Consultation paper

Renewing Queensland's Alcohol and Other Drugs Plan

Prevention of alcohol and other drug use and harm

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– Not Government Policy –

Introduction

Alcohol and other drug (AOD) use can affect the physical, social, emotional and financial wellbeing of individuals, families and communities.[1] It can have profound economic costs and is a leading cause of total disease impact in young Australians.[2] Prevention is a key public health strategy that involves initiatives 'upstream' to prevent uptake, delay first use and reduce harms from AOD. Effective prevention can significantly reduce the individual, family and community harms caused by AOD use and is a cost-effective strategy with excellent return on investment.[3-5] There is growing evidence for what works in prevention, and prevention in young people can have lifelong effects.

Alcohol and other drugs in Queensland

According to the Australian Alcohol Guidelines, consumption of more than four standard drinks on a single occasion places a person at risk of injury. In Queensland, nearly four in 10 people aged 15 to 34 drink at this level at least once a month.6 Although Queensland has achieved a steady decline in the proportion of people drinking at this level, it remains higher than the national average.6 Moreover, one in five Queenslanders drink more than two standard drinks on an average day, which exceeds the Australian Alcohol Guidelines to minimise risk of lifelong harm.6 This prevalence is also higher than the Australian average, with Queensland not observing the same declines that other states in recent years.7

The proportion of Queenslanders who reported using at least one illicit drug in the previous twelve months increased from 13.7% in 2007 to 16.9% in 2019 - a trend that occurred in all states aside from Western Australia and the Northern Territory.8 The most commonly reported illicit drug used by Queenslanders in the previous 12 months was cannabis (12.8%), followed by cocaine (3.6%), un-prescribed use of pharmaceutical pain-relievers and opiates (2.7%), ecstasy (MDMA, 2.6%) and meth/amphetamine (1.2%).8 Among Queenslanders receiving treatment for AOD use in 2018-19, alcohol was the most common drug of concern, followed by cannabis and amphetamines.9

While tobacco use will not be addressed in detail in this paper, it is worth noting that over the past 15 years, Queensland has seen a reduction in the number of people who smoke daily and an increase in the proportion of people who have never smoked.10 This follows substantial national investment in public health, legislation changes, and prevention and treatment, and has included plain packaging, taxation and public health campaigns.11 However, there is still a need to address smoking, particularly in Northern Queensland, which has the highest proportion of daily smokers Australia-wide.12

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There have been substantial reductions in the proportion of Aboriginal and Torres Strait Islander peoples using AOD, with the proportion of Aboriginal and Torres Strait Islander people abstaining from drinking higher than that for non-Indigenous Australians. 13 However, for many substances, use is higher among Aboriginal and Torres Strait Islander Australians compared to non-Indigenous Australians.14 These differences demonstrate the importance of a continued focus on culturally appropriate and community-led AOD prevention and treatment initiatives that recognise unique risks and protective factors for Aboriginal and Torres Strait Islander peoples.

There is significant investment in AOD treatment services in Queensland.15,16 However, it has been found that few people with a substance use disorder seek treatment. This is particularly the case among young people, with fewer than 1 in 4 people aged 16-24 with a diagnosed mental health or substance use disorder – which often co-occur – seeking treatment.17 In addition, there are sometimes long delays to receiving treatment, meaning a person's disorder is often more entrenched.18-20

Prevention

There are several levels of prevention, each targeting different groups:

- Primary prevention is delivered prior to substance use problems occurring and can be "universal", with delivery to a whole group, regardless of individual risk factors, or "selective", with delivery to higher-risk individuals.
- Secondary or "indicated" prevention (also referred to as "early intervention") is delivered to individuals who are already experiencing substance use problems but have not yet developed a substance use disorder.
- Tertiary prevention is delivered to individuals who have developed a substance use disorder.

This paper will focus on primary prevention and will incorporate examples of evidence-based universal and selective initiatives.

Delaying the age of initiation of AOD use is a powerful protective factor against later development of a substance use disorder.21-23 The age of initiation in Queensland and nationally for each of the most common substances is shown in Table 1.24 Since 2007 there has been a promising trend towards later AOD initiation for all substances other than ecstasy (MDMA), with particular success in tobacco initiation. However, young people on average are still initiating use well before their brains have matured, posing significant risk of harm25 and in Queensland, the average onset of use for most substances is 2-5 months earlier than the national average. Effective prevention in adolescence, before initiation, is essential to improve the health of the next generation of Queenslanders.

Table 1. Average age of initiation of AOD use

	Queensland average		**National average**	
Substance	2019	2007	2019	2007
Tobacco (full cigarette)	16.2 yrs	15.6 yrs	16.6 yrs	15.8 yrs
Alcohol (full standard drink)	17 yrs	16.8 yrs	17.2 yrs	17 yrs
Cannabis	18.6 yrs	18.6 yrs	18.9 yrs	18.8 yrs
Ecstasy (MDMA)	21.2 yrs	22.4 yrs	21.5 yrs	22.6 yrs
Meth/amphetamine	22.1 yrs	21.1 yrs	22.5 yrs	20.9
Cocaine	23.6 yrs	22.8 yrs	23.6 yrs	23.1 yrs
Illicit use of pharmaceutical pain-relievers and opiates	23.4 yrs	n/a	24 yrs	n/a

A prevention approach aims to reduce the impact of risk factors and enhance protective factors against AOD use. At the individual level, AOD use risk is influenced by personality factors including hopelessness, anxiety sensitivity, impulsivity, and sensation-seeking;26 and cognitive factors such as knowledge about the harms of AOD use, accuracy of perceived peer substance use, and attitudes towards AOD use.23 High psychological distress and exposure to adverse childhood events including abuse, neglect, and bullying increase an individual's risk of AOD use and harm.25,27,28 At the family level, parenting practices and social learning of modelled behaviours significantly influence the risk of AOD use.23,29 Parenting practices can either increase risk, for example early parental supply of alcohol, favourable attitudes towards alcohol, and parental drinking; or be protective, such as clear limit-setting, monitoring, and open communication patterns.29 At the school level, a young person's academic performance and their engagement, attendance, and relationship with teachers influence their level of risk.23 At the community level, a young person's engagement in community activities, such as religious or sporting groups, employment, community norms around AOD use, and a feeling of safety within their community influence risk level.23,27 Many Aboriginal and Torres Strait Islander people experience culturally distinct factors, including intergenerational trauma as a result of colonisation (risk factor), and connection to culture (protective factor).27 As the risk and protective factors for substance use are varied, prevention efforts can be delivered in a range of settings.

The Evidence

Policy, mass media, community, family and school-based approaches are supported by varying levels of evidence. Policy-based initiatives such as taxes based on alcohol content, advertising bans, increasing the minimum legal purchase age, and licencing restrictions to reduce supply and access (e.g., trading hour restrictions and limiting the number of licenced venues in an area) can have significant impact; however, these measures are not always feasible.5,30 There are substantial opportunities for AOD prevention in school, family and community settings, which are the primary contexts in which young people develop.31 The strongest evidence exists for prevention initiatives in schools due to the use of high-quality evaluations and gold standard randomised controlled trials (RCTs) that are typically lacking in non-school settings. As such, this report largely focuses on school-based prevention, however, approaches within the community, family, and media are also discussed.

School-based prevention

Schools are ideal settings for the delivery of AOD prevention initiatives as they provide access to large numbers of young people during the period when they are most likely to initiate AOD use. Although Australia has a mandated health education curriculum that addresses AOD, young people still report feeling unequipped to handle situations involving AOD which they may be faced with as they progress through their teenage years.

Schools are given a lot of flexibility around the delivery of AOD education, and teachers report that they do not always feel confident in identifying and delivering evidence-based AOD programs.32,33 The National Curriculum monitoring process has identified that some teachers do not dedicate adequate time to AOD due to the sensitive nature of this topic.34 Budgetary constraints mean that decisions about which AOD programs to run are often influenced most by price, however, even programs that receive government funding may lack evidence of effectiveness.33 There is therefore a need to better support teachers, schools and policymakers to identify and use evidence-based AOD prevention programs.

Even when evidence-based programs are identified, there are often barriers that can reduce uptake or effectiveness. For example, schools and teachers are often limited in time and training, which can lead to programs being adapted or abandoned. This may affect geographically isolated or low socio-economic status (SES) schools in particular, where resources are most limited.35 To overcome these barriers, AOD prevention programs not only need to have evidence of effectiveness, but also offer value without costing a lot of money, be widely accessible, and be easy to implement within the health education curriculum.

Australia has pioneered world-leading approaches to overcome barriers to implementation and to provide evidence-based AOD education consistent with the United Nations Office of Drugs and Crime's (UNODC) International Standards on Drug Use Prevention.36,37 For example:

- *Climate Schools:* A universal school-based program including a range of curriculum aligned, interactive online modules for students in years 8-10. Modules include realistic cartoon storylines that were *co-designed with young people*, along with additional teacher-facilitated activities. Rigorous evaluation through seven trials including >14,600 students from 169 schools across Queensland, New South Wales, Western Australia, the Australian Capital Territory and Victoria, found *Climate Schools* to be effective at improving knowledge about AOD and mental health, and reducing AOD use, truancy rates, psychological distress and anxiety for up to three years.38-40
- *Get Ready*: A universal school-based program involving specialist teacher training to run a 10-lesson curriculum-based AOD education program (years 7-9), shown to increase knowledge about AOD and decrease alcohol and tobacco use.41,42
- *SHAHRP*: A universal school-based program that addresses alcohol use through a two-year classroom-based program administered by teachers to year 8 and 9 students. It has demonstrated effectiveness at reducing alcohol use and related harms, with results replicated internationally.43,44
- *Preventure*: A selective school-based program including a personality-targeted initiative for high-risk youth, found to reduce alcohol use and related harms both within Australia and internationally.45,46

Although there is some support for the *No Smokes47* program, which aims to promote anti-smoking and healthy choices among young Aboriginal and Torres Strait Islander students, there is a need for more rigorous evaluations of school-based AOD prevention initiatives that are culturally safe and co-developed with Aboriginal and Torres Strait Islander peoples.48 One such program that is currently being evaluated is *Strong & Deadly Futures*, which builds on the effective *Climate Schools* model and - if found to be effective - could be an important consideration for future implementation

Climate Schools, *Get Ready, SHARHP* and *Preventure* are all endorsed by the Alcohol and Drug Foundation and the Australian Government funded *Positive Choices* portal. *Climate Schools* and *Get Ready* are recommended by *Dovetail,* a Queensland Government initiative.49 *Climate Schools* is also endorsed by *Communities that Care*, and was given the highest rating for effectiveness in a review of school AOD education conducted by the National Centre for Education and Training on Addiction (NCETA).50 The ADF has provided grants to several Queensland schools to cover the costs of administering the program, reducing a barrier to effective school-based AOD education.

Family-based prevention

Families play a key role in shaping young people, including their knowledge and decisions around AOD use.29,31,51,52 For example, there is growing evidence that parental supply of alcohol to teenagers increases the risk of binge drinking and alcohol-related harms, with earlier age of supply by parents linked to greater risk.53 Family-based prevention approaches may therefore be beneficial in reducing AOD use and related harms. These initiatives may focus solely on parents or include combined parents and child/student approaches. While there is evidence to support family-based prevention approaches, particularly with respect to universal initiatives, more rigorous research is required to determine which initiatives (e.g. those that target parents alone, those that target both parents and children) and which contexts (universal, selective, indicated) might deliver the most benefits.37,54

Research to date has shown that family-based universal prevention initiatives are most effective when they aim to improve a range of key personal and social skills (e.g., peer resistance, decision-making and refusal skills), rather than focusing on AOD use behaviours alone.55,56 However, prevention efforts are often hindered by low parental participation or a lack of active involvement, which is vital for success.35,37 Key barriers tend to include time, costs, childcare, and transport issues.35

Family-based universal initiatives focusing on parents alone have been effective in preventing AOD use by improving parent-child communication, parental rule-setting and monitoring skills.29,57 Similarly, combined parent and student prevention programs have had positive effects,55,58,59 although these effects are typically small.60 Although most research has been conducted in the USA or Europe, key Australian programs include:

- *Resilient Families*: A school-based program including teacher training and a 10-week social relationship curriculum, along with an information night and 8-week professionally facilitated program for parents. It has been shown to reduce AOD use, delinquent behaviour, and teenage-parent conflict.61,62
- *Climate Schools Plus (CSP):* A combined parent and student program currently being evaluated. *CSP* builds on the *Climate Schools* program for students by incorporating a parent component, based on the successful Dutch *Prevention of Alcohol Use in Students* (PAS) program.63,64 The parent component targets rule-setting, parental supply, modelling, and monitoring, and is delivered entirely online which may help to increase parental participation and engagement.64
- *Positive Parenting Program (Triple P*): Although not specific to AOD, this Queensland developed program addresses AOD prevention by developing parents' skills and providing strategies to help them strengthen protective factors and reduce risk factors of AOD use in their children. Facilitated by clinicians, *Triple P* has multiple levels, spanning universal, selective and indicated prevention approaches, and includes specialised programs such as *Indigenous Triple P*, which is tailored for Aboriginal and Torres Strait Islander families. *Triple P* has strong evidence of effectiveness, both within Australia and internationally, in reducing behavioural and emotional problems and improving parent-child relationships, but more research is needed to understand its effect on AOD outcomes.65 *Triple P* is funded by the Queensland Government, allowing Queensland families with children under 16 years to access the full range of programs free of charge.

Community-based prevention

Community-based AOD prevention approaches are initiatives delivered to whole communities or specific groups that may be at heightened risk of AOD-related harms (e.g. teenage boys living in a socially disadvantaged suburb). The approaches can be tailored to the needs of the community, address a range of risk factors, and be reinforced via multiple delivery methods. However, they typically require a lot of resources and can be difficult to deliver exactly as intended, which can reduce effectiveness.35 Overall, although there is some evidence supporting the use of community-based approaches in preventing AOD use,66,67 findings have been mixed and there is a need for more high quality trials to evaluate community approaches.37,68

The best-known Australian community based AOD prevention initiative is *Communities that Care (CTC)*. In addition to AOD use, *CTC* aims to prevent a range of youth problem behaviours such as risky sexual behaviour, violence, early school dropout, and low academic achievement, via whole community change. Rather than assigning specific programs to communities, *CTC* provides a framework for prevention for local community members to choose and facilitate the evidence-based activities that best suit the needs of their community.69 *CTC* was evaluated with more than 40,000 adolescents in four Australian communities in Victoria and Western Australia between 1999 and 2015. *CTC* led to more rapid reductions in alcohol, tobacco and cannabis use and antisocial behaviour compared to Australian trends.70 *CTC* is now being implemented and evaluated in a further fourteen communities, including several in Queensland.71

Local Drug Action Teams (LDATs) are community-led bodies supported by the Alcohol and Drug Foundation to develop community action plans and implement evidence-based activities to enhance protective factors against AOD.72 There are 44 LDATs in Queensland and, although their activities have not been rigorously evaluated, there are promising case studies demonstrating increases in protective factors.73 For example, the Queensland Blue Light LDAT has successfully reengaged a large number of at-risk young people in schooling and demonstrated improved self-esteem, mental health and attitudes towards risk-taking through their *Blue EDGE* initiative, which includes physical activity, healthy breakfasts, interactive mentoring, life skills sessions and transport to school.73

Many grassroots community initiatives in Queensland address risk factors for AOD use and promote protective factors. *Beat Da Binge*, a community-run initiative in Yarrabah, included a range of events and activities and was associated with significant decreases in binge drinking and increases in alcohol-related knowledge.74 Other promising case studies include the *Indigenous Wellbeing Centre's Youth Program*, *Care Goondiwindi's Youth Development* program and *YourTown's Youth Engagement Program*, although rigorous evaluations have not been conducted for these initiatives.

Mass media

Mass media AOD prevention approaches aim to use advertising and media campaigns to increase knowledge and awareness, change attitudes, reduce intentions to use, and shape patterns of AOD use.75 This approach offers advantages including the ability to reach and engage a large number of youth through multiple mediums (e.g., television, internet, print). However, campaigns are often costly and there is a lack of evidence to support their effectiveness in preventing AOD use,37 with some suggesting that they can instead increase use,75 or possibly promote stigmatising attitudes towards AOD use.76

Conclusions

Based on the existing evidence, it is clear that AOD prevention approaches can have a substantial public health impact by delaying and reducing AOD use and harms among young people. However, despite some positive changes in AOD use in recent years, individual and societal harms associated with AOD use remain high, and young people and parents are still feeling deficient in the information and skills required to navigate AOD-related situations. It is important to invest in AOD programs that are supported by strong evidence.

Although policy and public health approaches such as taxes based on alcohol content, advertising bans, increasing the minimum legal purchase age, and licencing restrictions offer significant potential for cost-effective prevention of AOD use and related harms, they are not always feasible.5,30 Approaches at the school, family and community level should be considered, with the strongest evidence existing for initiatives delivered in school settings, followed by family based approaches. More gold standard randomised controlled trials are required to support community-based prevention approaches.

There is also a need for more rigorous evaluations of programs that are culturally safe and co-developed with Aboriginal and Torres Strait Islander young people. Over the next two years there will be a review of the National Curriculum, which provides an opportunity for clearer integration of AOD education, with more guidance on evidence-informed approaches. The impacts of investments in AOD education may be increased by focusing on programs that use online technologies, as these initiatives can be easily scaled, can reduce reluctance to address sensitive topics, and are less likely to be adapted in ways that can reduce effectiveness. There are several well-intentioned programs that are supported by substantial funding but lack evidence of effect and contravene the UNODC guidelines for AOD education. A number of existing programs supported by high quality evidence have been included in this report and are recommended for funding consideration. Promising new initiatives have also been identified and should be monitored for potential future implementation. Schools, parents, and policymakers can stay up to date with evidence based AOD prevention programs as the field develops by accessing the *Positive Choices* and *Positive Choices Aboriginal and Torres Strait Islander* portals.

Disclaimer: MT, NCN, CC, KEC, LAG & SS report grants from the National Health and Medical Research Council, the Australian Government Department of Health & Philanthropy. MT and NCN are the directors of Climate Schools Pty Ltd a company established in 2015 to distribute evidence-based wellbeing resources to schools. These resources are available free to all schools during the time of COVID-19.

Terminology

- **Cost-effective:** Producing the most valuable results for the amount of money spent.
- **Evidence-based:** Rigorously evaluated and supported by scientific research.
- **Initiative**: A program or strategy that is rolled out with the aim of achieving a positive outcome.
- **Randomised controlled trial (RCT):** A study in which participants are allocated at random into separate groups to allow comparison of outcomes. Groups typically include an "intervention group", who receive the intervention/initiative being evaluated, and a "control group", who do not receive the intervention/initiative and act as a standard comparison.
- **Substance use disorder:** a problematic pattern of using alcohol or another substance that results in impairment in daily life or noticeable distress.
- **Upstream prevention**: The analogy of a river of often used to describe primary prevention, 'upstream' refers to addressing an issue at the source of the problem, Going 'upstream' is looking at where and why people are falling into the river, whereas 'downstream' refers to attempting to rescue people one by one from the river.

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