Evolve 2020:

Are we doing enough for young people with drug and alcohol addiction?

Sir David Martin Foundation Research Report

SIR david martin FOUNDATION
30 YEARS
helping young people in crisis

Acknowledgements

Sir David Martin Foundation would like to thank all those who contributed to make this publication possible.

Funding partner: The Neilson Foundation

Service partner: Mission Australia

Research partner: QImprove

Research committee: Helen Connealy, Laura Breslin, Jo Fildes, Sarah Reed

Editor: Helen Signy

Design: Clearly Creative Graphic Design

We acknowledge the traditional custodians of lands throughout Australia, and we pay our respects to the Elders past, present and future for they hold the memories, the culture and dreams of the Aboriginal and Torres Strait Islander people. We recognise and respect their cultural heritage, beliefs and continual relationship with the land and we recognise the importance of the young people who are the future leaders.

Aboriginal and Torres Strait Islander readers are advised that this publication may contain images of people who have died.

---

30 YEARS SIR david martin FOUNDATION

MAJOR PHILANTHROPIC PARTNER OF MISSION AUSTRALIA

A note on COVID-19

The research contained in this report was conducted before the Coronavirus (COVID-19) pandemic.

Sir David Martin Foundation would like to acknowledge the challenges faced by Australian youth, their families and community services during this period. We would like to thank all those who have ensured young people still receive care during this critical time.

It is important to note that the pandemic and its economic effects are likely to result in increased disadvantage, trauma and economic hardship for many young people in Australia. This will inevitably lead to an increase in demand for youth services nationwide.

Contents

Foreword

About us

Sir David Martin Foundation is a 30 year-old Family Foundation, helping young people in crisis. We enable best practice models of treatment for youth drug and alcohol addiction.

Our vision of safety, hope and opportunity for all vulnerable young Australians has empowered them to independence with 92% engaged in education and employment.

As the major philanthropic partner of Mission Australia, we have raised over $65 million since 1990 and are the primary funder of Mission Australia's Triple Care Farm, a best practice, holistic treatment centre for young people affected by drug and alcohol issues. Over 3,000 young people's lives have been saved, with zero suicide attempts among those we have reached.

In 2020 we celebrate 30 years of supporting Triple Care Farm. An evaluation of Triple Care Farm published in 2015 found that the program has had a significant positive social and economic impact on young people, their families and carers, Government and the wider alcohol and drug sector. It has helped to change, if not save, the lives of hundreds of young Australians.[1]

That is because Triple Care Farm offers integrated care, is responsive to different contexts of young people and their families, and actively involves young people in their care.

Part of the success of Triple Care Farm is due to the fact we measure, monitor and report the outcomes of our young people, and translate findings from research into practice.

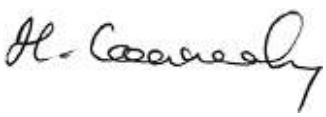
However, there is limited evidence either from Australia or overseas about what works to support young people with problematic drug or alcohol use. As a result, in 2019 we commissioned this research to understand market needs across Australia and to establish what published evidence exists of best practice treatment for young people who are using drugs and alcohol in a harmful way. This is the first such research report into the youth alcohol and other drug sector in Australia.

A key learning of this work is that there is continuing high demand for programs across Australia, with unmet need that is particularly high in certain groups of young people, particularly in Aboriginal and Torres Strait Islander communities.

The research has shown we need to do more for these young people – some of the most vulnerable in the country. And while data is limited in Australia on the effectiveness of youth alcohol and other drug programs, the literature offers us a clear roadmap of the way forward.

Sir David Martin Foundation is using this work with our partner, Mission Australia, to help develop future strategies, refine programs and scale effective treatment models.

We hope that the findings will be useful for others in the sector to enable us to work together to meet the needs of more young people who are struggling with alcohol and drugs.



Helen Connealy
General Manager
Sir David Martin Foundation

Introduction

The findings presented in this report are based on research conducted by an independent consultant on behalf of Sir David Martin Foundation. The research was conducted in the second half of 2019.

Literature review

A literature review covered discrete aspects of youth alcohol and drug treatment programs.

The literature review comprised a comprehensive search using the following databases:

- APAFT
- JSTOR
- Medline
- PsycINFO
- Proquest
- EBM Reviews – Cochrane Database of Systematic Reviews
- SOCINDEX
- Web of Science
- Aboriginal and Torres Strait Islander Health/Informit
- APAISAboriginal and Torres Strait IslanderS/Informit
- Indigenous Studies Bibliography
- AIAboriginal and Torres Strait IslanderS/Informit
- MAIS/Informit

In addition, the review analysed alcohol and drug sector organisations' published and unpublished literature, clearing houses and literature reviews and evaluations. Relevant state government literature was also reviewed.

Market needs analysis

A high-level market needs analysis included a review of the current federal, state and territory government policy and funding landscape and an analysis of demographic data relating to alcohol and drug use and treatments.

Stakeholder engagement

Consultations were conducted with 13 Mission Australia staff from relevant programs in New South Wales, Queensland, the Northern Territory, Western Australia and South Australia.

Definitions

Young people: There is no universally accepted definition of 'young people'. Sir David Martin Foundation defines young people as aged 16–24. However, in the literature young people can be defined as being anything from 12–29. They are a diverse group of individuals who are going through a transition and time of self-discovery, which is often accompanied by a level of experimentation with alcohol and other drugs.

Addiction: Is a chronic condition, defined by a physical or psychological dependence on drugs and/or alcohol, which is pursued despite harm and negative impact.

Harm minimisation: Is a globally accepted approach which aims to prevent and minimise alcohol and other drug misuse, to allow the young person to have control over their future health, independence and personal relationships. In Australia this is achieved through the three pillars of demand reduction, supply reduction and harm reduction.[5]

Executive summary

There is insufficient research into the effectiveness of treatment programs for young people with drug and alcohol addiction, both in Australia and overseas. To bridge this gap in knowledge, Sir David Martin Foundation commissioned research to identify:

- **best and emerging practices from Australia and overseas**
- **areas of demand and unmet need in relation to treatment and programs for young people with drug and alcohol addiction in Australia.**

This research has highlighted gaps in the service system and opportunities for future focus.

Key findings include:

HIGH DEMAND: There is a high demand for programs. While use of alcohol, tobacco and illicit drugs is declining in Australia, 38% (76,000 people) of those accessing alcohol and drug treatments were under the age of 30 in 2017-2018.[3]

GAPS IN FUNDING AND SERVICE CO-ORDINATION: There is inadequate funding and service coordination from all levels of government.[4]

INADEQUATE RURAL AND REGIONAL OPTIONS: There are not enough treatment options outside larger cities.[5]

LACK OF YOUTH SPECIFIC TREATMENT: There is a lack of youth-specific treatment, particularly residential withdrawal and rehabilitation programs. As a result, young people are being treated in adult programs.[6]

WIDESPREAD UNMET NEED: There is unmet need across the country, particularly in Aboriginal and Torres Strait Islander communities.[7] Other priority cohorts include young people with co-morbid mental health conditions,[8] those under youth justice supervision,[9] young people in rural and remote communities[10] and those identifying as lesbian, gay or bisexual.[11]

LIMITED DATA: There is limited data collection in Australia, and there is also a need for better integrated measurement and evaluation.

Executive summary

Whilst there are gaps in available evidence, this review suggests the following recommendations:

RECOMMENDATION 1 – Youth specific

Develop youth-specific programs across prevention and harm minimisation, withdrawal, rehabilitation and aftercare.

Programs that provide choices for young people to access the treatment option that best meets their needs achieve better outcomes. There are known risks associated with treating young people in adult programs.

RECOMMENDATION 2 – System-wide

Engage government, service providers and communities to develop systemic change.

A systems approach assumes that young people must be viewed as part of the broader community and society in which they live, and that a response must consider all the complex factors involved in influencing their health and wellbeing.

RECOMMENDATION 3 – Integrated care

Develop and deliver holistic programs, involving multiple services that address the complex needs of young people with drug and alcohol addiction.

Integrated care refers to programs that are coordinated effectively to address a young person's different presenting issues (such as alcohol misuse and mental health conditions). To provide best practice and meet the complex needs of young people, all new and existing programs should partner with other community, healthcare or government providers.

RECOMMENDATION 4 – Aftercare

Provide aftercare to all young people following withdrawal or rehabilitation treatment, directly or in partnership with other providers.

Aftercare refers to the timely support provided to prepare individuals to transition out of treatment and support them to reintegrate with their families and/or home community, ensuring treatment gains are sustained long term. Aftercare enables the young person to re-engage with education and employment.

RECOMMENDATION 5 – Culturally appropriate programs

Provide more and improved access to culturally appropriate programs for Aboriginal and Torres Strait Islander young people, that include connection to Country, family, kin and community.

While programs specifically and exclusively targeted at Aboriginal and Torres Strait Islander young people should be provided by Aboriginal and Torres Strait Islander organisations, there are opportunities to build partnerships with these organisations to provide culturally appropriate youth alcohol and drug programs to address the unmet need.

RECOMMENDATION 6 – Family focused care

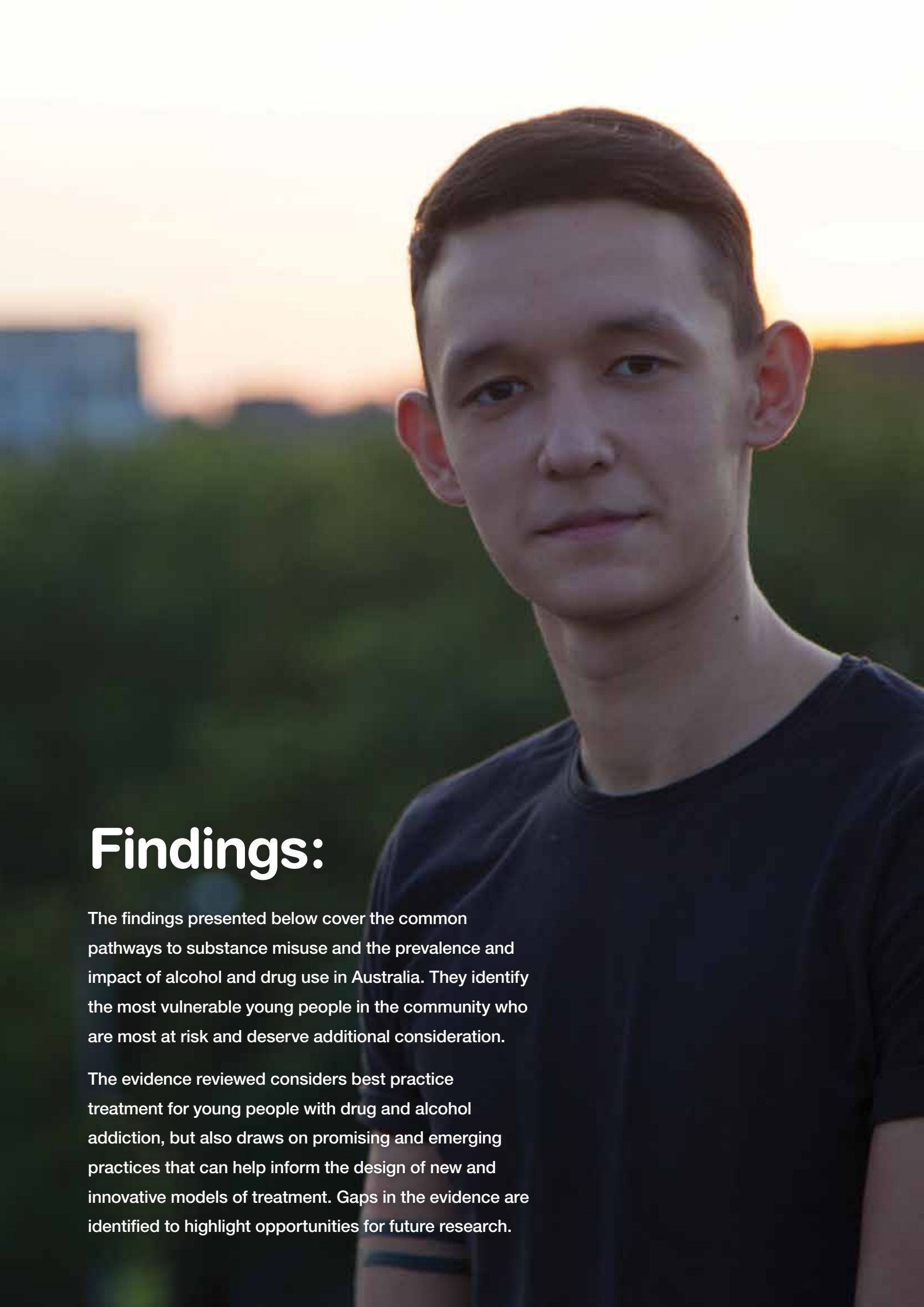
Develop therapeutic interventions through family focused therapy to address the risk and protective factors in a young person's environment that affect their drug and alcohol use.

A young person's family environment is one of the most significant predictors of harmful alcohol and drug use and related psychosocial difficulties. On the other hand, a family's strengths can positively impact on young people's behaviour and family focused care can positively help in their recovery.

RECOMMENDATION 7 – Diverse care

Provide a variety of supports to suit the individual young person, their context and the complexity of their needs.

Different models of care are suited to different young people, depending on their needs. To meet the needs of as many young people as possible, there should be a diverse service sector offering a variety of treatment options and settings including outreach, residential and non-residential treatment.



Findings:

The findings presented below cover the common pathways to substance misuse and the prevalence and impact of alcohol and drug use in Australia. They identify the most vulnerable young people in the community who are most at risk and deserve additional consideration.

The evidence reviewed considers best practice treatment for young people with drug and alcohol addiction, but also draws on promising and emerging practices that can help inform the design of new and innovative models of treatment. Gaps in the evidence are identified to highlight opportunities for future research.

Findings A: High demand

High demand for programs

Daily smoking, drinking at risky levels and experimenting with illicit drugs have all decreased in recent years for young adults aged 18–24.[12]

However, some who do use alcohol and other drugs are doing so in a harmful way. There are some groups of young people who are at particular risk of harm.

Prevalence of alcohol and other drug use among young people in Australia

Harmful alcohol and drug use is a serious issue for young people in Australia. People aged 12–24 years are more likely than any other age group to have used illicit drugs in the past 12 months, while 38% of all people in alcohol and drug treatment programs are aged under 30.[13]

While most young people will experience no long-term consequences of alcohol and drug use, some will develop chronic patterns of alcohol or drug use which become habitual and can affect their normal functioning, with potential negative repercussions that can impact the rest of their lives.[14] Young people, particularly adolescents, are at particular risk of permanent damage as their brains are still developing. For this reason, they are considered to be a vulnerable population.

Young people are more likely than any other age group to use illicit drugs:

Just under a third (28.2%) of those aged 18–24 have experimented with drugs. In 2017/18, people aged under 30 were most likely to present to treatment where cannabis was the principal drug of concern (38%), followed by amphetamines (29%).[15] Commonly, young people who use illicit drugs use cannabis between the age of 10 and 19 and start using amphetamines in their twenties.[16]

Alcohol consumption at risky levels is high:

Though more young people are abstaining from alcohol or waiting until they are older before they start drinking, some young people tend to drink alcohol at very high levels. In 2016, 42% of young adults aged 18–24 exceeded the single occasion risk guidelines by consuming on average more than four standard drinks in one occasion. In the same year, 15.3% of young adults aged 18–24 consumed more than 11 standard drinks on one occasion, placing themselves at high risk of alcohol-related harm.[17]

Tobacco is becoming less of a problem:

Tobacco use is down among young people and those who smoke are smoking less. In 2016, a total of 12.3% of males aged 18–24 and 10.8% of females smoked daily.[18]

Findings A: High demand

Burden of disease

The misuse of alcohol and drugs by young people has potentially significant consequences for individuals, their families and the community.

Alcohol and illicit drug use were the leading causes of total burden of disease in males aged 15–24 and the second and third leading causes (respectively) for females in 2015.[19]

83% of risky drinkers aged 14–19 were injured as a result of their drinking and 7% attended the emergency department for an alcohol-related injury in 2016-2017.[20]

38% (76,000 people) of those accessing alcohol and drug treatments were under the age of 30 in 2017-2018.[21]

The path to drug and alcohol addiction

Harmful alcohol and drug use and addiction are often the result of a complex interaction of individual and environmental risk factors.[22]

A young person's family environment is one of the most significant predictors of alcohol or drug misuse. Young people are at greater risk if they experience abuse and neglect, family conflict, unemployment, poor parental mental health and inappropriate family discipline.[23]

Other risk factors include neighbourhood violence, cultural norms, school culture, peer connectedness and media and advertising. A young person's individual characteristics, including their personality, mental health and social skills also play a role.[24]

While substance misuse generally begins in adolescence, it peaks when young people are between 20 and 24 years old.[25] Longitudinal research confirms that individuals who develop an alcohol or drug use disorder in adolescence are more likely to continue these problems into adulthood, a trend impacted by an earlier onset and with greater levels of use.[26]

It is essential to intervene early and provide programs and treatment before harmful alcohol and drug use becomes entrenched.

Findings A: High demand

Funding is inadequate to meet the need

The literature shows that, compared with the social cost associated with harmful alcohol and drug use, Australia's investment in treatment is relatively small.[27]

The Australian Government is allocating $268 million between 2019/20 and 2021/22 to support Australians with problematic alcohol and drug use. This includes investment in government and non-government drug treatment programs, research and sector capacity building activities.[28]

However, federal, state and territory funding appears to have stagnated and has in some instances resulted in a reduction of programs, as funding has failed to meet the increasing operating and compliance costs associated with providing treatment.[29]

Federal government funding constitutes 31% of total funding for alcohol and other drug treatment, with state and territory governments contributing 49%. However, the roles and responsibilities between the layers of government are not clearly delineated. This has resulted in a lack of strategic oversight about how funding is allocated to address need. Many organisations that receive funding from the Australian Government also receive state or territory funding.[30]

Peak bodies have identified that government funding is inadequate to meet the demand for treatment. Particularly, short-term contract extensions and ad-hoc funding are criticised for their negative impact on the stability of a skilled workforce.[31] This was also identified during staff consultations across states and territories, with government-funded programs reporting unpredictable, short-term funding and challenges around retaining experienced staff.

The remaining 20% of funding is contributed through private sources, including philanthropy and client co-payments. No recent analysis of philanthropic funding could be identified.

A whole of system response is needed

The Australian Government's National Drug Strategy 2017–2026 provides a framework that identifies priorities relating to alcohol and other drugs and outlines a national commitment to harm minimisation, addressing both supply and demand and promoting strategies that seek to reduce the harm of drugs.[32]

State and territory governments are responsible for planning alcohol and drug treatment in their own jurisdictions.

While several states and territories have allocated resources specifically to deal with the impact of the drug crystal methamphetamine, none identifies alcohol and other drugs as a specific state priority. Peak bodies have argued that this may be due to the stigmatisation of harmful alcohol and drug use.[33]

There are currently around 950 government-funded alcohol and drug treatment agencies in Australia. Nationally, alcohol and drug treatment programs are delivered by a mix of government and non-government programs. In the last 10 years, the proportion of non-government agencies has increased from 56% to 61%.[34]

There is a growing recognition of the need for whole-of-sector responses to deal with the interrelated health and social risk factors contributing to harmful alcohol and drug use, such as mental health conditions, homelessness and domestic and family violence. However, there is currently a lack of strategic planning and coordination between jurisdictions to support this.[35]

Findings B: Unmet need

Widespread unmet need

While there are limitations in data available, interviews with stakeholders indicated funding for youth alcohol and drug treatment and programs is inadequate to meet the demand.

There is unmet need:

- for youth-specific programs across the service spectrum (outreach, withdrawal support, rehabilitation, supported accommodation and aftercare), but particularly for youth-specific residential programs
- for integrated programs, addressing alcohol and drug issues as well as co-existing mental health issues across all states and territories. Stakeholders identified particular needs in the Northern Territory, Queensland, Western Australia and South Australia
- in rural, remote and very remote communities across Australia, due to a higher concentration of disadvantage and lack of programs
- for culturally appropriate service models to respond to the significant over-representation of Aboriginal and Torres Strait Islander young people in alcohol and drug treatment.

We need youth-specific services

Interviews with stakeholders identified a shortfall in youth-specific alcohol and drug treatment, including outreach, withdrawal support, rehabilitation, supported accommodation and aftercare.

Particularly concerning is the shortfall in residential withdrawal and rehabilitation, with young people often channelled into residential adult programs. Stakeholders are concerned that this may expose young people to those with more entrenched alcohol misuse histories and other negative role modelling, including exposure to criminal behaviour.

Research confirms that tailoring programs to a specific cohort, such as young people, translates into better outcomes and that exposing young people to adult programs carries significant risks.[39]

Treatment for young people[40]

64% occurs in a community setting, such as community centres or through hospital outpatient programs

16% takes places in a residential setting such as a drug service or hospital, where individuals are removed from their usual environment

13% occurs through outreach, often in a variety of locations, such as schools, cafes or local parks

Less than 1% occurs at home, usually under the supervision of a nurse or GP and with support from a family member or friend

Findings B: Unmet need

We need integrated care

Programs that target a single problem behaviour alone, such as harmful alcohol and drug use, can be ineffective if they do not consider other presenting issues such as mental health conditions, trauma, family conflict and housing insecurity.

Consultations with sector experts identified that there are too few holistic, integrated programs available to young people who require access to a continuum of care, from withdrawal support to rehabilitation and aftercare, or who require both alcohol and drug and clinical mental health support.

Often service elements are not offered from the same location or by the same service provider or are not available at all in their area. This can lead to young people cycling through treatment repeatedly or simply falling through the cracks.

There is need for an integrated approach to treatment that includes better coordination between different alcohol and drug programs (for example, providing greater continuity of care by co-locating withdrawal support and residential rehabilitation) or better collaboration between alcohol and drug and other programs, such as housing, mental health, education, employment and community health programs.[41]

We need programs in regional, rural and remote areas

Young people living in rural and regional areas in all states and territories are more likely to experience disadvantage, engage in harmful substance use and have poorer access to essential programs. Yet almost 60% of treatment agencies are located in major cities and only 6% in remote or very remote areas.[42]

Both staff feedback and data indicate increased need in all rural, regional and remote areas of Australia, particularly for Aboriginal and Torres Strait Islander communities.[43]

While some specific areas of high need are noted, such as Far Western New South Wales, Darwin and Katherine in the Northern Territory and the Pilbara Region of Western Australia, more research is required to confirm specific gaps and make recommendations for additional resourcing in particular locations.

Stakeholders indicated that identifying locations for new programs must not only consider the need in the region but also ensure reasonable access to urban and regional centres for essential programs and adequate access to a suitable workforce and transport.

Mapping of need against the available infrastructure is recommended, in order to identify suitable locations for future investment.

Findings B: Unmet need

We need programs for vulnerable groups

There are groups of young people in Australia who are most likely to experience multiple, interrelated and compounding risk factors for harmful alcohol and drug use. The literature shows that treatment planning should focus on the following groups of young people:[44]

Aboriginal and Torres Strait Islander young people:

Aboriginal and Torres Strait Islander people are significantly overrepresented in treatment programs: in 2017–18, 16% of individuals in treatment identified as Aboriginal and Torres Strait Islander.[45] Aboriginal and Torres Strait Islander young people are more likely to experience intergenerational trauma, racism, prejudice and socioeconomic disadvantage as well as disconnection from culture, traditions and Country. There may be increased disadvantage for those who live in regional, remote and very remote regions of Australia.[46] Young people from remote and very remote areas may struggle when removed from their families and communities in order to attend residential treatment programs, which are often located in more urban settings. As a result, they are more likely to disengage from treatment.

There is a need for the modification of existing mainstream programs and the development of programs specifically targeted for this group, taking into account the barriers to recovery posed by trauma and disadvantage.[47] There is an urgent need for programs on Country.

Young people with co-morbid mental health conditions:

Young people with a mental health condition are much more likely to use alcohol and other drugs in a harmful way than the general population. For example, in one survey 45% of young people with major depressive disorders reported drug use, compared to 14.5% of the general population.[48] Of particular concern is that alcohol and drugs can contribute to the risk of suicide,[49] which is the leading cause of death for young people aged 15–24 years in Australia.[50]

Many young people present for treatment with both a substance misuse problem and a mental illness, such as depression.

Young offenders:

There is a significant correlation between the use of alcohol and drugs and offending behaviours. Young people aged 10–17 who receive alcohol and drug treatment programs are 30 times more likely than the general population to be under youth justice supervision.[51] Young people under youth justice supervision are 33 times as likely to receive treatment for cannabis, 27 times as likely to be treated for alcohol, and more than 50 times as likely to be treated for amphetamines than compared to the general Australia population.[52]

More than a fifth (21%) of young Australians who are under youth justice supervision between the ages of 10 and 17 also receive alcohol and other drug treatment programs.[53] Aboriginal and Torres Strait Islander young people under the youth justice supervision are 14 times more likely than their non-Aboriginal peers to receive both treatment for substance misuse and be under youth justice supervision at the same time.[54]

Findings B: Unmet need

Young people in rural and remote communities:

Young people in rural and remote areas are more likely to drink at levels that put them at risk of harm and to experience higher numbers of drug-induced deaths than those who live in urban areas. Causes include a lack of youth-orientated activities, fewer education and employment opportunities, insufficient programs and a culture of high alcohol and drug use.[55] The impact of drug use increases with the level of remoteness: remote and very remote areas experience 2.1 and 2.7 times, respectively, the burden of disease attributable to alcohol use, compared with major cities.[56]

Young people identifying as lesbian, gay, bisexual, transgender or intersex (LGBTI):

There is insufficient data examining the use of alcohol and drugs by people identifying as LGBTI. The only available data source relates to lesbian, gay and bisexual people (excluding transgender and intersex people) aged 14 years and over and is not youth-specific.[57] However, existing data show that 25.8% of people identifying as homosexual or bisexual report drinking at levels exceeding lifetime risk guidelines, compared to 17.2% of heterosexual people. 41.7% used an illicit drug in the previous 12 months, compared to only 14.5% of heterosexual people.[58] This cohort experiences higher rates of poor mental health relating to substance misuse due to increased social stigma, discrimination and abuse.[59]

Young people from culturally and linguistically diverse backgrounds:

While people who speak a language other than English at home appear less likely to consume alcohol and other drugs compared to the rest of the population, some young people in this cohort are vulnerable due to experiences of trauma and torture. This can be further exacerbated by the stress associated with unemployment, language barriers and lack of culturally appropriate programs.[60]

How can we meet the need?

Evidence-based recommendations

Most of the literature reviewed for this report was derived from national and international academic articles, trials and publications based predominantly in Australia and the United States. Other literature was produced directly by Australian not-for-profit organisations, including both published and unpublished literature. State governments' policy frameworks and literature were also considered, as well as evaluations of not-for-profit programs and programs by independent consultants.

This analysis of different approaches and elements of alcohol and drug treatment has drawn on best, promising and emerging practices from Australia and internationally, to identify some of the critical elements to be considered when developing and investing in effective responses to harmful alcohol and drug use among young people in Australia.

The literature highlights the following best practice approaches.

Recommendations

RECOMMENDATION 1 – Youth specific

Develop youth-specific programs across prevention and harm minimisation, withdrawal, rehabilitation and aftercare.

The research clearly shows that tailoring programs to the particular needs of a subgroup has a positive effect on the retention of individuals in a treatment program and the outcomes that can be achieved. Reviews into the youth service system have confirmed these findings and make a strong case for offering targeted youth programs, that use developmentally appropriate strategies to meet the needs of young people.[61]

There are known risks associated with treating young people in adult programs. These include exposing young people to individuals with more entrenched drug use histories and potentially other negative role modelling, such a criminal behaviour. In addition, young people can be subjected to increased risk of being exploited by adult clients, particularly in residential programs.[62]

RECOMMENDATION 2 – System-Wide

Engage government, service providers and communities to develop systemic change.

A systems approach assumes that young people must be viewed as part of the broader community and society in which they live, and that a response must consider all the complex factors involved in influencing their health and wellbeing.[63]

What the evidence shows

The Alcohol and Drug Foundation is currently testing this approach by trialling an internationally acclaimed alcohol and drug prevention program in Australia, Planet Youth. This Icelandic model includes a coalition of social scientists and policy makers. It uses a community-based approach of interpreting local data, the place-based development of responses that are tailored specifically to local needs and a review process focused on participant feedback and outcomes data.[64]

Since this evidence-based program was introduced in Iceland more than 20 years ago, rates of harmful alcohol and drug use have dropped from among the highest in Europe to among the lowest. While this program was not alone in achieving these significant improvements, it was a significant contributor and has also translated into reduced rates of juvenile crime, young people entering drug treatment and rates of bullying.[65]

Between 1998 and 2018 the percentage of Iceland's Year 10 students who had been drunk in the past 30 days fell from 42% to 5%; and the number of Year 10 students who used cannabis once or more in their lifetime declined from 17% to 6%.[66]

The trial is funded by the Australian Government's National Ice Action Strategy and represents a unique opportunity to apply international evidence in the Australian context.[67]

Recommendations

RECOMMENDATION 3 – Integrated care

Develop and deliver holistic programs, involving multiple services that address the complex needs of young people with drug and alcohol addiction.

Integrated care refers to programs that are coordinated effectively to address a young person's different presenting issues (such as alcohol misuse and mental health conditions) and result in a better experience and outcome. This can be achieved either by providing a range of supports from one service or through collaboration between different programs.

What the evidence shows

Meta-analyses and reviews of evidence-based treatment programs for young people with behavioural issues (including alcohol and drug issues) have found integrated models are effective, including for young people with complex needs who are harder to reach. In addition, for homeless young people, integrated treatment models may also need to consider the provision of necessities such as food, shelter and attention to physical ailments.[68]

There is no single model of integrated care that is suited to all contexts, settings and circumstances. Meta-analyses and reviews of evidence-based treatment programs for adolescent behaviour problems (including alcohol and drug issues) have found that integrated models demonstrate consistent effectiveness in clinical trials, including for populations of hard-to-reach youth with complex needs.[69]

An integrated service delivery model would include standardised but flexible core components allowing the translation of integrated care into practice across multiple settings. It would also involve young people in design and implementation as best practice.[70]

Case study: Triple Care Farm, Robertson, New South Wales

Mission Australia's Triple Care Farm, primarily funded by Sir David Martin Foundation, is a holistic residential rehabilitation and treatment program for young people aged 16-24. Located on 110 acres in the Southern Highlands, Triple Care Farm provides an integrated service model, combining withdrawal management, residential rehabilitation and aftercare for young people with a dual diagnosis of mental illness and drug and alcohol problems.

The young people who participate in this program are considered a difficult cohort to treat, due to their history of chronic misuse of often multiple drugs. Many present not only with addiction and mental illness, but also homelessness, involvement with the criminal justice system and unemployment.

A 2015 evaluation, based on a Social Return on Investment methodology, confirmed that the program is achieving its goals and has helped change the lives of hundreds of young people across Australia. The critical elements of the program credited with its success include:

- a holistic model of care, providing support for the range of issues young people face, including their educational, emotional and medical needs
- an individualised approach, tailoring programs to the young person's particular goals
- ongoing support, providing essential care after a young person leaves the residential program to support their transition back into the community
- a commitment to continuous improvement, with activities critically reviewed and adapted to best practice
- experienced and dedicated staff, with the ability to genuinely connect with young people and their families.[71]

Recommendations

RECOMMENDATION 4 – Aftercare

Provide aftercare to all young people following withdrawal or rehabilitation treatment, directly or in partnership with other providers.

Aftercare refers to the timely support provided to prepare individuals to transition out of treatment and support them to reintegrate with their families and/or home community. Its aim is to empower young people to return to education and employment, reduce the risk of relapse and to sustain treatment gains.

There is a lack of appropriate step-down programs across jurisdictions. Staff interviews highlighted that aftercare is necessary to provide a more supported transition for young people back into the community, for example through the provision of supported accommodation.

"Sustained recovery requires a critical focus on what happens after young people leave treatment. Two-thirds of the value of our service model is created through our active aftercare program." Program Manager, Triple Care Farm.

What the evidence shows

Aftercare programs are now recognised in the international literature as a key component in preventing relapse and sustaining treatment gains following community-based or residential treatment.[72]

Aftercare is identified by practitioners and in the literature as highly effective. Recommendations from evaluations of aftercare indicate that fostering links with a young person's family and support network, while a young person is still in treatment, is key. Where appropriate family support is not available, other suitable adults must be sought out to support young people in an ongoing way.[73]

There is only one published randomised trial of continuing care for youth discharged from residential treatment. That study examined the effects of Assertive Continuing Care in North America. Assertive aftercare is when practitioners rather than young people are responsible for making sure that sessions occur and that they are conducted in settings that are more likely to retain the young person.[74]

The trial found that young people assigned to assertive aftercare after residential treatment were significantly more likely to receive continuing care, attend more sessions and to abstain from their primary drug (marijuana) after a period of nine months of follow-up. The authors also considered the benefits of providing outpatient aftercare programs for young people who leave residential treatment prior to completion/planned discharge (commonly against staff advice or at staff request) and subsequently fall through the 'treatment system cracks.' In such cases, many of this cohort are young people mandated to participate in treatment, providing a very significant opportunity for assertive aftercare practitioners to provide in-community sessions and help the young person connect to other needed programs.[75]

Recommendations

RECOMMENDATION 5 – Culturally appropriate programs

Provide more and improved access to culturally appropriate programs for Aboriginal and Torres Strait Islander young people, that include connection to Country, family, kin and community.

It is important that programs for Aboriginal and Torres Strait Islander young people embrace culture and spirituality, connection to Country and the importance of family, kin and community. Programs must consider the particular complexities of multiple disadvantage faced by this group, including social and economic inequalities, trauma, discrimination and identity issues.[76]

As with all alcohol and drug programs, those addressing the needs of Aboriginal and Torres Strait Islander young people and communities must adopt an integrated approach, combining a range of activities including education, case management and work-skills development. The most promising practices include mentoring, motivational interviewing and culturally secure Cognitive Behaviour Therapy techniques.[77]

What the evidence shows

The evidence in Canada suggests indigenous community-based alcohol and drug programs are appropriate alternatives to treatment at distant residential facilities,[78] though more research is required to test this in the Australian context.

Critical success factors identified in the Canadian research include strong leadership and community-member engagement and the ability to develop infrastructures for long-term program sustainability, including implementing paid positions for program coordinators, rather than relying on volunteers. The complexity of issues requires individualised and flexible approaches, specific to the communities' needs and objectives.[79]

It is essential that non-Aboriginal organisations should not compete with Aboriginal service providers but instead seek, where appropriate, to develop partnerships which strengthen Aboriginal organisations and consider and address any inherent imbalance in power.[80]

Partnerships between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander organisations have the potential to build the capacity of both, by sharing learnings and establishing effective practices to address youth substance misuse in culturally competent ways, as demonstrated by the case study below:

Case study: The Bunjilwarra Koori Youth Alcohol and Drug Healing Service, Hastings, Victoria

This capacity building partnership between the Victorian Aboriginal Health Service and Youth Support and Advocacy Service harnesses the expertise and experience of both organisations.

The partnership offers a 12-bed residential rehabilitation and healing service for Aboriginal and Torres Strait Islander young people aged 16–25. The service is situated on almost two hectares of bushland in Hastings, Victoria.

It is based on a spiritual healing model and was the first service of this type in Australia. It was developed through a comprehensive consultation process, involving representatives from the Koori community across Victoria.[81]

The model is based on an Aboriginal-defined notion of healing and supported by trauma-informed practice. The underlying principles of the program include:

- an Aboriginal worldview, inclusive of family, community and connected to Country
- the combination of a Western and a traditional understanding of trauma and wellbeing
- Aboriginal community ownership
- use of a strengths-based approach
- positive role modelling to embed safety and reliability and help develop routines
- a gendered approach, that incorporates women's and men's business.

Recommendations

RECOMMENDATION 6 – Family focused care

Develop therapeutic interventions through family focused therapy to address the risk and protective factors in a young person's environment that affect their drug and alcohol use.

A young person's family environment is one of the most significant predictors of harmful alcohol and drug use and related psychosocial difficulties. Abuse, neglect and parental drug and alcohol use represent significant risk factors. On the other hand, a family's strengths, such as positive family values and active and interested supervision, can positively impact on young people's behaviour, including their patterns of alcohol and drug use.[82,83]

Historically, service providers have given little recognition to the importance of involving parents and families in treatment. Over the past decade, however, there has been accumulating evidence supporting family involvement, so much so that it is now almost universally included in the evidence-based literature.[84,85,86]

How much a family can or should be involved in treatment must consider the nature and quality of the relationship between the young person and their family members. Young people may have little or no connection with their families and some may have parents facing their own drug problems or who are not supportive. Where families are not directly involved, programs should consider how family connections can be improved where appropriate, or identify alternative adults to support the young person after treatment.[87]

What the evidence shows

Best practice involves family in the treatment of young people with alcohol and drug issues and through family therapy or family-focused interventions:

Family therapy: There is a rapidly growing body of research demonstrating the effectiveness of several types of family therapy in the treatment of substance misuse in young people. However, specific skills and specialist training are required to undertake family therapy effectively, making it costly, not widely available and often beyond the role of youth programs. Several modalities are now recognised as well-established, including Multidimensional Family Therapy.

Family involvement: Even without specialist family training, practitioners can effectively involve family in ways that are beneficial to the treatment outcomes of the young person. There are options, including the provision of information, education, teaching of communication and conflict resolution skills, reducing stress and anxiety and supporting family members in their own right.[88,89]

Family-based approaches in Aboriginal and Torres Strait Islander communities: The research into family-based approaches in Aboriginal and Torres Strait Islander communities is not yet conclusive and more rigorous research is needed.[90] However, there are examples of service models that engage the whole family, as outlined in the case study below.

Case study: Cape York Family Centre, Far North Queensland

The Cape York Family Centre is delivered by Pinangba, an Aboriginal and Torres Strait Islander arm of UnitingCare. It provides culturally informed residential rehabilitation for Aboriginal and Torres Strait Islander families.

This service is considered unique as it includes the whole family unit of children and adults during the residential stay. It uses a systemic family therapy framework to deliver treatment, which is informed by a deep understanding of the impact of trauma on participants.

The program is open to young people from age 12 and runs for four to six months. It has structured stages, including Holding and Healing (supervision and support to maintain abstinence and support healing), Looking Inwards (reflection and goal setting) and Looking Outwards (young people are beginning to look ahead and test their relapse prevention skills).

Change is then embedded by providing long-term aftercare, which can be received for up to 18 months, following the return to community.

There is no single model of family therapeutic intervention. To meet the diverse needs of young people, the literature suggests therapeutic practice frameworks must incorporate a high degree of eclecticism, drawing on a variety of different therapeutic models and traditions.[91]

Recommendations

RECOMMENDATION 7 – Diverse care

Provide a variety of supports to suit the individual young person, their context and the complexity of their needs.

There is currently no definitive evidence specifying which treatment type is more effective than another for young people. The lack of conclusive research is in part due to the complexity of factors that influence outcomes of treatment, such as a person's presenting issues and the level of their alcohol and drug use.[92]

There is a range of residential and non-residential treatment options, depending on the young person's age, the severity and complexity of their issues, what support they have from family and friends, and the availability of treatment in their area.

Youth-specific programs include:[93]

- Outreach, providing assessment and support to young people and their families in a variety of locations
- Residential withdrawal, provided through a residential drug service or in a hospital setting
- Community and home-based withdrawal, for those experiencing mild to moderate withdrawal symptoms, usually provided under the supervision of a nurse or GP and with support from a family member or friend
- Residential rehabilitation, providing programs that offer a comprehensive range of interventions away from a young person's usual place of residence
- Supported accommodation, assisting young people in accessing housing after completing withdrawal or residential rehabilitation, often accompanied by ongoing support with the development of independent living skills and access to education and employment pathways
- Day programs, to develop social, emotional and intellectual skills through a wide range of activities.

What the evidence shows

Residential rehabilitation is generally beneficial for young people with complex needs who require intensive support. It is often recommended for young people who have failed to respond to community-based treatment, who use more than one drug, have little social support and present with a secondary diagnosis, such as a mental illness.[94,95]

The available literature demonstrates that residential rehabilitation programs lead to at least similar and sometimes better treatment outcomes for these young people than models such as outpatient programs. Reasons include the structured care environment as well as access to psychosocial and medical care.

Residential programs can also address service barriers related to homelessness and have higher rates of retention in treatment, translating to better outcomes.[96] Some evidence is starting to emerge that residential treatment is more effective for people who use certain substances, such as opioids.[97]

However, residential rehabilitation programs are not suitable for everyone. They are expensive and many people complete multiple treatment episodes across several years before gaining an extended period of remission.[98]

It is therefore important to provide options for alternative service models, and for care continuity after, and in between, residential treatment episodes. It should be noted there is little academic research that directly addresses alternatives to residential treatment programs.

The evidence on eHealth

eHealth, also known as telehealth, refers to health care delivered through and with information and communication technologies. It is aimed at delivering better quality and more efficient services and improving access for individuals over short and long distances.[99]

eHealth offers opportunities to improve access, better integrate and coordinate care and increase engagement of those receiving the care.[100]

The literature is scarce regarding the use of eHealth in alcohol and drug services, especially for young people. However, a systematic review of Australian eHealth models more generally suggests there is increasing evidence that they effectively address many of the challenges of providing health care in widely dispersed populations across large geographic areas.[101]

There is some evidence that mobile text and multimedia messaging are low cost and wide-reaching, and could be tailored for youth drug and alcohol treatment.[102] There is also emerging research evidence that digital technologies can be used to provide aftercare, with participants who receive telephone support achieving better short-term outcomes in terms of alcohol and drug use. More research is needed on the use of alternative monitoring methods such as text messaging and whether this approach can be adapted successfully for use with young people.[103]

Conclusion

Research indicates that young people and their families facing alcohol and drug addiction experience significant improvements in wellbeing by accessing youth-specific, evidence-based treatment and services.

Every $1 invested in alcohol and drug treatment results in **a $7 benefit to the Australian community** by improving health outcomes, reducing criminal behaviour and increasing psychological wellbeing and participation in the community. The improvements directly translate into savings achieved through a reduction of health care costs, less demand on the criminal justice system and gains in productivity.[104]

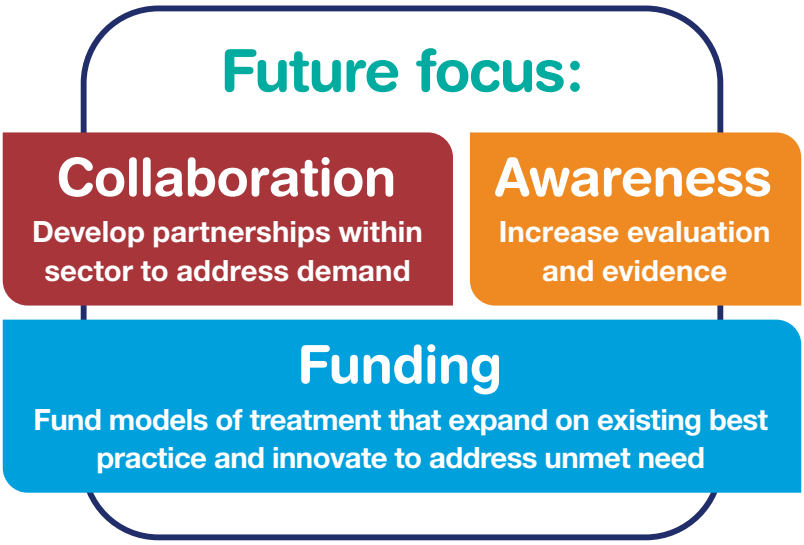
Developing evidence-based treatment makes economic sense and has the potential to significantly enhance community wellbeing, break the cycle of disadvantage and create opportunities for young people to reach their full potential and live healthy, fulfilling and productive lives.

This research report has indicated there is continuing high demand for programs in Australia, with unmet need, particularly among Aboriginal and Torres Strait Islander communities and those living in rural and remote areas, and inadequate government funding and service coordination.

The literature review also identifies a scarcity in research evidence relating to youth-specific alcohol and drug programs and treatment. Investment in rigorous evaluations and knowledge sharing is recommended to address the current gaps in the research evidence, which include:

- Alternatives to residential treatment programs, with no definitive evidence specifying which treatment type is more effective than another.
- The use of information and communication technology (eHealth) in alcohol and other drug treatment for young people.
- Supporting young people in remote and very remote communities effectively. While there is international research available, this has not yet been tested in the Australian context. It should be noted that ongoing partnerships between whole communities, local programs and researchers are central to developing, implementing and evaluating alcohol and drug programs and interventions.

More rigorous evaluations across the alcohol and drug sector would address the current limitations and gaps identified in the literature and improve the definition of integration, multiple and complex needs among young people and standardise the evaluation of outcomes and impact.



References

1. Mission Australia and Social Ventures Australia (SVA) Consulting, Triple Care Farm: Baseline Social Return on Investment Analysis,2015, accessible at: https://www.missionaustralia.com.au/publications/research/young-people/382-triple-care-farm-baseline-social-return-on-investment-analysis/file
2. Roarty L, et al, My Journey Map: Developing a qualitative approach to mapping young people's progress in residential rehabilitation. Contemporary Drug Problems. 2012, Vol. 39, (4), pp. 715-733
3. Australian Institute of Health and Welfare 2017. National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW, accessible at: https://www.aihw.gov.au/getmedia/a9ca9f9d-5263-4389-a4cf-5a6d9af92c96/AODTSFactsheet_YP.pdf.aspx
4. Queensland Network of Alcohol and Other Drug Agencies Ltd. accessible at: https://www.pc.gov.au/__data/assets/pdf_file/0004/209398/subpfr312-human-services-identifying-reform.pdf
5. Australian Institute of Health and Welfare 2019. Alcohol and other drug use in regional and remote Australia: consumption, harms and access to treatment 2016–17. Cat. no. HSE 212. Canberra: AIHW
6. YSAS, The Victorian Youth Alcohol and Other Drug Service System: A vision realised, 2019, accessible at https://www.ysas.org.au/sites/default/files/A%20Vision%20Realised%20report.pdf
7. Australian Institute of Health and Welfare (2019) Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018. Accessible at: https://www.aihw.gov.au/reports/indigenous-australians/atsi-adolescent-youth-health-wellbeing-2018/contents/summary
8. Lawrence D, et al, The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, 2015, accessible at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/9DA8CA21306FE6EDCA257E2700016945/$File/child2.pdf
9. Australian Institute of Health and Welfare 2018. Overlap between youth justice supervision and alcohol and other drug treatment services: 1 July 2012 to 30 June 2016. Cat. no. JUV 126. Canberra: AIHW
10. Australian Institute of Health and Welfare 2019. Alcohol and other drug use in regional and remote Australia: consumption, harms and access to treatment 2016–17. Cat. no. HSE 212. Canberra: AIHW
11. Australian Institute of Health and Welfare 2019. Alcohol, tobacco & other drugs in Australia. Cat. no. PHE 221. Canberra: AIHW
12. Australian Institute of Health and Welfare 2017. National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW
13. Australian Institute of Health and Welfare 2017. National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW, accessible at: https://www.aihw.gov.au/getmedia/a9ca9f9d-5263-4389-a4cf-5a6d9af92c96/AODTSFactsheet_YP.pdf.aspx
14. Ministry of NSW Health,Substance Use and Young People Framework, 2014, accessible at: https://www.health.nsw.gov.au/aod/professionals/Publications/substance-use-young-framework.pdf
15. Australian Institute of Health and Welfare 2017. National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW, accessible at: https://www.aihw.gov.au/getmedia/a9ca9f9d-5263-4389-a4cf-5a6d9af92c96/AODTSFactsheet_YP.pdf.aspx
16. Australian Institute of Health and Welfare 2019. Alcohol and other drug treatment services in Australia: state and territory summaries. Cat. no. HSE 203. Canberra: AIHW.
17. Australian Institute of Health and Welfare 2017. National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW, accessible at: https://www.aihw.gov.au/getmedia/a9ca9f9d-5263-4389-a4cf-5a6d9af92c96/AODTSFactsheet_YP.pdf.aspx
18. Ibid
19. Australian Institute of Health and Welfare 2019. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Cat. no. BOD 22. Canberra: AIHW, accessible at: https://www.aihw.gov.au/getmedia/a9ca9f9d-5263-4389-a4cf-5a6d9af92c96/AODTSFactsheet_YP.pdf.aspx
20. Australian Institute of Health and Welfare 2019. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Cat. no. BOD 22. Canberra: AIHW, accessible at: https://www.aihw.gov.au/getmedia/a9ca9f9d-5263-4389-a4cf-5a6d9af92c96/AODTSFactsheet_YP.pdf.aspx
21. Australian Institute of Health and Welfare 2019. Alcohol and other drug treatment services in Australia 2017–18: key findings. Cat. no. HSE 224. Canberra: AIHW.
22. K. Hetherington and C. Spooner, Social determinants of drug use. National Drug and Alcohol Research Centre, 2004, Report No. 228; C. Spooner, Social determinants of drug use – Barriers to translating research into policy. Health Promotion Journal of Australia, 2009, Vol. 20(3), pp. 180
23. G. Vimpani and C. Spooner , Minimizing substance misuse by strategies to strengthen families. Drug and Alcohol Review, 2003, Vol. (22), pp. 251-254
24. NSW Ministry of Health, Substance Use and Young People Framework, 2014,accessible at: https://www.health.nsw.gov.au/aod/professionals/Publications/substance-use-young-framework.pdf
25. YSAS, The Victorian Youth Alcohol and Other Drug Service System: A vision realised, 2019, accessible athttps://www.ysas.org.au/sites/default/files/A%20Vision%20Realised%20report.pdf
26. NSW Ministry of Health, Substance Use and Young People Framework, 2014, accessible at:https://www.health.nsw.gov.au/aod/professionals/Publications/substance-use-young-framework.pdf.
27. Ritter A, et al, New Horizons: The review of alcohol and other drug treatment services in Australia. Drug Policy Modelling Program, National Drug and Alcohol Research Centre, 2014, accessible at: https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/New%20Horizons%20Final%20Report%20July%202014.pdf
28. Department of Health, National Drug Strategy 2017-2026, 2017, accessible at: https://www.health.gov.au/sites/default/files/national-drug-strategy-2017-2026_1.pdf
29. Network of Alcohol and other Drugs Agencies (NADA), Submission to the NSW Health Minister and NSW Ministry of Health for the provision of additional residential rehabilitation and withdrawal management beds in NSW, 2019, accessible at: https://www.nada.org.au/wp-content/uploads/2019/03/NADA-Submission_-NSW-AOD-Beds_120319.pdf
30. Ritter A, et al, New Horizons: The review of alcohol and other drug treatment services in Australia. Drug Policy Modelling Program, National Drug and Alcohol Research Centre, 2014, accessible at: https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/New%20Horizons%20Final%20Report%20July%202014.pdf
31. Queensland Network of Alcohol and Other Drug Agencies Ltd (QNADA), Response to Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform, 2016, accessible at: https://www.pc.gov.au/__data/assets/pdf_file/0004/209398/subpfr312-human-services-identifying-reform.pdf
32. Department of Health, National Drug Strategy 2017-2026, 2017, accessible at: https://www.health.gov.au/sites/default/files/

References

national-drug-strategy-2017-2026_1.pdf

33. Queensland Network of Alcohol and Other Drug Agencies Ltd (QNADA), Response to Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform, 2016, accessible at: https://www.pc.gov.au/__data/assets/pdf_file/0004/209398/subpfr312-human-services-identifying-reform.pdf
34. Australian Institute of Health and Welfare 2019. Alcohol and other drug treatment services in Australia 2017–18: key findings. Cat. no. HSE 224. Canberra: AIHW.
35. Ritter A, et al, New Horizons: The review of alcohol and other drug treatment services in Australia. Drug Policy Modelling Program, National Drug and Alcohol Research Centre, 2014, accessible at: https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/New%20Horizons%20Final%20Report%20July%202014.pdf
36. Victoria State Government, Drug Rehabilitation Plan: New action to help save Victorian lives, 2017, accessible at: https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/drug-rehabilitation-plan
37. Tasmanian Liberals, Policy, 2019, accessible at: https://www.tas.liberal.org.au/policy
38. Queensland Government, Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023, 2018, accessible at: https://www.qmhc.qld.gov.au/sites/default/files/files/qmhc_2018_strategic_plan.pdf
39. YSAS, The Victorian Youth Alcohol and Other Drug Service System: A vision realised, 2019, accessible at https://www.ysas.org.au/sites/default/files/A%20Vision%20Realised%20report.pdf
40. Australian Institute of Health and Welfare 2019. Alcohol and other drug treatment services in Australia: state and territory summaries. Cat. no. HSE 203. Canberra: AIHW
41. Savic M, et al, Strategies to facilitate integrated care for people with alcohol and other drug problems: A systemic review. Substance Abuse Treatment, Prevention and Policy, 2017, Vol. 12(29).
42. https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-state-territory-summaries
43. Australian Institute of Health and Welfare 2019. Alcohol and other drug use in regional and remote Australia: consumption, harms and access to treatment 2016–17. Cat. no. HSE 212. Canberra: AIHW
44. World Health Organization,Alcohol: Key facts, 2019, accessible at https://www.who.int/news-room/fact-sheets/detail/alcohol
45. Australian Institute of Health and Welfare 2019. Alcohol and other drug treatment services in Australia 2017–18: key findings. Cat. no. HSE 224. Canberra: AIHW
46. Australian Institute of Health and Welfare 2019. Alcohol and other drug treatment services in Australia 2017–18: key findings. Cat. no. HSE 224. Canberra: AIHW
47. Australian Institute of Health and Welfare (2019) Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018. Accessible at: https://www.aihw.gov.au/reports/indigenous-australians/atsi-adolescent-youth-health-wellbeing-2018/contents/summary.
48. Lawrence D, et al, The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, 2015, accessible at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/9DA8CA21306FE6EDCA257E2700016945/$File/child2.pdf
49. Headspace, How does alcohol affect mental health, 2019, Accessible at: https://headspace.org.au/young-people/how-does-alcohol-affect-mental-health/
50. Australian Institute of Health and Welfare 2019. Deaths in Australia. Cat. no. PHE 229. Canberra: AIHW.
51. Australian Institute of Health and Welfare 2019. Youth justice. Canberra: AIHW
52. Australian Institute of Health and Welfare 2018. Overlap between youth justice supervision and alcohol and other drug treatment services: 1 July 2012 to 30 June 2016. Cat. no. JUV 126. Canberra: AIHW
53. Australian Institute of Health and Welfare 2019. Alcohol, tobacco & other drugs in Australia. Cat. no. PHE 221. Canberra: AIHW. .
54. Australian Institute of Health and Welfare 2018. Overlap between youth justice supervision and alcohol and other drug treatment services: 1 July 2012 to 30 June 2016. Cat. no. JUV 126. Canberra: AIHW
55. Donnelly J and Bradhurst B (NADA Conference Paper),Effective Aftercare: Lessons learn from AOD-affected young people and their allies, 2018, accessible at: https://nadaconference.org.au/presentations/2018/day1-workingwithyoungpeople-donnelly-bradhurst.pdf
56. Australian Institute of Health and Welfare 2019. Alcohol and other drug use in regional and remote Australia: consumption, harms and access to treatment 2016–17. Cat. no. HSE 212. Canberra: AIHW
57. Australian Institute of Health and Welfare 2017. National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW
58. Australian Institute of Health and Welfare 2019. Alcohol, tobacco & other drugs in Australia. Cat. no. PHE 221. Canberra: AIHW
59. National LGBTI Health Alliance, The Statistics at a glance: The mental health of Lesbian, Gay, Bisexual, Transgender and Intersex People in Australia, 2019, accessible at: https://lgbtihealth.org.au/statistics/
60. Australian Institute of Health and Welfare 2019. Alcohol, tobacco & other drugs in Australia. Cat. no. PHE 221. Canberra: AIHW
61. YSAS, The Victorian Youth Alcohol and Other Drug Service System: A vision realised, 2019, accessible at https://www.ysas.org.au/sites/default/files/A%20Vision%20Realised%20report.pdf
62. Ibid
63. The Department of Health, Applying a systems approach to young people and AOD work, 2004, accessible at:: https://www1.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-front7-wk-toc~drugtreat-pubs-front7-wk-secb~drugtreat-pubs-front7-wk-secb-2~drugtreat-pubs-front7-wk-secb-2-1
64. Planet Youth by ICSRA, The method - A community based, bottom-up approach, 2019, accessible at:: https://planetyouth.org/the-method/
65. Ibid
66. Alcohol and Drug Foundation, Iceland's Planet Youth lands in Australia, 2019, accessible at: https://adf.org.au/insights/planet-youth-lands-australia/
67. The Department of Health, Applying a systems approach to young people and AOD work, 2004, accessible at: https://www1.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-front7-wk-toc~drugtreat-pubs-front7-wk-secb~drugtreat-pubs-front7-wk-secb-2~drugtreat-pubs-front7-wk-secb-2-1,
68. Bruun A. and Mitchell PF (2012) A resource for strengthening therapeutic practice frameworks in youth AOD services, 2012, Melbourne: YSAS
69. Ibid
70. C. Foley, Collaborating with clinicians and consumers to improve the uptake of integrated care in a residential mental health rehabilitation unit: A co-design approach.
71. Social Ventures Australia (SVA) Consulting (2015) Triple Care Farm:

References

Baseline Social Return on Investment. Full report. Social Ventures Australia (SVA) Consulting

72. SED Consulting,Koori Youth Alcohol and Drug Healing Service: Final Report. Victoria: Department of Human Services, 2004, accessible at: https://www2.health.vic.gov.au/about/publications/researchandreports/Koori-Youth-Alcohol-amp-Drug-Healing-Service--Final-Report-October-2004--SED-Consulting
73. Donnelly J and Bradhurst B (NADA Conference Paper),Effective Aftercare: Lessons learn from AOD-affected young people and their allies, 2018, accessible at: https://nadaconference.org.au/presentations/2018/day1-workingwithyoungpeople-donnelly-bradhurst.pdf
74. .H., Godley, et al,The Assertive Continuing Care Protocol: A Clinician's Manual for Working with Adolescents After Treatment of Alcohol and Other Substance Abuse Disorders, 2006, accessible at: https://www.chestnut.org/resources/bf15f268-dfa3-440f-9b5d-05b5041b26f4/acc_manual_revised_2nd_ed_111306.pdf?trackid=acc_manual_revised_2nd_ed_111306.pdf
75. Ibid
76. Gomez M, et al. Adapting the Drug and Alcohol Service Planning Model for Aboriginal and Torres Strait Islander people receiving alcohol, tobacco and other drug services: Components of care and a resource estimation tool. National Drug and Alcohol Research Centre, UNSW, 2014, accessible at: https://ndarc.med.unsw.edu.au/resource/adapting-drug-and-alcohol-service-planning-model-aboriginal-and-torres-strait-islander
77. Bruun A. and Mitchell PF (2012) A resource for strengthening therapeutic practice frameworks in youth AOD services, 2012, Melbourne: YSAS.
78. A. Jiwa,Healing the community to heal the individual: Literature review of aboriginal community-based alcohol and substance misuse programs. Canadian Family Physician, 2008, Vol. 54(7).
79. Ibid
80. Aboriginal Peak Organisations of the Northern Territory (APO NT) (2013) Developing agreed principles to guide service delivery and development work by non-Aboriginal NGOs in Aboriginal communities in the Northern territory. Accessible at: http://www.amsant.org.au/apont/wp-content/uploads/2015/01/130129-APO-NT-NGO-Service-Delivery-discussion-paper-Final.pdf
81. SED Consulting,Koori Youth Alcohol and Drug Healing Service: Final Report. Victoria: Department of Human Services, 2004, accessible at: https://www2.health.vic.gov.au/about/publications/researchandreports/Koori-Youth-Alcohol-amp-Drug-Healing-Service--Final-Report-October-2004--SED-Consulting
82. G. Vimpani and C. Spooner , Minimizing substance misuse by strategies to strengthen families. Drug and Alcohol Review, 2003, Vol. (22), pp. 251-254
83. Kumpfer KL, et al, , Effectiveness outcomes for four age versions of the Strengthening Families Program in Statewide Field Trials. Group Dynamics: Theory, Research and Practice, 2010, Vol. 14 (3), pp. 211-229.
84. HA Liddle, Family-based therapies for adolescent alcohol and drug use: research contributions and future research needs. Addiction, 2004, Vol. 99, pp. 76-92.
85. A. Bruun. and PF Mitchell, A resource for strengthening therapeutic practice frameworks in youth AOD services, 2012, Melbourne: YSAS.
86. R. Brannigan, et al, The quality of highly regarded adolescent substance misuse treatment programs. Archives of Paediatric and Adolescent Medicine, 2004, Vol. 158, pp. 904-909.
87. Waldron HB, et al, Engaging resistant adolescents in drug abuse treatment. Journal of Substance Abuse Treatment, 2007, Vol. 21, pp. 133-142.
88. A. Bruun. and P.F. Mitchell, A resource for strengthening therapeutic practice frameworks in youth AOD services, 2012, Melbourne: YSAS.
89. Marsh A, Dale A and Willis, Evidence Based Practice Indicators for Alcohol and Other Drug Interventions: Literature Review, 2nd edition, 2007, Drug and Alcohol Office WA.
90. B. Calabria, et al,A systematic review of family-based interventions targeting alcohol misuse and their potential to reduce alcohol-related harm in Indigenous communities. Journal of Studies on Alcohol and Drugs, 2012, Vol. (73), pp. 477-488.
91. A. Bruun. and P.F. Mitchell, A resource for strengthening therapeutic practice frameworks in youth AOD services, 2012, Melbourne: YSAS.
92. Neumann N, et al, Evaluation of the value for money of residential rehabilitation compared to the model for the delivery for community-based alcohol and other drug (AOD) interventions for young people, 2019.
93. De Andrade D, et al, The effectiveness of residential treatment services for individuals with substance use disorders: A systematic review. Drug and Alcohol Dependence, 2019, Vol. 201, pp 227-235.
94. NSW Ministry of Health, Non-Government Organisation Alcohol and Other Drug Treatment Service Specifications, 2017, accessible at https://www.health.nsw.gov.au/aod/resources/Publications/treatment-service-specifications.pdf
95. Neumann N, et al, Evaluation of the value for money of residential rehabilitation compared to the model for the delivery for community-based alcohol and other drug (AOD) interventions for young people, 2019.
96. Reif S, et al,Residential Treatment for Individuals With Substance Use Disorders: Assessing the Evidence, Psychiatric Services, 2014, 65 (3) pp. 301-312.
97. De Andrade D, et al, The effectiveness of residential treatment services for individuals with substance use disorders: A systematic review. Drug and Alcohol Dependence, 2019, Vol. 201, pp 227-235.
98. Ibid
99. Australian Government Department of Health,Telehealth, 2019, accessible at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/e-health-telehealth
100. Imison C, et al,Delivering the benefits of digital health care, 2016, accessible at: https://www.nuffieldtrust.org.uk/research/delivering-the-benefits-of-digital-health-care
101. Bradford NK, et al, Telehealth services in rural and remote Australia: a systematic review of models of care and factors influencing success and sustainability. Rural and Remote Health, 2016, Vol. (16), pp. 42-68;; Molfenter T, et al, M. Boyle, et al, Trends in telemedicine use in addiction treatment. Addiction science & clinical practice, 2015, Vol. 10 (14); Armfield NR, et al, Telemedicine – is the car being put before the horse?. MJA, 2014, Vol. 200 (9).
102. Hall AK, et al, Mobile Text Messaging for Health: A Systematic Review of Reviews, 2015, accessible at:https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4406229
103. McKellar J, et al, One-year outcomes of telephone case monitoring for patients with substance use disorder. Addictive Behaviour, 2012, Vol. 37 (10).
104. Ritter A, et al, New Horizons: The review of alcohol and other drug treatment services in Australia. Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW, 2014, accessible at: https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/New%20Horizons%20Final%20Report%20July%202014.pdf.

SIR david martin FOUNDATION

30 YEARS

MAJOR PHILANTHROPIC PARTNER OF

MISSION AUSTRALIA

Contact us

martinfoundation.org.au

admin@martinfoundation.org.au

(02) 9219 2002

REGISTERED CHARITY

Sir David Martin Foundation is a registered charity with ACNC