Alcohol and Drug Foundation

Preventing and delaying AOD uptake by young people.

Background paper

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Contents

Background

Substance use disorders are one of the leading causes of disease and disability in young people across the world.[1,2]

The onset and peak functional and symptomatic impacts caused by these disorders arises between the ages of 15-24 years.[3] These issues are further compounded by the prevalence of stigma associated with substance use, which can in turn become a barrier to someone seeking early intervention and treatment.[4]

This highlights the critical importance of focussing on substance use disorder prevention in young people.

The body of evidence to support approaches and programs for the prevention of substance use disorders and issues is growing and includes a range of interactions, including amongst vulnerable youth.

Some examples of these programs are mentoring, peer support education programs, personality-targeted programs, family-based interventions, community-based programs and screening and brief interventions.[5]

This paper details an alcohol and drug prevention framework that examines the risk and protective factors for alcohol and other drug (AOD) use in young people and explores the strength of the evidence underpinning different interventions, programs and campaigns.

It describes strategies to prevent and delay the uptake of AOD use by 12-17 year-olds who have not commenced alcohol and/or other drug use.

Why target 12-17 year-olds?

High school-aged young people are at a critical stage in their lives.

Adolescence is a time of immense physical and social change. The brain undergoes rapid growth, trimming grey matter and entrenching neural pathways. The frontal cortex brain region - which affects reasoning and judgement - is still developing.

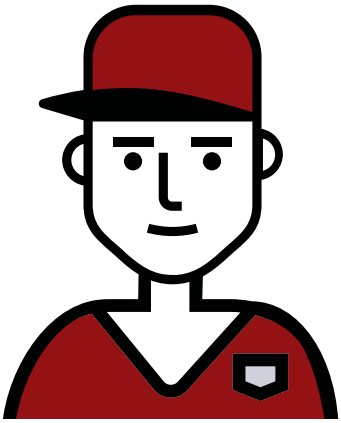
Because there is some concern that it can affect brain development, the use of any psychoactive drug at this stage in life is risky.

There are also concerns that a person who initiates early AOD use may experience more significant AOD harms in the future.

Delaying uptake as long as possible can help to reduce harms.

There is good data on alcohol and other drug use by young people aged 12-17 years through the Australian Secondary School Alcohol and Drug Survey. The findings of this survey demonstrate that overall, AOD use by young people is relatively low and has been declining.[6]

There is an opportunity to maintain and enhance the declining rates of AOD use by young people, with strategies to do so variously targeting the different domains of influence in a young person's life.



Addressing multiple domains of influence

There are many interconnected factors, or domains, that influence a young person's health, wellbeing and development. Peers, family, social activities, and school are all elements that can influence behaviours.

Understanding the risk factors and the protective factors related to AOD harms within each of these domains, and how they can be influenced, is crucial to ensure health and wellbeing in young people is optimised.

This includes understanding protective factors to reduce the likelihood of - and at what age - they might begin using alcohol and other drugs.

Many different elements influence the strength of protective factors and, in any one community multiple factors often combine to produce best case outcomes.

Activities such as participating in organised sports, increasing parental involvement in young people's leisure time, strengthening relationships between parents, and parents knowing where their young person is, are all factors that have been demonstrated to have positive effects in reducing alcohol and other drug use. [7]

Risk factors, or factors that may increase the likelihood of a young person experimenting with AOD use, have also been identified.

These include difficult family environments, low school engagement and negative peer influences.

By identifying both the risk and protective factors, families and communities can work together to reduce AOD harm and delay uptake of alcohol and other drugs among young people. (See Table 1)

(Table 1) Risk and protective factors for 12-17 year-olds

Domain	Risk factors	Protective factors
Peer and individual domain	• Mental health issues • Negative peer influence • Favourable personal and peer attitudes towards alcohol and other drug use • Personality traits, such as sensation-seeking	• Knowledge of harms/health beliefs that support low risk AOD use and the supports available in the AOD space
Family domain	• Parental supply of alcohol • Favourable parental attitudes towards alcohol use • Family alcohol and drug issues • Family conflict • Cultural norms	• Sense of belonging/connectedness to family • Parental monitoring • Parent-child relationship quality • Parental support • Parental involvement • Clear rules against alcohol use • Parental discipline • Cultural norms
Leisure domain	• Attending unsupervised parties	• Participation in positive activities with adult engagement • Involvement in supervised recreational activities
School domain	• Academic failure • Low attachment to school • Early school leaving	• Sense of belonging/connectedness to school • Evidence-based drug education
Local community	• High availability of AOD in the community • Low attachment to community • Lack of engagement in activities with adults	• Sense of belonging/connectedness to community • Community building activities • Positive role models, including around AOD
Broader environment	• Unregulated or poorly regulated promotion of alcohol, including advertising and sponsorship • Availability of alcohol	• Price of alcohol (through a minimum unit price, or through taxation)

Models of prevention of AOD harm among young people

Several international models that recognise the complexity of the factors that influence AOD use among young people have been developed. Two well-known models are the Plant Youth Icelandic Prevention model and the Communities That Care model. Both group the factors into a number of domains, influenced by the broader environment.

Planet Youth / the Icelandic Prevention Model[8]

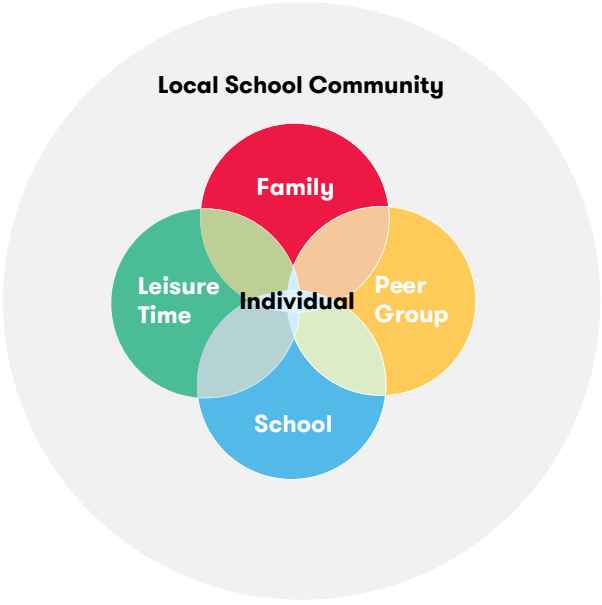
The Icelandic Prevention Model (IPM) conceptualises the behaviour of young people as being the product of the social environment in which they have been raised and in which they are living.

Risk and protective factors for AOD use are elements of this social environment.

The IPM details three main risk factors:

- lack of environmental sanctions (e.g. from parents)
- low individual and/or community investment in traditional and positive values (e.g. high educational aspirations)
- lack of pro-social opportunities (e.g. organised recreational/extracurricular activities).

The model is centred around the domains of: family, school, peers and leisure time.



Communities That Care[9, 10]

The Communities that Care (CTC) model applies a prevention and early intervention framework to guide communities, families and schools to identify, implement and evaluate interventions that promote prosocial bonding with young people.

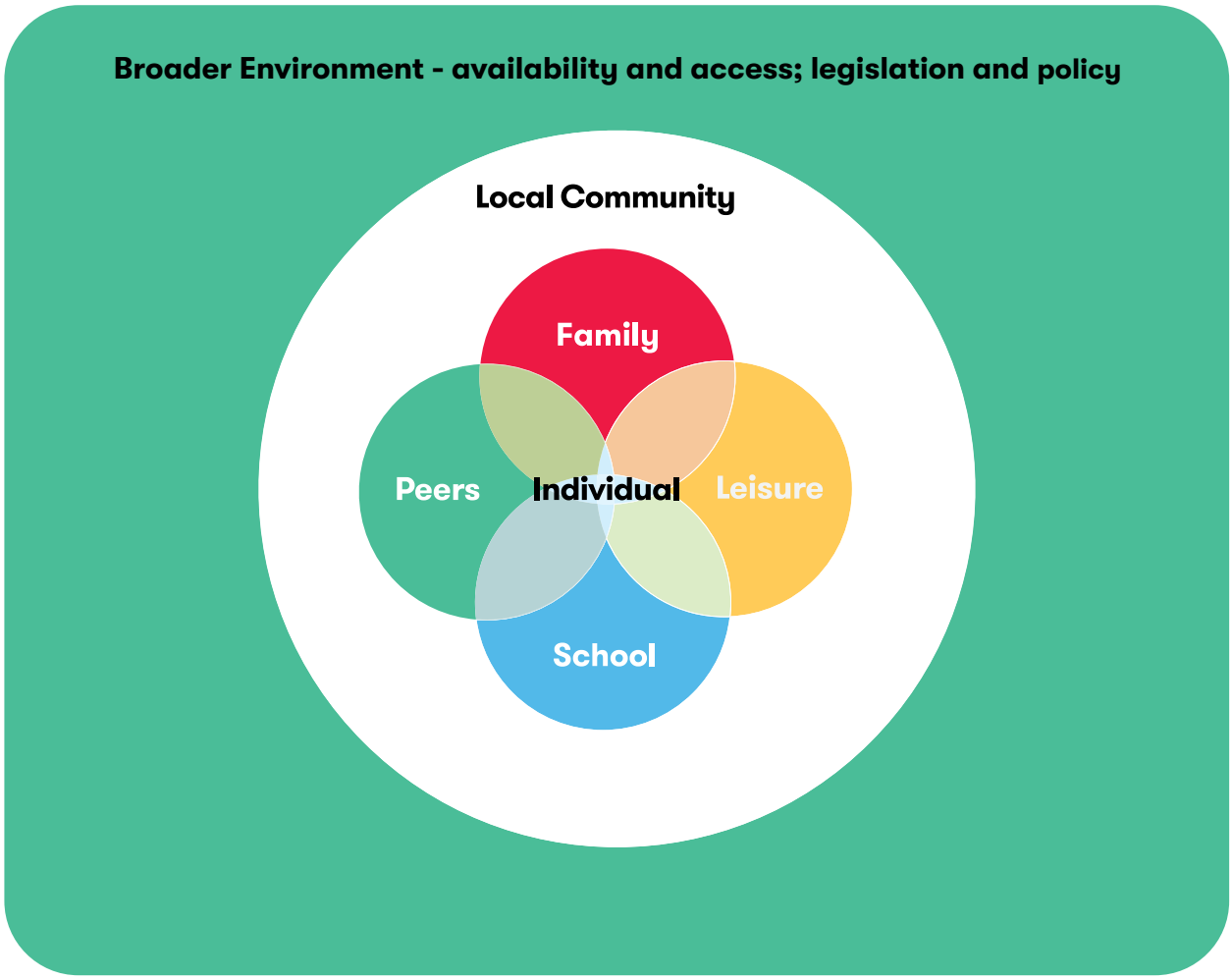
This bonding is facilitated by participation in a social group (e.g. family or classroom, or community), possessing the skills to participate, and being recognised for participating. The program aims to foster healthy behaviour and social commitment among children and youth to prevent and reduce youth problem behaviours.

The model is similar to the Icelandic model and organised under the domains of: community, family, school and peer/individual.

Proposed framework for the ADF

In developing a framework to guide the Alcohol and Drug Foundation's approach we have incorporated aspects of both the Icelandic and CTC models, as both provide useful approaches that can prevent and delay uptake of alcohol and other drugs amongst young people.

We have also considered the broader environmental factors below.



Evidence for interventions

Interventions that seek to prevent, or delay, AOD uptake among young people focus on strengthening protective factors in each of the domains as well as influencing the broader environment. This section looks at the evidence for interventions in each domain.

Peer domain

In adolescence, people typically become more involved with peer friendship groups and activities and have more unsupervised time, including time outside the home. Peer influences are an important factor in this domain.

Peer support

A peer support relationship is based in the equality of the participants. It centres around support and connection being provided by someone who is relatable and potentially more credible to the young person as a member of their peer group.

Peer programs comprise activities led by peers of the same age or older age in formal and informal settings such as schools, community centres, and youth clubs.[11] In education settings they are usually one component of a larger program, rather than a sole intervention.[4]

Evidence supporting this approach

There is evidence for peer support approaches that is promising,[5] however, program design should be mindful that some peer support initiatives may lead to an increase in AOD use.[4, 5]

A systematic review and meta-analysis of peer-led interventions to prevent tobacco, alcohol and/or drug use among young people aged 11-21 years identified 17 eligible studies representing 13,706 young people from 220 schools.[11] This review could not compare or assess the various types of peer interventions to identify the most or more effective types, nor could it identify the most effective sites for action or the most effective duration of programs. Nor were all the studies positive or neutral in outcome. In two studies the intervention group increased their use of substances over the control group.

The authors concluded that peer interventions have a role to play in preventing alcohol and drug use among adolescents, but they noted that their findings were limited as they could not identify effects on socio-economic, gender and ethnic subgroups.

Analysis of six of the studies supported an association between peer-led interventions and lower odds of alcohol use and a meta-analysis of three studies suggested peer-led interventions reduced cannabis use. The authors noted, however, that their findings were limited by poor quality evidence, recognising a need for more rigorous studies with a longer follow up period.

Research further suggests that, if implemented, peer-led interventions should be part of a larger program of prevention and not stand-alone programs.

Best practice peer education programs include the following attributes:[4]

- are led by peers who are nominated by peers; rather than non-peer adults
- if the initiative involves peers sharing the messaging through their social networks, that the peer group has not already started using alcohol or other drugs
- peer leaders role-model the desired behaviour
- involve young people who will be engaged in the program in the development of the content.

Family domain

Parents, guardians and carers play a critical role in a young person's development, and they can take steps to help prevent - or delay - a young person's initiation of alcohol and other drug use.

Please note: the research informing the risk and protective factors listed below focuses only on alcohol, not other drugs.

Parenting behaviours

Parenting behaviours and attitudes are key influencers of alcohol consumption by adolescents.

One systematic search identified 131 articles that considered the role of parenting factors in alcohol use and/or problems with alcohol in adolescence or adulthood.

Several factors were found to be associated with the age of alcohol initiation and/or alcohol-related problems in adolescence or adulthood.

Factors that increased the risk of adolescent alcohol use and/or alcohol problems in adolescence or adulthood included parental provision of alcohol, favourable parental attitudes towards alcohol and parental drinking.

Underage drinking was also likely to rise when a parent treated drinking as humorous or disclosed their own negative experiences with alcohol.[12]

Factors that were protective included parental monitoring, the quality of the parent-child relationship, parental support and parental involvement.[12]

Some evidence suggests that reductions in adolescent alcohol use over the past two decades may be associated with a corresponding reduction in favourable parental attitudes to adolescent alcohol use.[13, 14]

Empowering parents and carers with knowledge to boost their understanding about why their children shouldn't drink during adolescence, and the supportive actions they can take, may reduce the likelihood that their child will drink and drink in harmful ways.

Creating a parental culture that recognises the harms of adolescent drinking may further help to create a community-level culture which disapproves of youth drinking. The message that adolescent drinking is unacceptable can be more effective when it is clearly and consistently repeated to young people both inside and outside their home.

Given the role parenting factors play in alcohol use, parent-focused initiatives may seek to enhance protective factors and reduce risk factors.

Awareness campaigns to reduce parental supply

Research shows that when parents give young people alcohol, or let them drink at home, that young person is more likely to start drinking earlier, drink more often, and drink higher quantities of alcohol.[12]

That young person will also be at a higher risk for experiencing problems with alcohol both in adolescence, and later in life.[12]

Some researchers have suggested that there is potential for education campaigns aimed at parents and the general community to help motivate parental behaviour change [12] and several campaigns have been run in Australia with this objective.

One such campaign, 'Stop the Supply', aimed to increase knowledge of the laws around purchasing alcohol for minors (secondary supply) and encourage parents to think again about doing just that. This program is yet to be formally evaluated; however, a survey report found that 36% of respondents were not previously aware of the secondary supply legislation. [15]

Social marketing and community mobilisation to reduce alcohol-related harms

Communities That Care, in partnership with Deakin University, is developing and trialling a social marketing campaign which seeks to educate parents and young people about the National Health and Medical Research Council's drinking guidelines. The campaign objective is to convince parents and young people to make an agreement that parents will not supply alcohol to people under 18 years.[16]

Mentoring

Overview

Mentoring is a relationship between a person with less experience and a person with more experience, often a young person and someone who is slightly older.

The relationship is often focused on the older person (mentor) providing support and guidance to the younger person (mentee) based on their experience and skills.

The mentor is not paid or expecting personal gain in exchange for this support.[17]

While mentors may be either formal or informal, formal mentoring arrangements are typically the type that is subject to evaluation, therefore contributing to the evidence-base.

Mentoring programs may be run in a number of settings, such as through an in-school program, an after-school program, a weekly meeting in a community setting, or online. Mentoring programs may provide training and ongoing support for the mentor.

Evidence supporting this approach

There is some evidence about the effectiveness of youth mentoring to prevent or reduce young people's use of alcohol and other drugs, although some researchers have found that existing studies are at risk of producing biased results, and that individual studies have had mixed findings.[17, 18]

Generally, the research record for mentoring has produced inconsistent results and insufficient robust research has been conducted to enable a definitive conclusion about the effects and the circumstances in which the effect is found. Although there is a dearth of research into Australian mentoring programs there is a body of resources that mentors can draw on to inform their work.[19, 20]

One research analysis of 46 studies published between 1970 and 2011 reported some positive benefits of mentoring on behavioural outcomes of young people, including AOD use.[18] The authors could not identify the type of program that was more effective than others.

Another study examined the results of four studies that were of sufficient quality for analysis. Two of these found mentoring prevented alcohol use and one found mentoring prevented drug use.[17]

Other studies have variously found lower rates of alcohol and other drug initiation among mentees, reduced alcohol initiation (but not other drug initiation), no effect on alcohol or cannabis use, and no effect on 'substance use'.[17] The research suggested that a component which might make a mentoring program effective include a focus on the mentor providing emotional support.[5]

Parenting programs

The term 'parenting program', is often used interchangeably with other terms such as 'parent education' or 'parent training'.

Parenting programs aim to provide parents with opportunities to enhance their knowledge, skills and understanding in order to improve both child and parent behavioural and psychological outcomes. Parent programs typically focus on

social competence skills including communication, promoting parent-child connection, problem solving and conflict resolution on the grounds that a mutually close and trusting relationship will bond the child to the parents' values and help the child to reject substance use.[21]

While many parenting programs focus on the parents of children younger than the demographic included in this paper, there are some iterations of parenting programs focused on older young people that could be targeted to parents of 12-17 year-olds – although these are less common.

High levels of parent-child connectedness and good quality communication/conversations (both general and substance-use specific) are protective against adolescent alcohol, tobacco and drug use.[22] These conversations about drug use must be two-sided and involve explanations about health implications of using substances; rather than discussing rules and consequences.

The enforcement of rules – as opposed to just talking about them - also appears to lead to less substance use.[22]

Evidence supporting this approach

The literature supporting parenting programs is mixed, both in terms of findings and the quality of research. [23] Some experts have flagged the lack of robust studies into how family factors affect a young person's health as a "striking knowledge gap".[24]

However, some evidence still suggests that parenting programs can positively affect young people's use of alcohol and other drugs.[23]

Programs don't necessarily need to focus on substance use, either.

Elements that may make an initiative more likely to be successful are that the parents are actively involved, good bonds between parents and children are nurtured and there is good conflict resolution in the family.[23]

Strengthening Families Program

Developed in the USA, the Strengthening Families Program (SFP) seeks to improve parenting, family, and children's relationship skills.[25] Since the 1980s, a number of iterations have been developed and run in multiple countries.[25]

Depending on which iteration of the program is being implemented, SFP involves different age brackets (e.g. 10-14 years, or 12-16 years) with a different number of sessions depending on the age group (e.g. 7-8, or 14). Sessions are typically broken into separate parent and child skill sessions, as well as a joint family skills session.

The extensive content of SFP-14 addresses adolescent development, listening and communications, rules and consequences, conflict resolution, problem solving, peer pressure, stress management and family values, and the methods include discussions, role play, viewing videos, and games that are designed to build skills and strengthen positive connection between family members.[26] SFP's positive results are challenged by critics who believe its evaluation methodology has limitations.[27]

The program was trialled in Australia with 8 to 12 year-olds, who were at increased risk for mental health concerns.[28] Both the eight session and the 14 session iterations of the program were included in the trial, with both achieving similar outcomes.

Although researchers were not looking for an effect on substance use, they did note positive improvements in mental health. Their findings suggest that the Australian version of SFP may be successfully implemented.

While this age bracket is otherwise out of scope for this paper, a Dutch adaptation of SFP, with 12 to 16 year-olds, also reported positive results.[25]

Leisure domain

How young people spend their leisure time may influence their use of alcohol and other drugs.

Having significant unsupervised and unstructured time, such as attending unsupervised parties, increases the risk of alcohol or other drug use.

Being engaged in structured and supervised activities or hobbies could potentially reduce the risk of alcohol and other drug use.

Supervised extracurricular activities

The provision of supervised leisure options for children may prove protective against alcohol and drug use, theoretically because of the potential to increase the protective factors of:

- participation in positive activities with adult engagement
- positive role models, including around AOD
- sense of belonging/connectedness to community.

An interesting aspect of the Icelandic Prevention Model is the provision of leisure activity cards for use by young people aged 6-18 years.[29] These provide free access to a range of diverse activities, such as dance, sport, and music through registered providers, regardless of the young person's socio-economic background.

Evidence supporting this approach

Evidence on the impact of extracurricular activities on alcohol consumption by young people is mixed. Research often looks at sport specifically as a protective factor, although supervised recreational activities are not limited to sport only.

A body of research, conducted primarily in the USA, found that participation in sport was associated with an increase in alcohol consumption, and in some studies earlier initiation of alcohol use.[30]

This same body of research also indicates that participation in sport may be associated with lower levels of other drug use.

A study conducted in Norway suggests that the impact of sport participation on alcohol consumption may differ depending on the type of sport; for example, team sports may be associated with higher alcohol consumption than individual-based sports.[30] However, more research is needed.

An earlier research paper, that examined participation in supervised activities (including sport as well as other activities like scouting, rescue squads, etc.), found that participation in such activities was associated with lower levels of alcohol consumption.[31]

This paper particularly emphasises the importance of supervised activities, as unsupervised adolescent activities are risk factors for alcohol use - this includes going to parties or hanging out in the city on nights and weekends.

School domain

Schools can play a role in preventing and delaying the use of alcohol and other drugs by young people.

Initiatives to do so may seek to increase protective factors, such as enhancing a person's sense of belonging and connection to their school.

Schools can also ensure they implement evidence-based drug education programs as part of their broader alcohol and other drug strategy.

Whole-of-school approach

Overview

A whole-of-school approach takes a holistic view of the school environment, recognising that student health and wellbeing is the result of complex and overlapping factors.

This approach identifies the substantial social learning which happens outside of the classroom as a critical component of, and key outcome from, a person's school experience.

The culture of a school, and student's day-to-day experience at the school, are important factors that inform a child's health and wellbeing. These may be leveraged to create a warm and supportive environment for young people.

Evidence supporting this approach

While the evidence specific to the impacts of a whole-of-school approach on alcohol and other drug use is somewhat mixed, some evidence has shown small improvements in health measures, ranging from increased physical activity to reduced bullying.[32]

In terms of protective factors, some studies have suggested that school initiatives which specifically improve student participation in the school and encourage a positive school culture are associated with reduced alcohol and other drug use.[33]

In terms of risk factors, some studies suggest that poor quality student-teacher relationships and students feeling disengaged from their school are associated with higher alcohol and other drug use.[33]

Alcohol and other drug education in schools

Current and effective school-based drug education explores students' values, attitudes, knowledge and skills with the aim of improving their capacity to make healthier decisions about using alcohol, tobacco and other drugs.

Typically delivered as part of health education, school-based alcohol, tobacco and other drug education aims to increase students' self-efficacy to refuse alcohol, tobacco and other drugs and equip them with knowledge and skills to reduce harms.[34, 35]

A note about drug education in schools

Evidence-based drug education can play a role in preventing or delaying the use of alcohol and other drugs by young people. Although the positive impact of drug education on individual students' drug use is generally small, access to appropriate and accurate information about alcohol and other drugs is still important.

The selection of an evidence-based drug education program is also important because some programs have been found to increase drug use. [36, 37]

Drug education programs are either delivered to all students, regardless of level of risk (universal) or designed for adolescents and young people who may be at greater risk of AOD harm (selective).

Universal programs, such as Climate Schools (outlined below), have the advantage of being able to reach large numbers of participants at relatively low cost; but this can lead to minimal impact.

Selective programs, such as Preventure (outlined below) can be tailored to reach those that may be at greater risk; but this approach may be more expensive and lead to stigmatisation.

Climate Schools

Overview

Climate Schools is a program for 13-14 year-olds. It is based on harm reduction and social influence approaches and is designed to be implemented within the school health curriculum.

It comprises 12 x 40 minute lessons which address the use of alcohol and related problems. A psychostimulants and cannabis module - over six lessons - for Year 9-10 is also available.

In each lesson, students view a cartoon-style story of teenagers grappling with real life situations. The cartoon is followed by classroom discussions and student interaction exploring the topic covered in the story.

Evidence supporting this approach

Climate Schools has been shown to increase students' alcohol knowledge, decrease their positive expectancies about alcohol and reduce alcohol consumption.

At 12 months follow up, there was a reduction in weekly alcohol consumption and the frequency of excessive drinking.[38]

A Climate Schools module that combines education on alcohol with cannabis was also found to reduce alcohol consumption; reduce frequency

of binge drinking; reduce frequency of cannabis use; increase resistance to peer pressure; and, reduce psychological distress and truancy. [39, 40]

School Health and Alcohol Harm Reduction Project (SHAHRP)

Overview

SHAHRP is a classroom-based program that aims to reduce alcohol-related harm and prevent high risk drinking among students in Year 7-8, and Year 9-10 – a time that research suggests is a vulnerable period for alcohol experimentation.

The program takes a harm reduction approach, with an emphasis on interactive skills building and individual and group decision making.

SHAHRP is based on the social influence approach which understands that young people begin to use drugs due to psychological and social pressures from peers, family and the media.

The intervention comprises 17 interactive, skill-based activities in year 8 with 12 follow-up activities in year 9. Activities include problem-solving and rehearsal tasks in which students develop and rehearse harm reduction, help-seeking, making safety plans, decision-making about situations involving drug use, as well as discussions based on scenarios suggested by students.

Evidence supporting this approach

The initial SHAHRP study in 14 secondary schools in Western Australia reduced alcohol consumption and related risks and harms.

A SHAHRP-inspired program, Drug Education in Victorian Schools, (DEVS) conducted for students aged 13–15 years in 21 secondary schools in Victoria, included tobacco and illicit drugs, in addition to alcohol. Participants in the pilot study were found to be more knowledgeable about drug use issues, communicated more with their parents about alcohol, drank less alcohol, engaged in risky drinking less often, and experienced fewer alcohol-related harms.

In comparison, harmful levels of drinking increased amongst students in the control group.[41]

Preventure

Overview

Preventure engages high-risk teenagers who are identified to possess one of the personality traits of: sensation seeking, impulsivity, anxiety sensitivity, and negative thinking.

The young people then participate in workshops tailored to their personality trait. The program may be successfully delivered by trained school staff.

Developed in Canada, and adapted for the Australian classroom, Preventure is a school-based, selective prevention program that aims to reduce alcohol and other drug use among selected students in Year 7-8 and Year 9-10.

Students identified through a screening questionnaire as at-risk are invited to participate in two x 90-minute groups, delivered by a trained facilitator and co-facilitator in a classroom setting (training is now being offered in Australia). The workshops are designed to encourage an understanding of how a student's personality style can influence their emotions and behaviour.

Four different workshops are available, each focused on the development of coping skills relevant to the four higher risk personality traits.

Evidence supporting this approach

Studies have been conducted on iterations of this program in Canada, the UK, and Australia.

Findings are somewhat different, and the effectiveness of the program might be different depending on the individual's personality type and the drug in question.

Research conducted in Australia found that Preventure reduced the uptake of alcohol use and the frequency of drinking at risky levels.[42]

Another study in the UK, which only examined cannabis use, suggests that Preventure may delay the uptake of cannabis by students with sensation-seeking personality types.[43]

Local community and the broader environment

The broader environment, mass media campaigns and the local community can have a role to play in preventing, or delaying, the uptake of alcohol and other drugs by young people.

Initiatives to do so may seek to address risk factors in a community, such as the high availability of alcohol, by increasing awareness of AOD-related harms and reducing accessibility and promotion.

Mass media campaigns aimed at young people

Public health efforts sometimes include mass media campaigns to share information and encourage behaviour change.[44]

Depending on the campaign and the target audience, this may be done through channels ranging from television and social media to print and outdoor advertising. Various campaigns have been run in Australia by state and federal governments to prevent illicit drug use.

Caveat about campaign approaches

Some campaign approaches, such as those which use alleged 'before and after' photos of so-called drug use-related transformations can stigmatise people who use drugs and reinforce negative stereotypes.

Evidence supporting this approach

There is insufficient evidence on the effectiveness of mass media campaigns in preventing the use of illicit drugs by young people to draw conclusions.[45] This is due largely to ineffective or poorly designed evaluation of campaigns. [46]

Research into alcohol-focussed media campaigns, demonstrated high recall of the campaigns and a positive impact on knowledge, attitudes and beliefs about alcohol consumption – although their impact on young people was not specifically examined.

The campaigns did not appear to be effective in reducing alcohol consumption; although they did not claim to be designed to target consumption. [47]

The Australian 'Alcohol, Think Again' campaign demonstrates promise as an effective method to increase awareness, decrease parental supply of alcohol and improve knowledge of guidelines and evidence. [48]

Long term harm reduction mass media campaigns have shown some success in areas such as the reduction of alcohol-impaired driving and the reduction of tobacco uptake among young people. These campaigns were accompanied by a range of policy interventions, such as reducing accessibility to tobacco for minors.

The successes of these campaigns demonstrate that for mass media to be effective, a long-term investment is required, and they must be accompanied by other policy measures. [46]

Mass media campaigns should be undertaken with caution, as there are concerns that some campaigns are ineffective and may inadvertently produce a backfire effect.[45, 49]

Availability of alcohol

The availability of alcohol refers to how easy it is to get alcohol in an area.

The availability of alcohol is affected by factors such as how many venues sell alcohol in an area (outlet density), the opening hours of those venues, and the age for legal purchase of alcohol.[50]

Outlet density

Liquor outlet density refers to the number of licensed liquor vendors in a given area, including bars, pubs, clubs, etc., as well as packaged liquor outlets (i.e. bottle shops).

The evidence for the impact of liquor outlet density on underage drinking is mixed.[51]

Some international studies have found a significant relationship between outlet density and drinking or heavy drinking among young people, whereas other studies have found no relationship. [51]

Australian research has found a higher density of outlets selling alcohol in a community – specifically take-away liquor outlets – is linked to a higher risk of alcohol consumption for adolescents between 12–14 years of age.[52]

These findings suggest that minimising the density of alcohol outlets in a community may be a protective factor to reduce young people's alcohol consumption. As such, communities and regulators should be given the ability to have meaningful input and control over the density, and type, of liquor outlets licenced in their local area.

Online sales

Online sales are being increasingly used to access packaged liquor.

Given the rapid transformation of the market, little is known about the risks of online alcohol sales to young people; however, increased access to alcohol via online alcohol sales to minors is an area of growing concern.

One US study of young people showed one in ten 17-18 year-olds in the US have consumed home delivered alcohol, with home delivered alcohol also associated with high risk drinking (more than five drinks on one occasion).[53]

Studies examining adherence to regulations around alcohol identify that home delivered alcohol sales are not well monitored in relation to underage drinking.

A Dutch study revealed that all orders placed by underage children were fulfilled, and there were no requests for proof of age on delivery.[54]

In the US, half of the orders placed by underage drinkers were fulfilled.[55]

To date there has been limited research in Australia to understand how an online sales model can comply with alcohol sales regulations.

A report published in 2019 found that more than one third of people aged under 25 who purchased alcohol online did not have their identification checked upon delivery.[56] Further research is needed to understand if an online alcohol sales model is increasing access for minors.

Enforcing purchase laws

Enforcing purchase laws of 18 years of age[50] and secondary supply laws (provision of alcohol to those under 18 years) is an important aspect of reducing the availability of alcohol to young people.

Communities That Care, in partnership with Deakin University, is undertaking the testing and evaluation of a 'secret shopper'-style intervention to check retailer compliance with identification laws.[57]

One study conducted in the USA found that compliance checks increased compliance with retailers who were issued with citations for non-compliance as well as retailers who were only exposed to media coverage about the issuing of the citations.[58]

Price of alcohol

Controls on the price of alcohol have been identified by the World Health Organization as some of the most effective measures to reduce the harms caused by alcohol.[59, 60]

Cheaper alcohol tends to encourage underage drinking and higher levels of alcohol consumption, including short-term risky drinking.[61, 62]

Young people appear sensitive to changes in the price of alcohol. When the cost of alcohol increases they are likely to consume less, which reduces the likelihood of experiencing alcohol-related harms.[63, 64]

There are two mechanisms to influence the price of alcohol - a minimum unit price (MUP) for alcohol beverages (also known as a floor price, which establishes a minimum price per standard drink) or taxation.

Promotion of alcohol

Australians are exposed to an extensive volume of alcohol promotions through a myriad of channels – traditional media, digital media, outdoor media, promotional activities and sponsorships. Alcohol advertising and marketing is governed by a mix of

quasi-regulatory and self-regulatory regimes with limited or no involvement of government.

Advertising

Young people are exposed to alcohol advertising through television, radio, print media, alcohol branded merchandise, and outdoor billboards.

Exposure to alcohol advertising is one factor that shapes young people's attitudes to, and consumption of, alcohol.[65-67]

A systematic review examining the relationship between alcohol marketing and youth consumption of alcohol identified 12 studies involving 35,219 participants.

All studies showed a positive relationship between the level of alcohol marketing and the level of youth consumption. A clear association between level of exposure and hazardous drinking was also found.[65]

Exposure to alcohol advertising is also associated with normalising alcohol consumption,[68] young people's expectation of consuming alcohol, reduced age of initiation and is associated with more harmful drinking practices, such as excessive consumption.[69]

Social media

Alcohol brands are innovators in the use of social media and they are using it to target young people.

Social media allows brands to target young people in a host of ways that may be difficult to regulate, be 'self-regulated' by the industry, or not yet covered by current regulations. It can also go unnoticed by many adults, including parents.

One example of this below-the-line marketing is an alcohol brand that leveraged its sponsorship of a music festival by having a photographer take pictures of people at the event for posting on the alcohol brand's Facebook page. People in the photos then tagged themselves and shared them with their friends, enabling the alcohol company to collect more data on the young person so they could continue to target them with things like competitions and discussions around appealing cultural topics.

Social media has become an environment where alcohol consumption has been normalised and, to an extent, glamourised among young people.

Studies have shown that 89% of males and 91% of female adolescents and young adults were exposed to alcohol marketing on social media.[70] The authors concluded that exposure to alcohol content in social media may increase the likelihood that young people will initiate alcohol consumption.

Advertising of alcohol brands via social media platforms and via online gaming has created a new avenue for exposure to alcohol advertising by young people.

Online gaming has become a popular recreational activity. Many games are now competitive (referred to as 'esports') and attract many viewers and opportunities for sponsorship.

Research in 2016 showed that major brands, including fast food, betting, energy drink and alcohol companies, are sponsoring players and thus exposing viewers to their products. Analysis of advertisements found 15% of online esports sponsorship is from alcohol companies.[71]

As alcohol marketing becomes more targeted, it's hard for anyone to know, or measure, how much alcohol advertising young people are seeing. Some young people under 18 years of age may use social media often – they can set up a Facebook account at 13.

This makes it increasingly important for young people to have media literacy and critical thinking skills to apply to how they understand social media advertising and brand engagement.

Sponsorship

The sponsorship of sport provides a platform for brands to reach large segments of the population - including children and adolescents - with sponsors providing support for individual athletes, national sports teams, and national, state, regional and local sporting competitions.

Due to the prevalence of alcohol sponsorship in Australia, anyone playing or watching sport is exposed to the message that the consumption of alcohol is a natural accompaniment to that sporting activity.[72]

In Australia, although alcohol advertising on television is prohibited during children's viewing hours, it is still currently permitted in this time slot during the broadcast of sporting events.

At many sporting venues, advertising is also present on the field, billboards around stadiums, broadcast on the stadium TV screens, featured on some jerseys or players' attire, and in the names of various on-site bars or licenced venues.

Research has shown that children who wear clothes or own merchandise that carries alcohol branding are attracted to alcohol, have higher expectations of drinking, are more likely to start drinking early, and drink more often during adolescence.[73]

Popular support exists for protecting children from alcohol advertisements.

According to the Foundation for Alcohol Research and Education, results from the Annual Alcohol Poll 2018 show 62% of respondents believe alcohol advertising should be phased out from television during sporting broadcasts.[74]

Conclusion

Adolescence is a complex time of growth, development, new influences, expanding boundaries and personal discovery for young people.

It is also a time of vulnerability and a time when evidence-based interventions to prevent and reduce the harms associated with alcohol and other drug use may have the greatest impact.

The Alcohol and Drug Foundation strongly supports the implementation of community and school-based initiatives to prevent and delay AOD uptake by young people – however, it cautions that these programs must be evidence-based and should consider the broad range of interconnected factors – or domains – that together influence a young person's health, wellbeing and development.

The ADF has expanded upon on a range of proven models to produce a Framework of Risk and Protective Factors for 12-17 year-olds in Australia, anchored around the following domains:

- Peer and individual domain
- Family domain
- Leisure domain
- School domain
- Local community
- Broader environment.

By identifying risk and protective factors within each of these domains, AOD workers, families, schools and communities can work to reduce AOD harm and early uptake among young people.

The changing environment will also have an influence.

Key factors such as the availability of alcohol within a community, ease of access, promotion of alcohol through advertising, sponsorships and social media will continue to create new challenges.

New initiatives, resources and further research will be required to identify effective approaches to counteract their negative influence in the future.

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