were more likely to have consumed 11 or more standard drinks in a single day than non-Indigenous people in 2022–2023.
- First Nations people were 1.8 times as likely to have done so at least once a month in the previous year.

First Nations people were 1.4 times as likely as non-Indigenous people to have used any illicit drug in the previous 12 months and rates of use were higher than the non-indigenous population for cannabis, amphetamines, pharmaceuticals and pain-relievers.

First Nations people also suffer more harms relating to alcohol, tobacco and other drug use, compared to other Australians.

In 2022–23, 18% of clients of alcohol and other drug treatment services aged 10 and over were First Nations people.

23,24,25

In certain locations, including those with long term low socio-economic indicators, people tend to experience more harms relating to alcohol use[26]. Disadvantage in Australia is concentrated in a disproportionate number of communities. The 2021 Dropping off the Edge (DOTE) report from Jesuit Social Services found that 13% of locations in New South Wales accounted for 55% of the most disadvantaged positions across all 37 indicators for disadvantage.

The report also shows that disadvantage is more prevalent in regional and remote areas[27]. People in regional and remote areas also use AOD treatment services more often than those in big cities[28], with around 1 in every 153 people seeking treatment, compared to around 1 in every 171 people in major cities.

23. (Department of Health and Aged Care 2017).
24. Alcohol and other drug treatment services in Australia: early insights. Australian Institute of Health and Welfare. AIHW. Australian Government. 2024.
25. National Aboriginal and Torres Strait Islander Health Survey, 2018-19. Australian Bureau of Statistics. 2020.
26. *Dropping Off the Edge 2021: Persistent and multilayered disadvantage in Australia.* Tanton, R., Dare, L., Miranti, R., Vidyattama, Y., Yule, A. and McCabe, M. Jesuit Social Services: Melbourne. 2021.
27. Report of the Special Commission of Inquiry into crystal methamphetamine and other amphetamine-type stimulants, Professor Dan Howard SC, 2020, Part A, pp.65
28. Report of the Special Commission of Inquiry into crystal methamphetamine and other amphetamine-type stimulants, Professor Dan Howard SC, 2020, Part A, pp.65

AOD use and disadvantage share common risk factors; each can perpetuate the other

The social determinants of health, endorsed by the World Health Organisation (WHO), provide a framework for understanding some of the complex factors that contribute to harmful AOD use.

The WHO describes social determinants of health as: 'the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.'

In general, people from lower socioeconomic backgrounds with less income, wealth and education are at greater risk of poor health than more advantaged people. The NSW Ice Inquiry noted 'a large volume of evidence showing that harmful and dependent drug use is often rooted in complex social, economic and psychological determinants, such as socioeconomic disadvantage, unemployment, homelessness and trauma'[29].

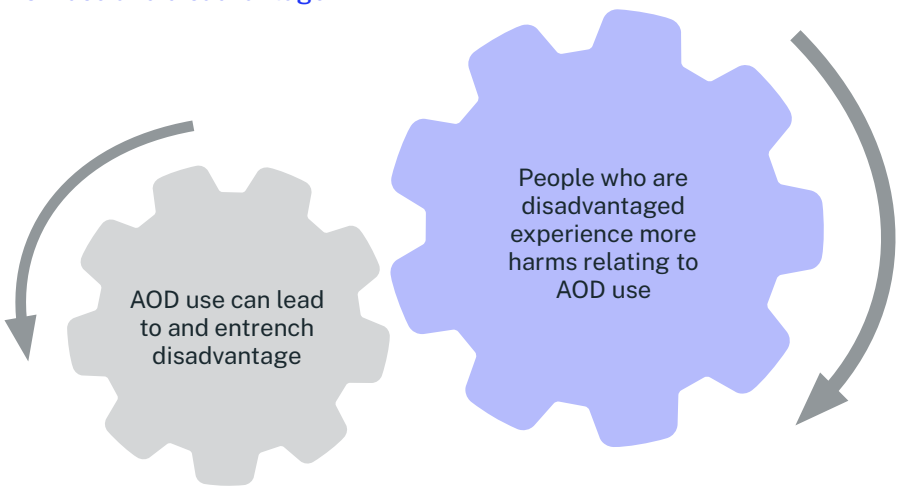
In a survey of regular users of Sydney's King's Cross injecting facility, 96% of participants reported a history of trauma, 82% had a mental health diagnosis, 54% had attempted suicide, and one third had a history of self-harm[30].

Disadvantage, including the intersections of poverty, unemployment, limited access to resources and social exclusion, is a risk factor for AOD use. People living in households and communities experiencing disadvantage are also less likely to experience protective factors for AOD use, such as access to safe housing, appropriate healthcare services and economic stability.

- A study by the National Drug and Alcohol Research Centre highlighted how risk factors for AOD dependency, including genetic predisposition and early trauma, are worsened by low family socio-economic status[31].
- The Brotherhood of St Laurence (BSL) Social Exclusion Monitor estimates that over 1.2 million Australians face multiple challenges including unemployment, poor health, and lack of education, which prevent them from fully participating in society[32].

Overlapping risk factors, such as those relating to social exclusion and lack of financial and social resources, contribute to both disadvantage and AOD use. The relationship between the two can be two-way – that is, disadvantage can increase use and harms, and to a lesser extent, the use of drugs can lead to disadvantage[33]. Chronic stress, reduced access to resources, and environmental factors contribute to this connection.

Figure 5. AOD use and disadvantage



29. Report of the Special Commission of Inquiry into crystal methamphetamine and other amphetamine-type stimulants, Professor Dan Howard SC, 2020, Part A, pp.65
30. *Mental health among clients of the Sydney Medically Supervised Injecting Centre (MSIC)*. Goodhew M et al. Harm Reduction Journal. 2016.
31. Social Determinants of Drug Use. Spooner C., Hetherington K. National Drug and Alcohol Research Centre, UNSW. 2004. https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.228.pdf
32. *Brotherhood of St Laurence Social Exclusion Monitor, 2020.* https://www.bsl.org.au/research/our-research-and-policy-work/social-exclusion-monitor/ The Brotherhood of St Laurence (BSL) Social Exclusion Monitor, combines information on 30 indicators of disadvantage to track social exclusion in Australia. The Monitor uses data from the annual Household, Income and Labour Dynamics in Australia (HILDA) survey, which surveys over 13,000 people.
33. Catherine Spooner and Kate Hetherington, National Drug and Alcohol Research Centre, UNSW Sydney, Social determinants of drug use (Technical Report No 228, 2004) ix. Cited in Report of the Special Commission of Inquiry into the Drug Ice, Part A, pp66

Figure 6. Evidence based risk and protective factors for AOD use

	Risk Factors for AOD use	Protective Factors for AOD use
Individual physical make-up and access to health care	• Genetic predisposition or family history of harms relating to AOD. • Neurochemical factors and variations in brain chemistry can influence susceptibility to dependency and co-occurring disorders such as depression, anxiety, or ADHD[34,35]	• Access to quality and culturally appropriate healthcare services, including mental health support. • The provision of equitable and accessible opportunities and resources that supports harm minimisation relating to AOD use.
Psychological factors and family environment	• High and chronic levels of stress and/or traumatic experiences, including trauma-related behaviours within the family environment such as family and domestic violence and neglect.[36,37]	• Supportive relationships with family, friends, and community members play a vital role in reducing the risk of problematic substance use. • A sense of safety.
Social & peer influences	• Peer pressure and influence from friends, colleagues, or social circles where AOD use is normalised[38].	• Positive experiences at school, as well as participation in extracurricular activities and supportive relationships with teachers and peers.
Community characteristics	• Social and community norms, cultural acceptance of AOD use, and the availability of AOD impacts usage patterns[39]. • Availability can relate to a range of circumstances where AOD use may be relevant – in the home and at a community level, but also at a systems level, including hours of retail and venue sales for alcohol.	• Public health awareness and education • The availability of opportunities for community engagement and connections, including involvement in cultural, creative, and sports programs, peer support, employment opportunities, and mentoring
Socioeconomic characteristics	• Poverty, unemployment, and lack of access to resources	• Economic stability and access to safe housing
Access to AOD	• Early initiation of AOD use	• Parental and/or caregiver involvement, supervision, and support. Effective strategies include parental monitoring and clear communication about expectations surrounding AOD use.

34. Researchers have identified numerous genes as affecting risk for dependence on alcohol and other drugs. These include genes involved in alcohol metabolism as well as in the transmission of nerve cell signals and modulation of nerve cell activity.
35. The Genetics of Alcohol and Other Drug Dependence. Dick DM, Agrawal A. Alcohol Res Health. 31(2):111-8. 2008.
36. Trauma and addiction frequently co-occur. About 1 in 2 people in addiction treatment settings have symptoms of PTSD, yet integrated treatment is not routinely available. Arunogiri S, Mills K. Trauma & Addiction. Turning Point. 2020. https://www.turningpoint.org.au/about-us/news/trauma-and-addiction
37. Predictors of alcohol and substance use among people with post-traumatic stress disorder (PTSD): findings from the NESARC-III study. Dell'Aquila A., Berle, D. Social Psychiatry and Psychiatric Epidemiology 58, 1509–1522. 2023.
38. A meta-analysis study on peer influence and adolescent substance use. Watts, L.L. et al. Current Psychology 43, 3866–3881. 2024.
39. How Social Relationships Influence Substance Use Disorder Recovery: A Collaborative Narrative Study. Pettersen H. et al. Substance Abuse: Research and Treatment, 13. 2019.

AOD use entrenches disadvantage via a range of pathways

Entrenched disadvantage is often multi-generational and manifests across a range of day-to-day experiences and activities. Further, entrenched disadvantage can increase the probability that AOD use will be harmful and that it will deepen disadvantage.

Research suggests that while individuals with higher social economic status often use AOD as much, if not more, than those with lower socioeconomic status, the latter group disproportionately suffers harms relating to that use. A 2016 cross-sectional meta-analysis from the USA indicated that socioeconomic status is inversely related to negative alcohol-related consequences. Economic disparities and their secondary impacts moderate the relationship between alcohol use and the experience of negative alcohol-related consequences[40]. **This difference is amplified within marginalised communities, such as racial minorities and people experiencing homelessness, who face a higher burden of consequences due to an interplay of factors like race, ethnicity, and gender[41].**

This interrelationship emphasises the importance of approaches that address disadvantage and AOD use holistically.

Figure 7. Pathways through which AOD use entrenches disadvantage

Exacerbating social exclusion	• People who are disadvantaged are at higher risk of trauma and social exclusion, increasing risk of mental health disorders like chronic stress, anxiety, depression, or PTSD, in turn, this may heighten their risk of AOD use. • Without adequate health, social, and financial support, particularly in regional and remote areas, self-medication can lead to dependence and severe health and social issues. • Belonging and connection are essential human needs; lacking these can worsen a cycle of exclusion and substance use, intensifying its impact on an individual's life.
Reduced access to resources deepens hardship	• AOD use can compound existing challenges like poverty or social exclusion, worsening health concerns and straining relationships. It can make accessing support services more difficult, for instance, housing stability can worsen due to limited help or housing options available. • Disadvantaged individuals are at higher risk of harms from AOD use, such as incarceration, ongoing justice system involvement, and hospitalisation. • This can create a cycle of further loss of social capital and ongoing interactions with health, social support, and criminal justice systems.
AOD use in the family or household can negatively impact child development	• AOD use during pregnancy can significantly impact child development, such as causing Foetal Alcohol Spectrum Disorder (FASD). • Household social conditions in early childhood strongly shape future life chances, including skills development, education, and job opportunities. • A child's lifelong development and outcomes in education, income, health, and wellbeing are closely linked to their parent or carer and their daily living situation.

40. Associations Between Socioeconomic Factors and Alcohol Outcomes. Collins SE. Alcohol Res. 2016;38(1):83-94.
41. Racial/ethnic discrimination and alcohol use disorder severity among United States adults. Glass JE, Williams EC, Oh H. Drug Alcohol Depend. 2020.

Justice system interactions can entrench disadvantage	• The criminalisation of certain substances and behaviours related to AOD use subjects individuals to legal processes, exacerbating stigma and deterring help-seeking. • Criminal convictions create barriers to employment, housing, and education, limiting opportunities for rehabilitation and reintegration. • Incarceration often fails to address, and can worsen, underlying issues such as AOD dependency, mental health disorders, and socioeconomic factors. People exiting prison face high risks of AOD-related harm due to factors like homelessness, self-harm, violence, and overdose from reduced tolerance after a period of non-use in prison. • In 2022, nearly three-quarters of prison entrants reported using illicit drugs in the previous 12 months.
People seeking help for AOD use can face prejudice and lower-quality care	• Stigma and discrimination in health and support services involves treating individuals differently based on perceived characteristic[42]. • A 2017 Queensland study found widespread expediences of stigma and discrimination among individuals with substance use issues[43]. Participants noted that stigma worsened feelings of worthlessness and hopelessness, acting as a barrier to seeking help and causing degradation, shame, and anger. • This in turn resulted in repeated stigma, poor health outcomes and limited access to services – further hindering social, psychological and emotional wellbeing and the ability to reconnect with the community.

Foetal Alcohol Spectrum Disorder (FASD)

FASD is a lifelong condition caused by prenatal alcohol exposure and those affected may experience challenges in daily life and require support in various areas to reach their potential.

Alcohol exposure can affect genetic and neurodevelopmental functions, potentially altering the developmental trajectory of a foetus and disrupting multiple body systems.

International data suggests that FASD affects between 1.1% and 5.0% of children in Western countries. However, there is currently no accurate data on FASD prevalence in Australia's general population.

Studies have examined FASD rates in some cohorts:

- One study in a remote Indigenous community reported the highest FASD rates, of 12%-19.4%, documented, but it had a small sample size and focused on one community. FASD prevalence varies widely among First Nations communities.
- A high prevalence - almost 17% - of FASD among children in out-of-home care has been found in international studies, but there is no Australian data.
- Young people with FASD are disproportionately represented in youth justice settings, with rates as high as 36% in some Australian studies, particularly in Western Australia, where First Nations youth are also overrepresented in detention.

Australian experts stress the importance of obtaining precise data to understand the scope of FASD, aiding prevention efforts, as well as health and support service planning.

A deeper understanding of which children require more support services would also shed light on factors influencing alcohol consumption during pregnancy and identify high-risk populations, supporting the development of targeted interventions over time.

Please refer to section 3.6 for further information about progressions in FASD prevention and management. 44,45

42. Stigma and discrimination among the NSW Health and NGO workforce towards people experiencing harm from use of alcohol or other drugs Report of mixed-methods research conducted on behalf of the NSW Ministry of Health. Zest. 2021.
43. Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use. A report for the Queensland Mental Health Commission Final report. Dr Kari Lancaster et al. Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of New South Wales 2 Faculty of Law, Monash University. 2017.
44. Information taken from the 'National Organisation for FASD Australia' ('nofasd' Australia) website - https://www.nofasd.org.au/alcohol-and-pregnancy/what-is-fasd/
45. Fetal Alcohol Spectrum Disorder (FASD): An update on policy and practice in Australia. Sara McLean. Australian Institute of Family Studies. 2022. https://aifs.gov.au/resources/policy-and-practice-papers/fetal-alcohol-spectrum-disorder-fasd-update-policy-and

Insights and implications

1. **Responses to individuals, families and communities with complex needs should be integrated and holistic** to recognise the complex social determinants of health, and mitigate harmful AOD use. This requires structural change to funding, change to policies and practice, and expansion of evidence-based programs that address complex needs, including:
    a. Governments and philanthropic organisations employing outcome-focused funding and commissioning strategies that incentivise integrated responses for those with complex needs, including AOD-related harms.
    b. A 'no wrong door' approach, delivered through integrated care, which recognises that people should receive care addressing the spectrum of their health needs, including comorbid AOD and mental health issues, regardless of where they present.
    c. 'Housing first' approaches for people experiencing homelessness and harms from AOD use, rather than housing being conditional on addressing AOD issues.
    d. Governments and service providers expanding comprehensive, family-centred approaches to AOD issues to provide all-encompassing support.
2. Governments adopt an 'investment approach' with the aim to **rebalance expenditure away from crisis responses and towards evidence-informed prevention, early intervention and health-led responses**, including proactive and tailored responses for high risk groups.
3. Governments fund **the true cost of delivering AOD treatment and response services** that are trauma-informed and culturally appropriate; and provide adequate funding to meet demand, informed by data-driven, demand-response strategies to address local needs, so that timely access to treatment is improved and harms are reduced.
4. Governments facilitate improved cross-sector collaboration between police, the justice system and health services **to prioritise health and harm reduction in response to AOD**, supported through policies and frameworks and reallocation of resources – a long term change that also requires a shift in attitudes to AOD within services and wider society.
5. Organisations advocating for change create **a coalition to foster collaborative and inclusive advocacy at a national level**, bringing together a broad range of stakeholders, including experts, communities and policymakers, to create momentum for policy and system changes that prioritise vulnerable populations and address the broader impacts of commercial determinants on community health.
6. Governments and service providers improve the **collection and use of data to better understand and respond to AOD-related needs** across various service systems. This includes data to understand how AOD use varies according to social and economic factors.
7. Governments, academics, service providers, and users should partner and work together to **strengthen the evidence base and understanding of effective AOD treatments and responses**.
8. Government and philanthropy support and empower more **place-based initiatives to respond to community needs**, ensuring meaningful and integrated solutions with long-term impact and resilience, enabled through a flexible funding and accountability environment.
9. Governments, businesses, and philanthropic organisations invest in **comprehensive awareness and education campaigns to tackle stigma** and improve understanding of AOD-related issues in the community. This should involve both broad community outreach and targeted campaigns for healthcare providers, justice system professionals, media, and politicians, promoting a more informed and compassionate approach.

Figure 8. The drivers of better outcomes ('driver tree')

Vision: By working to minimise harms relating to AOD use, Australians who are at risk of entrenched disadvantage are better supported and empowered to live healthy and fulfilling lives.

1. Systems prioritise and support population wellbeing, safety and recovery

1.1. Early intervention and prevention approaches for AOD are prioritised, with universal & targeted elements

1.2. Evidence-based, holistic policies, programs and funding to minimise AOD harms, that are integrated within and across sectors

1.3. Commitment to integrated data and continuous improvement of AOD policies.

1.4. Responses to AOD use and harms prioritise health and safety, over punitive, justice system-led responses

1.5. Policy and regulation recognises commercial drivers of use

2. Inclusive communities and services that support connection and equitable access to support

2.1. Safe and socially inclusive communities that foster a sense of belonging

2.2. Community ownership, self-determination and accountability to address AOD harms

2.3. Employment, education and training pathways

2.4. Positive Policing

2.5. AOD services are strengths-based and respond to individual needs

3. Individual and family environment that promotes positive norms around healthy behaviours

3.1. Positive role modelling, mentoring and practical pathways are available to all

3.2. Environment free from experiencing/witnessing trauma, abuse, violence, neglect and chronic stress

3.3. Positive and nurturing relationships are maintained within the household

3.4. Kinship and social connection inside and outside of the home is strengthened

3.5. Individuals have a sense of purpose

3.6. Individuals are supported to develop responsibility & accountability, including for meeting health & wellbeing needs

3.7. Parents and caregivers are adequately skilled and supported

Enablers:

1. Systems and responses to AOD use are i) trauma informed and culturally appropriate; ii) free from stigma; iii) supportive of healthy norms and behaviours; iv) shaped by people with lived experience, who participate in decision-making at all levels
2. Material needs of individuals and communities are met, including housing, food security, financial resources and local infrastructure

Understanding the drivers of better outcomes

By working to minimise harms relating to AOD use, Australians who are at risk of entrenched disadvantage are better supported and empowered to live healthy and fulfilling lives.

Achieving this vision requires action at three levels – systems (the rules, regulation and design), community, including access and quality of services, and the individual and family. We identify unique drivers within each of these levels, as well as 'enablers', which apply across all three.

Enablers of better outcomes

1. **Systems and responses to AOD use are: i) trauma informed and culturally appropriate; ii) free from stigma, iii) supportive of healthy norms and behaviours and iv) shaped by people with lived experience, who participate in decision-making.**

    i. **Trauma informed and culturally appropriate policies and services**. A trauma informed approach is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage. It improves engagement and adherence to treatment and referral and so is more effective in delivering positive outcomes for individuals and communities. A trauma informed approach needs to be applied through policies, services and practice. Cultural safety refers to shared respect, meaning, knowledge and experience of learning, living and working together with dignity[46,47]. Access to culturally safe treatment interventions greatly influence First Nations people's decision to seek assistance[48]. Integrating culturally specific practices — such as traditional values, spirituality, and activities — into mainstream interventions can increase their effectiveness and relevance for First Nations people[49].

Key elements of trauma informed practice include:

- Client empowerment, leveraging an individual's strengths to support them in the development of their treatment.
- Clients are informed about their treatment options so they can choose their preferences.
- Collaboration is maximised among health care and service provider staff, clients, and their families in organisational and treatment planning. Providers share information where appropriate and permitted by the client.
- Health care and service delivery settings and activities prioritise the physical and emotional safety of clients.
- Expectations are established with clients about what treatments may entail, aiming to create trust and transparency.

46. *Cultural safety — what does it mean for our work practice?* Williams R. Australian and New Zealand Journal of Public Health, Volume 23, Issue 2, April 1999,
47. Informed by the National Indigenous Drug and Alcohol Committee (NIDAC), a committee of the Australian National Council on Drugs (ANCD), provides advice to government on Indigenous alcohol and other drug issues.
48. *The National Congress of Australia's First Peoples* was announced by the Australian Commonwealth Government in November 2009.The congress was registered as a charity in December 2012 but in June 2019 went into voluntary administration due to no ongoing funding or other commitment from the Commonwealth Government.
49. *Working with diversity in alcohol and other drug settings.* Network of alcohol and other drugs agencies (NADA) and Australian Government Department of Health. 2014.

ii. **Systems, processes, services and community attitudes are free from stigma**. Stigma is a common problem for people who use and seek support for AOD. The World Health Organisation (WHO) has ranked illicit drug dependence as the most stigmatised health condition globally, with alcohol dependence listed at number four. People who use drugs experience significant levels of discrimination, impacting their access to health services and subsequent health and social outcomes. Stigma often disproportionately affects individuals who are already marginalised for various reasons. Strategies to address stigma need to focus on individuals, the wider public and those working with people who use AOD.

Case study – Turning Point 'Rethink Addiction'

Rethink Addiction was an awareness raising campaign run from 2020-22, initiated by Turning Point, and run in collaboration with 60 cross-sector partner organisations. Key initiatives included a national conference, a television series, online videos, and a public report. The idea behind the campaign was to give voice to the voiceless and share real stories of addiction using a humanising, strengths-based narrative that breaks down stigma, promotes help seeking, and improves health outcomes.

In Rethink Addiction's case the desired change is breaking down stigma, and it is striking how the three levels of system change (also the domains of the driver tree) correspond to the three levels of stigma:

1. **Structural/institutional stigma** occurs at the system level through rules, policies, and practices that negatively affect or constrain the opportunities and resources of the stigmatised person or group (e.g., 'tough on crime' drug laws that imprison people for drug use rather than helping them access healthcare and treatment).
2. **Social/public stigma** is the disapproval, negative attitudes, and stereotypes held by others that lead to prejudice and discrimination towards a stigmatised person or group. This type of stigma is widespread, even in health settings, because addiction is frequently seen as a moral failing rather than a health issue.
3. **Self-stigma** is the negative thoughts and feelings people have about themselves when they identify with a stigmatised group. This can manifest as feelings of shame, unworthiness, or embarrassment, leading to isolation and delays in help-seeking.

This campaign aimed to reduce the stigma and misinformation that surrounds addiction, which was described as a misunderstood health condition. The campaign also advocated for more balanced policy and funding approaches that prioritise health and social care.

[50]

iii. **Healthy norms and behaviours are modelled and supported at a services, systems and community level**. Positive role modelling from across local services, organisations and leaders is important for the development of healthy AOD related behaviours and can be better promoted across all levels of society. Existing norms around alcohol consumption for example are deeply held. Attitudes to different drugs can be traced back to the opium crisis in the nineteenth century[51]. Shifting these mental models requires a significant cultural change strategy, alongside policy change.

50. https://www.rethinkaddiction.org.au/
51. *The first loss of freedom: early opium laws in Australia*. Drug and Alcohol Review 7(4):439 – 453. 2009; *Trends and Influences in the History of Australian Drug Legislation*. Journal of Drug Issues, Volume 22, Issue 3.1992.

iv. **Decision making at all levels is informed by people with lived experience of AOD use and/or people who have been impacted by others' AOD use**. Participation by system users in consultation and decision-making processes, is identified by the WHO as a key driver of health equity. It facilitates community engagement, ownership of local issues and subsequent interventions[52]. People facing disadvantage are often the least empowered to influence high level decision making. However, they bear the brunt of these decisions, lacking the resources and influence needed to drive change at a systems level. Ensuring the voices of people with lived experience are heard has potential to:

- improve design of policies and programs that affect them,
- provide a stronger feedback loop on what is working, for continuous improvement, and
- raise awareness of commercial strategies that are used to promote products and choices that are detrimental to health.

2. **Material needs of individuals and communities are met, including housing, food security, financial resources and local infrastructure.**

Economic stability, access to safe housing and access to services including health care are important protective factors for AOD use:

- Providing access to **adequate financial resources** can reduce AOD related harms. Strategies include addressing poverty through employment, taxation, and education policies, and implementing both universal and targeted programs to reduce intergenerational harm relating to AOD use.
- Access to **safe and appropriate housing** means that people are at less risk of inadequate living circumstances that put them at risk of violence, assault, trauma and day to day disruption. Research indicates that people without accommodation, or with marginal or inadequate housing, face a greater risk of developing problematic patterns of AOD use[53]. In addition, people using AOD in harmful ways often have complex, interrelated needs that cannot be properly addressed while housing is unstable.
- **Equitable access to health and social care** is important for preventative and early intervention supports for AOD harm and for treatment. Despite higher need, many disadvantaged communities have poorer access than more advantaged communities.
- **Access to transport, affordable energy, and a range of community services** create liveable communities that support health, social connection and access to jobs and services – important protective factors for AOD use. Transport and infrastructure are also important for access to AOD-specific services – which can be impacted by the physical accessibility of the service, the places available within a service, and how warm and welcoming staff are.
- **Services must be accessible** to people experiencing harms from AOD use. Currently an individual experiencing AOD dependency may be turned away from services because they are intoxicated, because they are homeless or because of judgements made about their use of alcohol or other drugs.

52. *Participation as a driver of health equity*. World Health organisation. 2019.
53. NSW Ice inquiry – part 1a, pp xliv https://www.nsw.gov.au/sites/default/files/noindex/2023-07/Special-inquiry-ice-report-volume-1a.pdf

1. Systems prioritise and support population wellbeing, safety and recovery

Policy, regulatory and funding mechanisms set the parameters for responses to AOD use. This includes the aspects of AOD use that are legitimised. How the market shapes availability of different substances, access to different service responses and how well those responses meet the needs of individuals/families is determined by the mechanisms in place.

Harm Minimisation is the broad approach applied across the AOD policy and services landscape in Australia – as set out in the National Drug Strategy 2017–2026. This acknowledges that AOD use occurs across a continuum, from occasional use to dependent use, that a range of harms are associated with different types and patterns of drug use and that the response to these harms requires multifaceted action.

Harm minimisation incorporates:

- **Demand reduction** – strategies to delay, prevent, or lessen substance use, including prevention and treatment approaches.
- **Supply reduction** – strategies to restrict availability and access to AOD, with the aim to control who can use, as well as when, where and how use occurs, to reduce the harms experienced by users and the community.
- **Harm reduction** – strategies to reduce or minimise risks relating to AOD use. This includes promotion of safer behaviours, decreasing preventable risks, and reducing health and social disparities among at risk groups.

Reducing harms associated with AOD use is dependent on service and system responses that better prioritise and support population wellbeing, safety and recovery. While all elements of harm minimisation are important, the most effective strategies focus on pricing, availability and marketing of products, alongside health promotion and educational initiatives.

Shifting the balance of focus across these sub-components and the nature of specific strategies and policies within each can drive improved outcomes.

1.1. Early intervention and prevention approaches for AOD use are prioritised, with universal and targeted elements

There are three key areas of response and treatment for AOD use:

Prevention and early intervention occur prior to AOD use

Prevention strategies aim to proactively address AOD use by focusing on helping people avoid, reduce, or modify their use, rather than waiting for issues to escalate into crisis.

Prevention also includes a focus on strengthening personal and social protective factors that aim to reduce risk of harms relating to AOD use, particularly among young people. This approach promotes mental and physical health and enhances life opportunities.

Harm reduction and brief intervention occurs when AOD use is not causing significant harm.

Harm reduction promotes safety for those who use AOD and can be directed towards people who have a higher risk of harms (includes needle and syringe programs and live monitoring of pharmaceutical drug prescriptions).

Brief intervention includes information sharing, education and awareness building, which is typically targeted to people who seek support or who are risk of harms (includes health assessment to use patterns and subsequent treatment).

Treatment and crisis responses occur when a person's AOD use has evolved into dependency.

Treatment and crisis response, including hospitalisation, occurs when a person's life, and often the lives of those around them, is significantly, negatively impacted by their use and where that person has limited or no control over that use.

Strategies that tackle multiple aspects of AOD use at the prevention and early intervention level can provide significant population health benefits and be cost-effective[54]. While these strategies are promoted in policies and strategies (see box), investment continues to be skewed to crisis responses.

The Australian Government's National Preventative Health Strategy 2021-30 (the Strategy), states targets of reducing harmful alcohol consumption (10% reduction by 2025) and recent illicit drug use (15% decrease in prevalence by 2030)

The Strategy addresses prevention across all aspects of society, with targets directed at changes to the health system overall, as well as in individual and community environments

Approaches include overarching principles to enhance harm prevention and build enablers to shift the health system focus to prevention, and focus areas that require stronger and better-coordinated actions to reduce the risks of poor health and wellbeing

[55]

Given the relationship between socioeconomic disadvantage and AOD use, prevention efforts need to address the risk factors and protective factors for social exclusion as well as AOD use. Effective prevention strategies should be further prioritised in funding and commissioning and can be enhanced by a broad approach across government and the community. For example:

- Built environment interventions, such as limiting the availability and trading hours of legalised AOD
- Health promotion programs including education around AOD related risks, as well as information relating to the physiological effects of specific drugs (noting evidence on the long-term effectiveness of these programs is uncertain).
- Primary prevention through engagement activities in schools, community groups and sports clubs.
- Structural interventions, including locally-driven policy changes[56].

Targeted interventions can be effective as they are typically directed to people who are more at risk of experiencing harms. They are also a necessary way to address existing inequities, such as in the targeting of tailored responses to groups who experience a higher rate of AOD related harms, including single-parent families and First Nations people.

1.2. Evidence-based, holistic policies, programs and funding to minimise AOD harms, that are integrated within and across sectors

The most effective responses for individuals with complex needs are those that integrate with other services. It is important to address the social determinants of health and encompass all aspects of a person's life, including housing, employment and physical and mental health. AOD issues must be addressed within this holistic response and not put to the side. This requires policies, systems and services to be brought together across sectors. Successful strategies include:

- Integrated care – involving practitioners from different health, human services, and welfare services to give coordinated support that matches individual needs, enabled by clear plans and strong partnerships.
- Outcomes-based funding, incentivising services to work together to achieve an outcome.

54. *The value of primary prevention to reduce alcohol consumption- An Evidence Check rapid review*. Crossland P et al. The Australian Prevention Partnership Centre, 2022.
55. *National Preventive Health Strategy 2021–2030. Commonwealth of Australia as represented by the Department of Health 2021*. https://www.health.gov.au/sites/default/files/documents/2021/12/national-preventive-health-strategy-2021-2030_1.pdf
56. *The value of primary prevention to reduce alcohol consumption- An Evidence Check rapid review*. Crossland P et al. The Australian Prevention Partnership Centre, 2022.

Case Study – Newpin: Australia's first Social Impact Bond

The Newpin (New Parent and Infant Network) program works to restore children in out-of-home care to the care of their parents. Parents and their children regularly attend a centre-based program for up to 18 months to engage in a range of activities that promote wellbeing, improve parenting capacity and support the development of positive family relationships. Therapeutic, non-judgemental support helps parents to address emotional issues, improve bonding with their children and develop positive parenting skills.

The Newpin program was chosen as Australia's first social impact bond arrangement in 2013 – in a partnership between UnitingCare, SVA and the NSW Government. The SIB brought a sharp focus on measuring impact and a more deliberate approach to supporting families who could most benefit from the program – resulting in an overall restoration rate of 61%. The program continues to be delivered by UnitingCare in NSW under an outcomes-based contract with the NSW Government and SVA has supported launch of two further Newpin Social Impact Bonds in Queensland and South Australia.

In South Australia, Newpin is delivered by Uniting Communities, one of South Australia's largest providers of community services. Families entering the Newpin Program in SA present with varied and complex backgrounds – 88% present with AOD addiction issues, 64% with mental health concerns and 88% with experience of family and domestic violence.

Families are referred to specialist AOD counselling and detox programs to help address the underlying issues that contribute to addiction as well as better understand the impact of their addiction on their parenting. Newpin staff have strong relationships with Uniting Communities' New ROADS and Streetlink programs which provide parents with the tools to support their goals of abstinence or safe reduction in use.

The proven success of the Newpin program, emphasises the value of a holistic and integrated response to families with complex needs that include harms from AOD use – rather than on a siloed, service-driven approach.

Sadie and Hope's Story

Daniel, Sadie and their one-year old child, Hope, were referred to Newpin in December 2022. Sadie's first two children were removed from her care and Daniel and Sadie had a further two children together, who were also removed from their care at birth. After giving birth to Sadie's fifth child, the family chose to call their last child Hope, in the hope that this was their one last chance to be a united family.

Daniel and Sadie had a long-term history of methamphetamine use and their relationship was characterised by significant domestic violence, alongside neglect of their older children. During the family's engagement with Newpin, there was a significant domestic violence incident, where Daniel perpetrated violence towards Sadie in their home. Sadie felt safe and supported by the Newpin team and chose to end the unhealthy relationship and continue to work towards reunification with Hope.

Newpin referred Sadie to a drug and alcohol counsellor, who supported Sadie to develop a relapse prevention plan. Recently Sadie celebrated one year of sobriety with Newpin. Sadie has also engaged positively with different parenting modules offered by Newpin.

In May 2023, Hope was reunified with Sadie. Sadie was able to celebrate Hope's first birthday with a picnic in a local park, together with her family and other Newpin parents and their reunified children.

Sadie is currently working on post reunification goals of employment, study and obtaining her driver's licence. Sadie proudly shared with Newpin that she got her learner's permit and is working towards obtaining her full driver's licence.

1.3. Commitment to integrated data and continuous improvement of AOD policies

The National Quality Framework for Drug and Alcohol Treatment Services emphasises the importance of integrating continuous improvement systems into funding agreements and contracts[57]. This approach allows for the implementation of standardised service delivery guidelines, sets expectations for organisational governance and workforce management, and clarifies responsibilities for measuring and evaluating outcomes, as well as data sharing across the sector.

1.4. Responses to AOD use and harms prioritise health and safety, over punitive, justice system-led responses

Contact with the criminal justice system, including having a criminal conviction for simple possession of an illicit substance, is directly associated with adverse impacts on employment, earning prospects, access to housing, access to treatment, relationships and wellbeing[58]. This can exacerbate existing challenges and social disparities, as well as being a source of stigma. There is growing recognition of the limitations of punitive approaches to addressing AOD use within the criminal justice system and of justice reform as a pathway to improved outcomes for individuals and communities.

Alternative approaches recognise drug use as primarily a health issue rather than a justice issue. These include diversion programs, drug courts, and harm reduction strategies, that aim to provide support and treatment, rather than focusing on punishment. These approaches can disrupt cycles of incarceration and disadvantage. For example, if a user is of First Nations background, they are more likely to be engaged with the justice system due to regulation around public consumption. Alternative approaches to public intoxication better support individuals and reduce harm.

Case Study - Victorian Government public intoxication reforms

In recent years, the death of Tanya Day, a proud Yorta Yorta woman, in police custody highlighted the urgent need to address the criminalisation of public drunkenness in Victoria. Her case illustrates the severe consequences of a punitive approach, which can lead to unjust, discriminatory, and intergenerational impacts on vulnerable communities. Data reveals discrimination against First Nations people, Sudanese and South Sudanese communities, the homeless, those with substance abuse issues, and individuals experiencing mental health problems.

Historically, Victoria's justice system-led response to public intoxication disproportionately affected First Nations people. Numerous reports over the past 30 years, including the Drugs and Crime Prevention Committee's 2001 Inquiry into Public Drunkenness and the Victorian Parliament's 2005 Implementation Review of the Royal Commission into Aboriginal Deaths in Custody, have consistently called for decriminalisation. Extensive advocacy by First Nations communities ultimately led to the decriminalisation of public drunkenness in November 2023.

The new health-led response model, developed in consultation with the Aboriginal Advisory Group and other First Nations stakeholders, prioritises services for First Nations communities. This model aims to divert individuals from justice pathways, increase access to health and social services, enhance safety and wellbeing, and reduce Aboriginal deaths in custody.

Harm reduction via needle and syringe programs are also effective. These programs offer people who inject drugs access to sterile injecting equipment and also bring individuals who inject drugs into contact with health professionals. Australia has one of the world's lowest HIV rates among people who inject drugs, a success largely attributed to the early implementation of needle and syringe programs and the involvement of peer-based organisations[59].

57. *National Quality Framework for Drug and Alcohol Treatment Services*. Commonwealth of Australia as represented by the Department of Health. 2018
58. NSW Ice inquiry – exec summary
59. Example taken from 'Harm Reduction Australia' website - https://www.harmreductionaustralia.org.au/what-is-harm-reduction/

1.5. Policy and regulation recognise the commercial drivers of use

AOD regulation in Australia varies according to the category of substance. This has been shaped by factors such as economic interests, political influences, racial biases, and social perceptions[60].

Strategies for supply reduction apply differently across three key categories of substance:

- **Legal drugs, such as alcohol and nicotine**, are subject to regulations that restrict use, sales, advertising and product contents.
- **Medicinal substances** are governed based on an assessment of their risks compared to benefit – including requirements for a prescription and controls in relation to the quantity of the drug supplied and directions for consumption. Some mechanisms are in place to limit supply of pharmaceutical drugs for non-medical use including information sharing agreements in place to reduce doctor and chemist shopping.
- **Illicit substances**, including non-medical cannabis, amphetamines, ecstasy, cocaine, and heroin are prohibited. Research with people who use drugs reveals that illicit drugs are readily available in Australia.
- Preventing illicit supply includes dismantling or disruption of distribution networks and manufacturing and cultivation facilities or locations. It can be closely associated with policing activities aimed at organised crime.

The legal status, and regulation influence the impact, context, harms and potential drivers of AOD use. For example, some limited research has shown that packaged liquor outlet density is much higher in some low SES areas[61] increasing access to alcohol.

Evidence for effective government policies to reduce alcohol-related harm has grown stronger in recent years. The most effective policies focus on reducing alcohol's affordability, availability, and cultural acceptance. The most effective strategies to protect public health are taxation that decreases affordability and restricts the availability of alcohol. A total ban on alcohol marketing is an effective strategy to reduce consumption, as are drink-driving counter measures.

60. National Anti-Racism Framework Scoping Report. Australian Human Rights Commission. 2022.
61. *The social gradient of alcohol availability in Victoria, Australia.* Livingston M. Australian and New Zealand Journal of Public Health. 2021. https://www.sciencedirect.com/science/article/pii/S132602002301717X

Case Study – Alcohol and Drug Foundation, Art of Community Alcohol Management Guide

The 'Art of Community Alcohol Management Guide', developed by the Alcohol and Drug Foundation and VicHealth, provides a framework for local governments to prevent and minimise alcohol-related harm. The guide highlights key areas where government bodies can create levers for change:

1. **Policy and regulation**
   Festivals and Events: Implementation of policies to support low risk alcohol consumption at local events.
   Public Spaces: Enforcement of local laws to curtail alcohol consumption in certain public areas and times.
2. **Licensing and planning**
   Licensed Venues: Development of strategic plans and policies for assessing planning permits for licensed premises, including location and operation guidelines.
   Liquor License Objections: Submission of objections to liquor license applications that negatively impact community amenity or contribute to alcohol misuse.
3. **Community engagement**
   Partnerships: Collaboration with police, health services, and community organisations to synchronise actions and share resources.
   Education and Awareness: Promotion of healthy, alcohol-free activities and events to change social norms.
4. **Internal policies**
   Workplace Policies: Implementation of internal policies to regulate alcohol consumption among council staff, reducing workplace alcohol-related incidents.
5. **Economic and social impact**
   Evaluation and Monitoring: Collection of relevant data to evaluate the effectiveness of alcohol management strategies and make necessary adjustments to improve outcomes.

The guide, which includes tools, templates, and case studies, provides support and resources for Victorian local governments to prevent and minimise alcohol-related harm, with the aim of creating safer and healthier communities.

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62. 'The Art of Community Alcohol Management', the Drug and Alcohol Foundation and and Vic Health, 2021. https://community.adf.org.au/run-activities/local-gov-guide/#art-community-alcohol-management

2. Inclusive communities that support connection and equitable access to support

The community and services environment influences norms around AOD use, including availability and access to AOD. It also shapes the impacts of AOD use. Inclusive communities that promote connection and offer equitable access to universal and targeted services reduce harms from AOD use. Communities that deliver place-based approaches, funding local solutions to meet local needs supports communities to build effective AOD interventions and create sustained behaviour change.

2.1. Safe and socially inclusive communities that foster a sense of belonging

The local community plays a vital role in implementing effective prevention strategies for alcohol and drug-related harms. Evidence shows that community engagement is crucial, especially for high-risk groups like young people, First Nations communities, migrant communities, and low socioeconomic groups. Providing an environment free from violence is important to reduce trauma, stress and anxiety that can increase the risk of harms relating to AOD use.

Community members from across all age, cultural and ethnic groups can flourish if they feel welcome and included in local activities, events and decision making. Belonging and connection is a central human need, and without it, a cycle of social exclusion and AOD use to cope may lead to diminishing returns and heightened sensitivity, exacerbating the overall impact on individual and community life[63]. Inclusive approaches help individuals flourish by providing environments where they can connect, build relationships, and learn from each other.

2.2. Community ownership, self-determination and accountability to address AOD harms

Addressing an historical and ongoing lack of control and powerlessness over individual community trajectory is essential to reducing preventable diseases and improved outcomes for First Nations peoples[64]. Self-determination is key to empowering First Nations people and communities to pursue their cultural, social, and economic rights. Further, self-determination means that First Nations people and communities must be involved in every layer of decision-making and should be leading the discourse around self-determination itself.

The significance of community control is illustrated in a 2017 report from Jumbunna Indigenous House of Learning, University of Technology Sydney, which concluded that Community Controlled Organisations contribute to numerous positive outcomes for First Nations people[65]. These organisations are valued for their flexibility and their ability to forge partnerships within and between communities, as well as with government departments and non-governmental organisations.

Community-led, place-based approaches can empower communities to address complex issues including harms arising from AOD use. For a place-based intervention to succeed, it must align with the community's readiness and identify where additional support or resource is required. That may relate to how the community is placed to identify and implement change collaboratively and/or to the systems, processes and facilities that exist to support change. For example, a community with adequate housing and strong community engagement may be ready to implement localised AOD prevention programs. However, a community lacking sufficient housing and struggling with disconnected relationships needs to address these fundamental issues before AOD education can be effective.

Stronger Places, Stronger People is a community-led, collective impact initiative, stewarded by the Australian Government (Department of Social Services) in partnership with state and territory governments and 10 communities across Australia. Stronger Places, Stronger People seeks to disrupt disadvantage and create better futures for children and families through locally tailored and evidence-driven solutions to local problems, led, developed and delivered in partnership with local people[66].

A unique feature of the collective impact approach is the shared commitment to a local strategy by communities, governments, service providers and investors, underpinned by shared accountability for planning, decision making and results.

63. *Exploring the Links Between Social Exclusion and Substance Use, Misuse, and Addiction.* Wesselmann Eric D., Parris Leandra. Frontiers in Psychology. 2021.
64. *Mind, body, spirit: co-benefits for mental health from climate change adaptation and caring for country in remote Aboriginal Australian communities.* Berry HL et al. NSW Public Health Bull. 2010
65. *Self-determination: Background concepts - Scoping paper 1 for the Victorian Department of Health and Human Services.* Behrendt L et al. Jumbunna Indigenous House of Learning, University of Technology Sydney, Sydney. 2017
66. *Stronger Places, Stronger People*, Families and Children, the Australian Government, Department of Social Services, 2023. https://www.dss.gov.au/families-and-children-programs-services/stronger-places-stronger-people

Case study – Far West Community Partnership, Stronger Places, Stronger People (SPSP)

The Far West Community Partnership in South Australia is supported by SPSP. The partnership leverages the Far West Aboriginal Leaders group, active for about 10 years, to improve service delivery across five distinct communities.

Despite the vast geographic area and unique needs of each community, the Far West Aboriginal Community Leaders Group, comprising five CEOs, has successfully bridged gaps through a leadership model driven by Aboriginal community leaders. This approach represents a significant shift from past methods, empowering Aboriginal leaders to guide initiatives.

The leadership group's priority has been to build trust and foster a sense of ownership among community members. Through patient relationship-building, they've created a welcoming environment where members feel comfortable participating. This sense of ownership is a key measure of success.

Community ownership also brings responsibility and accountability, impacting service delivery and program implementation. The relationship between the leadership group and the government has evolved from a top-down approach to one where the government steps back, allowing the Far West Community Partnership to lead. This shift empowers the group and alleviates traditional pressures unless they are fundamental to the success of the approach.

Another feature of the initiative is that the community is leading the exploration and prioritising of key, local issues, supporting the grass roots approach and again, fostering the sense of ownership, accountability and ultimately responsibility for outcomes.

First Nations ownership of solutions to AOD use and harms is crucial, reflecting the principle of self-determination for First Nations peoples. It allows them to chart their own paths and determine localised and targeted solutions and pathways to address issues. Consultations conducted by the National Indigenous Drug and Alcohol Committee (NIDAC) for the National Aboriginal and Torres Strait Islander Peoples' Drug Strategy, identified that First Nations ownership should be integral from the initial stages of program planning, through to implementation, provision, and subsequent monitoring and evaluation. This perspective aligns with existing international research, as well as with the principles outlined in the United Nations Declaration on the Rights of Indigenous Peoples.

Data sovereignty is a key element of ownership – referring to the "right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as their right to maintain, control, protect and develop their intellectual property over these". This includes the rights and need for First Nations people and communities to maintain control over and ownership of the narratives that emerge from the data and information that is collected, around how it is understood and used. This is particularly important for communities where there is a long history of lack of respect for local information and knowledge systems and lack of local control of information shared that directly relates to them.

2.3. Employment, education and training pathways

Education and training pathways play a pivotal role in shaping an individual's sense of self and opportunities for social mobility. As a young adult or adult pursues education and training, they not only enhance their economic prospects but also lay a foundation for better long-term health outcomes, including mental health. Replicating and scaling up successful programs for those who are experiencing deep exclusion, as well as those with greater skill deficiencies or disabilities remains challenging. More investment and innovation are needed to address these gaps and ensure that all Australians have access to education and training pathways that empower them to thrive.

Reducing intergenerational impacts from AOD use may require tailored responses at a community level in education and training settings. For example, students with FASD are most likely placed within mainstream classrooms, and it is therefore important that school staff have some knowledge and understanding of FASD, the possible needs of students with FASD, and effective strategies to implement within the classroom and school-wide setting.

2.4. Positive Policing

Legislation across Australia grants police significant authority and discretionary powers. Certain communities and individuals are particularly vulnerable to the inequitable application of these powers, including people from a First Nations background, people from culturally and linguistically diverse backgrounds, LGBTQIA+ people, people experiencing homelessness/rough sleeping, people experiencing socioeconomic disadvantage, people living with disability and people experiencing mental ill-health. Transparent and accountable policing that emphasises prevention, diversion, and community-based support yields improved results[67].

Discrimination is an ongoing issue in Australia, with attitudes permeating policies, processes and systems. Police and associated systems have the opportunity to take a leadership role to work against racism and discrimination, protecting and promoting human rights, and improving responses in relation to AOD use. These approaches are often best delivered in partnership with other agencies to provide a health-focused response and access to necessary supports.

Case study – Maranguka Justice Reinvestment Project: Caring for Others

The Maranguka Justice Reinvestment project, meaning "caring for others" in Ngemba, was established in Bourke, NSW, to tackle high levels of social disadvantage and rising crime rates among First Nations families. Initiated by the Bourke Tribal Council, Just Reinvest NSW, and the local community, this project represents a groundbreaking model of First Nations self-governance.

Maranguka aims to empower the Aboriginal community by coordinating services through an Aboriginal-led, multidisciplinary team that partners with relevant government and non-government agencies. The project follows a "life-course" approach, addressing issues from early childhood to adulthood that might push individuals into the justice system. This strategy is supported by the "Growing Our Kids Up Safe, Smart, and Strong" initiative, which focuses on comprehensive data collection and coordinated care across sectors such as mental health, education, housing, and healthcare. Key elements of the initiative include:

- Community-led governance – Aboriginal leaders drive the agenda and guide community initiatives, ensuring that solutions are culturally appropriate and locally relevant.
- Data-driven – Continuous data collection helps track a young person's journey through the criminal justice system and assess outcomes in early life stages.
- Collaborative partnerships – The project collaborates with local police, health services, and educational institutions to create a supportive network around vulnerable families and children.

Maranguka has achieved remarkable results including:

- A 23% reduction in domestic violence, 38% drop in juvenile offenses, a 14% decrease in bail breaches, and Bourke has seen a 23% reduction in major offenses.
- A 31% increase in Year 12 student retention rates
- In 2017, KPMG reported a gross impact of $3.1 million, mainly from lower justice system costs. This figure represents five times the project's operational cost, demonstrating significant economic efficiency.

Maranguka continues to focus on sustaining these positive changes and exploring further investments in education, jobs, and vocational training. The project emphasises the importance of community involvement and leadership in decision-making processes, advocating for a shift in government spending from incarceration to community-led interventions.

68

67. *Public intoxication reform.* Victorian State Government Department of Health. 2023. https://www.health.vic.gov.au/alcohol-and-drugs/public-intoxication-reform
68. https://www.justreinvest.org.au/community/bourke-maranguka/

2.5. AOD services are strengths-based and respond to individual needs

A strengths-based approach shifts from the 'deficits' (illness, issues and challenges) of someone who is experiencing harms or dependency relating to AOD use and focuses instead on the strengths and resources of that person and the community around them. This allows them and their supporters to leverage those strengths and to work towards solutions, such as established relationships and connections, or accessing pathways for education or training, in a proactive way.

Responsive services seek to understand the needs of an individual at the time they reach out for support. Service availability at that time is critical to connect with the individual's 'window' of help-seeking and willingness to engage. An estimated 200,000 to 500,000 people each year across Australia need and seek AOD treatment but do not receive it[69]. Providing responsive treatment to meet unmet demand requires increased treatment funding that covers the full costs of delivery.

There is also a need for further research and analysis to understand and articulate the key enablers that support successful treatment outcomes in the long term. Current treatment approaches are outlined in Appendix 2.

Case Study – The Glen Centre, Strengths-Based Rehabilitation for Aboriginal Communities

The Glen Centre, an Aboriginal Community Controlled organisation on the Central Coast of NSW, operates AOD rehabilitation centres. It offers a culturally safe, 12-week program within a supportive environment, designed to aid individuals in recovering from AOD dependency.

The Glen's rehabilitation programs are based on the Aboriginal Drug and Alcohol Residential Rehabilitation Network model of care. This model integrates the collective wisdom and expertise of Aboriginal community-controlled residential rehabilitation services, emphasising culturally appropriate and holistic care.

Key Features:

- Culturally Safe Environment – The Glen provides a space where Aboriginal people feel respected and understood, crucial for effective rehabilitation.
- Community Engagement – A significant aspect of The Glen's approach is fostering connections between clients and the broader community. This helps build social support systems and networks crucial for sustained recovery.
- Support Systems Management – The Centre assists residents in managing external services and support systems, preparing them for life after the program.

The Glen operates on a strengths-based philosophy, focusing on the inherent strengths of individuals and communities. This approach is reflected in various ways:

- The Glen is deeply embedded in the Central Coast community. Clients actively volunteer during crises like floods and fires, reinforcing their connection to the community and building a sense of purpose and belonging.
- By engaging clients in community activities and fostering connections, The Glen helps individuals develop essential skills and self-confidence.
- Community stakeholders frequently visit The Glen, contributing to a supportive environment that extends beyond the Centre.

A recent accreditation report highlighted that The Glen is "part of the fabric of the Central Coast Community." The CEO of The Glen encapsulates their philosophy by stating, "There's a saying that the opposite of addiction is 'connection' and we are connecting clients with the general community to build new support systems and social networks from the day they arrive." This approach has proven effective in creating lasting, positive outcomes for clients.

70 , 71

69. Alison Ritter et al, Drug Policy Modelling Program, New Horizons: The review of alcohol and other drug treatment services in Australia (Final Report, July 2014) 13
70. https://www.adarrn.org.au/model-of-care
71. https://www.theglencentre.org.au/the-glen

3. Individual and family environment that promotes positive norms around healthy behaviours

The family and/or immediate carer environment remains the primary source of attachment, nurturing, and socialisation for humans in our society. An individual using AOD has a unique and powerful impact on the family and individual household members. These impacts are particularly felt by children and include unmet developmental needs, impaired attachment, economic hardship, legal problems, emotional distress, and even violence being perpetrated against them.

3.1. Positive role modelling, mentoring and practical pathways are available to all

Evidence shows positive role models are key protective factors for harm prevention, in particular in childhood and into young adulthood. Adult behaviours around AOD can significantly influence young peoples' attitudes and approach to AOD consumption[72]. Parental and carer drinking, supply of alcohol and favourable attitudes towards alcohol are all risk factors in teenage drinking, hence, role modelling lower risk AOD behaviours can positively influence their approach to AOD use[73,74].

Targeting interventions among peers to reduce AOD use behaviours over time[75] is also important. Social and behavioural norms are established by the values, beliefs, attitudes and behaviours that dominate across a community or family group. For example, social norms may mean going to school, getting a job, playing sport, respecting elders and others in family and community, and maintaining a safe home environment. A recent Australian meta-analysis suggests that adolescents tend to align their AOD use behaviour with that of their peers so changes need to be normalised within the peer environment.

The Alcohol and Drug Foundation has identified activities such as participating in organised sports, increasing parental involvement in young people's leisure time, strengthening relationships between parents, and parents knowing where their young person is, have positive effects in reducing AOD use[76]. Key programs they operate to address this include 'Good Sports' and the 'Local Drug Action Teams' (LDAT) Program.

72. *Positive Choices. Drug and Alcohol Education*: Parent Booklet 2019
73. *Exposure to drinking mediates the association between parental alcohol use and preteen alcohol use. Addictive Behaviors*. Smit K et al. 2018
74. *Exposure to Parent and Peer Alcohol Use and the Risk of Drinking Onset and Escalation Among Adolescents*. Randolph KA et al. Child and Adolescent Social Work Journal. 2018
75. Beyond susceptibility: Openness to peer influence is predicted by adaptive social relationships. Allen, J. P. et al. International Journal of Behavioral Development. 46(3), 180–189. 2022.
76. *Family domain, Alcohol and Drug Foundation*. 2023. https://adf.org.au/talking-about-drugs/parenting-talk/preventing-aod-uptake/evidence-interventions/family-domain/

Case study: Planet Youth Partnership with the Alcohol and Drug Foundation (ADF)

The Alcohol and Drug Foundation (ADF) has partnered with Planet Youth, an internationally recognised prevention model from Iceland, aimed at reducing AOD use among young people while improving their overall well-being. This partnership underscores a commitment to fostering healthier communities through evidence-based approaches. Planet Youth employs a primary prevention strategy to curtail youth AOD use, fostering a supportive, health-oriented community environment. The model's core objective is to delay the onset of use, thereby mitigating long-term health and social harms.

Planet Youth has been adopted in over 30 countries globally and is being piloted in seven regions across New South Wales and South Australia to evaluate its effectiveness in the Australian context. A key component of this initiative involves surveying local Year 10 students to gain insights into their AOD experiences. By 2023, four out of six participating regions completed their third round of surveys, providing valuable data to inform the program's ongoing implementation.

Community-Centric Initiatives

A key ADF program, Local Drug Action Teams (LDATs) have launched several initiatives that align with the Planet Youth model, focusing on mentoring, modelling, and community engagement:

- These campaigns target parents to reduce the supply of alcohol to minors, emphasising the importance of responsible adult behaviour in shaping youth attitudes towards alcohol.
- Community and school workshops on vaping and other AOD-related topics provide education and raise awareness among young people and their families.
- Engaging recreational programs offer healthy alternatives to substance use, promoting physical activity and social interaction in a safe environment.
- These events strengthen community bonds and provide platforms for discussing AOD prevention, making it a community-wide effort.
- Creating safe, supportive environments where young people can gather and access resources, fostering a sense of belonging and community support.

A central aspect of the Planet Youth model is the emphasis on positive mentoring and role modelling. Adults and peers who demonstrate healthy behaviours and decision-making processes provide crucial examples for young people. This approach helps create a community culture that discourages substance use and supports overall well-being.

Iceland experienced a dramatic reduction in youth substance use over two decades using the Planet Youth model. For example, the percentage of 15-16-year-olds who had been drunk in the past 30 days dropped from 42% in 1998 to 5% in 2016. In Australia, surveys indicate a decrease in AOD use and increased youth participation and community engagement.

Impact and Future Directions

The partnership between ADF and Planet Youth represents a positive, collaborative step towards creating healthier communities in Australia. As the program continues to develop, ongoing evaluation and adaptation will ensure that the strategies remain effective and relevant to the needs of Australian youth. By focusing on mentoring, modelling, and community engagement, this initiative aims to sustain long-term reductions in youth substance use and enhance the overall quality of life for young people.

[77,78,79]

77. https://community.adf.org.au/run-activities/stories/blue-mountains-planet-youth/
78. https://planetyouth.org/
79. https://community.adf.org.au/ldat-program/about/ldat-planet-youth/

3.2. Environment free from experiencing and/or witnessing trauma, abuse, violence, neglect and chronic stress

Negative experiences, directly or as a witness, are shown to impact negatively upon an individual's emotional, social and physical development.

"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." (Substance Abuse and Mental Health Services Administration (SAMHSA)).

Exposure to abuse, neglect, discrimination, violence, and other adverse experiences increase a person's lifelong potential for serious health problems and engaging in health-risk behaviours, as documented by the landmark Adverse Childhood Experiences (ACE) study[80,81,82]. In part due to the ACE study findings, health care policymakers and providers have increasingly accepted that exposure to traumatic events, especially during childhood may heighten an individual's health risks well into adulthood.

3.3. Positive and nurturing relationships are maintained within the household

Evidence shows that growing up in a nurturing environment is vital for development, supporting social and emotional regulation and resilience throughout the challenges of adolescence and adulthood. Positive and negative patterns of behaviours are adopted or copied. Life experiences from early childhood shape our understanding of acceptable behaviour. We learn values from direct, repeated exposure to our immediate social environment, influenced by parents, peers, community, and society. These values are also shaped by respected and admired individuals and those in authority.[83]

AOD use in the household can present an increased risk of children and young people developing AOD dependence themselves. The use of evidence-based, whole of family and carer approaches has demonstrated success over individual AOD responses. Treating the individual without family involvement may limit the effectiveness of treatment as it ignores the devastating impact of AOD dependence on the family/carer system and home environment, and it does not recognise the family as a potential system of support for change. Involvement of family and community members can be pivotal in achieving the best health related outcomes for First Nations people[84].

Families and communities may also need assistance with responding to those experiencing harms relating to AOD use. Family and community involvement should be discussed at the time of assessment and, depending on the wishes of the person being assessed and the needs of the family and community, incorporated into further treatment planning.

3.4. Kinship and social connection inside and outside of the home is strengthened

The maintenance and building of supportive networks, relationships and systems is critical for social, emotional connection, learning and support, and can foster the development of protective factors against AOD related harms.

Cultural and ethnic traditions, and local First Nations leadership play a significant role in the health and wellbeing of communities across Australia. Studies show that keeping cultural practices alive and having control over community decisions can help protect against poor mental and physical health, and strong family bonds and connections within the local community supports people to stay healthy and resilient. Policies and programs that respect First Nations self-determination are key to success; strengthening family and community connection helps break cycles of trauma and acts to reduce chronic stress, supporting people to develop to their potential.

80. *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study*. V.J. Felitti, et al. American Journal of Preventive Medicine, 14, no. 4 (1998): 245-258.
81. *The Lifelong Effects of Early Childhood Adversity and Toxic Stress.* J. P. Shonkoff, A. S. Garner, and the Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; and Section on Developmental and Behavioral Pediatrics. Pediatrics, 129, (2012b): 232–246.
82. *Findings from the Philadelphia Urban ACE Survey*. Public Health Management Corporation (2013). Available at: http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf407836.
83.'Why children and their early years matter'. An evidence summary in support of the early years strategy, 2024-2034'. Australian Government, 2024. https://www.dss.gov.au/sites/default/files/documents/05_2024/why-children-and-their-early-years-matter-evidencesummary-support-early-years-strategy-2024-2034.docx
84. *Systematic review of Indigenous involvement and content in mental health interventions and their effectiveness for Indigenous populations*. Seungyun Lee R. et al. Aust N Z J Psychiatry. 2022.

3.5. Individuals have a sense of purpose

A sense of purpose, including through paid employment, caring or education, has shown that individuals who have a sense of purpose tend to experience greater levels of happiness, fulfilment, and resilience in the face of challenge. When we feel that our work has meaning and contributes to something larger than ourselves, we are more motivated, engaged, and committed to achieving our goals. Engagement in a workplace, as a volunteer or as a community based carer, can support people with poor mental health to build experience, capability and meaningful connections.

3.6. Individuals are supported to develop responsibility and accountability, including for meeting health and wellbeing needs across the lifespan

Individuals report that they need support to develop a sense of ownership over what's going on in their home and their community and to take part in understanding what this means as well as the development of ways to improve outcomes.

Parents and carers require support to understand the varying physiological and emotional needs across the lifespan. Research highlights that the middle years of childhood, the transition to adulthood, and adulthood itself entail significant and ongoing developmental milestones and challenges and there is a growing recognition of how early development influences learning, mental health, behaviour, and physical health throughout life.

Public health officials acknowledge key areas of challenge including the diagnosis and flagging of risk of FASD early on in a child's life, as well as the provision of holistic care - medical and social - from that early diagnosis onwards. To reduce the damage caused by FASD, community based prevention campaigns must be reinforced with education, capability and knowledge building for medical practitioners, and supported through access to support and medical services.

A recent three-year implementation review of the National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018-2028, found that progress has been made in raising awareness about FASD and its prevention[85,86,87]. Progress includes the launch of the "Every Moment Matters" campaign and the introduction of mandatory pregnancy warning labels on alcoholic beverages. There have also been advancements in diagnostic tools and support resources - The FASD Diagnostic Tool (originally launched in 2016) was reviewed and updated, and key resources like the FASD Australian Register and FASD Hub Australia continue to provide valuable support[88].

According to FASD Hub, it remains difficult to determine the most effective FASD prevention strategies. However, the advice - 'to prevent harm from alcohol to their unborn child, women who are pregnant or planning a pregnancy should not drink alcohol' - remains crucial. The Hub notes that health professionals must consistently communicate that message, supporting all communities to be made aware of the risks of drinking alcohol during pregnancy and its effects on the fetus.

Further, the Hub suggests that to be effective, FASD information and awareness building campaigns must:

- be culturally sensitive and respectful
- informed by community knowledge
- focused on the damage caused by alcohol rather than blaming the woman
- work with whole communities, including men
- be consistent with Australian guidelines to reduce health risks from drinking alcohol.

3.7. Parents and caregivers are adequately skilled and supported

Parents and carers should be supported, ideally through education and awareness building activities that are community and peer based, to understand the range of needs for family members across the lifespan. This includes general nutrition and lifestyle information as well as information specific to AOD use. Conditions in early childhood have a strong impact on early child development. Children who lack the necessary nutrition and stimulation during the early months and years may experience significant developmental delays due to this sensitive period of brain development.

85. The National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan, 2018-2028.
86. Commonwealth of Australia, Department of Health, 2018.
87. National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018-2028 – Three-year implementation review. Curtis, A. et al, Deakin University. Commonwealth of Australia, Department of Health. 2022).
88. FASD Hub. https://www.fasdhub.org.au/fasd-information/prevention-strategies/

Exposure to significant and repeated stressful events, such as violence, and neglect, can adversely affect neural development and other body systems, including the immune system. This is recognised as a physiological response to stress and can have long-term effects on an individual's stress response, potentially leading to issues, including managing of stress responses (and hence risk of development of AOD dependency) later in life.

Children's lifelong development and outcomes in education, income, health, and wellbeing are closely aligned with their parents' situations[89]. Investment in early childhood development has been shown to result in improved outcomes across various domains for both individuals and society with relative efficiency[90].

Case study: Maternal Early Childhood Sustained Home-visiting (MECSH)

The MECSH program is a structured, nurse-led intervention designed to support families facing adversities such as socioeconomic disadvantage, mental health issues, family violence, and child protection concerns. The program primarily focuses on the biological mother, with referrals often made antenatally or at birth.

Key principles of the approach

- The 'Core and Adaptation Model' ensures that MECSH implementation is tailored to meet the specific needs of each community. This flexibility allows the program to be effective across diverse settings, adapting to local cultural and social contexts.
- Capacity building is a critical element of MECSH, empowering families to effectively manage parenting challenges. By providing parents with the necessary skills and support, the program fosters confidence and self-efficacy in caregiving.
- MECSH prioritises the creation of health and well-being rather than merely addressing illness. This proactive stance promotes overall family health and development, supporting positive long-term outcomes. As such, the program is embedded within local child and family health services. Delivered by specially trained nurses, the program offers sustained support to families, ideally starting prenatally and continuing through the early postnatal period. This comprehensive approach ensures that families receive continuous care tailored to their unique needs and circumstances.
- MECSH integrates within local child and family health services, delivered by nurses with specialised knowledge. Families ideally enrol prenatally but can join within 6-8 weeks postpartum. The program operates through a tiered service model, encompassing both primary and specialised healthcare services.

MECSH has demonstrated effectiveness through two randomised controlled trials in Australia that showcase positive outcomes for children, mothers, families, and the broader community. These positive outcomes include:

- Children show improved development, communication, and symbolic behaviour.
- Mothers indicate enhanced warm parenting, reduced hostility, improved health and mental health, prolonged breastfeeding, and increased parenting confidence.
- Families exhibit an improved home environment and child development.
- There are fewer vulnerable children at school entry, emphasising the importance of equipping parents and caregivers with essential skills and support.

[91]

89. Public Health Association of Australia, Submission (34, p7) to the Select Committee on Intergenerational Welfare Dependence on Entrenched Disadvantage, 2018.
90. https://www.westernsydney.edu.au/teeach/research/beacon_2/maternal_early_childhood_sustained_home_visiting_mecsh_and_right_@_home ; Evaluation of the impact of the MECSH programme in England: A mixed methods study, Kemp
91. https://www.earlychildhoodconnect.edu.au/home-visiting-programs/mecsh-public/about-mecsh

Appendix

Appendix

Appendix 1 – Steering Committee (SteerCo) participants

Figure 9. Table of Steering Committee members

Name	Title/role	Organisation
Erin Lalor	Chief Executive Officer	Alcohol and Drug Foundation
Gino Vumbaca	Principal	3V Consulting Services Harm Reduction Australia
Dr Annie Madden	Executive Officer	Harm Reduction Australia
David Kelly	Executive Director, Programs	Odyssey House NSW
Jill Rundle	Chief Executive Officer	Western Australian Network of Alcohol and other Drug Agencies
John Harding	First Nations Practice Lead	Social Ventures Australia

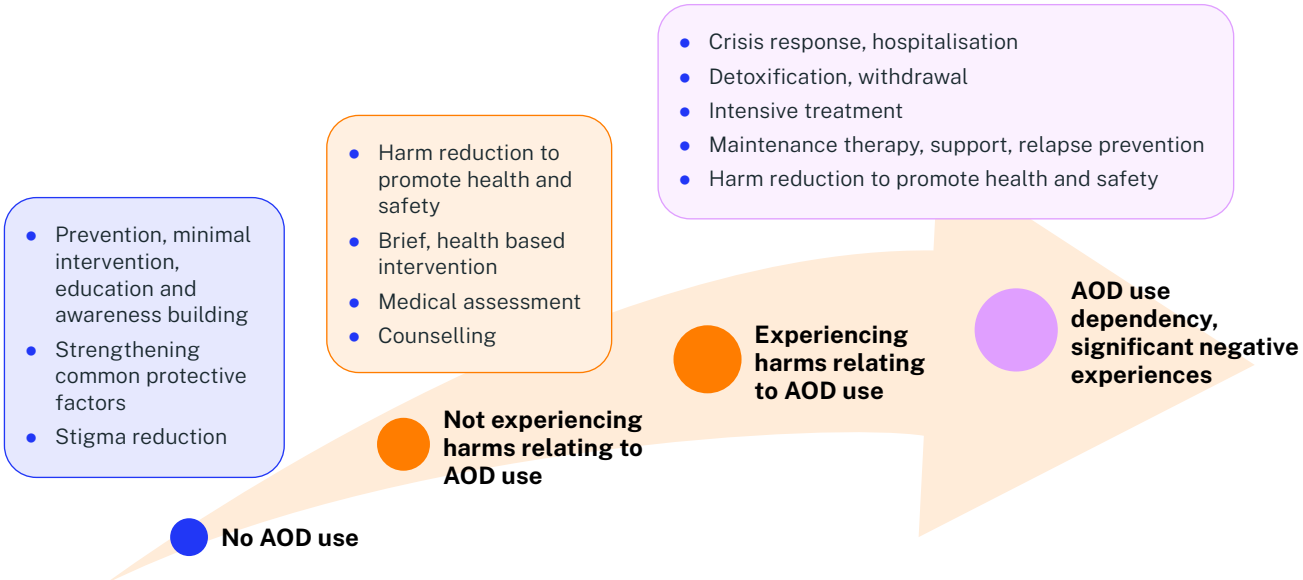
Appendix 2 - Treatment types, further detail

(As listed by the Australian Institute of Health and Welfare[97].)

Figure 14. Table of main treatment types in Australia

Treatment type	Description
Assessment only	Where only assessment is provided to the client. Note that service providers would normally include an assessment component in all treatment types.
Counselling	Is the most common treatment for AOD use and can include cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing
Pharmacotherapy	Includes drugs such as naltrexone, buprenorphine and methadone used as maintenance therapies or relapse prevention for people who are dependent on certain types of opioids. (Part of the 'withdrawal' category also). Usually delivered in conjunction with additional treatment mode/s.
Rehabilitation	Focuses on supporting clients in stopping their AOD use and helping to prevent psychological, legal, financial, social and physical consequences of that use. Rehabilitation can be delivered in a number of ways, including residential treatment services, therapeutic communities, and community-based rehabilitation services.
Support and case management only	Support includes activities such as helping a client who occasionally calls an agency worker for emotional support. Case management is usually more structured than 'support'. It can assume a more holistic approach, considering all client needs including social, emotional and general welfare, and it includes assessment, planning, linking, referral, monitoring and advocacy.
Withdrawal management (detoxification)	Includes medicated and non-medicated treatment to assist in managing, reducing or stopping the use of a drug of concern. Typically delivered in a medical setting.

Figure 15. Spectrum of AOD use responses and treatment types



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