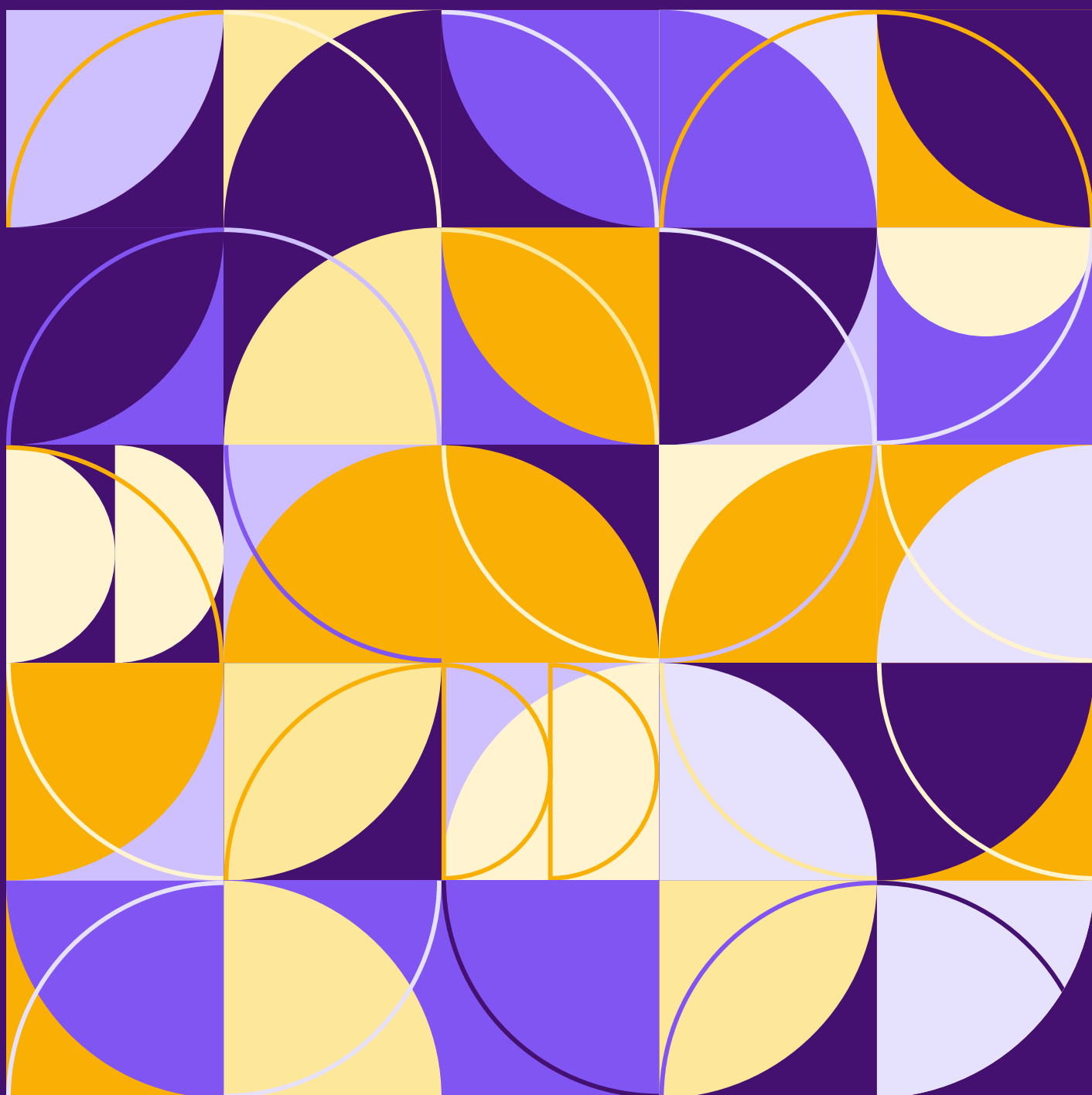


Alcohol and Other Drug Primary Prevention Guide

Evidence informed alcohol and other drug
primary prevention and early intervention



Acknowledgement of Country

The Centre for Alcohol and Other Drugs, NSW Ministry of Health recognises Aboriginal people as the first people of NSW and traditional custodians of this land. We acknowledge that sovereignty was never ceded; always was, always will be Aboriginal land. Aboriginal people are the oldest living culture and most resilient, with connection to culture and Country protecting against some of the harms described in this guide. We recognise and celebrate their resilience, culture and ways of being.

Recognition of lived and living experience of AOD use

The Centre for Alcohol and Other Drugs, NSW Ministry of Health recognises the important role that people with lived and living experience of alcohol and other drug (AOD) use play in shaping and improving policy, programs and services. We recognise the dedication and persistence needed to improve the service system and achieve better health outcomes for all.

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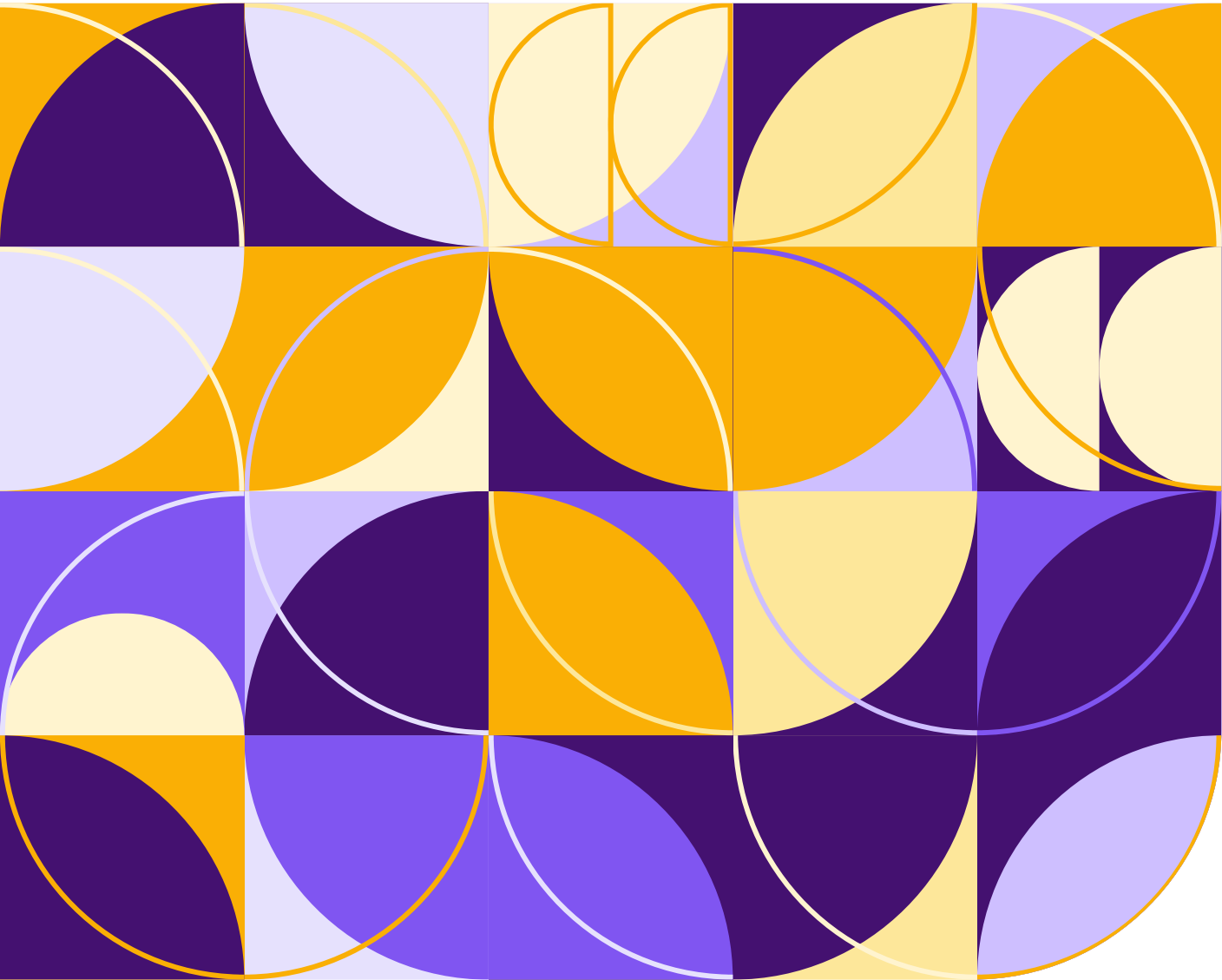
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Contents

Introducing the Guide	4
Defining AOD primary prevention and early intervention	5
Elements of effective AOD primary prevention and early intervention	8
Life Stages	13
The evidence built from evaluations	20
Appendix 1: Strategic context	44
Appendix 2: Overview of process and method for developing the guide	46
References	48



Introducing the Guide



This is a guide for effective investment in alcohol and other drug (AOD) primary prevention and early intervention

It presents the key factors for targeted and responsive initiatives, summarising the evidence of what works in a clear, accessible form.

Information on evidence-based AOD primary prevention and early intervention, can be fragmented and difficult to find. This creates ambiguity around what works and contributes to program development influenced by assumptions or biases, rather than evidence. The Guide addresses a need for available, trustworthy and authoritative advice on AOD primary prevention and early intervention.



The social and economic benefits are clear

Alcohol and other drugs are a major cause of preventable illness, disease and death and account for over \$104.7 billion in social and economic costs annually in Australia¹¹. AOD use affects individuals, families and communities, and the impacts include health, productivity, social connection and crime.

Primary prevention is an efficient response, with a high return on investment, that benefits the whole community. Research in the US and Australia estimate that every dollar invested in AOD primary prevention and early intervention returns \$8.22¹ and \$5.71², respectively. This is why prevention activities are a significant part of the National Drug Strategy's harm minimisation approach.

Primary prevention and early intervention can reduce costs to our health system, improve quality of life and public amenity and prevent future harms and costly interventions, such as hospitalisation or police intervention^{3, 4, 5, 6, 7, 8}.



Scope of the Guide

This Guide focuses on AOD primary prevention and early intervention activities.

Tertiary prevention is defined and described briefly in the context of the prevention spectrum but is not explored in detail.

The audience for this guide is decision makers. This can include all levels of government, non-government organisations and other community organisations, like schools and sporting clubs.

This Guide does not address tobacco, vapes, or school-based prevention initiatives. These are covered by separate, dedicated NSW Government funding, policy, and strategic plans, including the NSW Health Tobacco Strategy and the Principles for School Drug Education. However, evidence for approaches that complement existing school-based and tobacco prevention programs are highlighted.

The Guide explains how social and economic factors influence AOD use. It highlights programs that work at the local and community level, while noting that broader State and Commonwealth policies across employment, health, education, policing, housing and other areas also shape these factors.



Structure of the Guide

This guide has three sections. The first defines prevention, outlines its significance and how it relates to the harm minimisation approach.

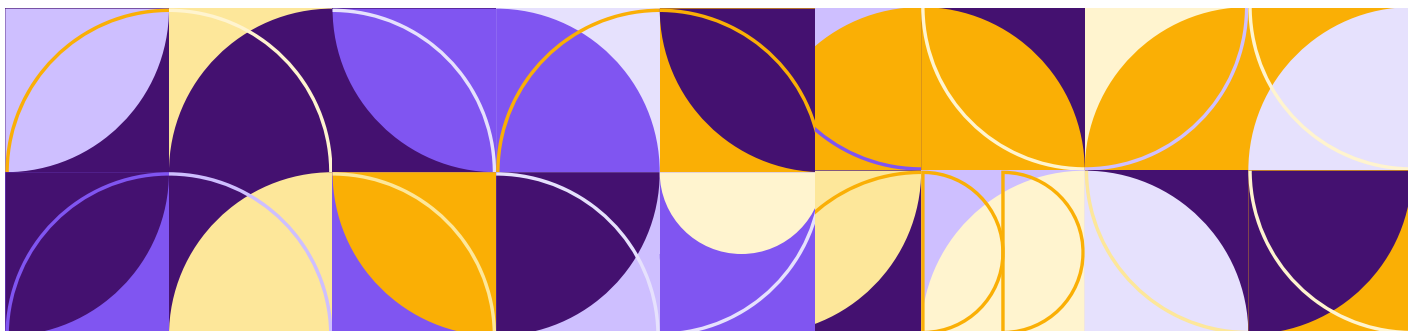
The second section describes important considerations for AOD primary prevention and early intervention initiatives, including patterns and drivers of harmful AOD use, and population subgroups that experience disproportionate harms from AOD.

The final section summarises the evidence for different interventions, outlining the life stages for which they are most effective, key implementation and sustainability considerations, and the strengths and limitations of each approach.

Defining AOD primary prevention and early intervention

This section defines AOD primary prevention and early intervention. It also describes how it reflects features of the harm minimisation approach to AOD.

1



AOD primary prevention and early intervention is the use of strategies, programs and policies that aim to delay or stop the uptake of alcohol and other drugs.

Although this concept has much in common with traditional preventative health strategies, it is distinct and broader.

Preventative health focuses on avoiding the onset of illness, disease, or injury, often through behavioural and environmental changes, which can include reducing alcohol or drug use.

AOD primary prevention and early intervention goes further. It aims to prevent substance use and a wider range of potential harms linked to use, including legal, financial, social and personal consequences, beyond just health-related outcomes.



The prevention spectrum describes opportunities to intervene

All AOD interventions occur on a prevention spectrum: before use starts, early in use, or after use has become harmful. The terms primary, secondary and tertiary prevention refer to this spectrum⁹⁻¹².

Primary prevention attempts to prevent or delay uptake before use starts.

It includes education, health promotion and regulation. It also includes initiatives beyond typical health activities, such as market levers and targeting underlying social determinants by addressing risk and protective factors.

The goal is to improve overall wellbeing, build resilience, and create supportive environments for healthy behaviours.

Secondary prevention aims to prevent or interrupt harmful patterns early in use. It is often referred to as early intervention and includes health promotion programs, routine screening and brief intervention by health professionals and other support services. These approaches can prevent, reduce or delay alcohol and other drug related harms.

Tertiary prevention focusses on reducing impact after harmful use is established.

Tertiary prevention includes treatment and harm reduction to support the person, their family, and the community.

Prevention is a significant part of the harm minimisation approach

Prevention is key to reducing the harms of alcohol and drug use.

It is a major part of the broader harm minimisation strategy, which describes the NSW Government, and all other Australian governments' approach to alcohol and other drugs. The National Drug Strategy 2017 – 2026 describes the harm minimisation approach.

Harm minimisation aims to minimise total accumulated social costs from alcohol and other drug use. Harm is minimised by reducing use (demand and supply reduction), or impact when use occurs (harm reduction). Demand reduction, supply reduction and harm reduction form the three pillars of *harm minimisation*.

This approach accepts drug use cannot be eliminated. It is both a health and social issue requiring a whole-of-government and community response, with a focus on avoiding unintended consequences.

Prevention activities fit under each of the pillars. Primary and secondary prevention activities contribute to demand and supply reduction, and harm reduction contributes to tertiary prevention.

Demand reduction aims to prevent uptake, delay onset, and reduce consumption. Prevention activities under this pillar include:

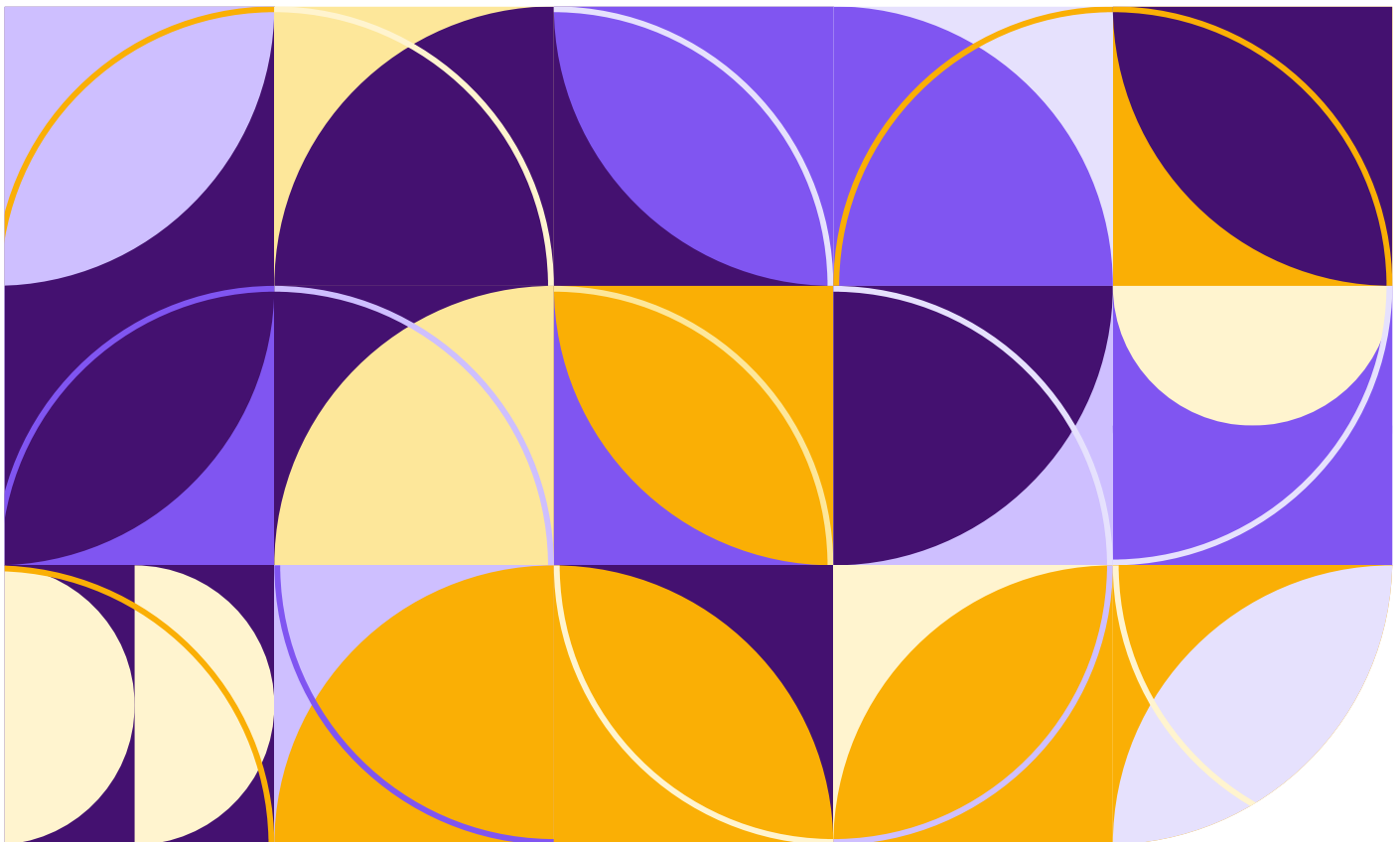
- awareness and education, including school curriculum and programs
- price, promotion and labelling
- ensuring people have somewhere to live, something meaningful to do, community and connection.

Supply reduction aims to regulate or disrupt supply and reduce availability. Prevention activities under this pillar include:

- regulation
- restricting availability.

Harm reduction aims to reduce the potential harm of drug use when it occurs, improve safety and encourage less risky behaviours. Prevention activities under this pillar include:

- needle and syringe programs
- opioid replacement therapy
- overdose prevention, like naloxone and the Medically Supervised Injecting Centre
- reducing stigma.



Elements of effective AOD primary prevention and early intervention

Effective primary prevention and early intervention programs aim to reduce the likelihood of harmful AOD use by addressing the factors that influence use across different populations and life stages. This section brings together information on the diverse components and factors influencing program design.



Summary of elements

Key factors to consider when planning or assessing an AOD primary prevention or early intervention activity include:



Patterns of AOD use

AOD use changes over time. It is important to understand the drugs being used, how they are used and other linked behaviours.



Target populations

Some groups of people experience disproportionate harm from AOD. These include Aboriginal and Torres Strait Islander people, culturally and linguistically diverse (CALD) communities and LGBTQ+ people. Reviewing local AOD risk and harm data, can identify target populations in a specific area.



Life Stages

The effectiveness of targeted interventions is partly dependent on the life stage of the target group, ranging from perinatal and early years, children and young people, to adults and older adults.



Drivers of harmful AOD use

These include social and cultural determinants of health and wellbeing, commercial determinants of health and risk and protective factors. Factors across different levels (individual, interpersonal, community and society) influence risk, and many of these can be modified to mitigate risk.



The principles of effective primary prevention and early intervention

Research indicates that successful primary prevention and early intervention activities share several common principles, including holistic and multi-faceted approaches, community collaboration, co-design, partnership, and a focus across the life course.



The evidence built from evaluation of other initiatives

Using evidence to inform initiatives ensures that programs are based on proven strategies rather than guesswork, increasing the chances of success. This evidence also helps avoid repeating ineffective approaches, supports better use of resources and strengthens accountability by showing measurable outcomes.

Patterns of AOD use



Effective interventions are often tailored to a specific drug, or drug use behaviour, that is causing harm, or at risk of causing harm.

Alcohol

Alcohol is the most commonly used drug in NSW, with 31% of the NSW population aged 18 years and over exceeding the Australian Alcohol Guidelines for adults (NHMRC Guideline 1) in 2024¹³. The Guidelines are:

Adults

To reduce health risks, drink no more than 10 standard drinks per week and no more than 4 in one day. Less is better.

Under 18s

Children and teens should not drink alcohol to avoid health and safety risks.

Pregnancy & Breastfeeding

Women who are pregnant, planning pregnancy, or breastfeeding should not drink alcohol to protect their baby.

Older and younger adults are key targets for prevention, due to their higher rates of risky alcohol consumption. Older adults (e.g., 50+) drink most frequently, relative to the rest of the population^{14,15}. Young adults (aged between 18 and 24 years) are the most at risk in terms of short-term drinking. There are some positive trends in alcohol consumption among young people, including delayed initiation (i.e. consuming their first alcoholic beverage at a later age) and drinking less frequently^{14,16}. The decrease in risky drinking among young men has not been observed among young women¹⁴. Effective prevention approaches can build on these positive trends.

Alcohol use and harms also vary between priority groups. Aboriginal and Torres Strait Islander people are 1.4 times more likely to abstain from alcohol than the general population¹⁷. However, the ongoing impacts of colonisation have led to higher harms among those who use AOD¹⁸ (see section on target populations for more detail).

Illicit drugs

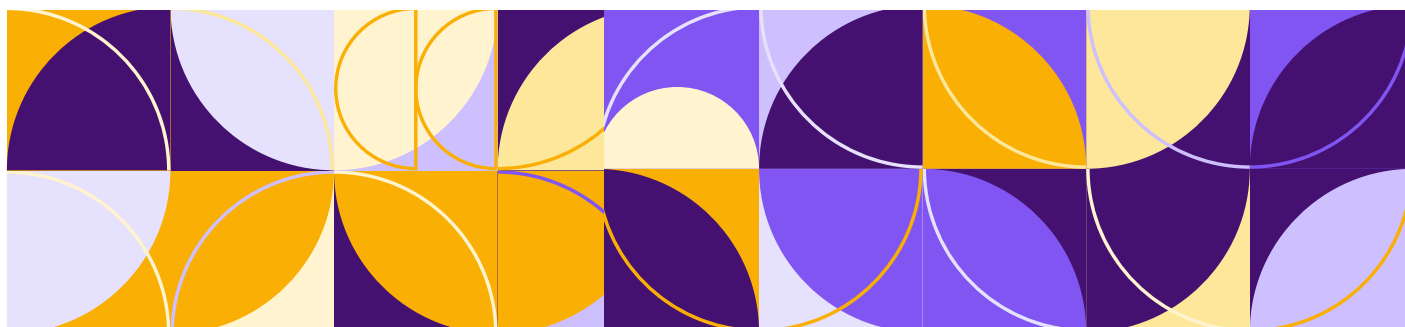
Of substances other than alcohol, cannabis is the most commonly used for non-medical purposes, with 8% of people aged 16 and over reporting use in the last 12 months followed by cocaine (3.5%) and MDMA/ecstasy (2.3%) for the period 2022-2023¹⁹.

Reported use of heroin and methamphetamine is uncommon in NSW. In 2022-23, 0.5% of people in NSW aged 16 years and over reported using methamphetamine or amphetamine in the previous 12 months, and 0.1% reported using heroin¹⁹. It should also be noted that stigma and fear of legal consequences can lead to people underreporting use of these drugs²¹.

In NSW, young adults aged 18 to 24 years are the age group with the highest prevalence of illicit drug or nonmedical pharmaceutical self-reported use in the past 12 months at 30.7%¹⁴.

This makes young people a key focus for primary prevention and early intervention initiatives for drugs, as well as alcohol.

These data are current at the time of publication. However, the most recent data will always be available at [HealthStats](#) NSW.



Target Populations



The risk of harm from AOD use varies among population subgroups. Groups that experience disproportionate harm from AOD use benefit from tailored interventions that address their unique needs.

These groups include Aboriginal and Torres Strait Islander people^{(33,40)(18,22)}, lesbian, gay, bisexual, transgender and queer + (LGBTQ+) communities^{23–25}, culturally and linguistically diverse (CALD) communities^{26,29}, young people and older adults³⁰.



Aboriginal and Torres Strait Islander people

While Aboriginal and Torres Strait Islander peoples are more likely to abstain from alcohol use¹⁷, those who do drink alcohol are more likely to experience alcohol-related harms than non-Aboriginal and Torres Strait Islander populations^{17,22}.

The ongoing impacts of colonisation, disenfranchisement, racism, dispossession of land and suppression of culture, can be attributed to greater alcohol-related harms for Aboriginal and Torres Strait Islander people^{17,18,22,31}.

Elements of effective primary prevention initiatives suggested by the literature include:

- embedding culture into the design and delivery of the intervention
- initiatives that are community-led^{32–35}. Local organisations, like Aboriginal Community Controlled Health Services, are crucial in the development and delivery of these initiatives^{32,33,36}
- initiatives that are co-designed with Aboriginal and Torres Strait Islander peoples
- strengths-based approaches³²
- culturally adapted resources, where possible, e.g. The Grog Survey App provides a culturally adapted screening and brief intervention tool^{37,38,39}
- programs, activities or events for young people that include AOD use education, skills development, and cultural knowledge^{32–34,40,41}
- group approaches including men's and women's groups, peer support or cultural activities as healthy and safe social options
- building the capacity of local organisations to deliver initiatives
- sustainable funding
- regular, rather than one-off initiatives³²
- initiatives grounded in trauma informed principles¹¹⁰.



LGBTIQ+

Drivers of risky AOD use in this group include stigma and discrimination, the role of alcohol in social connection, the historical significance of dance culture in community-formation, illicit drug use in sexual experimentation and socio-sexual pleasure (“chemsex”), and stressors associated with ‘coming out’^{25,42–44}.

There is limited research on primary prevention for LGBTIQ+ populations. Research evidence suggests:

- eHealth interventions for men who have sex with men are generally accepted, particularly when they are tailored to reflect their experiences, use affirming language and use a sex positive approach⁴⁵
- services for men engaged in chemsex should incorporate harm reduction and lived experience, take an interdisciplinary approach and address mental health, sexual health and wellbeing, and AOD use across mainstream and specialised settings^{46,47}.
- psychosocial interventions, such as motivational interviewing and cognitive behavioural therapy, and community-based harm reduction, like education about safer injecting practices, can reduce methamphetamine use and sharing of injecting equipment among men engaged in chemsex⁴⁸.

Effective interventions for LGBTIQ+ communities typically share these characteristics. They:

- are delivered by a community-based LGBTIQ+ organisation that has a history of delivering effective harm reduction and primary prevention interventions^{49–51}
- structure the physical setting to project inclusivity and perceived safety
- employ staff from diverse LGBTIQ+ backgrounds and ensure cultural competency
- adopt person-centred and trauma-informed treatment to address specific treatment needs with a focus on building trust and allowing clients to freely express themselves^{52–55}.



CALD communities

Culturally and linguistically diverse (CALD) communities include those who are born in non-English speaking countries and those who don't speak English at home.

CALD people are less likely to access AOD services compared to the general Australian population^{56,57}. This disparity is important because it is probably not explained by lower treatment need^{26–29,58–61}. People from CALD backgrounds may have less access to services due to communication barriers, discrimination and low levels of cultural sensitivity^{57,62,63}.

Among CALD individuals, refugees or other newly arrived migrants may be at greater risk of experiencing AOD harms due to the stresses around migration to Australia. These stresses often involve significant trauma and high rates of mental health disorder, particularly posttraumatic stress disorder, and problems with resettlement including poor economic conditions and unemployment^{26–29}.

Considerations for AOD primary prevention and early intervention initiatives for this group are:

- ensure effective communication including access to interpreter services, suitable and culturally relevant resources, and exploring clients' cultural identity and familial responsibilities to inform service delivery^{62,64,65}
- adopt a trauma-informed approach and conduct a welfare check when working with refugees
- co-design with the target population to address relevant needs and ensure cultural appropriateness
- recruit bilingual and bicultural program facilitators can enhance cultural competence^{61,66,67}
- cultural protective factors, like strong family units, can enhance client outcomes, so families should be involved where possible and appropriate^{68,69}
- initiatives that target the social determinants of health and use theoretical frameworks, like social cognitive theories of behaviour change, can be more successful⁷⁰
- adopt an empathetic person-centred approach and allow time for engagement and outreach to build trust and rapport⁷¹
- barriers to service access, such as difficulties with transportation and information access, experiences of trauma and racism, comorbidity, and the impact of stigma, should be actively identified and addressed.



Young people

Rates of risky behaviours tend to be higher among young people than the general population⁷², which helps to explain why they are more likely than any other age group to exceed alcohol consumption risk guidelines⁷³.

Adolescence, a stage characterised by growth and development, is a peak period for initiation of AOD use, and studies have found links between early age of onset of drug use and severity of use and health harms later in life^{14,74–78}.

Effective AOD primary prevention and early intervention initiatives for this group should target their risk and protective factors. Risk factors include impulsivity, poor emotional regulation, screen time, low parental education and having peers who use AOD⁷⁹. Protective factors include optimism, mindfulness, a desire to maintain one's health, social connectedness and structured activity⁷⁹.



Older adults

Harmful AOD use, including extra-medical use of prescriptions, has been increasing in older adults (i.e. 55 years or older)³⁰. Increased use of AOD among this group may be due to increased leisure time, or through use as a coping mechanism relating to deteriorating physical health and lack of mobility, mental health, or increased loneliness^{30,80}. Some of these risk factors may also hinder participation in AOD primary prevention and early intervention community mobilisation initiatives³⁰.

Considerations for AOD primary prevention and early intervention initiatives for this group are:

- rapport building, screening and advice (health and social connection) from physicians
- delivery of educational materials on health impacts with personalised feedback and follow-up^{30,80}
- web-based or telephone-based initiatives, where appropriate or required³⁰.

Life Stages



AOD use, attitudes and behaviours are shaped across the life course. A life-stage approach recognises that people experience different risks, protective factors and influences at different points in their lives, from early childhood through to older age. These experiences interact with family, community, cultural, social and environmental factors, and can influence AOD-related outcomes over time.

Primary prevention efforts are most effective when they are age-appropriate, developmentally informed and responsive to people's lived contexts. Focusing on life stages supports early action to strengthen protective factors, reduce exposure to risk and build skills and environments that promote health and wellbeing before AOD-related harms occur. Importantly, prevention at one life stage can have benefits across later stages, contributing to long-term positive outcomes.

The following table provides a practical overview of key issues, risk and protective factors, influences and helpful activities across major life stages. It is intended to support communities, services and organisations to plan, adapt and deliver AOD primary prevention initiatives that are relevant, inclusive and aligned with community needs, rather than a one-size-fits-all approach.



Table 1: Life Stages¹¹¹

Life Stage	Key Issues	Risk Factors	Protective Factors	Key Influences	Helpful Activities
0-5 years Early Childhood	Alcohol/drug use in pregnancy; parenting environment	Family conflict; harsh parenting; abuse/neglect; AOD use in home; social disadvantage	Caring relationships; confident parents; family routines; cultural connection; clear info on alcohol in pregnancy	Parents/ carers; health professionals; early childhood educators	Parenting programs; culturally connected activities; safe home routines; early health checks
6-11 years Primary School Years	Parenting approaches; early behavioural issues	Family instability; poor school engagement; AOD use in home; social disadvantage	Strong family involvement; positive role models; school/ community belonging; recreation	Parents; teachers; health professionals; coaches	After-school activities; evidence-informed drug education; mentoring; recreation
12-17 years Adolescence	Early AOD use; risky drinking; vaping; mental health	Peer pressure; low school attachment; parental supply; mental health issues; easy access to AOD/vape	Clear family rules; trusted adults; positive activities; cultural connection; harm knowledge	Parents; teachers; coaches; peers	Youth programs; sport and recreation; school-based drug education; safe social events
18-30 years Young Adults	Risky drinking; drug use; drink driving; life transitions	Stress; unemployment; isolation; relationship issues; AOD availability	Supportive relationships; community belonging; work/ study pathways; harm information	Peers; employers; GPs	Employment support; harm-reduction education; social connection programs
30-50 years Mid-Adulthood	Risky drinking; medication use; stress; mental health	Work stress; conflict; chronic pain; sleep issues; isolation	Strong relationships; community connection; non-stigmatising health advice; healthy coping	Peers; GPs; family	Mental health support; community groups; sleep and pain management program
50-60 years Later Working Years	AOD use; prescription misuse; pain; sleep issues	Isolation; health problems; misunderstanding medication risks	Supportive networks; clear AOD/ medication information; social connection; wellbeing supports	GPs; peers; family	Health education; exercise programs; social groups; safe medication management
60-70 years Early Older Age	Poly-drug use; health decline; mobility issues	Elder abuse; retirement stress; isolation; misunderstanding AOD harms	Supportive carers; clear health advice; age-friendly activities; purpose and connection	GPs; carers; family	Age-friendly activities; mobility/ exercise support; community connection programs
70+ years Older Age	Alcohol-medication interactions; chronic health; bereavement	Pain; mobility limits; isolation; elder abuse	Strong support networks; safe health advice; social belonging; mobility and sleep support	GPs; carers; family	Social connection groups; gentle exercise; grief support; medication reviews

Acknowledgement: This information has been sourced from the Alcohol and Drug Foundation's Lifecycle planner. The full version is available at <https://community.adf.org.au/get-started/aod-lifecycle/> and is updated regularly as new evidence emerges.

Drivers of harmful AOD use



Effective primary prevention and early intervention address the causes of AOD use. AOD use is influenced by complex social and structural factors, commercial determinants, and individual risk and protective factors.

Identifying these factors, especially those that strongly impact local health and wellbeing, helps make sure the intervention is directed where it will be most effective.



Social determinants of health and wellbeing

Social determinants of health and wellbeing describe the conditions in which people are born, grow, live, work and age, and include broader systems and forces that shape daily life⁸¹. These forces can significantly impact AOD use and include^{9, 81}:

Economic Stability

Income, employment, and financial security affect access to resources and opportunities that promote health.

Education

Access to quality education and educational attainment influence health literacy, employment opportunities, and overall well-being.

Social and Community Context

Social support networks, community engagement, and the quality of interpersonal relationships can impact mental and physical health.

Health Care Access and Quality

Availability of and access to healthcare services, as well as the quality of care received, are crucial for maintaining health.

Neighbourhood and Built Environment

The physical environment, including housing quality, access to safe recreational spaces, environmental hazards, and density and location of alcohol outlets, can affect health outcomes⁸².

Food Security

Access to nutritious, affordable food is essential for maintaining a healthy diet and preventing diet-related diseases.

Structural factors

Colonisation, racism, stigma and discrimination help maintain social inequalities and disenfranchisement between different groups in society and can amplify health inequalities and harms from AOD use²².



Cultural determinants of health

Culture is not just a determinant of health; it is a powerful protective force. Cultural identity, connection to Country, kinship, language, and practices all contribute to positive health outcomes. The cultural determinants of health influence the social determinants of health and are equally as important for improving long-term wellbeing.

For Aboriginal and Torres Strait Islander peoples, health is a holistic concept. It encompasses physical, social, emotional, and cultural wellbeing across the life course of individuals, families and communities.

Strengthening cultural connection supports improved outcomes across broader social determinants. Embedding cultural determinants into primary prevention strategies helps in building sustainable, self-determined, and thriving communities.



Commercial determinants of health

The commercial determinants of health refer to activities by commercial actors that affect health. Examples include the role of the alcohol industry in promotion and advertising, product packaging and lobbying.

Commercial activities can help shape policy and the physical, environmental and social environments in which people live²². They can also influence behaviours and preferences around AOD consumption⁸³.

There are a range of actions that governments can take to regulate the commercial environment and limit harms, such as restrictions on advertising.

Other stakeholders, such as community members and groups, can also influence the commercial determinants of health. For example, engaging in consultation on local liquor license applications or referring a potentially undesirable liquor promotion to Liquor and Gaming NSW.



Risk and protective factors

Risk and protective factors either increase or decrease the likelihood of a person consuming alcohol or using drugs. Protective factors lower a person's chances of harm or reduce the impact of a risk factor. Risk factors increase a person's likelihood of experiencing harmful use.

While having a lot of risk factors can increase someone's risk of harmful AOD use, it does not mean they will develop AOD-related issues⁸⁴. Similarly, someone might have many protective factors but then go on to experience harmful AOD use⁸⁴.

Some common risk and protective factors, and the levels at which they exist, are^{9,12,22,79,85,86}:

Individual

Personal experiences of trauma, stress and mental health issues can increase risk of harmful AOD use, whereas optimism and good coping strategies and emotional regulation can decrease risk.

Interpersonal

Family attachments, parenting practice and peer use can work to protect or increase risk. For instance, parental AOD use and the supply of alcohol or other substances to underage children can increase the likelihood of harmful use. In contrast, positive parental role modelling and clear limit-setting can help protect young people from harm.⁸⁷

Community

Attachment to school and community, and the existence of opportunities for recreation and structured activities can decrease risk of harm. While social norms that encourage excessive drinking, high levels of crime and socioeconomic disadvantage can increase risk of harm.

Societal

The broader social determinants of health impact risk and protection at the level of society.

Risk and protective factors are not fixed. They vary between population subgroups and change across the lifespan.

For Aboriginal and Torres Strait Islander people, racism and intergenerational trauma caused by colonisation and government policies, are risk factors, while connection to culture and Country are protective factors^{22,88}.

In CALD communities, many cultural values, norms and ways of being are protective factors⁸⁹.

As children develop, their influences expand from primarily family to include school, peers and then the broader community¹². These shifting environments shape the risk and protective factors they are exposed to.

Major life events, like transitioning from prison or the death of a loved one can also influence risk of harmful AOD use⁹⁰⁻⁹³.

The interaction between risk and protective factors and social determinants of health is complex. Social determinants such as income, education, and access to healthcare can influence the presence of risk factors like stress, trauma, and social isolation, which in turn can increase the likelihood of harmful AOD use⁹⁴. On the other hand, protective factors such as strong social support networks, positive coping mechanisms, and access to mental health services can mitigate the impact of risk factors and reduce the likelihood of harmful use⁷⁴.

Fig. 1 (following) summarises the risk and protective factors for AOD use found in the literature.



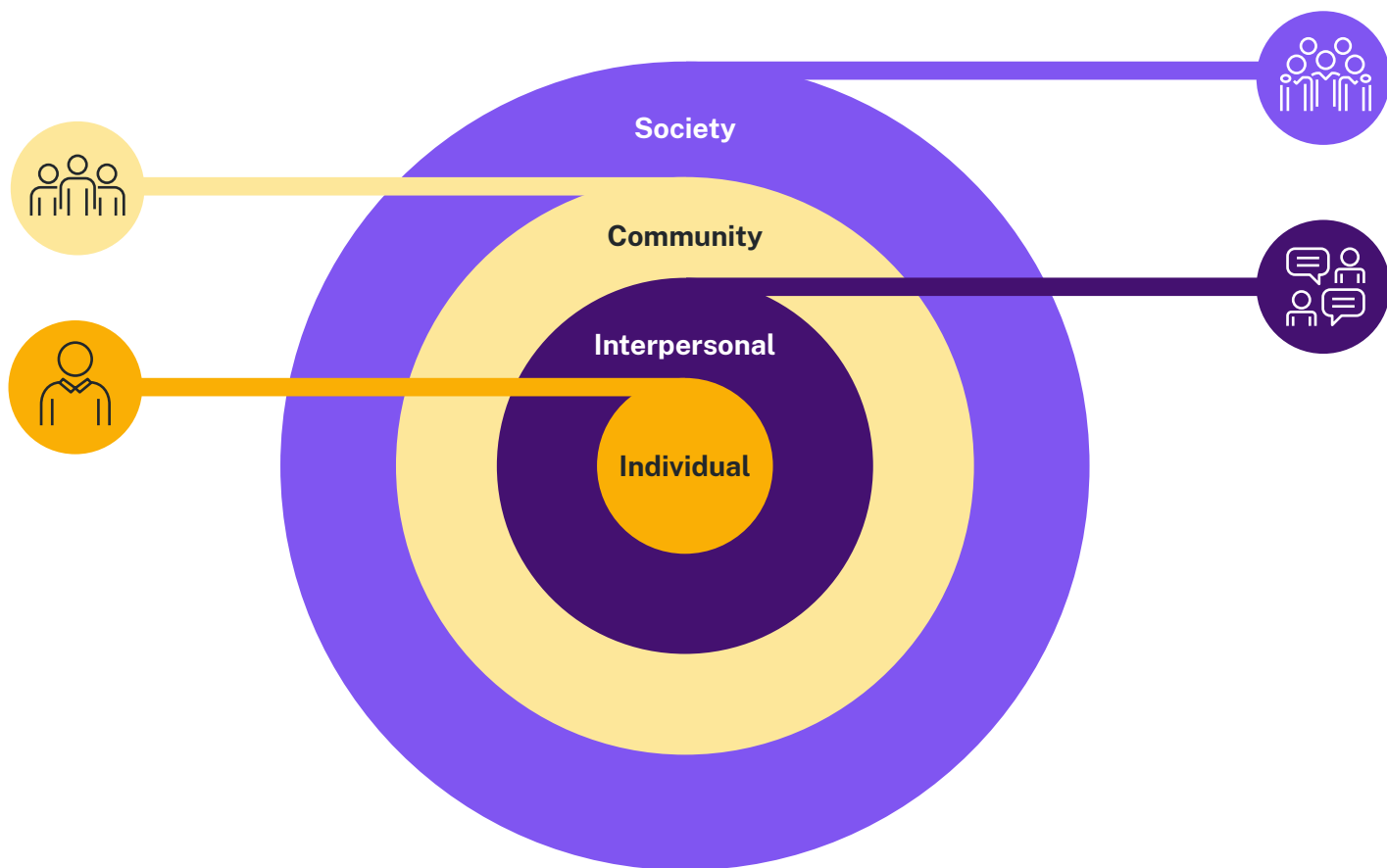


Figure 1: Examples of risk and protective factors for AOD use (adapted from the United Nations' substance use risk and protective factor model and Snijder et al's ecological model of drug and alcohol use)^{38, 41}

	Protective	Risk
	Factors that promote positive health and reduce substance use harms	Factors contributing to increased substance use harm
 Society	• Restrictions on price and supply	• Cheap and available supply • Lack of access to quality education • Racism • Commercial determinants
 Community	• Positive school environment • Sense of belonging and attachment to community • Opportunities for recreational, structured activities	• Poor school attachment • Community use and norms
 Interpersonal	• Positive family attachment • Effective parenting • Healthy relationships	• Peer use and norms • Poor family function • Parental use and supply
 Individual	• Optimism • Health knowledge • Emotional regulation • Good health and wellbeing	• Trauma • Stress • Genetic disposition • Poor coping skills • Mental health issues

Principles of effective primary prevention and early intervention



Effective primary prevention and early intervention programs share common principles. They guide intervention planning and support implementation. All AOD primary prevention and early intervention activities should align with these principles.



Holistic and multifaceted approach

Various factors influence the initiation of AOD use. One-off interventions are less likely to be effective or make a lasting impact. Effective primary prevention should target the individual and the broader underlying drivers, like community and societal factors, using a combination of whole-of-population, localised and targeted approaches (e.g. see figure 1).



Government coordination and collaboration

Effective primary prevention strategies cannot be developed in isolation. There needs to be a coordinated approach with complementary strategies across government agencies and sectors. There are significant AOD prevention contributions to be made in health, education, housing, licensing and regulation, and community and social services. Coordination is also required at all levels of governments, including local, state and Commonwealth.



Across the life-course

Effective primary prevention and early intervention should occur throughout life. Delaying or preventing uptake and preventing harmful AOD use is particularly important for children and young people as adolescence is a peak period for initiation. Studies have found links between early age of onset of drug use and severity of use and health harms later in life^{75,78,95,96}. However, all populations can benefit from prevention. Risk factors change through the life-course, so understanding the factors that influence different behaviours for different ages is critical in being able to respond effectively.



Evidence-informed

Approaches should be based on proven strategies. An evidence-informed approach prevents investing in initiatives that are ineffective, cause greater harm (for example through creation or reproduction of stigmatising images) or duplicate existing efforts⁹⁷. In cases where good quality data doesn't exist, investment and innovation can be supported by a strong theoretical framework, understandings of local context, human motivation and change processes. It is also important to develop and collect evidence of effectiveness as part of the implementation process (see next section). Evidence should be considered in the context where it will be used.





Innovation, evaluation and implementation monitoring

Initiatives must be monitored and evaluated to ensure they are effective and continuously improving. Significant gaps in primary prevention research exist due to limited robust research. Evaluating new initiatives and publishing results helps build the evidence base on what works in primary prevention, specifically for different local communities and groups. It can also highlight successful elements that can be applied to other primary prevention activities and drive innovation.



Community partnership, collaboration and co-design

Primary prevention initiatives should be designed in collaboration with the communities they are for to ensure they are relevant, culturally appropriate and effective. This includes adapting initiatives from mainstream or other fields. Co-design is a highly effective and inclusive approach to collaboration because it engages local communities in an equal partnership^{98,99}. Communities are best positioned to identify their own needs and determine the most effective ways to address them. Co-design is especially important for initiatives impacting Aboriginal and Torres Strait Islander populations where there is a history of inappropriate and culturally unsafe programs being enforced from the top down, undermining successful locally devised strategies and structures^{100,101}.



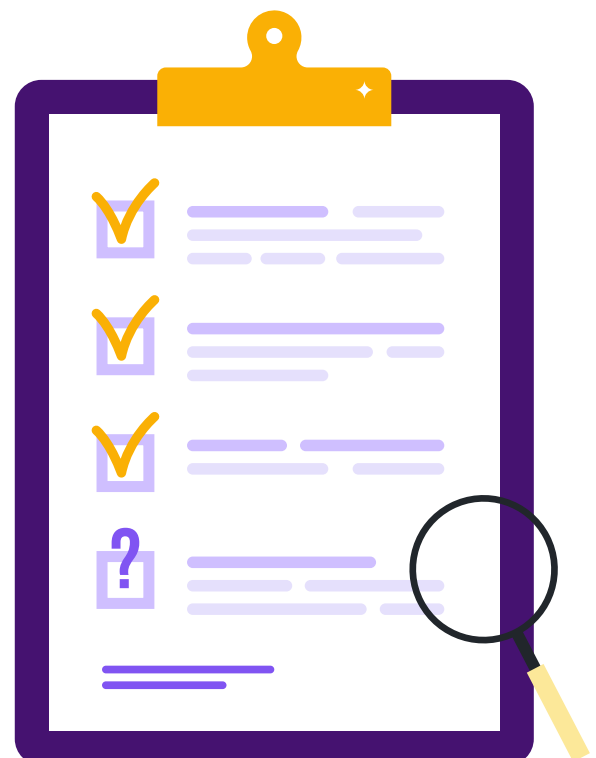
Human rights and equity

A human rights-based approach recognises and respects the human rights and dignity of every person, including the right to the highest possible standard of health and physical, mental and social well-being¹⁰²⁻¹⁰⁴. Some populations in NSW are disproportionately impacted by AOD-related harm. Applying an equity lens recognises the inequalities that exist and their underlying structural drivers. Using a human rights and equity lens ensures that all approaches are accessible, culturally safe, inclusive and value diversity.



Non-judgemental, non-stigmatising and non-discriminatory

People who experience harms from AOD frequently experience stigma and discrimination¹⁰⁵, which is a major barrier to accessing healthcare and other services^{106,107}. Prevention initiatives may unintentionally reinforce stigma and discriminatory attitudes towards people experiencing AOD harms^{97,108}. To avoid this, interventions must be evidence-based and avoid stigmatising language, imagery and behaviours. Working in partnership with people with lived and living experience of AOD use and other stakeholders ensures that language and approaches are inclusive and non-discriminatory¹⁰⁹.



The evidence built from evaluations

This section presents a synthesis of available evidence on effective initiatives across a range of approaches that can be considered by decision makers. By drawing together information that was previously fragmented, it provides a single, comprehensive and reliable resource to support the assessment and development of alcohol and other drug (AOD) primary prevention initiatives.



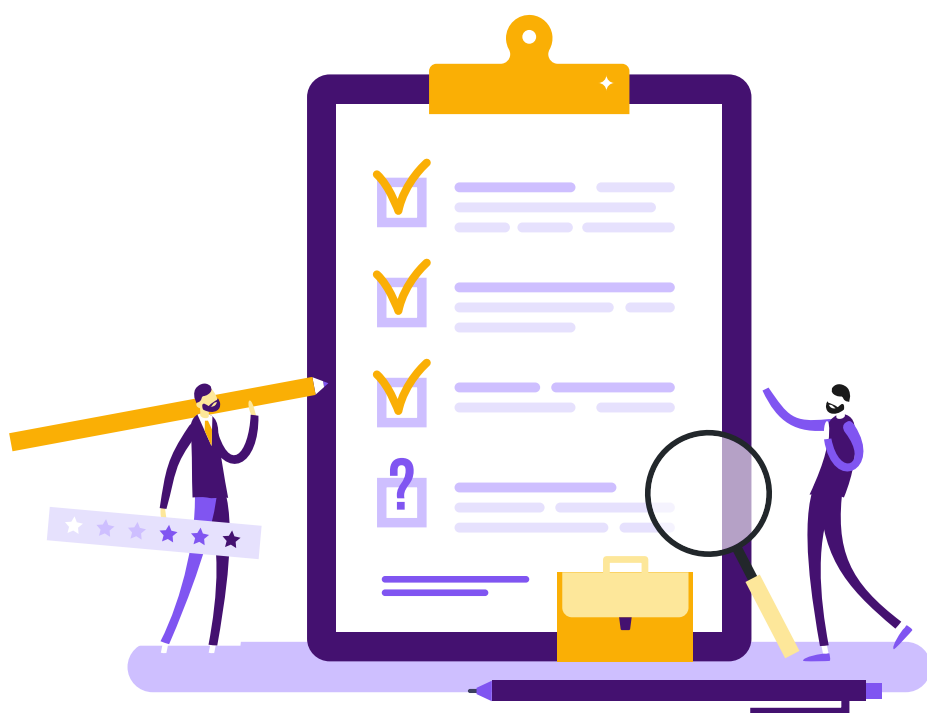
Approaches are most successful when multiple initiatives are combined

Prevention efforts are most effective when they comprise a coordinated suite of complementary initiatives rather than relying on a single intervention. Effective prevention programs target multiple risk and protective factors across the social ecology of individuals and communities. This includes interventions at the individual level (e.g. knowledge, skills and resilience), interpersonal level (e.g. family, peer and social influences), community level (e.g. schools, workplaces and local environments), and societal level (e.g. policies, legislation and social norms). By coordinating initiatives across these levels, prevention efforts can create mutually reinforcing effects that support healthy behaviours and reduce exposure to risk.

Consistent with the principles of effective primary prevention and early intervention (see page 18), initiatives should be developed and delivered in partnership with the communities they are intended to serve. Community engagement helps ensure that programs are culturally appropriate, responsive to local needs and priorities, and more likely to be accepted and sustained over time. **A comprehensive, community-informed approach is therefore more likely to achieve meaningful and lasting reductions in substance use and related harms than isolated or short-term interventions.**

As a result, the available evidence base is more limited for some initiative types and target populations than for others. **A lack of rigorous evidence should not be interpreted as evidence that an initiative is ineffective. Rather, it indicates that further research is required to determine whether, and under what circumstances, the initiative achieves its intended outcomes.** This limitation is particularly evident for initiatives aimed at preventing cannabis and other illicit drug use, where the evidence base remains comparatively underdeveloped. A notable exception is mass media campaigns, for which there is a more reasonable body of evidence demonstrating effectiveness in influencing illicit drug knowledge, attitudes and, in some cases, behavioural outcomes. In contrast, one-off community events have a reasonable body of evidence demonstrating a lack of effectiveness for illicit drug outcomes.

This guide is intended as a guide to support evidence informed decision making and should not be used to exclude consideration of emerging, innovative, or community led initiatives that may not yet have a strong evidence base. Innovation is critical to advancing prevention and early intervention practice, particularly in complex and evolving contexts. **Trialling new approaches, alongside appropriate monitoring and evaluation, is a key mechanism for growing the evidence base, strengthening practice knowledge and identifying new opportunities to improve outcomes over time.**



Draw on the evidence of what works

A large body of evidence has been built by researching and evaluating real programs in operation. The following provides guidance on which approaches are effective, the circumstances in which they are most likely to succeed, and the outcomes that can reasonably be expected.

The evidence of effectiveness for different initiative types varies according to the target population, setting, substance of concern, and intended outcome. An initiative that is effective in reducing alcohol consumption may not necessarily reduce alcohol-related harms, and approaches that are effective for alcohol may differ from those that work for other drugs. Similarly, interventions shown to be effective in schools may not achieve the same outcomes in workplaces, communities, or healthcare settings. Decision makers should therefore consider both the quality of the available evidence and its relevance to their specific objectives, target populations and implementation context.

Table 2: Evidence on AOD primary prevention initiatives

Initiative type	Page
Substance-free community activities (recurring or ongoing)	23
Substance-free one-off community events	24
Community education	25
Community sports clubs	26
Community coalitions and place-based initiatives	27
Parenting and family-based primary prevention – Perinatal	28
Parenting and family-based primary prevention – Early years	29
Parenting and family-based primary prevention – Children and young people	30
Police presence	32
Media campaigns	33
Workplace primary prevention strategies	34
Primary care: Screening and Brief Intervention and Referral to Treatment (SBIRT)	35
Technology-based / remotely delivered primary prevention services	36
Outreach and client advocacy	37
Government: Pricing regulations	38
Government: Restrictions on advertising and promotion	39
Government: Regulation of sales and availability	40
Government: Bans on sale / curfews	41
Government: Safety infrastructure / environmental strategies	42
Retailers: Responsible Service of Alcohol (RSA) training	43
Retailers: Licenced service policies	44

Substance-free community activities (recurring or ongoing)



Definition

Community-based activities designed to promote a substance-free lifestyle or to provide activities for young people to attend on a reoccurring or regular basis as a healthy alternative to using AOD.



Implementation

These activities are varied, though typically designed and implemented through funded community coalitions and involve community engagement and volunteers.



Sustainability

Short durations due to the significant amount of time and resources needed to manage these initiatives limits their sustainability.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
Perinatal and early years	- Free community-based activities - Skills building classes - Youth work experience - Health or fitness-based classes	- Activities involving joining fees - Using activities primarily as an AOD information delivery mechanism - Holding events in venues that do not sell or promote AOD use
✔ Children and Young People		
✔ Adults		
Older Adults		

Example: “Beat da Binge” was an Australian two-year project targeting binge or risky drinking that commenced in April 2010. The initiative involved the promotion of enjoyable alcohol-free activities to alleviate boredom among members of the Yarrabah Indigenous community in far north Queensland. Activities were offered with co-sponsorship from local organisations and included music, movie nights, self-defence training and restraint techniques (START), a touch-football camp, and boxing. The initiative was associated with increased awareness of risky drinking and a reduction in drinking. More information can be found [here](#):

Jainullabudeen TA, Lively A, Singleton M, Shakeshaft A, Tsey K, McCalman J, Doran C, Jacups S. The impact of a community-based risky drinking intervention (Beat da Binge) on Indigenous young people. BMC Public Health. 2015;15(1):1319. [Article is available here.](#)

Substance-free one-off community events



Definition

One-off substance-free community-based events, or “dry events” held to raise awareness of an identified AOD-related concern, discourage AOD use or encourage healthy lifestyle choices.



Implementation

This strategy is typically implemented as part of a wider primary prevention strategy through coalitions who have received funding to support AOD primary prevention.



Sustainability

One-off events or events with limited frequency lack sustainability.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
Perinatal and early years	• External hire of experienced event organisers • Marketing to raise awareness of the event • Community engagement to inform potential interest and event activities • Fun runs and healthy lifestyle programmes • Piggybacking on major annual events	• Promotion of generic events without a clear AOD-free association • Attendance by young people is low
✔ Children and Young People		
✔ Adults		
Older Adults		

Example: The ‘Community Action Project’ was an early demonstration program that combined an extensive mass-media campaign with the sponsorship of a rock band that was popular with some selected provincial cities in New Zealand in the 1980s. A series of rock concerts were held with the aim of changing attitudes about alcohol use. The impact of the program was shown by population surveys of attitudes toward alcohol availability and promotion with comparisons made with cities that received the media alone and with reference cities which were not exposed to either initiative. The combined initiative was shown to have the greatest impact. More information can be found [here](#):

Casswell S, Ransom R, Gilmore L. Health promotion and the alcohol industry: a critical analysis. Health Promotion International. 1990;5(1):9-17. [Article is available here](#).

Community education



Definition

Community education refers to the process of providing whole communities with information, resources, and support to reduce or prevent AOD use. It is often delivered via workshops or training sessions. Education can be delivered in different settings and may be formal (delivered in school or educational institutions), informal (unstructured and without curriculum, based on life experiences), and non-formal (structured but without formal certification of completion).

Within this guide, this initiative refers to formal education (when delivered outside of schools such as education workshops delivered by a research institution) and non-formal education (such as distributing educational flyers).



Implementation

The education content can be sourced through existing reputable services but often requires a researcher or community coalition lead to first identify local needs and funding to tailor resources to the local context.



Sustainability

The development of wide scale education requiring in-person delivery (training or workshops) is very resource intensive and so community education is often limited to distributing flyers with minimal impact.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
✓ Perinatal and early years	- Secure budget to enhance recruitment of educators and information dissemination - Follow up between education sessions to improve retention (for workshops or training) - Delivery is considerate of local circumstances, i.e. time and location is accessible, outside working hours, etc. - Target topics of locally identified concern - Harm reduction focus	- Limiting education to the impacts of AOD use - Single setting or targeted resource delivery - Impact will be limited for those with low literacy for text-based or text-heavy resources.
✓ Children and Young People		
✓ Adults		
✓ Older Adults		

Example: The 'Alcohol, less is better' project was a community-led initiative ran by community leaders and institutional and volunteer organisations in Italy between 1999 and 2006. The initiative involved a series of meetings held to educate and sensitise the population to alcohol-related problems alongside further community mobilisation. An existing population survey was used to assess alcohol consumption by comparing targeted communities with matched control communities. The initiative was associated with reduced consumption, particularly by males. More information can be found here:

Bagnardi V, Sorini E, Disalvatore D, Assi V, Corrao G, De Stefani R, Collaborative 'Alcohol, less is better' Group. 'Alcohol, less is better' project: outcomes of an Italian community-based prevention programme on reducing per-capita alcohol consumption. *Addiction*. 2010;105(11):1912-9. [Article is available here.](#)

Community sports clubs



Definition

Sports clubs are well positioned to deliver alcohol primary prevention strategies focused on reducing overall consumption during sporting events and preventing risky drinking around sporting premises. Strategies typically include tailored practices and policies to improve the safety of the club environment.



Implementation

Participating sports clubs can apply for funding, typically supplied through government led initiatives, to facilitate implementation. In NSW, interested clubs can generate an AOD policy through the “Good Sports” program which is managed through the Alcohol and Drug Foundation.



Sustainability

This initiative is limited to club settings and requires commitment from club management.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
Perinatal and early years	- Commitment from club management and staff - Higher levels of participation (including written policy changes to reduce alcohol promotions) - Prohibiting free or cheap alcohol promotions and alcohol sponsorships	- Sports clubs with limited commitment to implementation - Assuming compliance with liquor licensing laws without reviewing current practices - Immediate changes to drinking practices following implementation is unlikely - May have an impact on children and young people but no evidence to date - Alcohol/industry sponsorship of events may have an impact on consumption and harms (see Regulation of sales and availability below).
Children and Young People		
Adults		
Older Adults		

Example: The ‘Good Sports’ program, run through the Alcohol and Drug Foundation, offers a two-step online accreditation program that is free for all Australian community sporting clubs. This program has been evaluated and demonstrated that, while alcohol consumption is high in community sports clubs, less alcohol consumption occurred in clubs who had greater participation in the program. More information can be found at [Good Sports - Alcohol and Drug Foundation \(adf.org.au\)](https://www.adf.org.au/good-sports)

Rowland B, Allen F, Toumbourou J. Impact of alcohol harm reduction strategies in community sports clubs: pilot evaluation of the Good Sports program. *Health Psychology*. 2012;31(10):323-333. [Article is available here.](#)

Community coalitions and place-based initiatives



Definition

Community coalitions refer to formal collaborative partnerships between public, private organisations and community organisations, within a shared community. They often involve multiple sectors such as government agencies, schools, healthcare providers and non-governmental community organisations. These intersectoral partnering organisations collaborate and pool resources to build local community or organisational capacity, and action a shared goal such as preventing AOD use and harms within their community. They are often referred to as place-based initiatives.



Implementation

Community coalitions are typically formed by a well-connected lead organisation who is an early identifier of a local AOD priority. Community coalitions typically act as the mechanism to identify, plan and deliver other initiatives described in this guide.



Sustainability

Community coalitions based solely on voluntary participation have difficulties with sustainability.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
✓ Perinatal and early years	• A shared understanding of roles and responsibilities among partnering agencies with an agreed upon lead • Coalitions who are supported to identify evidence-based strategies to achieve their shared goal • Connection to the community is key and coalition membership should include representatives from all local cultural backgrounds • High performing coalitions include representatives from local council, health sector, police and education	• Supporting locally suggested activities without considering research evidence • Undefined goals or lack of clear communication of specific AOD prevention targets • Community input is key. External funding to coalitions should minimise conditions on areas of focus and specific activities • Partner agencies who may have conflicting interests
✓ Children and Young People		
✓ Adults		
✓ Older Adults		

Example: In Australia, there are two main programs that provide funding to support the formation of coalitions; the Local Drug Action Team (LDAT) program and Community Drug Action Teams (CDATs) program. The LDAT program is nation-wide and the CDAT program is based in NSW only. Both programs offer financial and technical support to coalitions with the aim of building local capacity to address local alcohol and other drug issues. Other programs that are founded upon coalitions, such as Communities That Care (CTC), provide services that offer similar support but with a greater focus on involving schools. The CTC program has been extensively evaluated and shown impact in Australia and internationally.

[Local Drug Action Team program overview](#) | [ADF Community Hub](#)
[NSW CDAT -Odyssey House NSW](#) | [Alcohol and drug recovery programs](#) | [Communities That Care](#)

Parenting and family-based primary prevention – Perinatal



Definition

Programs that promote family planning, secure attachment, positive parenting, education, employment and nutrition for potential parents or parents and carers of children in the perinatal phase (at the time of becoming pregnant and up to a year after giving birth) and that address or minimise AOD use.



Implementation

Available around pregnancy particularly for families at high risk of AOD use. Programs can be integrated into existing health visit programs or can be delivered in other settings. Support is provided for parents of children up to 1-2 years of age.



Sustainability

These programs have limited reach, requiring health service infrastructure and specifically trained health workers.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
Perinatal and early years Children and Young People Adults Older Adults	- Delivered by health workers who have specific training - Support families to address a range of socioeconomic issues (health, housing, employment, legal, etc.) - Follow clinical guidelines for highly dependent women during pregnancy and advise women about no alcohol in pregnancy and associated risks including Foetal Alcohol Spectrum Disorder (FASD)	- Judgemental and stigmatising language - Parenting programs only focused on the mother (rather than parents/carers)

Example: Nurse Family Partnerships (NFP) is a program targeted at low-income households and involves nurse visits from pregnancy through to the child’s second birthday: [Nurse-Family Partnership \(NFP\) - Nursed visiting low-income homes, from pregnancy to the second birthday | www.euda.europa.eu](#)

Family Foundations is a universal program that aims improve coparenting among couples expecting their first child. It provides pre-and post-natal group sessions. The program provides advice and discussion on emotional self-management, conflict management and communication: [www.blueprintsprograms.org/programs/family-foundations](#)

Parenting and family-based primary prevention – Early years



Definition

Programs that promote secure attachment, positive parenting, education, employment and nutrition for parents and carers of children in the early years.



Implementation

Programs can be integrated into existing health visit programs for new mothers or can be delivered in other settings. Support is provided for parents of children 2-6 years of age.



Sustainability

These programs have limited reach, requiring health service infrastructure and specifically trained health workers.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
✓ Perinatal and early years	- Delivered by health workers who have specific training - Support the development of parenting skills and include strengthening protective factors, e.g., increasing parents' mental health, physical health, housing and nutrition - Support families to address a range of socioeconomic issues (health, housing, employment, legal, etc.)	- Judgemental and stigmatising language - Parenting programs only focused on the mother (rather than parents/carers)
Children and Young People		
Adults		
Older Adults		

Example: Triple P (Positive Parenting Programs) aim to prevent and treat social, emotional and behavioural problems in children by enhancing the knowledge, skills and confidence of parents. Programs are offered for families with children from birth to age 16, and include child assessments, parenting seminars and skills-training sessions. Research suggests Triple P may lead to effective family outcomes (although there are substantial risk of bias in some studies). The Australian Government offers free Triple P parenting courses: <https://www.triplep-parenting.net.au/au/free-parenting-courses/triple-p-online-under-12>.

Other examples of parent and family based programs with children in early years are Generation PMTO Home - (generationpmt.org) and Parentcorps: <https://www.blueprintsprograms.org/programs/parentcorps>

Parenting and family-based primary prevention – Children and young people



Definition

Structured programs that recognise the role of families in a child's development by involving parents and family in AOD primary prevention activities. These programs may include psychosocial approaches that aim to enhance protective factors while addressing risk factors around a range of behaviours (not just AOD use alone).

Programs often provide education, support, and resources to parents to help them build effective parenting skills and communication strategies and foster a supportive family environment that reduces the likelihood of children engaging in harmful AOD use.



Implementation

Programs typically involve several sessions delivered by specially trained counsellors to groups or individual families in community settings, participant homes or schools (inside or outside school hours). Family-focused primary prevention may also be delivered in primary health care settings or by paediatricians.



Sustainability

This initiative is resource intensive, involving trained counsellors in paid positions delivering multiple sessions, with limited scope beyond small groups or individual families.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
Perinatal and early years	- Counsellors must have specific training - Programs focused on parental skill building and fostering parent-child relationships - Programs may provide information about AOD use, develop AOD-related house rules, encourage parental monitoring and supervision, and improve parent-child communication - Focused on reducing parental supply of alcohol - More effective when focused on families with children in early adolescence	- Programs focused only on education involving fact sheets or information-only resources - Encouraging punitive responses to adolescent substance use - Programs focused on parents or children alone and not as a unit
✓ Children and Young People		
Adults		
Older Adults		

Example: “EFFEKT” is a Swedish intervention that is used in some European countries. It seeks to reduce teenage alcohol use by changing parental attitudes. Parents are encouraged to communicate a zero-tolerance position on alcohol, establish agreed rules about alcohol use and social activities with other parents of children in the same class, and access information about organised community activities that offer an alternative to drinking. More information can be found here: https://www.euda.europa.eu/best-practice/exchange/effekt%C3%B6rebro_en

Other examples of parenting and family based programs include the [Strengthening Families Programme](#) and [PROTEGO](#).

Police presence



Definition

This strategy refers to the strategic and highly visible deployment of police officers in and around community areas associated with high rates of AOD-related incidents and crime and includes police presence around one-off events, such as music festivals.

In relation to alcohol, where policing of alcohol-related incidents is part of a package of interventions, there is good evidence to support this initiative as deterring individuals from drinking excessively.

In relation to other drugs, there is some evidence to suggest that police presence at events like music festivals, can have a limited deterrence effect on the consumption of drugs. However, police presence can also change drug use behaviours to become more risky, increasing harms, including overdose. These risks should be considered and can be mitigated through approaches less likely to encourage risky behaviours.



Implementation

This strategy is supported by a partnership between police and organisations with data on community priority areas relating to AOD incident rates or crime and information on AOD harm reduction.



Sustainability

Increasing enforcement activities is likely to require external funding.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
Perinatal and early years	- Increasing police presence on historically problematic weekends or locations known for alcohol-use - Identifying areas with high rates of Alcohol-related incidents and crime should involve community consultation to complement health and crime data	Drug detection dogs have limited detection efficacy and may increase risky drug-use behaviours
✓ Children and Young People		
✓ Adults		
✓ Older Adults		

Example: A multi-component community intervention that focussed on police enforcement, the ‘Student08’ initiative in Stockholm, ran in Sweden during the Spring of 2007. The police were informed by event coordinators and local restaurants regarding student parties and increased their presence accordingly. Data from emergency departments showed a decrease in violence-related injuries associated with the initiative. More information can be found [here](#):

Ramstedt M, Leifman H, Muller D, Sundin E, Norstrom T. Reducing youth violence related to student parties: Findings from a community intervention project in Stockholm. *Drug and Alcohol Review*. 2013;32(6):561–565. [Article is available here](#).

Media campaigns



Definition

Media campaigns refer to conveying specific AOD prevention-related evidence-based information, or to raising awareness of wider AOD prevention initiatives, to whole communities through various forms of mass media such as television, radio, or social media. These messages can also be promoted by respected individuals.



Implementation

The specific information for dissemination must be evidence-based and ideally developed following a process of co-design with the intended audience.



Sustainability

Developing and delivering a media campaign is extremely resource intensive, typically requiring funds from government grants or sponsor organisations.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
✓ Perinatal and early years	- Reach specific populations through intentionally placed printed media or by using social media advertisement algorithms - Campaigns which promote healthy life-style choices and raise awareness of AOD health impacts - Campaigns which support wider AOD primary prevention initiatives	- Most research shows impacts on intentions rather than actual behaviour “Antidrug” campaigns and scare tactics can be stigmatising and deter help seeking, and can encourage use among some young people
✓ Children and Young People		
✓ Adults		
✓ Older Adults		

Example: “The Australian ‘Spread’ campaign aims to increase awareness of alcohol-caused cancer. This campaign is a joint initiative between the Mental Health Commission and Cancer Council Western Australia and has been evaluated to have a likely impact on consumption.

[Spread Campaign | Alcohol Think Again](#)

Workplace primary prevention strategies



Definition

Workplace primary prevention strategies refer to the promotion of policies, rules or guidelines to prevent workplace AOD use or to reduce any related risks. It can also include providing cultural change initiatives, providing evidence-based AOD prevention-related information and support to employees through the workplace, and the use of alcohol or drug testing.



Implementation

Workplace primary prevention is typically implemented by workplaces who have joined with a community coalition to gain access to evidence-based AOD-prevention resources or who otherwise have access to services and resources such as those supplied by the National Centre for Education and Training on Addiction (NCETA). Workplaces can then distribute this information to employees, provide other support or use sobriety checks where relevant.



Sustainability

Workplace strategies require ongoing monitoring and mechanisms for effective communication and pathways to support.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
Perinatal and early years	- Workplace activities should be culturally appropriate, comprehensive and address employees' home lives - Policies developed in consultation with employees and that are clearly communicated - Testing must consider employees' right to privacy, and protocols to avoid specimen tampering to ensure the validity of results	- Lack of data to support any critical elements to workplace strategies - Unclear at which point strategies should be implemented (such as when starting, following job changes or annually) - Brief or information only strategies are less effective than strategies that include feedback or follow-up - Evidence of effectiveness of workplace drug tests on use is weak - Use of drug or alcohol tests ethically questionable where immediate workplace safety is not a primary concern
Children and Young People		
✓ Adults		
✓ Older Adults		

Example: A workplace initiative involving the introduction of a formal workplace alcohol policy, employee and management training programs and a referral pathway was implemented in stages over one year in two Australian manufacturing companies. The two companies were compared with a third company which did not receive the initiative to show a comparative increase in awareness of policies and assistance available, although there was no significant difference in risky drinking. More information is available here:

Pidd K, Roche A, Cameron J, Lee N, Jenner L, Duraisingam V. Workplace alcohol harm reduction intervention in Australia: Cluster non-randomised controlled trial. *Drug and Alcohol Review*. 2018;37(4):502–513. [Article is available here.](#)

Primary care: Screening and Brief Intervention and Referral to Treatment (SBIRT)



Definition

SBIRT can be provided within primary healthcare services by general practitioners or other health professionals or could be self-directed (digitally). Standardised screening questions can be asked and based on the individual's responses, a targeted conversation about AOD use and referral to more intensive treatment can be provided. A 'brief' intervention typically comprises five or fewer sessions of a total duration of less than 60 minutes.



Implementation

Screening and brief interventions can include an initial screening process (to all patients or those at high risk) asking about AOD-related risk or harm, providing personalised feedback on AOD-related risks or harms and strategies to reduce AOD use. There is increasing evidence in support of using technological innovations to extend SBIRT to those who may be reluctant to seek help in person or are unable to attend health services.



Sustainability

SBIRT requires initial investment into training, and identification of validated screeners and protocols. Effort focused on training up existing workers in SBIRT (including workers without AOD training) in SBIRT may increase workforce capacity around AOD, going some way to address the current shortage of access to AOD services in some parts of the state.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
Perinatal and early years	- Using a patient-centred or empathic approach to focus on the therapeutic alliance - Using evidence-based (validated) screening tools - Use of motivational interviewing techniques such as providing decisional balance and goal-setting exercises that focus on building motivation to reduce AOD use	- Providing information only - Advice based only on the opinions of the clinician without using evidence-based tools such as the Alcohol Use Disorder Identification Test (AUDIT)
✓ Children and Young People		
✓ Adults		
✓ Older Adults		

Example: In 2003, the Substance Abuse and Mental Health Services Administration (SAMHSA) endorsed SBIRT through a grant program to promote the adoption and sustained implementation of SBIRT in the US. Through this grant, a large trial of 17,575 patients in various medical settings was conducted. The initiative was associated with a substantial reduction in alcohol use as well as illicit drug use. More information is available [here](#):

Aldridge A, Linford R, Bray J. Substance use outcomes of patients served by a large US implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT). *Addiction*. 2017;112(S2):43–53. [Article is available here](#).

Technology-based / remotely delivered primary prevention services



Definition

Advances in technology and telecommunications provide the opportunity to deliver AOD primary prevention services to even the most remote locations and to those who may not otherwise access traditional services due to travel requirements or perceived stigma. Strategies may involve short-term or ongoing support such as through helplines, mobile application (“apps”) online programs, or remotely delivered contingency management, as well as the delivery of self-help information or resources.



Implementation/ Sustainability

These strategies operate on a broad spectrum of resource requirements. Strategies requiring significant resources may involve digital platforms requiring ongoing maintenance and updates or those needing support from remote workers. Low-cost strategies would include automated text messaging services.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
Perinatal and early years	- Services must take steps to protect confidentiality and maintain privacy “Blended” care models which incorporate both self-directed efforts and remotely delivered counselling - Feedback and contingency management to enhance engagement - Text-messaging is effective at delivering information, however evidence around its impact on use or related-harms is limited - Programs of more than five sessions have shown greater impact than less intensive programs	- Further research is required to understand the key program components of apps such as use of feedback, consumption tracking, gamification, or user profile - Further research needed to determine impact among people consuming AOD at higher levels
✓ Children and Young People		
✓ Adults		
✓ Older Adults		

Example: The Rethinking Drinking initiative ([RethinkingDrinking.niaaa.nih.gov](https://www.rethinkingdrinking.niaaa.nih.gov)) is a popular resource developed in the US by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The website offers free alcohol education, and access to interactive tools for assessing and understanding drinking patterns with personalised feedback and suggested strategies to reduce drinking.

Outreach and client advocacy



Definition

This initiative refers to community outreach or case management, where a service provider meets an individual in their environment to form a relationship or build rapport before providing services, including practical or emotional support and referral to services. This initiative is aimed at individuals who are homeless, have experienced family disruption or lack of engagement with schooling or employment.



Implementation

This initiative may be implemented in fixed locations such as a drop-in centre or health service that are easily accessible, as well as by mobile outreach in which health workers meet people in their usual environment.



Sustainability

AOD use concerns may be a secondary target for this initiative which addresses social, economic and material challenges. The sustainability of this initiative will reflect the location or reach of services and the flexibility of the service to response to the needs of those who are within reach.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
Perinatal and early years	• Use of peer workers with knowledge of key locations may have increased visibility and credibility • Community partnerships and inter-agency collaboration required to enhance referral options • Service must be able to address individuals with complex needs such as severe mental health conditions and poverty	• Coercive measures for enforcing referral to services • There is a lack of evidence for a best practice model. However, a dose-response relationship is likely where time to build rapport and level of support offered impacts on outcomes
✓ Children and Young People		
✓ Adults		
✓ Older Adults		

Example: Advocacy Australia provides direct relief and support for individuals, children, families and marginalised groups. Through their advocacy work, Advocacy Australia aims to relieve the suffering, distress and helplessness of individuals, children and families and also acts to prevent harm and promote the right of Australians to achieve the highest attainable physical, emotional and mental health.

Advocacy Australia-Awareness | Equity | Social Justice

Government: Pricing regulations



Definition

This strategy refers to introducing increases in the price of alcohol.



Implementation

There are many methods to implement this strategy though it typically includes taxation. Constitutionally, only the Australian Government can change alcohol taxation; however, methods that are within the remit of State Government include increasing licensing fees paid to sanction the selling of alcohol or tobacco, increasing minimum unit pricing (a minimum cost per unit of alcohol), or the banning of volumetric discounts (such as “buy one, get one free” offers) or other promotional practices such as “Happy Hour”.



Sustainability

The impact of price increases on the demand curve are more pronounced in the long term and rely on sustained implementation.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
Perinatal and early years	Pricing regulations have an impact on population level consumption rates (i.e. increasing price lowers consumption), particularly on younger people and those with heavier drinking patterns	- Less evidence for narrow pricing strategies (such as those targeting spirits only) or for short term strategies such as time-limited discounts - Pricing strategies will be ineffective if not adequately enforced - Impact can be moderated by community income, affordability of alcohol, and levels of unrecorded consumption (home-produced or illicitly obtained alcohol) - Considered by some to be a regressive tax (imposed on those least able to afford it)
✓ Children and Young People		
✓ Adults		
✓ Older Adults		

Example: The Living With Alcohol (LWA) program, introduced a special tax on beverages with greater than 3% alcohol content by volume to fund education initiatives and introduce treatment and rehabilitation services over five years in the Northern Territory. Evaluation of data collected by the Australian Bureau of Statistics showed a reduction in alcohol-attributable acute and chronic conditions. More information is available here:

Chikritzhs T, Stockwell T, Pascal R. The impact of the Northern Territory's Living With Alcohol program, 1992-2002: revisiting the evaluation. *Addiction*. 2005;100(11):1625 – 1636. [Article is available here](#).

Government: Restrictions on advertising and promotion



Definition

This strategy refers to federal or state policies or reforms to regulate the advertising, marketing and promotion of alcoholic beverages.



Implementation

Policies can include full advertising bans, partial bans, the regulation of internet-based advertising and social media marketing, and statutory or voluntary codes of conduct. Partial bans can apply to certain products (e.g. spirits) or to types and location of advertising (e.g. bans near schools, TV bans at certain hours) or bans on promotions at certain events (e.g. sports sponsorship).



Sustainability

This low-cost initiative requires sustained implementation and monitoring to respond to new marketing strategies and platforms.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
Perinatal and early years	• There is strong evidence that exposure to advertising and promotion is associated with alcohol consumption and increased consumption • Full bans likely offer the best protection from marketing impact • Advertisement restrictions should be statutory and monitored by governmental regulatory agency	• Evidence of intervention impact on use and harms is weak and mixed but precautionary principle is relevant given link between advertising and use • Positive benefits of partial bans only likely to only be short-term • Digital/online marketing harder to recognise and regulate • International evidence suggests that voluntary self-regulation codes are regularly breached • Alcohol sponsorship of sporting events is not regulated in NSW
✓ Children and Young People		
✓ Adults		
✓ Older Adults		

Example: The Victorian state government announced new legislation in 2017 banning alcohol advertisements within 150 metres of a school: <https://www.vic.gov.au/responsible-alcohol-advertising-and-promotions>

The World Health Organization lists advertising bans one of their 'best buys', and has a number of resources on their website: <https://www.who.int/initiatives/SAFER/alcohol-advertising>

Government: Regulation of sales and availability



Definition

This strategy refers to policies, laws or reforms that govern the sale and consumption of alcohol through liquor licensing (bans on sales and curfews are dealt with separately below).



Implementation

Sales restrictions are through licensing provisions and include trading hours and days, the number and density of retailer outlets, minimum legal purchase age and whether premises are permitted to provide online sales, off-premise sales or on-premise consumption.



Sustainability

The sustainability of new policies is largely determined through the level of community support and the likelihood of industry opposition.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
Perinatal and early years	- Lower outlet density is associated with lower alcohol consumption and lower alcohol-related harms including injury and violence - Evidence, while inconsistent, suggests restricting alcohol sales on particular days can affect overall rates of drinking and harms	- Evidence more consistent between large changes in alcohol availability and consumption levels, but less clear for smaller or more gradual changes - Reducing operating hours by less than two hours is unlikely to have significant impact. Some evidence for imposing whole-day limits to sales - Can be competing government priorities to boost night life, local economies and creative arts sectors
✓ Children and Young People		
✓ Adults		
✓ Older Adults		

Example: The sale and consumption of alcohol in NSW is regulated by the NSW Government Liquor & Gaming agency: <https://www.liquorandgaming.nsw.gov.au/operating-a-business/liquor-licences/liquor-licence-types>

Government: Bans on sale / curfews



Definition

This strategy refers to the introduction of enforceable rules or regulations that prohibit or restrict the sale, purchase or consumption of alcohol either by the time of service (such as in “lockouts”) or by specific geographic areas (such as the areas surrounding public beaches or other high traffic locations), or during specific events, such as festivals.



Implementation/ Sustainability

Considering the potential social and financial impact of this strategy, implementation should be informed through consultation with the communities and businesses that would be impacted by changes.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
Perinatal and early years	- Delivered as part of a wider strategy including community education to raise awareness and consistent media coverage - Ongoing location bans enforced with increased police presence or perceived presence, supported by neighbourhood watch	- Lack of adequate enforcement “Lockouts” has the potential for displacement of harms from one location to another - Some evidence that lockouts not more effective than restricted trading hours, managing outlet density and employing price restrictions
✓ Children and Young People		
✓ Adults		
✓ Older Adults		

Example: “In 1995 a ban on alcohol consumption at Piha beach, a popular tourist destination in New Zealand, was introduced after the community experienced a ‘spate’ of alcohol-related problems. The ban was petitioned for by residents and supported with a publicity campaign throughout Piha. When compared to the previous summer period, the initiative was associated with a decline in alcohol-related incidents. More information is available [here](#):

Conway K. Booze and beach bans: turning the tide through community action in New Zealand. Health Promotion International. 2002;17(2):171–177. [Article is available here](#).

Government: Safety infrastructure / environmental strategies



Definition

This strategy refers to changing the physical environment within a community to reduce the environmental risk factors that contribute to AOD consumption and harms. Examples may include installing surveillance cameras, or improving public transport options.



Implementation

This strategy is typically initiated or driven by community coalitions and involves a risk assessment before subsequent environmental changes are implemented by local governmental bodies to reduce risk.



Sustainability

Making these changes takes time and often requires partnership with local council or governing bodies and ongoing monitoring.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
✓ Perinatal and early years	• Risk assessment is key to informing responses • Well maintained bars, comfortable, uncrowded venues	• Environmental strategies can be expensive and are rarely evaluated for cost-effectiveness
✓ Children and Young People		
✓ Adults		
✓ Older Adults		

Example: A 'community safety action project' was launched first in Surfers Paradise in 1993 and then in three North Queensland cities between 1995 and 1996. Part of the initiative was to conduct safety audits of the spaces in and around venues that served alcohol and to make required changes; introduce security checks; and reduce the number and density of venues. The initiative was associated with reductions in observed incidences of alcohol-related violence and male drunkenness. More information is available [here](#):

Hauritz M, Homel R, McIlwain G, Burrows T, Townsley M. Reducing violence in licensed venues through community safety action projects: the Queensland experience. *Contemporary Drug Problems*. 1998;25(3):511–551. [Article is available here](#).

Retailers: Responsible Service of Alcohol (RSA) training



Definition

This strategy refers to training licensed venue operators in the responsible service of alcohol, including legal responsibilities, identifying intoxicated patrons, and providing information and resources on alcohol risks and harm reduction.



Implementation

This strategy involves ensuring staff participate in appropriate training or can show accreditation. Increasing the confidence of staff to refuse the service of alcohol to intoxicated or under-age patrons is a critical component of the responsible service of alcohol.



Sustainability

This strategy may need to be repeated regularly even within a single venue due to staff turnover and to identify areas that may require greater attention.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
Perinatal and early years	- Participation in accredited courses - Incentivised training directed to managers, bar and security staff - Implementing frequent risk assessments - Provide information about the strategy, why it is beneficial to the industry and community, and what kind of commitment is necessary	- Lack of consistent regulation/ policing by authorities of implementation of RSA actions - One-off training with no follow-up or feedback process - Home delivery and RSA: new Responsible Supply of Alcohol Training (RSAT) for same day alcohol delivery in NSW has been introduced but no evaluation to date
✓ Children and Young People		
✓ Adults		
✓ Older Adults		

Example: RSA and RSAT training is regulated by the NSW Government Liquor and Gaming Industry. More information on RSA can be found here: [Responsible Service of Alcohol \(RSA\) - Liquor & Gaming NSW](#).

More information on RSAT can be found here: <https://www.liquorandgaming.nsw.gov.au/working-in-the-industry/training-to-work-in-the-industry/getting-trained/responsible-supply-of-alcohol-training-rsat>

Retailers: Licenced service policies



Definition

This strategy involves retailers of alcohol using in-house store policies, tools, and the training of venue staff and security personnel on methods to maintain a safe environment in and around licensed venues. This strategy can include maintaining a register of patrons known to be frequently intoxicated or aggressive, developing clear policies on when and why service will be refused, and enforcing service bans where appropriate. (It does not include RSA, covered above).



Implementation

Venue management may need additional resources for staff training and clear communication mechanisms around store policies for staff and patrons.



Sustainability

This strategy requires top-down support from retail management and mechanisms to recognise and resolve difficult situations within the serving venues and surrounding community that may arise from implementing service bans.

Life stage typically targeted	Conditions under which the initiative can have positive effects	Limitations and cautions
Perinatal and early years	• Clear code of practice and mechanisms to monitor compliance • Increasing compliance around times or events known to be associated with increased drinking • Being mindful of community needs and preferences when adapting venue policy or introducing service bans • Facilitating the uptake of service policies through training • Creating a regulatory environment which is financially worthwhile for licensees to adhere and enforceable through law	• Unregulated, voluntary participation by venue staff • Policies limited to patron behaviour that do not consider the impact of staff behaviours that may act to encourage consumption • Low knowledge and understanding of patron banning. Ban breaches are common especially when relying on the visual recognition of patrons
✓ Children and Young People		
✓ Adults		
✓ Older Adults		

Example: Liquor & Gaming NSW have a range of guidelines and resources for licensed venues to assist in creating a safe environment: <https://www.liquorandgaming.nsw.gov.au/working-in-the-industry/serving-alcohol-responsibly>

Appendix 1: Strategic context

4

Strategic context

In NSW, most of the health budget has always been committed to acute care delivery. This aligns with the state's historic treatment-focused approach to healthcare. With chronic conditions now the leading cause of disease burden in Australia, there is a growing emphasis on primary prevention to reduce avoidable illness and improve population health.

In recognition of this, many state and national health policies prioritise evidence-based primary prevention efforts. Alcohol and other drugs are significant risk factors for chronic diseases and injuries, and actions to prevent, delay or reduce use feature in many of these policies.

State

[Future Health: Guiding the next decade of health care in NSW 2022-2032](#) emphasises the importance of investing in prevention to promoting wellness and early intervention.

[The NSW Cancer Plan 2022-2027](#) highlights the importance of reducing alcohol consumption as part of cancer prevention efforts.

[NSW Aboriginal Health Plan 2024-2034](#) highlights the importance of prevention as part of the broader commitment to improving health outcomes for Aboriginal people in NSW. Emphasising the need for initiatives that reduce the incidence and severity of health issues, including substance use, through proactive approaches.

[NSW Special Commission of Inquiry into the drug 'ice'](#) found that preventing and delaying AOD use is a critical component of AOD policy and that there should be greater effort in responding to harms before they occur, in preventing use and preventing transition to more risky and harmful use.

The [2024 NSW Drug Summit](#) recognised primary prevention and early intervention as a key priority area.

National

[National Drug Strategy 2017-2026](#) is the main guiding document for Australia's national approach. It provides a national framework for action that can accommodate new and emerging AOD issues and provides a guide for jurisdictions in developing their individual responses to local AOD concerns.

[National Preventive Health Strategy 2021-2030](#) is a 10-year plan to strengthen the focus on prevention in Australia's health system. It aims to improve health and wellbeing for all Australians by addressing broader health factors, reducing inequalities, and lowering disease rates.

[National Foetal Alcohol Spectrum Disorder \(FASD\) Strategic Action Plan 2018-2028](#) lists prevention as one of four national priorities for FASD.

Appendix 2: Overview of process and method for developing the guide

5

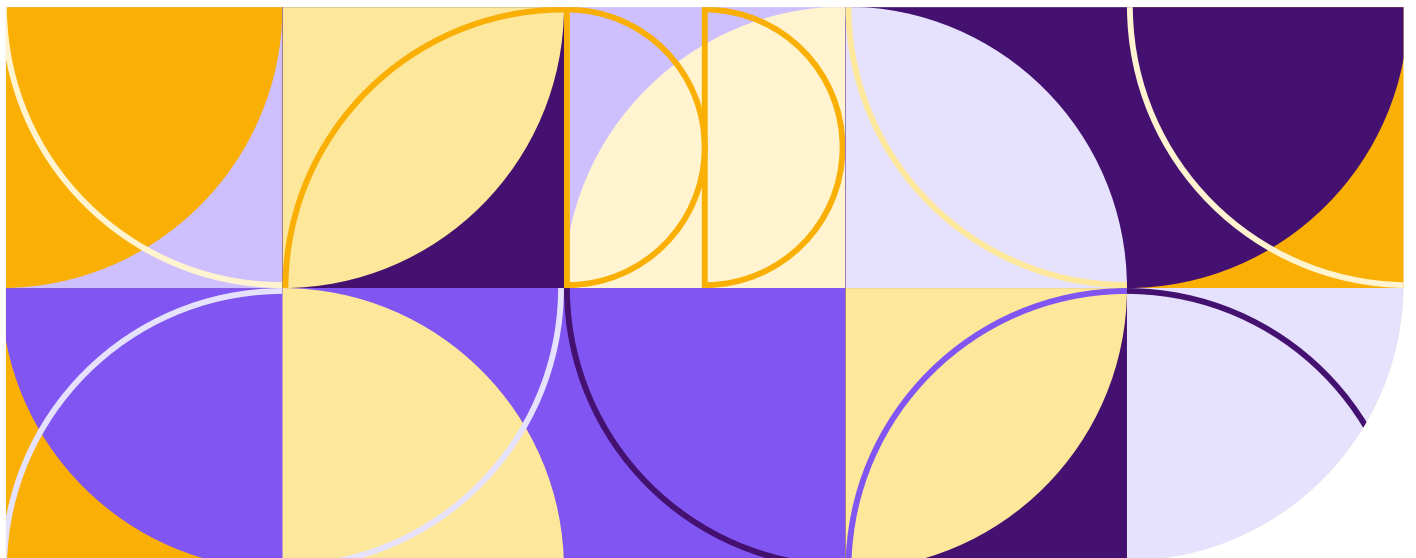
Overview of process and method for developing the guide

The guide was developed through a multi stage consultation process and evidence review led by NDARC and the Drug Policy Modelling Program for the NSW Ministry of Health.

Stakeholder engagement occurred across two consultation rounds, involving government agencies, community organisations, peak bodies, priority population representatives and subject matter experts. Feedback from online forums, interviews and written submissions directly informed both the initial structure and the full draft of the guide. Final refinements were made following internal review by CAOD experts and Executive, with additional evidence incorporated to support key positions.

The evidence review drew on a structured, library-supported search strategy across major databases including Embase, PsycINFO, PubMed and Cochrane Reviews limited to articles published in English in or after 2015. Searches incorporated terms relating to substances, patterns of use, prevention and early intervention, and systematic review methodologies. This process identified over 2,000 records, which were screened by title and abstract to remove duplicates and non-relevant studies, resulting in a curated dataset of approximately 680 systematic reviews and meta-analyses. Evidence was synthesised by intervention type and population group and cross checked against existing national and international prevention frameworks.

Foundational evidence sources included key international frameworks such as the United Nations International Prevention Standards, the European Monitoring Centre for Drugs and Drug Addiction European Prevention Curriculum, and the World Health Organization Best Buys, supplemented by high-quality reviews relevant to the Australian context and prior systematic reviews conducted by the project team. Additional targeted searches were undertaken for specific priority populations to ensure comprehensive coverage, as well as examples of interventions, with priority given to high-quality study designs, including randomised controlled trials where available.



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6

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