Life Education Australia

Response to Australia’s National Drug Strategy – Beyond 2009 Consultation

Introduction

Life Education Australia, is pleased to provide input into the development of Australia’s National Drug Strategy – Beyond 2009 Consultation, as well as recommendations for directions and priorities for the next phase of the Strategy 2010-2015.

As a not-for-profit organisation, Life Education Australia provides positive, preventative drug and health education programs which motivate, encourage and empower young people to make the best possible life choices for a healthy future, free from the harms associated with drug misuse. Life Education’s mission is excellence in drug education especially for young people. Life Education is the largest non-government provider of drug and health education throughout Australia reaching 750,000 primary and secondary school students each year¹.

The organisation acknowledges that its major role is to build the capacity of classroom teachers through Life Education’s specialist resources, to enable teachers to undertake their role of delivering health and drug education more effectively in their schools.

This submission addresses key consultation questions in the required format, with a focus on the role of education in the next Strategy.

Given the concerning trend of earlier onset of drug and alcohol use, Life Education’s submission mainly focuses on prevention education related to partnerships with school communities and with tertiary institutions that offer courses in the health, education and allied industries.

Integral to this focus, a comprehensive case will be presented to support (and revive) a major recommendation made in the Evaluation of the National Drug Strategic Framework (1998-2003). That is the:

“Inclusion of education as a full partner in the strategy (alongside health and law enforcement) with a major role to play in prevention and early intervention”.

The approach taken has been to examine previous Strategies (and their relevant evaluations) as well as to research drug trends both nationally and internationally in order to build an evidence-base to support the recommendations of this submission.

¹ Best Practice in Drug Education as Applied to Life Education Australia, Erebus International, October 2006

Section A - Feedback on Emerging Issues to MCDS

How emerging issues and new developments identified in the Consultation Paper impact on patterns of tobacco, alcohol, illicit drug use and the misuse of licit substances (e.g. pharmaceuticals, performance and image enhancing substances) in the next five years, and appropriate response to these patterns

**Life Education’s Response:**

Two main emerging issues are noted in the Consultation Paper in the section entitled “Patterns of Drug Use”, (page 2). They are: ‘poly drug use’ and the issue of ‘greater harms from alcohol and drug use’.

**A1 - Emerging issue # 1 - Poly-drug use**

**Overview**

The emerging issue of poly drug is one which needs to be urgently addressed by the National Drug Strategy. While research into the harms of individual drugs is vital, and much is being done in Australia to provide accurate data, it is also equally important to identify drugs which are most commonly used in combination. In doing so, information will be more readily available to help determine the health and social impacts, in order to effectively prevent and reduce the associated harms.

This response will address the issue of cannabis combined with alcohol.

**Rationale**

This submission has focussed on poly drug use related to the combination of cannabis and alcohol for the following reasons:

1. The available evidence of the increasing harms of alcohol abuse and cannabis use is clear.

2. There is little current Australian data to indicate the harms associated with combining these substances (i.e. poly drug use of alcohol and cannabis).

**Evidence base: Alcohol misuse:**

A snapshot of the vast and growing evidence base:

‘Alcohol misuse costs the Australian community 15.3 billion dollars each year when factors such as crime and violence, treatment costs, loss of productivity and premature death were taken into account. 51% of alcohol consumed is drunk at levels that pose a risk of short-term harm over 3 000 Australians die each year as a result of harmful drinking over 450 000 children (13.2%) live in households where they are at risk of exposure to binge drinking by at least one adult’.

Evidence-base - Cannabis use

In Monographs 63 and 69 ‘Illicit Drug Use in Australia: Epidemiology:

‘Cannabis remains the most widely used illicit drug in Australia. In 2004 33.6% of the population aged 14 years and over had ever used cannabis, with 11.3% having used it in the preceding 12 months. Adolescents aged 14-19 years are more likely to have ever tried cannabis (25.5%) than tobacco (16.2%). Recent (past year) cannabis use is most common among males in the 20-29 year age group. Males also tend to use more frequently, and use the more potent parts of the cannabis plant. People with lower education are more likely to become regular cannabis users, and cannabis dependence has been associated with unemployment’.

Source: Illicit drug use in Australia: Epidemiology, use patterns and associated harm. (2nd Edition) Monograph No's 63 and 69

‘A further issue of concern is the growing rate of cannabis use and associated problems in the indigenous Australian communities (Clough et al., 2002). The 2001 National Household Survey found that cannabis use among Aboriginal and Torres Strait Islanders (ATSI) was higher than for the non indigenous population: 27% of ATSI respondents reported using cannabis in the last 12 months compared to 13 % of non-indigenous Australians. Cannabis use in indigenous communities has received little research attention and the social and health impacts of cannabis use in such communities remain largely unknown. Surveys in the mid-1980s in the Northern Territories “Top End” did not detect cannabis use among indigenous peoples (Watson, Fleming & Alexander, 1988). By 1999, however, cannabis use was reported by 55% of males and 13% of females in the same region (Clough et al., 2002). A random sample of indigenous peoples in two contiguous communities in Arnhem Land recently reported that 67% of males and 22% of females were current cannabis users (Clough et al., 2004). On a broader level, this highlights the importance of investigating cannabis use in ethnically diverse groups within the Australian population.

There is some recent research suggesting that cannabis use is higher in Sydney youth of English speaking background compared to those from Vietnamese and Arabic speaking backgrounds (Rissell, McLelland & Bauman, 2000)’.

Recommendations:

That the National Drug Strategy:

1.1 provides opportunities for urgent research into the impacts of poly drug use related to the combination of alcohol and cannabis

1.2 ensures that education campaigns reflect the findings of research into poly drug use to ensure better penetration of knowledge within our communities.

1.3 makes special provision to ensure improved health care of Indigenous Australians, with regard to the impact of poly drug use in their communities.
A2 - Emerging issue # 2 - Greater harms caused by drug use

Life Education’s Response:

Overview

As evidenced by increasing numbers of hospitalisations, the harms caused by drug use appear to be increasing in severity and frequency. This response will address issues related cannabis and alcohol.

Rationale

This submission has focussed on greater harms caused by the use of cannabis and misuse of alcohol for the following reasons:

1. The legally accessible drug, alcohol statistically causes the most harm in Australia.

2. Cannabis is the most commonly used illicit drug in Australia and the evidence now indicates links with significant mental health issues.

Evidence base: Harms of Alcohol misuse:

The Australian Bureau of Statistics Alcohol Consumption in Australia: A Snapshot, 2004-05 reports that:

- One in eight adults (approximately 2 million people) drink at risky/high risk levels. The proportion of people drinking at risky/high risk levels has increased from 8.2% in 1995 to 13.4% in 2004-5.

- Research shows that the number of 12–17 year olds who are drinking alcohol are drinking at harmful levels and that this number has increased significantly in that time.

The 2007 National Drug Strategy Household Survey reports that:

- Over 10 per cent of Australians aged 14 years and over, drank at levels that increased their risk of alcohol-related harm in the long-term.

- At least 26.8 per cent drank at levels that increased their risk of alcohol-related harm in the short-term at least monthly.

- Among 16–24 year olds, alcohol-related harm is one of the leading causes of disease and injury.

- The proportion of teenagers drinking at least weekly was around 22%. One-quarter (25.4%) of Australians aged 14 years or older had been verbally abused and 4.5% had been physically abused by someone under the influence of alcohol.
Evidence base: Harms of Cannabis use:

A growing evidence base indicates the following concerning trends to support the fact that those who use cannabis are experiencing greater harms:

For instance: The National Cannabis Prevention and Information Centre reports that:

‘Long-term users of cannabis in Australia report that cannabis appears to be stronger than in the past. On the available evidence it would appear that the strength of cannabis has increased to some extent over the last 25 years.

It would appear that the main difference nowadays is the part of the plant people smoke and the age at which people commence regular use. It is more common for people today to smoke the flowering heads of the plant which are much more potent than the leaf product. In addition, people are more likely to smoke cannabis in a ‘bong’.

These changes in the patterns of use may result in users of today taking in higher levels of THC than in the past. Additionally, the younger people start and the more regularly they use, the more likely they are to be adversely affected by cannabis.

Generally speaking, those who start smoking cannabis earlier (early adolescence) and smoke heavily are more likely to experience negative consequences. This may in turn lead to mental health problems, but also lead to more general life problems, like conflict at home or school / work, financial problems and memory problems’.


Further: The 2007 NDS Household Survey results show that:
‘Marijuana/cannabis had been used at least once by one-third of Australians aged 14 years or older in 2007 (33.5%).

One of the reasons for continued acceptability of cannabis use, could be the misconceptions about the safety of cannabis.

For example: ‘More than one in four Australians aged 14 years and over approve of personal cannabis use (27.4%)’. This figure climbs to in excess of three quarters of regular cannabis users, approving of their personal use of the drug.

Cannabis is also widely available in the community with more than one in two respondents (58.2%) reporting that they had the opportunity to use cannabis in the previous year’.

Source: Illicit drug use in Australia: Epidemiology, use patterns and associated harm. (2nd Edition) Monograph No’s 63 and 69
A concerning trend in the most recent NDS Household Survey (2007) regarding ‘Drugs thought to be associated with a drug ‘problem’ Marijuana/cannabis was nominated by 25.2% of respondents in 2007; a decrease over the proportion in 2004 (29.2%).

Recommendations:
That the National Drug Strategy:

2.1 supports the continuation of current national initiatives that have been implemented to reduce binge drinking

2.2 provides opportunities for a similar comprehensive national strategy to prevent and reduce cannabis use – one that includes ongoing public education and social marketing, community initiatives and more stringent law enforcement.
A3 - Other Emerging issues –

Life Education’s Response – the Critical Issue of ‘Earlier onset of use of alcohol and cannabis’

Rationale

This submission has identified the trend towards an earlier onset of alcohol and cannabis use as being a significant emerging issue for the following reasons:

1. There is evidence to suggest that alcohol causes harm to the developing brain, and this directly relates to those who drink under the legal age of 18.

2. Cannabis is the most commonly used illicit drug in Australia and the evidence now indicates links with mental health issues, particularly when it is used during adolescence.

Evidence base: Alcohol use and the developing brain:

Some of the most recent evidence from the AMA in the United States indicates the following recent findings:

‘The brain goes through dynamic change during adolescence, and alcohol can seriously damage long- and short-term growth processes. Frontal lobe development and the refinement of pathways and connections continue until age 16, and a high rate of energy is used as the brain matures until age 20. Damage from alcohol at this time can be long-term and irreversible. In addition, short-term or moderate drinking impairs learning and memory far more in youth than adults. Adolescents need only drink half as much to suffer the same negative effects’.

Drinkers vs. non-drinkers: research findings

- Adolescent drinkers scored worse than non-users on vocabulary, general information, memory, memory retrieval and at least three other tests

- Verbal and nonverbal information recall was most heavily affected, with a 10 percent performance decrease in alcohol users

- Significant neuropsychological deficits exist in early to middle adolescents (ages 15 and 16) with histories of extensive alcohol use

- Adolescent drinkers perform worse in school, are more likely to fall behind and have an increased risk of social problems, depression, suicidal thoughts and violence

- Alcohol affects the sleep cycle, resulting in impaired learning and memory as well as disrupted release of hormones necessary for growth and maturation

- Alcohol use increases risk of stroke among young drinkers
Adverse effects of alcohol on the brain: research findings

Youth who drink can have a significant reduction in learning and memory, and teen alcohol users are most susceptible to damaging two key brain areas that are undergoing dramatic changes in adolescence:

- **The hippocampus** handles many types of memory and learning and suffers from the worst alcohol-related brain damage in teens. Those who had been drinking more and for longer had significantly smaller hippocampi (10 percent).

- **The prefrontal area** (behind the forehead) undergoes the most change during adolescence. Researchers found that adolescent drinking could cause severe changes in this area and others, which play an important role in forming adult personality and behavior and is often called the CEO of the brain.

**Lasting implications**

Compared to students who drink moderately or not at all, frequent drinkers may never be able to catch up in adulthood, since alcohol inhibits systems crucial for storing new information as long-term memories and makes it difficult to immediately remember what was just learned.

Additionally, those who binge once a week or increase their drinking from age 18 to 24 may have problems attaining the goals of young adulthood—marriage, educational attainment, employment, and financial independence. And rather than "outgrowing" alcohol use, young abusers are significantly more likely to have drinking problems as adults.

**Evidence-base: Harms of Cannabis - earlier onset of use**

Evidence suggests that higher proportions of people are beginning to use cannabis during adolescence.

‘Whereas around one fifth of cannabis users born between 1940 and 1949 first used by age 18, about three quarters of cannabis users born between 1970 and 1979 had used by the same age’.


‘This drop in the age of initiation is concerning because an earlier age of cannabis initiation is associated with an increased likelihood of regular use.

In turn, regular use at a young age is a risk factor for dependence and other problems such as criminal activity and the use of other drugs of dependence’.

‘Overwhelming evidence exists to support the fact that the age of first cannabis use is an important predictor of progression to heavier drug use and need for treatment’.

Sources:

Recommendations:
That the National Drug Strategy:

3.1 supports a targeted educational campaign in schools, TAFE’s and universities, as well as in the national media, to deter adolescent cannabis users and, simultaneously supports the removal of confusing legislation which enables decriminalization to be the national ‘norm’.

3.2 develops a framework of initiatives that will reduce the incidence of underage binge drinking including: ways to reduce access to alcohol for children and youth; increasing enforcement of underage drinking laws; providing more education about the harmful effects of alcohol abuse; restrict alcohol advertising in terms of timeslots on radio and television.
Section B – Feedback on Priorities for Action during the next 5 years

Life Education’s Response - The Case for Education to become a full partner in the National Drug Strategy

Overview:

Life Education considers that a top priority in the new Drug Strategy should be that of including the Education Sector as full partner in the Strategy.

One of the major suggestions made in the Evaluation of the National Drug Strategic Framework (1998-2003) was that of the:

“Inclusion of education as a full partner in the strategy (alongside health and law enforcement) with a major role to play in prevention and early intervention”.

Further, the current Consultation Paper acknowledges on page 3 that:

“Research has shown that demand for drugs can be curbed through information and education, targeted social marketing campaigns, brief interventions and other psychosocial treatment”.

This submission offers the following evidence-base and recommendations concerning the increased (and more effective) role of education in the development, implementation and monitoring of the new drug strategy, particularly in the areas of:

- Strategy and policy development
- Effective school community education
- Parent/carer education and support strategies
- Ongoing, targeted social marketing initiatives
B1 - Drug Strategy and Policy Development

Rationale and evidence

From the outset, Education has been included only as a partial player in strategies related to drug and alcohol policy and practice. For instance, the Ministerial Council on Drug Strategy (MCDS) which functions as a peak policy and decision-making body in relation to licit and illicit drugs in Australia, is represented by Federal and State/Territory Ministers of Health and Law Enforcement, but only Federally by the Minister for Education.

Policy for school communities has become less transparent since 2003, following the implementation of the National School Drug Education Strategy (in 1999) and the National Action Plan on Illicit Drugs 2001 to 2002-3.


In 2010, the only remaining guidelines for school drug education are the Principles for School Drug Education. While these are based on a sound evidence in their own right, they fall short of comprehensive strategies which require mechanisms for accountability such as measuring key performance indicators, outcomes and outputs.


Recommendations:

1. That State Education Ministers be included as equal members of the Ministerial Council on Drugs Strategy, along with the Ministers of Health and Law Enforcement.

2. That the National Drug Strategy 2010-2015 includes a comprehensive educational component that requires accountability and measurement in terms of key performance indicators, timeframes, resourcing, outcomes and outputs.
B2 - Effective School Community Education

Overview and definition of Education

‘Education’ in the broadest sense is any act or experience that has a formative effect on the mind, character or physical ability of an individual. In its technical sense education is the process by which society deliberately transmits its accumulated knowledge, skills and values from one generation to another.

In Australia, ‘education’ is an all-encompassing term which includes formal, institutionalized approaches such as that taken in schools (from pre-school to secondary levels) universities and TAFE’s. It can also include community awareness campaigns through social marketing initiatives, using a range of media to assist in promotion of events and core messages. These recommendations relate to school communities in the broadest sense and include strategies to support students, teachers and, in particular, parents and carers.

Rationale and evidence

As defined in the Principles for School Drug Education ‘school drug education’ is intended to encompass all policies, practices, programs and initiatives/events in schools connected with the prevention and reduction of drug-related harm.

In the past, some excellent work has been done with school communities to encourage a comprehensive, multi-faceted approach to school drug education. (The National School Drug Education Strategy (mentioned in 3.1) is an example). While this has had a mix of outcomes, many of which have been positive, there now needs to be a targeted approach within school communities, based on a nationally consistent strategy that will enable their individual, identified issues and potential solutions.

This approach would be consistent with the Principles for School Drug Education, but would go further to build a strategic framework, based on national guidelines within the new National Drug Strategy.

Recommendation:

3. That a nationally consistent, flexible, evidence-based strategic component be developed within the new National Drug Strategy, to ensure accountability in school drug education, which enables the ability to meet the individual needs of each school community.
B3 - Parent/carer education and support strategies

Rationale and evidence

An example of a comprehensively evaluated approach to parent education is that of Dr Gilbert Botvin’s LifeSkills™ Training, a science-based prevention curriculum for elementary school students. The objective is to provide 8 sequential sessions in 3rd grade, 4th grade and 5th grades, and their families. The three major content areas covered are personal self-management skills, general social skills and drug-resistance skills. Sessions for participants are approximately 30-45 minutes and are provided during and after school hours. Staff members conduct parenting presentations. Parent sessions are offered once a week for five weeks and provide parents with the opportunity to learn cooperative activities to use with their children. http://www.council-houston.org/Public/index.asp?page_ID=342

Recommendation:

4. That a greater focus on parent support and education on how to manage prevention and early intervention of drug use in their families.

B4 - Social marketing initiatives

In recent years we have seen some successful social marketing campaigns, using a multi-faceted approach to ensure a clear message permeates communities across Australia. For example the National Binge Drinking Strategy launched in 2008 by the personal responsibility Department of Health and Ageing, included a range of measures to help tackle binge drinking among young Australians, such as funding:

- to intervene earlier to assist young people and ensure that the assume for their binge drinking;
- advertising that confronts young people with the costs and consequences of binge drinking.

Significantly, it recognised that binge drinking among young people is a community-wide problem that demands a community-wide response. This approach can quite easily be translated to address other drug use, by identifying, utilising and maximising existing community resources.

Recommendation:

5. That long term, effective social marketing campaigns to address issues concerning drug use be strategically planned and implemented on a national scale.
Section C – Responding to key consultation questions within the paper

C1 - Cross Sectoral Approaches

How can structures and processes under the National Drug Strategy (NDS) more effectively engage with sectors outside health, law enforcement and education? Which sectors will be particularly important for the NDS to engage with?

**Life Education’s Response:**

In Section B of this submission, a case for the education sector in Australia becoming a full partner in the new Strategy was made. Until these concepts, which follow a recommendation made in the *Evaluation of the National Drug Strategic Framework (1998-2003)* are carried out, there will be little change in the effectiveness of education as a full impact initiative within the new Strategy. Education needs to be given a ‘fair go’, and not written off without a comprehensive effort at the strategic level.

Now is the time to do this, given the concerning trends about earlier onset of alcohol and drug use, as well as the trend of greater harms being caused by alcohol and drugs.

Parent groups, organizations and relevant government instrumentalities that support parents and carers also need to be involved at some level.

C2 - Indigenous Australia

Where should efforts be focused in reducing substance use and associated harms in Indigenous communities?

How could Aboriginal and Torres Strait Islander people’s needs be better addressed through the main National Drug Strategy Framework?

In that context, would a separate National Drug Strategy Aboriginal and Torres Strait Islander Complementary Action Plan continue to have value?

**Life Education’s Response:**

Indigenous people need assistance with their physical and mental health issues under the strategy, with more research and action planning/implementation related to poly drug use – particularly the combined use of alcohol and cannabis. This should be integral to the new Strategy and not singled out or separated into a separate framework or Action Plan. There is a need to eliminate existing stigmas about indigenous people and substance use and a separate Action Plan may, as an unintended consequence, exacerbate this.
C3 - Capacity Building

**Where should effort on the support and development of drug and alcohol sector workforce be focused over the coming five years?**

**Life Education’s Response:**

With the increase in numbers of people with multiple and complex needs who are alcohol and drug dependent and also have mental health issues, there is a need to focus on specialist training in these areas. To complement this, there is also a need to build capacity in treatment facilities to cope with the special needs of clients who fall into these categories.

The need for training within the AOD workforce to help workers manage family counseling and holistic rehabilitation, so that significant others can be brought into the healing process in a more timely and effective way.

**Where should efforts be focused over the coming five years to increase the capacity of the generalist health workforce to identify and respond to substance use problems?**

**Life Education’s Response:**

Specialist educational programs should be developed for the generalist workforce, in early stages of their training at TAFE and/or university. Teachers in training should also be included in such a cohort, so that they are able to detect drug use early amongst their students, and/or identify family programs to complement their mandatory reporting responsibilities.

C4 - New Technologies

**What are the particular opportunities and challenges that technology development is likely to pose for the community and the alcohol and drug sector over the next five years?**

**Life Education’s Response:**

New technologies could benefit the AOD sector in a number of ways, and in particular when there is a need to train individuals or groups in rural and remote regions. Social networking sites, SMS, Skype and online training initiatives are making the ability to contact those who are isolated, far more regularly and effectively.

An unintended consequence might be that some may become totally reliant on such methodologies and reduce resourcing into enabling the ‘human factor’ to be available at a reasonable level. For instance, face to face contact may often be an important factor, in order to establish initial rapport when training people or for talking to clients.
C6 - Increased Vulnerability

How can efforts under the NDS better complement the social inclusion agenda such as addressing unemployment, homelessness, mental illness and social disadvantage.

Where should effort be focused in reducing substance use and associated harms among vulnerable populations?

Life Education’s Response:

There is a need for the new Strategy to dovetail into other strategies related to social inclusion at a national level, particularly homelessness and mental illness. In addition, some excellent concepts and practices to prevent and resolve homelessness and associated social issues, have been introduced into some European countries and also in the United States. Most of these are long term plans, which are not linked into electoral or other time constraints. Reference to each of these is available at the following websites:

Ireland:  

UK  

Scotland  
http://www.opsi.gov.uk/legislation/scotland/acts2001/asp_20010010_en_1

Wales  

Finland  

Portugal  

There is also evidence of an effective program of integrated services related to homelessness and mental illness in Canada – outlined in the following report: ‘Homeless Action Plan – City of Vancouver, 2005’

Source: http://intraspec.ca/hap05jun.pdf
C7 - Performance measures

Are publicly available performance measures against the NDS desirable?

If so, what measures would give a high level indication of progress under the NDS?

Life Education’s Response:

It is always helpful and in current times, increasingly desirable, to be able to justify a course of action or strategy by establishing performance measures. To date, the NDS has established a way forward which has been evaluated, but increasingly there are questions which need to be answered in a quantitative manner. Under its current format, this might be difficult.

A good example of a National Strategy that has such accountability is that of Ireland. The 2009–2016 (interim) Drugs Strategy is comprehensive and built on five pillars (supply reduction, prevention, treatment, rehabilitation and research). It is constructed around a hierarchy of aims, objectives and key performance indicators, and comprises 54 different actions.

For a copy of the Strategy go to: