

# centre lines

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## issuing **forth**

Community action to reduce alcohol problems: What should we try in Australia?



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## ed**space**

**W**elcome to the first issue of CentreLines for 2004.

In his last contribution to *Headspace*, Professor Tim Stockwell reflects on his 15 years at the National Drug Research Institute. Tim has accepted a position as Director of the new Centre for Addictions Research based at the University of Victoria in British Columbia. He welcomes the opportunity to explore new horizons and to take on new challenges, but it is with some regret that he says farewell to his home in the sun. He hopes to continue his association with NDRI and will encourage collaboration between the two Centres.

In this month's edition of *Issuing Forth*, Associate Professor Richard Midford argues in favour of community interventions to reduce alcohol-related harm. He claims a community approach to prevention will benefit a greater number of people, and be more likely to affect structural change, than an approach that focuses only on high risk individuals.

Nyanda McBride's School Health and Alcohol Harm Reduction Project (SHAHRP) has placed NDRI in the spotlight this month. The project won the National Drug and Alcohol Excellence in Research Award. Phase two of the project is described in *Project Notes*.

I hope you enjoy this issue of CentreLines. For further information, I invite you to visit the NDRI website at [www.ndri.curtin.edu.au](http://www.ndri.curtin.edu.au).

**Sheridan Webb**

**Editor**

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## Reflections on 15 years in the sun

As this is my last contribution to Headspace, I hope I will be forgiven for using it to indulge in some reminiscences and for expressing my gratitude for the great opportunities I've had living and working in Australia. If you want to learn anything about the prevention of alcohol and other drug problems, however, please turn immediately to Richard Midford's *Issuing Forth* on community interventions and read no further!

The reason for my departure is still a mystery to all those who know how perfect Perth is and what great a place NDRI is to work. I can think of no serious difficulty or problem with either and will miss my friends and colleagues a great deal in the months ahead. The reasons for going are more to do with feeling it is the right time for a fresh set of challenges and a new environment – for me and my family. I have recently accepted a new position as Director of the new Centre for Addictions Research of British Columbia based at the University of Victoria. The University is located on Vancouver Island but the Centre will have collaborating bases at three other BC universities. The Centre is supported by a generous endowment to the University of Victoria from the BC Addictions Foundation and will focus at a population health level on prevention, treatment and policy responses to problems arising from substance use. I will be maintaining some of my present research interests and am hoping very much to keep in touch with Australian colleagues at NDRI and elsewhere.

The first person I want to thank for the opportunities and experiences I have had in Australia is my predecessor David Hawks. David rescued me from the UK's National Health Service in 1988 to work at what was then the National Centre for Research into the Prevention of Drug Abuse (NCRPDA – now NDRI). I was bowled over almost as much by the absence of rain as the sense of the possibility of having an influence on drug and alcohol policy. I was so impressed with the fact that David actually knew politicians and had even talked to Bob Hawke about drug policy. David inspired the belief that it was possible to make a difference. I had also read some Australian alcohol policy research and was impressed with examples such as those provided by Ian Smith's evaluations of state by state experiments in the liberalisation of alcohol's availability e.g. the increase in road deaths when the drinking age was lowered and increases in road accidents when the trading hours of pubs were increased (e.g. Smith, 1988). The strange

concept of a federal political system appealed to the researcher in me. I relished the prospect of evaluating 'natural experiments' in policy. Examples abounded of astoundingly good policy experiments in Australia (e.g. the thiamine fortification of flour, random breath-testing, tax incentives for reduced strength beers) though a few that are depressingly bad have followed. I have always felt that both provide an opportunity for researchers to add to our store of knowledge of what works and also what fails. Since those early days we have seen proposals for a trial of prescribed heroin come and (sadly) go, different models of cannabis control introduced and evaluated and experiments in the hypothecation of tobacco and alcohol taxes such as the state-based health promotion foundations (in WA and Victoria), the Living With Alcohol program in NT and, more recently, the Alcohol Education and Rehabilitation Foundation. One policy development which would be top of my list of 'greatest policy disasters' was the loss of the powers of the states and territories to raise taxes on alcohol and tobacco as a result of a 1997 High Court decision. Although a sound national policy has since been introduced for tobacco there has been only limited progress with a national alcohol taxation system that takes account of public health and safety issues. The recent reforms of alcohol excise taxes to (i) give greater incentives for consumption of lower strength beer and (ii) increase the tax on once absurdly cheap alcoholic soft drinks, however, represent advances in public health policy. Absurdly cheap bulk wines remain that are favoured by many high risk drinkers and attract hardly any tax (Stockwell and Crosbie, 2000).

Early on in my time at NCRPDA I was amazed to see the recommendations of a small \$4,000 project lead to the proposal to introduce standard drink labelling being accepted by a peak government drug policy committee. The ensuing 6 years it took to implement was a case study for me in the ways in which partnerships in public health advocacy are essential if mere research evidence is to have any policy impact (see Stockwell and Single, 1997). Since then I have had a few other wins (and losses) on other alcohol policy issues in the areas of liquor licensing and taxation, each of which required partnerships with other individuals and organisations for success.

There have been wonderful opportunities in recent years for participating in drug policy debates. Memories of participating in the Drug Summits in NSW, WA and SA and, in particular, in

the NSW Alcohol Summit will always stay with me – as will memories of being heckled at the latter while attempting to present some of the arguments for a public health approach during a late night sitting in the historic NSW Parliament House. I am also hugely grateful for the opportunity to have worked on national policy committees and to learn from such luminaries as Charles Watson, Margaret Hamilton, Alex Wodak, David Crosbie, Ann Roche, Ian Webster and many others. Australia has been an exciting and friendly place to engage in debate and research on drug policy.

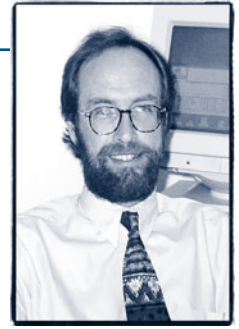
There are too many other good experiences to recall and colleagues to thank than there is room for here. It has been a huge privilege to have served as Director of the National Drug Research Institute for the last 8 years, to have been served so loyally by an excellent administrative staff and challenged by an incredibly able and good-willed academic staff. Last, and certainly not least, I would like to thank our funders! Individuals such as Sue Kerr and now Jenny Hefford and her staff at the Australian Government Department of Health and Ageing have really nurtured NDRI and the other national drug research centres. I know I leave NDRI in a strong situation in terms of the quality of the staff, the funding and the facilities provided by our host University.

Thank you all and very best wishes for the years ahead.

**Tim Stockwell**

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## Community action to reduce alcohol problems: What should we try in Australia?

Community action against alcohol and its attendant problems is not a new phenomenon. The American temperance movement arose during the early 19th century as a community based effort to make people aware of the threat that alcohol posed at home and at work (Holder, 1992). However, as the movement became more powerful it became more prohibitionist and less focused on individual communities. Its political influence culminated in the 1920 enactment of national prohibition. Yet, 13 years later 'the noble experiment' was seen as a failure because of the increase in crime associated with supply of illicit alcohol and prohibition was repealed. In the wake of this failure the Alcoholics Anonymous movement arose in America and received strong support from the medical profession (Bishop and Pittman, 1994). Individual disease and addiction came to be seen as the root of the problem rather than the substance and accordingly treatment became the response of choice.

Within this paradigm, community prevention meant early identification of 'alcoholics' and provision of resources to increase availability of treatment and social support (Holder, 1992). Modern concepts of community action as prevention really arose in the early 1970s when there was an emerging appreciation of the role alcohol played in a broad range of health and social problems. This shift in emphasis from individual medical disorder to a view that acknowledged the social determinants of alcohol and other drug problems has been important in recognising the role of the community in both producing and responding to these problems. The community produces particular alcohol problems because of the way community life is organised and the community is an appropriate setting for preventing alcohol problems, because it is here that these problems are personally experienced.

The legitimacy of focusing on the population as a whole, rather than on high risk individuals, was established at this time through the work of Rose (1981, 1985) and Kreitman (1986). Rose argued very convincingly that while prevention, which concentrates on high risk individuals, leads to intervention appropriate for those individuals, its ability to reduce the burden of disease at the community level is small. Conversely, a population or community approach offers little to high risk individuals, but provides substantial aggregate benefit because so many individuals are affected. Rose (1981) talked about this as the 'Prevention Paradox'. Kreitman (1986) explored this paradox in relation to alcohol use and found that contrary to conventional wisdom the majority of alcohol problems were caused by moderate drinkers, rather than heavy dependent users, because they comprised such a large proportion of the drinking population. Subsequent research by Stockwell et al (1996) and Gmel et al (2001) has identified binge

drinkers within this moderate consumption group as causing the most problems. This suggests the need for more targeted responses, but the same basic premise of Kreitman's findings remain: drinkers not considered problematic in traditional terms are in reality causing most problems.

Giesbrecht and Pederson (1992) point out that in Western societies there is pressure to cast alcohol use as a problem for the individual drinker, because cultural notions of autonomy and choice support individually oriented solutions to social problems. This makes it difficult to take an ecological approach to prevention and involve the community in controlling drinking. However, McGavran (1963) and Kreitman (1986) represent a substantial body of public health opinion in claiming that public health problems generally, and alcohol problems in particular, are unlikely to be controlled by early diagnosis and treatment of high risk individuals.

*We must face the fact that the health of individuals is dependent upon the health of communities – communities as entities, not as mere aggregates of individuals.*

(McGavran, 1963: p 59)

Rose (1985) pointed out there are powerful advantages to population level prevention. It attempts to remove or modify the underlying cause of the problem. It has considerable potential for change because of the large numbers involved. Once behavioural change has been achieved it is likely to be self sustaining because a new community norm has been established. In addition, such change can be initiated centrally by government decision. Polio vaccination, for example, was a public health prevention program mandated by state authority. In the alcohol area the state has exercised uniform preventative control through alcohol monopolies, regulation of trading hours and even total prohibition. However, Casswell (2000) suggested that there has been a move to less state control in western countries over recent decades and more influence of consumer forces. This has made it increasingly difficult to deal with population level alcohol problems by altering state policies and regulations. In this new environment of reduced state involvement, the community emerges as the natural vehicle for taking action against these problems.

Importantly, the community has to be involved in decision-making, rather than just being the site for prevention initiatives. Prochaska and DiClemente (1986) identified the importance of readiness to change in individuals with alcohol and other drug problems and the same is likely to apply to communities: if a community does not consider it has an alcohol problem there is unlikely to be any commitment to prevention. Thompson and Kine (1999) stress the 'principle of ownership' in change, which means that effective and lasting change is most likely to occur when the people

who are affected are part of the change process. The complexity of how a community functions also has to be taken into consideration and harnessed. Here the system perspective, offered by Holder and his colleagues (Holder, 1992; Holder and Wallack, 1986), is a useful heuristic. This views the community as a complex and enduring system of interacting components such as health services, workplaces, volunteer groups, recreational facilities etc. The system is held together by some degree of community co-operation and consensus on common goals, norms and values. The system provides the context for all activities, including individual drinking behaviour and produces certain outputs including alcohol problems. If, because of bureaucratic boundaries prevention is only initiated in one community component, such as health, it is less likely to impact on other relevant components, such as the political, legal, educational, media and recreational. Greatest change is likely to be achieved by operating at the level of the overall community system. Here change means not just influencing the operation of system components, such that they all coherently support safer drinking by individuals, but also systemic change, so that the structures and operation of the whole community are altered in a way that supports safer drinking.

Aguirre-Molina and Gorman (1996), in a comprehensive review of community-based drug prevention programs, found that those with the greatest promise relied heavily on community action as the means of achieving change; sought to empower the community through involvement in all decision making; were comprehensive in terms of targets and strategies; drew on the public health model to identify factors other than the individual as causing problems and drew on the best available research to guide interventions. Yet all too often in Australia, particular agencies are funded to undertake small scale, short term community alcohol prevention projects. Often these projects also seek to change the behaviour of high risk groups such as underage youth or regular, heavy pub drinkers. Adopting such approaches needs to be re-examined, as they are likely to be ineffective and a waste of resources. If there is to be meaningful commitment to effective community action, comprehensive long term programs need to be funded in receptive communities.

Ideally these would comprise locally organised and planned community-wide intervention, whereby individual stakeholders and relevant agencies such as police, health services, drug agencies, local businesses etc, collaborate on a range of complementary interventions. Intervention would occur at a number of different levels (e.g.

community input into local licensing regulations, development of local accords, media awareness campaigns, police action on drink driving, responsible service policies, etc) so as to simultaneously target the social and physical environment, local policies and individual behaviour. Finally evaluation would be built in to the implementation plan so that the community gains an appreciation of its achievements and what is learned can be offered to other communities and contribute to the body of knowledge on community prevention.

A number of research studies have shown that community action can change norms about alcohol use and alcohol harm (Casswell, 2000). This can facilitate structural change within the community, which in turn works to reduce actual harm. A few studies have also been able to directly demonstrate a significant change in patterns of local consumption and harm (Holder et al, 1997a, 1997b). However, the demonstrably effective programs tend to be complex, long term and demanding on resources. Comprehensive community action can be an effective prevention strategy. It is expensive, but weighing against that is the breadth of effect and institutionalisation of benefit through changed community function.

**Richard Midford**

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## project notes

### SHAHRP dissemination project

**Nyanda McBride, Fiona Farrington and Carole Kennedy**

Past reviewers of school drug education have noted that effective school drug education programs are not readily available to teachers in a useable format. This project, which is funded by the Alcohol Education and Rehabilitation Foundation, aims to disseminate the School Health and Alcohol Harm Reduction Project (SHAHRP) education materials, by providing training to teacher educators from Government, Private and Catholic Education sectors in several states of Australia. To date, teacher training has taken place in the four states involved in the study: South Australia (three sectors); ACT (three sectors); Tasmania (three sectors) and the Goulburn North East District in Victoria.

SHAHRP, has been particularly effective in changing the knowledge, attitudes and drinking behaviours of young teenagers and has attracted widespread attention nationally and internationally. Its significance was recognised at the recent National Drug and Alcohol Awards where it won the Excellence in Research Award, and a number of UK researchers

are seeking funding to replicate the program. For further details refer to the Abstracts section

### Does moderate drinking prevent heart disease? *A meta-analysis and re-estimation of alcohol-caused mortality in Australia*

**Tim Stockwell, Tanya Chikritzhs, Kaye Fillmore and William Kerr**

It was recently estimated that 6,513 lives were saved in Australia in 2001, largely as a consequence of the protective effects of low risk alcohol consumption against Ischaemic heart disease and Ischaemic stroke (Chikritzhs et al, 2003). The majority of the protective effect of low risk drinking is due to the reduced risk of Ischaemic heart disease usually experienced among adults in the middle to older years of life. While there has been a growing scientific consensus in support of the reality of such protective effects associated with 'moderate drinking', there have also been growing criticisms of the methods used within the key



**Accepting the Excellence in Research Award**  
**Mary Carmody Drug Education Officer**  
**Catholic Education South Australia**

studies – some of which even suggest that the protective effect may not exist or at least may be substantially smaller than currently assumed. It is proposed that studies which show large protective effects are subject to two main types of error i) failure to remove subjects with pre-existing illness

from the analysis either by removing former drinkers or through appropriate stratification of such variables in the analysis, and ii) contamination of the abstainer groups with occasional or light drinkers.

This study will employ meta-analysis methods to specifically determine if those studies which have eliminated one or both of these errors still show that moderate drinkers have a lower risk of mortality from either 'all causes' or Ischaemic heart disease in particular. The scientific world and the public at large have accepted the "fact" that moderate use of alcohol "protects" against CHD. This has had significant medical, social, economic and political implications. Should it be demonstrated that there is more than adequate reason to doubt this effect, it would be incumbent on physicians and policy makers to revise their recommendations that alcohol can be beneficial to health. This is a collaborative international study between the University of California and the Alcohol team at the National Drug Research Institute.

## The policing implications of petrol sniffing and other inhalant misuse in Aboriginal and Torres Strait Islander peoples' communities

**Dennis Gray, Peter d'Abbs, Anne Mosey, Gillian Shaw and Catherine Spooner**

Commissioned by the National Drug Law Enforcement Research Fund (NDLERF), the policing implications of petrol sniffing and other inhalant misuse in Aboriginal and Torres Strait Islander Peoples project, aims to examine the extent and nature of petrol sniffing and other inhalant misuse by Indigenous Australian peoples to promote understanding in the law enforcement sector and to offer a definition best practice in addressing such issues.

The project will be carried out over a 32-week period in five main stages. A cross-sectional study of six locales will be conducted including: Indigenous communities in five rural and remote regions of Western Australia, South Australia, the Northern Territory, Queensland, and an urban location in Western Australia. On the basis of a comprehensive literature review, data will be gathered through interviews with key stakeholders in each location. When analysed and developed, the data will be fed back to the stakeholders for comment and workshopped with Indigenous people in the jurisdictions, in which the study was conducted, as well as in the Indigenous community and within police in New South Wales.

The members of the research team bring to the project experience in the areas of substance misuse relating to petrol sniffing research and interventions, project evaluation, substance misuse education and law enforcement issues. The key personnel are supported by two Indigenous team members who bring local knowledge and a cultural perspective to the project. Throughout the project

the Indigenous members of the research team will be mentored to ensure that they develop their capacity to conduct further independent research.

The literature review will combine two major reviews on petrol sniffing and the role of police in preventing and minimising illicit drug use and associated harm; in addition it will inform the development of data collection instruments. The research team will identify the key people to be interviewed, and any additional statistical or documentary data required from the site visits. A broad range of community types and experiences of inhalant use and associated harm will be considered through the diverse locations. The team members responsible for the site visits have a history of collaborating with Indigenous communities and community organisations in those areas.

The data analysis and writing workshop planned for Alice Springs will produce a draft report and develop practical strategies for police and linking to broader intervention strategies. Further to this, draft recommendations will be negotiated with stakeholders to ensure that the final report is acceptable, appropriate and practicable.

## Randomised controlled trial of a brief intervention to reduce the risk of transmitting hepatitis C

**Susan Carruthers and Kristy Arden**

Injecting drug use can result in a variety of harms with consequences associated with crime, social welfare, education, employment and health. It is the health consequences of injecting drug use that are the focus of this report and in particular, the risk of exposure to hepatitis C and other blood borne viruses. The infectiousness of the hepatitis C virus, in combination with the high background prevalence, renders the most subtle of injecting practices a possible risk and as suggested by Wodak (1997) even the smallest of breaches in infection control can lead to transmission of hepatitis C.

It has become clear over the past decade that the incidence of hepatitis C among IDUs is unlikely to be reduced without changes being made to a range of injecting practices deemed to be risky. Brief interventions, designed to change injecting behaviours, represent a potentially effective strategy for achieving such change. Brief interventions are probably best known for their role in modifying harmful or hazardous drinking behaviours where they have consistently been found to be effective in reducing alcohol consumption or achieving treatment referral of problem drinkers (Bien et al, 1993). They have also been found to be successful in reducing HIV/AIDS risk among gay men and injecting drug users (Baker et al, 1993; Booth, Kwiatkowski & Stephens, 1998). However, their efficacy in reducing the risk of exposure to hepatitis C through injecting behaviours has not been thoroughly explored although a randomised controlled trial of a brief behavioural intervention among IDUs in Melbourne

has shown some promising results (Tucker, Fry, Baldwin et al, 2003). Given the significant level of morbidity associated with hepatitis C infection and the high prevalence rates among IDUs the use of brief interventions to encourage safer injecting practices and decrease transmission is worth investigating. The aim of this pilot project was to evaluate the efficacy of a brief hepatitis C prevention intervention delivered to a group of injectors in Perth, Western Australia using a randomised controlled trial. Pre- and post-test assessment consisted of the recorded observation of an injecting event followed by the scoring of the event using a risk assessment checklist (RAC). The RAC consists of 19 items covering the 5 domains of injecting; environment, context, equipment, technique and physical contact. Each domain consists of between 2 and 5 items and each is scored according to the filmed data; 0 indicating the risk was not observed and one that the risk was observed. Subjects were 45 current injecting drug users recruited via the West Australian Substance Users Association (WASUA) and snowballing. To be eligible to take part in the trial subjects had to be current injectors, injecting on a regular basis (at least once per week in the 6 months prior to screening). Participants were randomly allocated to control or intervention group and were followed-up at 4 weeks. The efficacy of the intervention was assessed by comparing the summed RAC scores for the control and intervention groups.

The mean summed pre-test score for the group as a whole was 6.8 (median 7; mode 8; range 1 – 14). The mean summed pre-test scores for the control and intervention groups were 7.1 (median 7; mode 7; range 13) and 6.5 (median 7; mode 8; range 8) respectively. When the mean scores for the control and intervention groups were compared no significant difference was detected ( $F=0.435$ ; sig. =0.513). The mean RAC score for the study group as a whole at post-test assessment was 5.7 (median 5.0; mode 5; sd 2.8). The mean summed post-test scores for the control and intervention groups were 6.6 (median 6.7; mode 9; range 12) and 5.0 (median 5; mode 5; range 10) respectively. The mean score differed between control and intervention groups although the difference did not reach significance at the .05 level ( $F = 3.792$ ; sig. 0.058). The RAC was then divided into separate domains depending on the modifiability of the individual items. The domains labelled environment and context were deemed to be largely non-modifiable while those directly related to the injection process (equipment, technique and physical contact) were considered to be highly modifiable. The behaviours within these domains were also the focus of the intervention. When the mean scores for the modifiable domains were compared between the control and intervention groups the findings were significantly different such that the intervention group post test summed score was significantly lower than the control group post intervention scores ( $F=6.18$ ; sig. = 0.017).

While the study group for this pilot was small and the follow-up time limited to one month, the findings indicate that the brief intervention as delivered was

effective in reducing the risk of hepatitis C transmission from injecting drug use among the intervention group. While these findings are very encouraging, further research with a larger study group and a follow-up period of between 3 and 6 months will be required before this intervention can be used on a wider scale.

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## abstracts

### International comparisons of alcohol consumption

**Kim Bloomfield, Tim Stockwell, Gerhard Gmel and Nina Rehn**

**Alcohol Research and Health, 2003, 27, (1), 95-109.**

Researchers in numerous countries have conducted analyses of alcohol consumption and general population surveys to ascertain the level and consequences of alcohol use. In recent years, investigators also have made attempts to compare drinking rates and other drinking variables across different countries. One reason for researching across national borders, which is of a political nature, is the need for descriptive epidemiology (Room, 1988). For example, national governments often want to know how their countries measure up against others in per capita consumption or in other comparative rankings of alcohol use. Another reason for comparative research is the desire to further theoretical knowledge; social scientists often employ comparative designs to develop theories. In the case of alcohol research, comparisons among different countries can help researchers determine how variations in social, cultural, political, environmental, and genetic factors can influence drinking behavior. For example in the case of research on gender differences in alcohol use, international comparisons could help distinguish which differences in men's and women's drinking behaviour can be attributed to biological differences and which to sociocultural factors (Wilsnack et al, 2000).

### Harm minimisation in school drug education. Final results of the School Health and Alcohol Harm Reduction Project (SHAHRP)

**Nyanda McBride, Fiona Farrington, Richard Midford, Lyn Meuleners and Mike Phillips**

**Addiction, 2004, 99, 278-291.**

Aims: The School Health and Alcohol Harm Reduction Project (SHAHRP study) aimed to

reduce alcohol-related harm in secondary school students.

Design: The study adopted a quasi-experimental research design, incorporating randomly selected and allocated intervention and control groups and measured change at eight, 20 and 32 month follow-ups.

Setting: Metropolitan, government secondary schools in Perth, Western Australia. Participants: The sample involved over 2300 students. The retention rate was 75.9% over 32 months.

Intervention: The evidence-based intervention was a curriculum program, with an explicit harm minimisation goal and was conducted in two phases over a two year period.

Measures: Measures of change included: knowledge, attitude, consumption, context of use, harm associated with own use and harm associated with other peoples' use of alcohol.

Findings: Significant knowledge and attitude effects occurred early in the study and were maintained to final follow-up, however, scores were starting to converge by 32 months. There was an impact on consumption during the program delivery phase with intervention students consuming 31.4% and 31.7% less alcohol, and 25.2% and 33.8% less likely to consume to harmful/hazardous levels. The program had no impact on context of alcohol use. The program was effective in impacting on the harm that young people experience associated with their own use of alcohol, with intervention students experiencing 32.7%, 16.7% and 22.9% less harm from first follow-up onwards. There was little program impact on the harm that students experienced associated with other peoples' use of alcohol.

Conclusions: The results of this study support two distinct areas for the future of alcohol education programs in schools: the adoption of a harm reduction goal and the fundamental use of classroom intervention to achieve change.

### Risk and protection factors for different intensities of adolescent substance use: When does the Prevention Paradox apply?

**Tim Stockwell, John Toumbourou, Primrose Letcher, Diane Smart, Ann Sanson and Lyndal Bond**

**Drug and Alcohol Review, 2004, 23, (1), 67-77.**

Because moderate and low level substance users are relatively common, a "Prevention Paradox" is observed in that most incidents of harm occur in these groups rather than amongst frequent and heavy substance users. To extend consideration to prevention in younger age groups, two studies of children and adolescents conducted in Victoria, Australia, were reanalysed by recombining developmental, social and individual measures to form cumulative risk indexes for substance use.

In a large cross-sectional student survey at around age 16 the majority of regular tobacco, alcohol, and cannabis use occurred in the moderate and low risk groups, hence the Prevention Paradox applied. However, the majority of illicit drug use occurred in the highest risk group (top 15%) and also the Prevention Paradox did generally not hold for drug use at younger ages.

In a major longitudinal study risk factors at around age 11/12 years were used to predict substance use at age 17/18 years. The Prevention Paradox held for involvement in frequent smoking, heavy drinking as well as any use of cannabis, but was less clear for frequent cannabis use.

It is concluded that universal prevention strategies are needed for late adolescent alcohol, tobacco and cannabis use and more targeted strategies for addressing harm related to early age drug use, frequent cannabis use and illegal drug use.

# recent publications

## MONOGRAPHS AND TECHNICAL REPORTS

**Farrington, F., McBride, N. and Kennedy, C.** (2004). *The SHAHRP National Dissemination Project. 2nd Progress report.* National Drug Research Institute, Curtin University of Technology, Perth, Western Australia.

**Heather, N. and Stockwell, T.R.** (2004). *The Essential Handbook of Treatment and Prevention of Alcohol Problems.* John Wiley and Sons Ltd, West Sussex.

**Moore, D.** (2004). *Final Report on A Current Project Grant. Victorian Health Promotion Foundation Research Program.* National Drug Research Institute, Curtin University of Technology, Perth, Western Australia.

## PUBLISHED ARTICLES, CHAPTERS AND BOOKS

**Bloomfield, K., Stockwell, T.R., Gmel, G. and Rehn, N.** (2003). International comparisons of alcohol consumption. *Alcohol Research & Health*, 27, (1), 95-109.

**Gray, D. and Siggers, S.** (2003). Substance misuse. In Thomson, N. *The Health of Indigenous Australians.* Oxford University Press, Melbourne. 158-185.

**McBride, N.** (2004). School drug education: A developing field and one element in a community approach to drugs and young people. *Addiction*, 99, 292-298.

**McBride, N., Farrington, F., Midford, R., Meuleners, L. and Philip, M.** (2004). Harm Minimisation in School Drug Education. Final Results

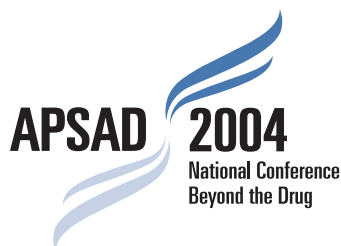
of the School Health and Alcohol Harm Reduction Project (SHAHRP). *Addiction*, 99, 278-291.

**Moore, D.** (2004). Talking to spotters. *Substance*, 6, 2.

**Roche, A. and Stockwell, T.R.** (2004). Editorial: Putting prevention back on the agenda. *Drug and Alcohol Review*, 23, (1), 3-4.

**Stockwell, T.R.** (2004). Editor's Introduction. In Heather, N. and Stockwell, T.R. *The Essential Handbook of Treatment and prevention of Alcohol Problems.* John Wiley and Sons Ltd, West Sussex. 194-198.

**Stockwell, T.R., Toumbourou, J., Letcher, P., Smart, D., Sanson, A. and Bond, L.** (2004). Risk and protection factors for different intensities of adolescent substance use: When does the Prevention Paradox apply? *Drug and Alcohol Review*, 23, (1), 67-77.



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**Speaker:** Mr Neil Donnelly: Research Manager, NSW Bureau of Crime Statistics & Research

**Date and Time:** Thursday May 6th, 2004, 3.00pm-5.00pm  
(including a short break for afternoon tea)

**Venue:** National Drug Research Institute, Health Research Campus, Curtin University of Technology,  
Level 2, 10 Selby Street, Shenton Park, WA 6008

Please register your attendance by contacting:  
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