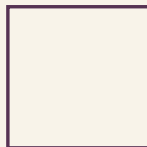
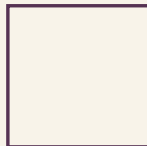




Australian Government

Department of Education, Science and Training



Principles for school drug education





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Principles for school drug education



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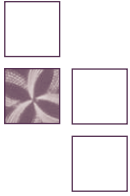
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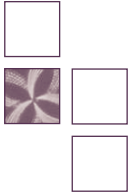
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Introduction

This document presents a revised set of principles for school drug education. The principles for drug education in schools comprise an evolving framework that has proved useful over a number of decades in guiding the development of effective drug education.

The first edition of *Principles for Drug Education in Schools* (Ballard et al. 1994) has provided a strong foundation for school drug education within Australia. *Principles for School Drug Education (2004)* has been prepared in response to emerging needs and outcomes of research in drug education and curriculum practice. Like the 1994 document, the 2004 Principles will be updated in response to future developments and professional feedback.

Background

In 2001 The National Drug Research Institute and the Centre for Youth Drug Studies at the Australian Drug Foundation were commissioned to review the 1994 Principles for the Commonwealth and did so through a literature review and consultation with a cross-section of stakeholders in school drug education. The outcomes of that project (Midford et al. 2002) formed the basis for this new set of Principles. In response to findings from that research, Lois Meyer of Learning Paradigms was commissioned to revise the format of the Principles, based on feedback from a series of national workshops with stakeholders and the most recent research in the field, to provide an evidence-based document.

School drug education

In this document, the term 'school drug education' is intended to encompass all policies, practices, programs and initiatives/events in schools connected with the prevention and reduction of drug-related harm.

There is a growing body of evidence suggesting that drug-related risk and harm share common causal pathways with other health and social outcomes such as youth suicide, social dislocation, mental health and sexual health problems, and that prevention and early intervention along these pathways can make a difference across those outcomes.

The potential for drug-related harm to affect young people is influenced by a range of factors that occur in the many different domains of their lives, including the community, family and school. Schools can and do make a difference, not only through their programs but also through the opportunities for learning and support that they bring to their students. In any consideration of school drug education it needs to be kept in mind that schools can contribute to, but not be expected to or be held fully accountable for, preventing or reducing students' drug use.

What is the purpose of the Principles?

The Principles for School Drug Education provide a framework of core concepts and values to support effective drug education practice within schools. They are intended to guide school executive, teachers and staff, as well as families, community agencies and other stakeholders, in making decisions related to drug education practice within school communities.

This document is not intended as a 'How to ...' manual, a set of detailed guidelines or an action plan for planning and implementing school drug education. Rather, the Principles are a broad set of underpinning concepts that collectively describe an ideal of effective practice. They are intended to underpin practice without describing exactly what it should look like. Given the diverse settings within which Australian schools exist, schools will interpret and implement these Principles to meet their own needs.

What are the Principles based on?

The 2004 Principles build on the Principles for Drug Education in Schools (Ballard et al. 1994) and recent research on effective drug prevention within school contexts. They are underpinned by current theory and research into what works in drug prevention and the promotion of health and wellbeing within school contexts.

Research of effective drug education programs

The Principles draw on drug prevention research that focuses on the features of effective drug education programs and the critical components for effectiveness. This body of research has focused largely on aspects of what and how programs should be delivered to impact on student's behaviour in relation to drug issues.

Research on the role of social environments and resilience

The Principles also draw on more recent research literature on youth development and resilience in determining the health of young people. This research stems from a range of disciplines that are now beginning to overlap, including epidemiology, social capital and life trajectory studies. It is now clear that young people's attachment and connection to others, through the quality of their relationships and their social environments, affects their health and academic achievement. We now know that the culture, relationships and opportunities in schools contribute to young people's social and academic outcomes and that these are relevant to a range of behaviours including drug use. Without reducing the role of drug education programs, research is demanding a shift in focus so that curriculum and classroom learning is seen as part of a broader and comprehensive approach to drug prevention and minimising drug-related harm for students and the school community.

What is the overall approach?

Evidence-based practice

The 2004 Principles use an evidence-based approach to inform their design. Evidence-based practice involves taking the best available evidence from a variety of reliable sources, considering its relevance and applying it to the situation to achieve an effective intervention.

In substance and format, the Principles promote an evidence-based approach. They have been written using current theory and research. Thus, for each Principle a summary of the research on which it has been based is provided, along with, for those interested in the research underpinning each Principle, clear indications of the literature that can be accessed to find out more.

The Principles suggest that it is important that the concept of evidence-based practice is implemented at the school level. This means that, within their own community context, schools draw on current theory and research in drug prevention and apply what is relevant to their needs and students, and evaluate the outcomes to determine effectiveness.

Comprehensive whole school approach

There is an increasing recognition of the need for comprehensive approaches to tackling drug use problems in young people. It is now recognised that there are multiple layers to drug use, involving the individual, their relationships to peers, family, school and community, as well as broader structural factors, all of which interconnect and are relevant to a young person's health outcomes. One-off, single approaches are viewed as limited. The 2004 Principles promote a comprehensive approach to drug education involving a whole of school response which addresses programs, the school environment and relationships with the broader community. Schools are encouraged to provide a multi-dimensional response that seeks to foster positive social networks and support structures within which young people have clear expectations for their conduct as well as opportunities to participate in the life of the school and the broader community.

A whole school approach requires moving beyond traditional notions of a teacher being responsible for drug education lessons within the health curriculum. The school executive, staff and all teachers have a role to play. A class program becomes part of a system-wide approach that seeks a comprehensive response across the school's policies, practices and programs.

Nurturing a positive climate and relationships across the school community is as fundamental to addressing drug-related harm for young people as is determining appropriate classroom programs.

How is this document structured?

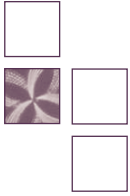
This document has been structured so that it can be used in different ways depending on needs and interest.

Section 1: Overview and summary provides a brief outline of the Principles, summarising the key themes and concepts. The 12 Principles are set out in summary over a double page for ease of use.

Section 2: The Principles, key considerations and evidence base provides the Principles in detail. Here each Principle is accompanied by a list of key considerations for its use, and an accompanying one-page summary of the evidence base that underpins it. The latter is a summary of key research findings that provide the current evidence base from which the Principle derives.

The format for this main section of the document is set out below:

<p>The key theme or area for the principle</p> <p><i>Summary phrase for the principle</i></p> <p>Principle</p> <p>Comment</p>	<p>Evidence Base</p>
<p>Some key considerations</p> <ul style="list-style-type: none"> • • • 	



Section 1: Overview and Summary

The 12 Principles for school drug education provide a broad conceptual tool to inform the planning, implementation and review of school drug education programs, policies and practices.

The Principles are intended to convey the essence of what is currently understood as effective school practice, without prescribing a specific set of actions or procedures within a school. The specifics of effective practice are dependent upon the local context and needs and the Principles have been developed so they can be interpreted at this level.

The 12 Principles are:

■ **Interrelated**

The Principles overlap and inform each other and are best understood and applied in an holistic and integrated manner.

■ **Broad and generic**

They embrace fundamental and general guidelines for effective school drug education and need to be understood and applied within the context of the school community and its specific needs and priorities.

■ **Focused on school-based interactions and interventions**

They are intended to assist school communities to address factors within their sphere of influence.

■ **Embedded within a broader health promoting approach**

They are consistent with broader principles for the promotion of physical and mental health and wellbeing within school communities.

■ **Informed by, and support, evidence-based practice**

They have been developed using current research and evaluation of effective curriculum practice. The Principles support the use of evidence-based practice as central to effective drug education.

The 12 Principles are organised around four key interconnecting themes for effective school drug education:

- Comprehensive and evidence-based practice,
- Positive school climate and relationships,
- Targeted to needs and context, and
- Effective pedagogy.

Diagram 1 outlines these four key themes.

Diagram 2 provides an overview of the Principles, showing the four themes and the key concepts for each.

Diagram 1: Outline of the key themes of the Principles

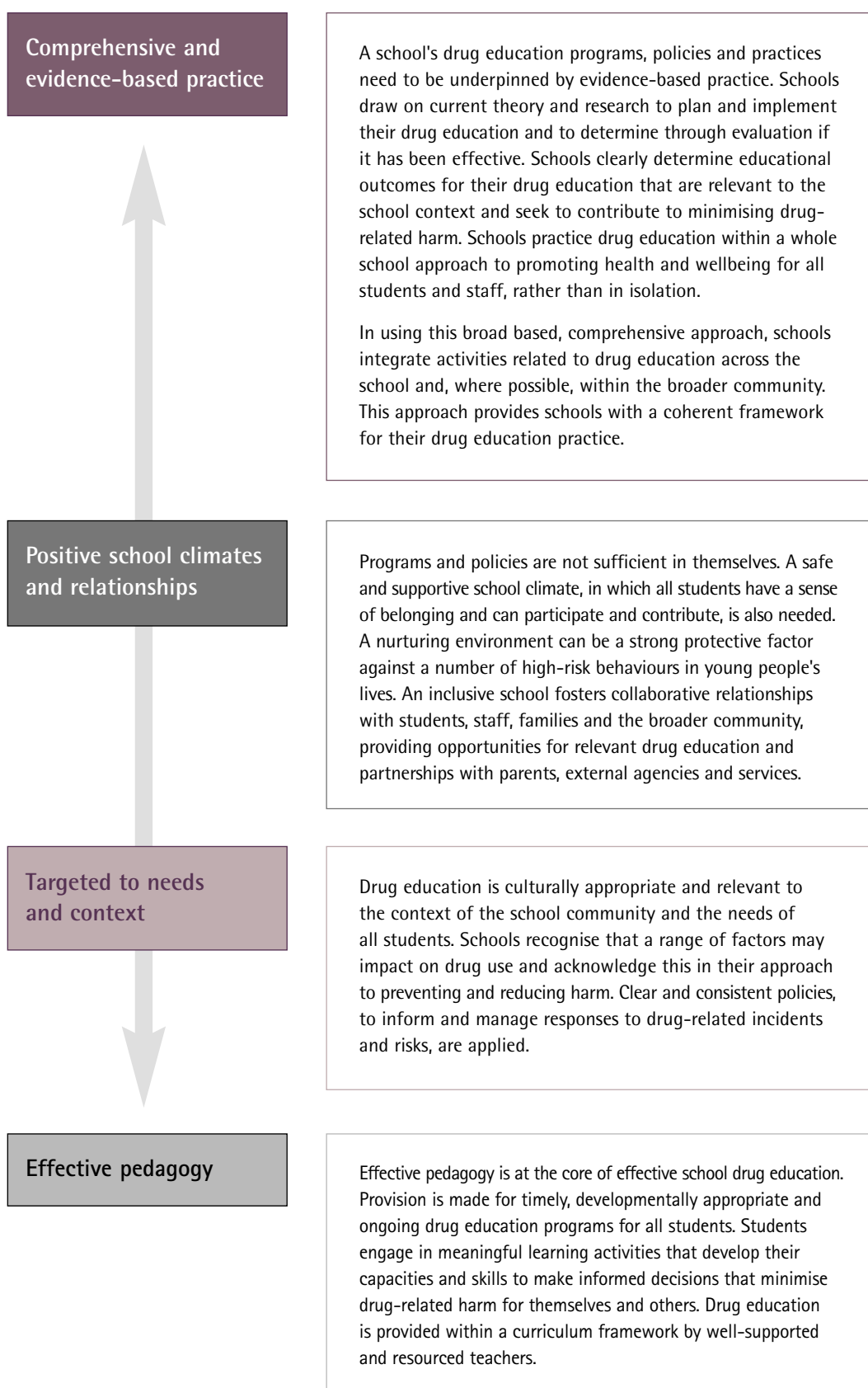


Diagram 2: Overview of the school drug education Principles, Themes and Key Concepts



Framing and underpinning effective school drug education is **Comprehensive and evidence-based practice** involving:

- 1: School practice based in evidence
- 2: A whole school approach
- 3: Clear educational outcomes

Part of a school's ability to provide effective outcomes for minimising drug related harm is through promoting a **Positive school climate and relationships** ensuring there is:

- 4: A safe and supportive environment
- 5: Positive and collaborative relationships

Each school needs to determine what is required to meet their own students through drug education that is **Targeted to needs and context** by ensuring:

- 6: Culturally appropriate and targeted drug education
- 7: Recognition of risk and protective factors
- 8: Consistent policy and practice

At the core of the Principles is **Effective pedagogy** involving:

- 9: Timely programs within a curriculum framework
- 10: Programs delivered by teachers
- 11: Interactive strategies and skills development
- 12: Credible and meaningful learning activities

Principles for School Drug Education

Comprehensive and evidence-based practice

School practice based in evidence

Principle 1: Base drug education on sound theory and current research and use evaluation to inform decisions.

Drug education needs to be based on what works. Evidence-based practice within a school involves staff: using current theory and research to determine programs that are appropriate to their students; staying informed about effective curriculum practice; applying professional judgement to implement and monitor programs; and evaluating outcomes to determine their impact. Regular evaluation of the school's drug education processes and outcomes is critical, providing evidence of the value of activities and informing future school practice.

A whole school approach

Principle 2: Embed drug education within a comprehensive whole school approach to promoting health and wellbeing.

Tackling drug-related issues in isolation and only at a classroom level is less likely to lead to positive outcomes. Drug education activities are best understood and practiced as part of a comprehensive and holistic approach to promoting health and wellbeing for all students. Through a whole school approach schools can provide a coherent and consistent framework for their policies, programs and practices.

Clear educational outcomes

Principle 3: Establish drug education outcomes that are appropriate to the school context and contribute to the overall goal of minimising drug-related harm.

When schools establish agreed goals and outcomes for drug education they have a common understanding for consistent and coordinated practice. The process of ensuring that those goals and outcomes are clear and realistic supports schools in achieving targets within their sphere of influence.

Positive school climate and relationships

Safe and supportive environment

Principle 4: Promote a safe, supportive and inclusive school environment as part of seeking to prevent or reduce drug-related harm.

A safe and supportive school environment is protective for young people against a range of health related risks, including substance use problems. A positive climate within and beyond the classroom fosters learning, resilience and wellbeing in students and staff. An inclusive school provides a setting where students, staff, families and the broader community can connect and engage in meaningful learning, decision-making and positive relationships.

Principles for School Drug Education continued

Positive and collaborative relationships

Principle 5: Promote collaborative relationships between students, staff, families and the broader community in the planning and implementation of school drug education.

Schools that use collaborative processes whereby students, staff, families and the broader community are consulted, are more likely to provide relevant and responsive drug education. Broad approaches that integrate school, family, community and the media are likely to be more successful than a single component strategy. Strong relationships with families, external agencies and the broader community can enhance students' sense of connectedness, and support access to relevant services.

Targeted to needs and context

Culturally appropriate and targeted drug education

Principle 6: Provide culturally appropriate, targeted and responsive drug education that addresses local needs, values and priorities.

Drug education needs to be relevant to all students. In providing programs, schools should be sensitive to the cultural background and experience of students. Diverse components of identity, including gender, culture, language, socio-economic status and developmental stage, should be considered when providing drug education that is targeted to meet students' needs.

Recognition of risk and protective factors

Principle 7: Acknowledge that a range of risk and protective factors impact on health and education outcomes, and influence choices about drug use.

Drug education should be based on an understanding of the risk and protective factors that affect young people's health and education. Schools that recognise the complexity of issues that may impact on students' drug use are in a better position to provide relevant drug education.

Consistent policy and practice

Principle 8: Use consistent policy and practice to inform and manage responses to drug-related incidents and risks.

The school's discipline and welfare responses should protect the safety and wellbeing of all students and staff. Policies and procedures to manage drug-related incidents and support students who are at risk are best determined through whole school consultation and implemented through well-defined procedures for all school staff. Vulnerable students may require additional support from the school and relevant community agencies. Retaining students in an educational pathway should be a priority of care for students who are at risk.

Principles for School Drug Education continued

Effective pedagogy

Timely programs within a curriculum framework

Principle 9: Locate programs within a curriculum framework, thus providing timely, developmentally appropriate and ongoing drug education.

Drug education programs are best provided within a clear curriculum framework for achieving student learning outcomes. Drug issues should be addressed within a broader health context relevant to students concerns and stage of development. The timing and continuity of drug education across students' schooling is critical. Programs should commence before young people start to make decisions about drug use, be developmentally appropriate, ongoing and sequenced, and provide for progression and continuity.

Programs delivered by teachers

Principle 10: Ensure that teachers are resourced and supported in their central role in delivering drug education programs.

Teachers are best placed to provide drug education as part of an ongoing school program. Effective professional development and support enhance the teacher's repertoire of facilitation skills and provide current and accurate information and resources. Appropriately trained and supported peer leaders and visiting presenters can complement the teacher's role.

Interactive strategies and skills development

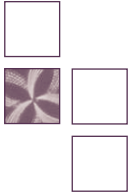
Principle 11: Use student-centred, interactive strategies to develop students' knowledge, skills, attitudes and values.

Skills development is a critical component of effective drug education programs. Inclusive and interactive teaching strategies have been demonstrated to be the most effective way to develop students' drug-related knowledge, skills and attitudes. These strategies assist students to develop their problem solving, decision-making, assertiveness and help-seeking skills. Inclusive methods that ensure all students are actively engaged are the key to effective implementation of interactive strategies.

Credible and meaningful learning activities

Principle 12: Provide accurate information and meaningful learning activities that dispel myths about drug use and focus on real life contexts and challenges.

Students need credible and relevant information about drugs and the contexts in which choices about drugs are made. They need to engage in meaningful activities with their peers, examine the social influences impacting on drug use and encounter normative information about the prevalence of use, which is typically lower than students expect.



Section 2: Principles, Key Considerations and Evidence Base

Comprehensive and evidence-based practice

School practice based in evidence

Principle 1: Base drug education on sound theory and current research and use evaluation to inform decisions.

Drug education needs to be based on what works. Evidence-based practice within a school involves staff: using current theory and research to determine programs that are appropriate to their students; staying informed about effective curriculum practice; applying professional judgement to implement and monitor programs; and evaluating outcomes to determine their impact. Regular evaluation of the school's drug education processes and outcomes is critical, providing evidence of the value of activities and informing future school practice.

Some key considerations

The importance of using sound theory and research

- Applying sound theory, research and evaluation to meet the needs and context of the school community and its students is critical to effective school drug education.
- Using intuition, ideology and unexamined assumptions can do harm, in some cases actually increasing the likelihood of drug use. Programs need to be based on sound theory and rigorously implemented to meet the needs and contexts of students.

The research available to inform school drug education decisions

- A comprehensive and expanding research base, from a range of disciplines, is available to inform the design and implementation of drug education in schools.
- International research on drug education programs has distinguished the key components of effective programs. These programs are defined as those that have demonstrated a reduction in drug use or risk-taking behaviours.
- Studies confirm that effective drug education programs are those based on the needs and interests of students, and which address their contexts, cultural backgrounds and experiences. They suggest that schools access local prevalence data, engage in community consultation and monitor needs and priorities, to determine relevant and culturally appropriate drug education for their students.

The use of monitoring and evaluation to inform practice

- Evaluating the school's drug education means systematically collecting, analysing and interpreting information on how the school's drug education related activities operate and their possible effects – positive and/or negative. Evaluation of drug education objectives, processes and outcomes provides formal evidence of the effectiveness of a school's approach and can inform improvements for the future.
- Monitoring the school's drug education should be conducted as part of the evaluation to check progress of outcomes. Monitoring might encompass teaching programs and practices, school climate, policy and procedures and referral capability.
- The literature clearly identifies the importance of well-implemented drug education programs if they are to achieve their intended results. Monitoring programs to determine that they are being implemented as intended can support effective implementation and provide meaningful evaluation of drug education outcomes.
- The educational literature on the development of expertise and professional judgement indicates that teachers use critical reflection to monitor and inform their own drug education practice.

Evidence base

The importance of using sound theory and research

Midford, Snow and Lenton (2001) note that intuitive and ideologically driven decisions have led to some poor choices in drug education and that poorly conceptualised programs can actually do harm. They recommend that programs be designed and selected on the basis of research. Hansen (1997) notes that theory driven efforts are distinguished from intuitive efforts by a reliance on a body of formalised research and that there is increasingly a shift to data driven prevention that can target the components of effectiveness. Dusenbury and Falco (1995) identify research-based, theory driven curriculum to be a critical component of effective drug education. Cuijpers (2002), in a systematic review of drug education, identifies programs having 'proven effects' as one of seven quality criteria for effectiveness.

The research available to inform school drug education decisions

Meta-analyses of drug education programs conducted by Dusenbury and Falco (1995) and Tobler et al. (2000) have distinguished the key components of effective drug education. Hawks et al. (2002), in their review of what works in the area of prevention for school-based programs, note the importance of the timing, relevance and continuity of interventions to ensure programs are based on needs and context. They suggest harm minimisation goals be included within program design and that careful consideration be given to including additional components to classroom-based delivery. They identify the critical features for program content and delivery, including the use of: life skills; a social influence approach; peer interactions and interactive methods; utility knowledge; a focus on behaviour change; teacher training; and effective programs through appropriate dissemination and evaluation methods.

Dusenbury and Falco (1995) identify cultural sensitivity as a critical component of effective drug education programs. White and Pitts (1998) suggest that there is a need to determine cultural appropriateness when considering the application of recommended components.

Tobler (2000) makes clear that the concept of what constitutes a drug education program is changing and that effectiveness needs to be understood beyond classroom-based features and content, to encompass system-wide changes across the school community. Cuijpers (2002) also suggests that research on school drug education entails going beyond classroom-based programs to include consideration of school culture and partnerships.

The use of monitoring and evaluation to inform practice

Dusenbury and Falco (1995) identify evaluation as a critical component of effective drug education. They propose that an important question to ask is, 'Has the program had an impact on drug use behaviour?'. Midford, Snow and Lenton (2001) suggest that programs should be evaluated to measure achievement against stated objectives and that these should be based on what can be realistically achieved to equip young people with the skills to keep themselves safe from drug-related harm.

McBride et al. (2000) note that the fidelity of implementing a program is not usually taken into consideration in evaluations, thus leading to poor results, ie expectations are based on full implementation rather than the reality of part completion. Tobler et al. (2000) note that if peer interactions and skills development are not implemented as intended, the effectiveness of the program will be reduced and this relates to teachers' professional development, capabilities and awareness.

Educational literature on the development of professional judgement and expertise (Schon, 1987; Eraut, 1994; Beckett and Hager, 2002) proposes the use of critical reflection to promote understanding of one's own teaching practice. This body of research suggests that trained teachers monitor and evaluate their teaching through critically reflecting on their own practice. This literature provides a useful adjunct to the drug education research on the importance of monitoring and evaluation.

Comprehensive and evidence-based practice

A whole school approach

Principle 2: Embed drug education within a comprehensive whole school approach to promoting health and wellbeing.

Tackling drug-related issues in isolation and only at a classroom level is less likely to lead to positive outcomes. Drug education activities are best understood and practised as part of a comprehensive and holistic approach to promoting health and wellbeing for all students. Through a whole school approach schools can provide a coherent and consistent framework for their policies, programs and practices.

Some key considerations

The need for comprehensive school drug education

- Seeking to prevent and reduce students' drug use through isolated programs that focus on drug issues only is not helpful. Comprehensive programs that place drug education within a broader health context and reinforce learning activities through a multifaceted approach are needed.
- Recent research confirms that drug-related outcomes for young people should be understood within a broad set of factors that can impact on health and wellbeing. Risk of problematic drug use is not an isolated issue but is related to a range of factors that can impact on a young person's learning, mental health and other life outcomes. An holistic approach that understands and addresses drug-related issues within a broader context of promoting health is required.
- The recent literature on what determines individual and community health and the factors that can lead to problematic drug use, clearly invites a comprehensive, broad based approach to drug prevention.
- A consistent and integrated approach best supports schools as they engage in health promotion that may range from prevention through to early intervention and referral. Prevention for students includes a broad health education curriculum as well as ongoing provision of student welfare/pastoral care. Schools can also play a key role in the early identification of students at risk of harm due to their own or another's drug use. Early intervention is provided in the form of additional care, support and referral.
- The following have been identified as important considerations for a comprehensive approach by schools to the promotion of health and wellbeing:
 - an approach that covers many aspects of health rather than a categorical or narrow focus;
 - relevance and attention to reinforcement across schooling and beyond, where practicable;

- empowering students to participate in a range of teaching and learning strategies with adequate time provided;
- integration of programs within a supportive school policy framework;
- maintenance of a healthy physical and social environment;
- well trained teachers;
- collaborative (and cooperative) involvement of teachers and students;
- involvement of health services; and
- adequate evaluation.

A whole school approach provides a coherent and consistent framework

- A whole school approach uses a coherent and consistent framework for drug education through policy, curriculum, student welfare/pastoral care, incident management, and partnerships with family, community and agencies. A whole school approach promotes health and wellbeing across the school community's processes and practices.
- The concept of the Health Promoting School (HPS), offering the three domains of curriculum, school ethos or environment and school partnerships, provides an integrated framework within which schools can design or review policy, practices, curriculum and partnerships.

Evidence base

The need for comprehensive school drug education

Dusenbury (2000) notes that the research suggests that the most effective drug prevention programs take a broad based, comprehensive approach that includes family, community and media interventions (Hawkins, Catalano and Kent 1991; Penz et al. 1989; Perry and Kelder 1992).

O'Donnell et al. (1995) argue that comprehensive programs are not only likely to succeed but have multiple benefits. Dusenbury (2000) recommends that school drug prevention will be more effective when targeted beyond a single setting and/or problem behaviour; that teachers should seek to extend their prevention efforts to be as comprehensive as possible, through engaging the family and community in learning activities. Roberts et al. (2001) propose 'seek comprehensiveness' as an important principle for the prevention of youth substance use and suggest that schools need to adopt a comprehensive approach by coordinating with families and the broader community as well as by being comprehensive within school organisational policies, programs and messages.

The Australian National Council on Drugs report *Structural Determinants of Youth Drug Use* (Spooner, Hall and Lysnkey 2001) distils research on the multiple and broad factors that influence drug use in young people. They note that problematic drug use is part of a range of problem behaviours that should not be seen in isolation, and recommend that drug prevention programs adopt a broad view that recognises the ineffectiveness of 'single, one shot strategies'. The report clearly recommends the need for comprehensive, coordinated and consistent strategies across communities, where possible. Similarly, the Australia's National Mental Health Strategy recognises the complex factors that impact on health and wellbeing and proposes that the causes of mental health problems (including drug-use disorders) require collaborative, inter-sectoral partnerships to promote social and emotional wellbeing (Sawyer et al. 2000, p 17).

Patton (1999) has identified that some of the most impressive demonstrations of change in adolescent behaviour have come from more broadly based interventions in schools. Elements have included addressing school policies and their enforcement, addressing classroom organisation and professional development of teachers in behaviour management strategies.

A whole school approach provides a coherent framework for drug education

The National Health and Medical Research Council (NHMRC) (1996) found that comprehensive and integrated health programs, which address the curriculum, environment and community, are more likely to lead to advancements in the health of school children and adolescents. They note that health behaviours can be fostered through the adoption of a whole school, broad based integrated and comprehensive approach involving the community. Integrative frameworks such as that of the Health Promoting School (HPS) are recommended to assist schools to take a whole school approach to enhancing social connectedness and promoting participation in learning (Glover et al. 1998; Wyn et al. 2000). The HPS concept has developed from a socio-ecological perspective that is consistent with a range of recent and emerging research that indicates that health is affected by a range of physical, emotional, economic and political considerations (Ballard, Dawson and Kennedy, 2002a).

With a specific focus on drug education, Tobler (2000, p 268) writes,

All recent reviews have highlighted the inadequacy of programs with a singular emphasis, stressing the need for comprehensive approaches ... System-wide change programs are those supported by family and/or community; and those that do not concentrate on fixing the youth but aim to alter the 'business as usual' school atmosphere and/or engage students in the learning process ... the prevention field is rapidly moving to system-wide change programs.

Comprehensive and evidence-based practice

Clear educational outcomes

Principle 3: Establish drug education outcomes that are appropriate to the school context and contribute to the overall goal of minimising drug-related harm.

When schools establish agreed goals and outcomes for drug education they have a common understanding for consistent and coordinated practice. The process of ensuring that those goals and outcomes are clear and realistic, supports schools in achieving targets within their sphere of influence.

Some key considerations

There is a need for clear and achievable educational outcomes that are relevant to the school context

- There appears to be a tension in some areas of school drug education research and practice as to what should be the expected goals and outcomes for drug education activities. Schools need to clarify the extent to which they are aiming to change students' behaviour in relation to drug use and the extent to which they are aiming to provide educational outcomes that improve students' understanding, attitudes and skills relevant to drug-related issues and behaviour. It is important that schools understand and determine their own goals and appreciate that being clear about expected outcomes will affect measures of success.
- Given that some form of drug experimentation is normative in young people and that students are also influenced by family, peers and the media, schools cannot be held solely responsible for students' attitudes and behaviour towards drugs. Schools are in a position to enhance students' capabilities and contribute to the goal of harm reduction.
- While experimentation with drugs is common in early adolescence, delaying use and avoiding regular use by young people are important goals.
- Schools require clearly defined and realistic goals and outcomes for their drug education programs, and activities that address local circumstances and guide coherent and consistent action across the school community. How these goals and outcomes are defined is the prerogative of the school community.
- The clear definition of goals and outcomes assists schools in monitoring and evaluating their drug education, which in turn provides a reference point for determining future improvements and actions for drug education initiatives.

The value of relating educational outcomes to minimising harm

- Minimising harm associated with drug use encompasses a range of strategies (including non-use), which aim to prevent or reduce the harmful consequences of drug use. Strategies seek to equip students with the attitudes, skills and knowledge they need to keep themselves safe in a society in which drug use occurs.
- Recent research within Australia indicates that harm reduction approaches, which take education objectives beyond maintaining no use or delayed onset to those that equip young people with the skills to keep themselves safe from drug harm, are useful.
- Approaches that minimise harm often provide students with concepts such as recommended levels for alcohol use and the law, as well as strategies for avoiding harm where drug use may be harmful.

Evidence base

There is a need for clear and achievable educational outcomes that are relevant to the school context

In discussing a range of intervention strategies within the community, Spooner, Hall and Lynskey (2001) recommend delay of use and avoidance of regular use as important goals to seek with young people. They note that young people are more vulnerable than adults when using drugs as they are still developing physically and psychologically; and that they are still developing their decision-making skills during a time of experimentation, exposing them to 'risky decisions' about drug use. Importantly early initiation into drug use is associated with a higher likelihood of problem drug use and other associated problems including lower educational achievement (p 15). Spooner, Hall and Lynskey also note that drug education has often been put under pressure to achieve a solution to 'the drug problem' (2001, p 25). They suggest that given that young people live in a society where drug use occurs, and the factors that lead to drug misuse are complex, drug prevention programs should be specific, measurable and have realistic objectives.

Midford (2000) notes that effective drug education can stop or delay the onset of drug use but that many programs have suffered from using ideal expectations around drug use, rather than focusing realistically on what can be achieved. He notes that this is self-defeating and leads to the discrediting of drug education as a whole.

Munro (1997) suggests that drug education has been critiqued as unsuccessful due to unrealistic expectations and suggests there is a need for clear understanding of the role and limitations of school programs in affecting drug use within the community. He suggests that schools seek to prepare students for living effectively in a drug using community and focus drug education programs on achieving educational outcomes.

Coggans, Haw and Watson (1999) cited in Lowdon and Powney (2000), also argue that, while most evaluations of drug education approaches indicate limited success, it should be borne in mind that many initiatives have been based on unrealistic expectations, and these have been used to measure their success. Referring to the British guidelines for effective drug education, Lowdon and Powney (2000) note that the following guidelines from Coggans, Haw and Watson (1999) are important considerations for guiding and evaluating effective drug education:

- identify a range of clear and realistic intervention objectives which relate to individual and community needs;
- identify a drug education approach/program which is compatible with needs and intervention objectives as well as being feasible in relation to resources; and
- clarify expectations of, and support from, stakeholders in the organisation and wider community.

Roberts et al. (2001) recommend that programs seek to prevent and/or reduce substance use, and that clear and realistic goals, which address local circumstances and are measurable and time limited, be set. They suggest the use of inclusive processes with key groups, particularly young people, to ensure goals are relevant and related to useful measures of success.

The value of relating educational outcomes to minimising harm

Many young people do not use drugs on a regular basis nor do they engage in problematic use, however from early adolescence, experimentation and risk-taking may occur. Minimising harm is a useful strategy, given the proportion of adolescents who engage in some form of experimentation with drugs (Ballard et al. 1994). Hawks et al. (2002) suggest that there is a strong logic behind the adoption of goals that minimise harm, particularly for tobacco, alcohol and increasingly, cannabis education, given the large prevalence of young people who begin use at a young age.

Midford et al. (2001) suggest that schools and teachers cannot 'drug proof' young people but they can use educational interventions that will support the minimisation of drug-related harm. They propose that harm reduction approaches should aim to equip young people with the knowledge and skills needed to keep themselves safe from harm in a society in which drug use occurs.

Positive school climate and relationships

Safe and supportive environment

Principle 4: Promote a safe, supportive and inclusive school environment as part of seeking to prevent or reduce drug-related harm.

A safe and supportive school environment is protective for young people against a range of health related risks, including substance use problems. A positive climate within and beyond the classroom fosters learning, resilience and wellbeing in students and staff. An inclusive school provides a setting where students, staff, families and the broader community can connect and engage in meaningful learning, decision-making and positive relationships.

Some key considerations

The protective role of a safe and supportive school environment

- There is a growing awareness of the role of a safe and supportive school climate in preventing and reducing drug-related harm.
- Recent research points to the importance of a young person's sense of attachment or belonging to his/her social environment. It is now clear that a sense of connectedness to family and to school are important protective factors against a range of health risk behaviours.
- The culture of a school is an important determinant of the health and wellbeing of students and staff. A sense of security, underpinned by care and respect, is central to a positive school climate. A sense of security involves feeling safe from physical threat as well as emotional harm and exclusion. A safe and supportive school environment for young people includes a climate in which there are trust, warmth and positive interest; clear messages of unacceptable behaviour; positive role models; learning opportunities; and access to social support.
- Nurturing a healthy social environment within the school involves staff consistently promoting an inclusive environment in and beyond the classroom, modelling positive behaviour and setting clear and consistent boundaries for acceptable student behaviour. Building a positive school environment requires attention to the culture, ethos, values, expectations and norms of the school community and to the role of these in influencing educational outcomes and health behaviours. Attention to the social and organisational health of a school is therefore an important part of seeking to address drug-related issues in the school community.

The importance of fostering resilience and engagement

- Feeling valued and socially integrated is critical in enhancing resilience and promoting long-term positive change in a young person's life.
- Enhancing students' sense of belonging, participation and meaningful contribution within and beyond the classroom promotes learning and engagement in school life. Positive learning opportunities enhance students' resilience and are protective against a range of health-related risks, including substance use problems.

Evidence base

The protective role of a safe and supportive school environment

There is now clear evidence of the role of positive social environments and social cohesion in promoting health and wellbeing (see Glover et al. 1998; Stansfeld 1999). Spooner, Hall and Lynskey (2001, p 1) note that there has been insufficient attention paid to the creation of health promoting environments as part of drug prevention. Research has identified the way in which social environments that are characterised by trust, social support and positive role models are important to the health and development of young people (Benard and Constantine 2001 Bond and Glover 2001; Glover et al. 1998; Fuller 2001).

A young person's sense of belonging or attachment to his/her social environments, particularly family and school, can directly influence emotional health and wellbeing (Glover et al. 1998, pp 11-12). A positive school environment that nurtures strong engagement and relationships is associated with building students' sense of connectedness to learning and school, helping to protect against a range of risk-related behaviours, including problematic substance use. A sense of connectedness to school, family or community is a key protective factor for young people (Fuller 1998; Resnick et al. 1997).

Glover et al. (1998 p 12) note that a safe and secure school environment includes feeling safe from physical as well as emotional harm. Although less obvious, being able to express a point of view without ridicule and to be included in class activities, is an important part of a secure and positive school climate.

Protective factors associated with positive school environments include: a sense of belonging, the presence of a pro-social peer group, required responsibility or helpfulness, opportunities for success and recognition, and school norms against violence (Commonwealth Health and Aged Care 2000). Experiences of failure and bullying or rejection within the school environment place young people at increased risk of negative health and learning outcomes. Risk factors in the school environment have been identified to include experiences of bullying; peer rejection; poor attachment to school; inadequate behaviour management; membership of a deviant peer group; and school failure (Commonwealth Health and Aged Care 2000).

The National Health and Medical Research Council (NHMRC) (1996) notes that the evidence clearly suggests that positive health outcomes can be fostered in schools through a whole school, broad based, integrated and comprehensive approach involving the community. The research report finds that health education curriculum is most successful when adopted with changes to the school environment, including a supportive infrastructure and school policy.

The importance of fostering resilience and engagement

Supportive and protective school communities have been demonstrated to enhance the resilience of young people. Benard (1997) outlines three characteristics of supportive and protective school communities as:

- the presence of caring relationships which convey compassion, understanding, respect, and which establish safety and basic trust
- high expectation messages, which offer guidance, structure and challenges
- opportunities for meaningful participation and contribution, including opportunities for valued responsibilities, making decisions, being heard and contributing to the community.

Henderson and Milstein (1996) identify the following features as important for fostering resilience within a school: providing opportunities for meaningful participation; setting and communicating high expectations; providing caring and support; increasing social bonding; teaching life skills and setting clear and consistent boundaries.

Howard and Johnson (2000) found,

Schools that are safe, positive and achievement-oriented help adolescents develop a sense of purpose and autonomy and promote connectedness. They can also teach valuable life skills such as social problem-solving as well as social competence. Perhaps most importantly, schools can ensure that every student develops the foundation academic competencies needed for further learning and the development of positive self-esteem. In these ways schools can 'teach for resilience' by promoting academic competence and attending to the social and emotional needs of students.

Positive school climate and relationships

Positive and collaborative relationships

Principle 5: Promote collaborative relationships between students, staff, families and the broader community in the planning and implementation of school drug education.

Schools that use collaborative processes whereby students, staff, families and the broader community are consulted, are more likely to provide relevant and responsive drug education. Broad approaches that integrate school, family, community and the media are likely to be more successful than a single component strategy. Strong relationships with families, external agencies and the broader community can enhance students' sense of connectedness, and support access to relevant services.

Some key considerations

The importance of involving students, families and the broader community

- There is strong agreement in the research that for drug education programs to be effective they need to be based on the needs of, and be relevant to, the students who will participate in them.
- Providing students, particularly in secondary education, with opportunities to assert their needs within program development and delivery is important for the determination of appropriate content and learning strategies.
- Informing, consulting and supporting families as part of the school's drug education process is likely to lead to better outcomes. A number of reviews on effective drug education programs recommend the inclusion of a parental component.
- Schools should seek the advice and participation of local Aboriginal and Torres Strait Islander community groups and specific ethnic, cultural and religious groups that are represented in the school population.
- Schools can strengthen their capacity for effective drug education by liaising with neighbouring schools and local agencies to coordinate local drug education strategies and access up-to-date information on local drug use trends.
- Schools can enhance the drug education program by involving local health agencies in school-based health promotion activities. Schools can promote community participation in classroom teaching programs and school functions and activities, as well as student participation in the community via sports, arts and community service programs.

- Students, staff and the community can benefit from the school defining and promoting help-seeking pathways for students, staff and parents and families, and providing appropriate education to facilitate student or family access to health and welfare services.
- As part of effective school drug education, schools need to establish referral procedures to ensure effective liaison between home, school and health services for those students or families in need of support.

The value of a broad, multifaceted approach

- Several reviews of school-based drug education recommend the provision of programs in conjunction with broader community interventions, particularly mass media programs.
- Recent research on the structural determinants of health, including drug use, for individuals and communities, indicates that comprehensive, multifaceted approaches are needed. Given the evidence that drug use is influenced by the cumulative effect of a number of risk factors to which young people are exposed, multi-component strategies provide opportunities to target a number of risk factors in and beyond the school setting.

Evidence base

The importance of involving students, families and the broader community

Hawks et al. (2002) recommend the value of schools undertaking preliminary consultation with key stakeholders, especially students, to monitor and determine needs and preferences; as well as piloting planned programs. They stress the importance of students and teachers being actively engaged in consultation prior to program implementation, to ensure its relevance and feasibility.

The involvement of families and the community in drug education programs can increase the likelihood of their effectiveness and promote longer-lasting results (Evans and Bosworth 1997). Parents are a major influence on the drug-taking behaviour of their children through their modelling of behaviour as well as their attitudes and family relationships, says McCallum (1994). The Health Department of Western Australia (2001), citing Mallick, Evans and Stein, suggests that parents need drug education themselves to be effective in helping their children.

Parent involvement helps increase communication and promotes positive attitudes towards healthy behaviour (Hawkins, Catalano and Miller 1992). Cohen and Linton (1995) suggest that parental involvement in drug education should be conceived as integral to the drug education process, rather than as separate and additional to it. As Ballard, Dawson and Kennedy (2002b) note, informing parents about drug education programs and involving them in collaborative decision-making on drug-related issues is now becoming recognised in Australian schools as an integral part of drug education.

The National Health and Medical Research Council (NHRMC) (1996) notes that parental involvement may involve parents taking an active part in helping to establish the school policies and procedures, as well as in the implementation, support and reinforcement of school health programs. Parental support enables students to relate health messages at school to a broader social context. Parent and community involvement in comprehensive, multifaceted approaches promotes consistent messages and strong partnerships (Tobler 2000). School programs are strengthened when complemented by a parent component (Rohrbach et al. 1994) and when social messages are reinforced at a community or media level (Dusenbury and Falco 1995; Perry and Kelder 1992; Perry et al. 1996).

The NHRMC (1996) report identifies the benefit of on-site, comprehensive clinics for school students, particularly in terms of access and equity for disadvantaged populations. Involvement of the local community appears to enable health messages to be reinforced; and support in the form of resources, expert advice and facilities appears to enhance the success of health programs.

Family interventions have ranged from the provision of information and skills to parents, to brief courses of family therapy. In the past, the more intensive interventions have been restricted to clinical settings but there is growing evidence that these strategies may be effective in prevention in very high-risk families (Patton, 1999). Providing parental education and support to those who have high risk children has been shown, in experimental situations, to reduce the uptake of a range of problem behaviours, including tobacco use.

The value of a broad, multifaceted approach

Spooner, Hall and Lynskey (2001, p 26) recommend that drug prevention should take a broad view and acknowledge that drug use is one of a range of problem behaviours. In particular, they suggest that it is important to acknowledge the role of family, community and the broader social networks that can affect a young person's health and development and to work at all levels of influence including the individual, family, local community and broader environment. They recommend that those involved in prevention, work collaboratively with others concerned with problem behaviours associated with drug use (such as educational difficulties, suicide and crime) to address the shared pathways to these outcomes. Cuijpers (2002), in a meta-analysis of school drug education, conclusively states that the effects of school programs can be increased significantly when community components are added.

Multifaceted approaches targeting multiple, as opposed to single, risk or protective factors appear to be more promising than single strategies. Hawks et al. (2002) suggest that there are sound conceptual reasons for providing comprehensive multifaceted approaches, as messages are likely to be reinforced by a number of sources to which young people are exposed. They note, however, that there has been limited research and evaluation to date on comprehensive school approaches that include broader community components. Patton (1999) states that school-based health education programs are more effective when reinforced by mass media interventions and parent or community programs.

Targeted to needs and context

Culturally appropriate and targeted drug education

Principle 6: Provide culturally appropriate, targeted and responsive drug education that addresses local needs, values and priorities.

Drug education needs to be relevant to all students. In providing programs, schools should be sensitive to the cultural background and experience of students. Diverse components of identity, including gender, culture, language, socio-economic status and developmental stage, should be considered when providing drug education that is targeted to meet students' needs.

Some key considerations

The relevance of gender, culture, language, socio-economic status, lifestyle and developmental stage

- Drug education needs to be based on an understanding of the factors that may predispose, enable and reinforce drug use among young people.
- The provision of effective school drug education involves consideration of the specific characteristics of the student group, including factors such as age, culture, gender and an understanding of broad social and community factors that may impact on attitudes and behaviours towards drug use.
- Location of the critical influences, values, attitudes and behaviours among the student group will support the development of relevant programs that acknowledge lifestyle issues and place drug education within a broader context that is meaningful to the student group.
- Adolescence is a developmental stage associated with experimentation with drugs. There is some evidence that experimentation is beginning at earlier stages, with particular increases in the number of young people who have tried cannabis.
- Drug education programs need to focus on the drugs most likely to be used within the target group and those that are most likely to cause harm to individuals and others within the community. Media attention or sensationalism about particular drugs should not be the basis on which to determine the drugs that are most used or those that cause most harm. As alcohol, tobacco and cannabis are the recreational drugs most commonly used by adolescents (in addition to caffeine, over the counter and prescribed medicines), these drugs should receive the greatest emphasis in school programs. In addition, local prevalence data, the cultural context and stages of youth development and risk, need to be considered in each situation. Programs should then be tailored to meet these specific needs.

The importance of cultural sensitivity in addressing local drug-related priorities

- Some cultural groups and those who are socially disadvantaged have proportionately high experience with drugs. Targeted interventions are needed to address those young people who are at a higher risk of drug use problems.
- It is critical that assumptions or stereotyping about drug use among particular cultural groups do not form the basis of drug education decision-making. Schools need to work with local communities and access local prevalence data to determine drug education needs and strategies. Schools that work collaboratively with local agencies, community and cultural representatives, families and students are more likely to provide responsive and targeted drug education programs, policies and practices.

Evidence base

The relevance of gender, culture, language, socio-economic status, lifestyle and developmental stage

Drug education can be more meaningful and relevant to students if it is responsive to the developmental, gender, cultural, language, socio-economic and lifestyle concerns of the target group. School drug education should focus on the most prevalent and harmful drugs (Ballard et al. 1994). While illicit drug use attracts disproportionate media attention and public concern, it should be addressed in particular contexts or subgroups where it is most prevalent and harmful (Midford, Snow and Lenton 2001).

Research indicates that while experimentation with licit and illicit drugs is common among young people, most do not become problematic drug users (Letcher and White 1998). Spooner, Hall and Lynskey (2001) note that adolescence is a period of initiation into drug use where most use tends to be non-problematic. Alcohol, tobacco and cannabis are the recreational drugs most commonly used by adolescents. From national data, we know that currently, apart from cannabis, other illicit drug use among young people is rare. Variations do exist due to gender, socio-economic and cultural background, geographical region (and occupation for adolescents no longer at school) (Spooner, Hall and Lynskey 2001; White 1999a;1999b).

Spooner, Hall and Lynskey (2001) recommend that in targeting drug prevention an understanding of child and adolescent development is also considered to ensure interventions are developmentally appropriate and targeted. They note that adolescence can be understood as a period of achieving particular developmental tasks, including a sense of identity, relationship with peers, emotional independence, a vocation and a sex-role identity. Based on work by Cavaola and Kane-Cavaola that adolescents need power, autonomy and non-conformity, freedom, structure and peer acceptance, Spooner, Hall and Lynskey (2001) suggest environments need to facilitate these needs constructively.

The importance of cultural sensitivity and of addressing local drug-related priorities

Dusenbury and Falco (1995) identify cultural sensitivity as a critical component of effective drug education programs, noting that although social skills training appears to be successful across different target groups, there is a need to provide culturally and ethnically responsive programs. Most of the research on issues of heterogeneity and drug education derives from the USA, the research in Australia on culturally targeted school drug education being very limited. Spooner, Hall and Lynskey (2001) note that despite the relevance of ethnic culture, little research has been conducted within Australia on this complex topic and that what does exist tends to be for specific groups within specific areas in specific time periods.

Spooner, Hall and Lynskey (2001, p 20) note that there are particular disadvantaged groups within Australia on whom the burden of risk factors associated with drug use falls heaviest. The vulnerability of socio-economically disadvantaged families, rural communities and Aboriginal and Torres Strait Islander peoples is noted. In particular, Indigenous people are about two to three times more impoverished than the rest of the population. They note that drug use problems are both symptomatic and contributory factors of underlying disadvantage and that targeted and tailored substance use prevention programs, incorporating cultural sensitivity, are needed.

Sanci et al. (2002, p 4) report that there are few intervention programs targeting young people from different social and cultural backgrounds at different stages of their drug use. This is despite the growing recognition that interventions and evaluations of effectiveness need to be tailored to different target groups.

Given the need to target drug education to local needs and contexts, schools would benefit from adopting community-based, consultative processes to ensure local demographic needs and issues are identified as part of effective drug education planning. Hawks et al. (2002) recommend that drug education programs be made culturally appropriate through the use of strategies such as undertaking formative research with students prior to the program's development and implementation, and ensuring teachers have the skills to adapt such programs to their students' cultural backgrounds and issues of relevance.

Targeted to needs and context

Recognition of risk and protective factors

Principle 7: Acknowledge that a range of risk and protective factors impact on health and education outcomes, and influence choices about drug use.

Drug education should be based on an understanding of the risk and protective factors that affect young people's health and education. Schools that recognise the complexity of issues that may impact on students' drug use are in a better position to provide relevant drug education.

Some key considerations

The role of risk and protective factors in understanding and responding to drug use in young people

- Problematic drug use is not a simple or individual issue. It derives from a complex range of factors associated with the individual's temperament, his/her family, peers, school, community and the broader social and economic environment. The more risks a young person experiences, the more likely that drug problems and related issues may occur. These risks interplay with that individual's strengths and assets – his/her protective factors.
- An understanding of the risk and protective factors impacting on patterns of youth drug use can assist schools to work more effectively at both prevention and intervention levels.
- A student at risk of drug-related harm is likely to be encountering additional risks, which may impact on his/her health and education. These include school failure, truancy or early school leaving, poverty, family break-up, transience, lack of parental supervision, experiences of abuse, mental health or substance use problems in the home and membership of a high-risk peer group. In this sense also, problematic drug use is not just an individual issue.
- It is important that understanding of the causes of drug use and associated behaviours is not oversimplified. Experimentation and infrequent use by young people are associated with peer and social factors. Drug dependence is associated with a range of factors including biology, psychology and broader structural determinants. There also appears to be a difference in risk factors in relation to specific drug use behaviours, for example initiation into smoking, binge drinking and needle sharing.

- Experience of drug use involves the interplay of the user (eg. the user's expectations of effect), the drug (eg. the type and amount used), and the setting (eg. the place and mood of the context).
- Students at risk of harm as a result of their own or another's drug use may benefit from education and interventions that address multiple risk factors and offer ongoing student welfare/pastoral care. School staff should be aware that students may experience disruption in their learning due to the negative impacts of the drug use patterns of family or community members. In particular, schools should steer responses away from a narrow 'blaming' approach to one that seeks to support vulnerable students.
- Many problems share common risk and protective factors. Research is suggesting that effective intervention in one area is likely to lead to benefits in other problem areas. When schools seek to enhance protective factors in young people's lives and enhance students' resilience, there are likely to be benefits in relation to drug-related issues *and also in other areas of their lives*.

Evidence base

The role of risk and protective factors in understanding and responding to drug use in young people

Drug use is not simply an individual behaviour, but is shaped by a range of macro-environmental factors including the economic, social and physical environment (Spooner, Hall and Lynskey 2001). A range of factors such as income, employment, poverty, education, access to community resources, gender, age and ethnicity can impact on health outcomes including mental health and drug use patterns (Marmot 2000; Yen and Syme 1999). Communities and families at higher risk are those that face economic disadvantage, social or cultural discrimination, isolation, neighbourhood violence, population density and poor housing conditions, and lack of facilities and services (Commonwealth Health and Aged Care 2000). People from lower socio-economic status groups and the unemployed are at much greater risk of substance abuse, and are at risk of earlier initiation – itself a risk factor (Stuart and Price 2000).

Complex personal, psychological, social and environmental factors must be taken into account in understanding drug-use and the effectiveness of drug education (Wragg 1986, 1992). Psychological studies and those focused on the individual can benefit from studies which place such behaviour in the broader social context in which it develops, is maintained and changes over the life trajectory (Luthar et al. 2000). Spooner, Hall and Lynskey (2001) suggest

that failure to see substance abuse as part of a larger pattern of behaviour can be a barrier to effective interventions, as each risk behaviour may be contributing to another risk behaviour. Evans and Bosworth (1997) note that to be effective, drug education programs must address environmental, personality and behavioural risk factors identified through research and move beyond behaviourist approaches that look at individual behaviour to understand drug use.

Catalano and Hawkins (1996, p 152) state that it is clear that multiple biological, psychological and social factors at multiple levels in different domains (that is within the family, school, peer, group and community) contribute to some degree to drug use and other risk behaviours. Brounstein and Zweig (1999) propose that drug use can be understood as the interplay between the individual and environmental domains of society, family, community, school and peers. They suggest that building on and enhancing protective factors is a promising approach that focuses on developing positive elements in individuals and environments.

A comprehensive study of risk and protective factors conducted with Victorian secondary students (Bond et al. 2000), found an association between the number of risk and protective factors and the use of licit and illicit drugs among this group of students. Importantly for schools, it was found that a small number of protective factors could reduce drug use. The study suggests that an individual's drug use needs to be understood as a complex inter-relationship of risk and protective factors, including the broader social and environmental factors within which he/she lives. Bond et al. (2000) and other studies (Benard 1995, 1997; Fuller 2001; Howard and Johnson 2000) strongly suggest that schools can make a difference through acting as a protective factor in a student's life. Schools can enhance student resilience through promoting caring relationships, setting high but positive expectations and providing opportunities for youth participation and contribution.

Benard and Constantine (2001), in a USA-based study, note that longitudinal developmental studies on resilience provide three important lessons for schools. First, most students do and can make it. When young people are tracked into later life more than half the 'high-risk' children do succeed and are caring and competent adults. Second, most young people succeed because somewhere in their families, schools and communities they have experienced important protective factors that gave them a sense of belonging and meaning. Third, teachers and schools are more often than not identified as the turnaround people and places that tipped the scales from risk to resilience. Turnaround teachers are characterised as those who meet students' basic needs for safety, belonging, respect, power, accomplishment and learning.

Targeted to needs and context*Consistent policy and practice***Principle 8: Use consistent policy and practice to inform and manage responses to drug-related incidents and risks.**

The school's discipline and welfare responses should protect the safety and wellbeing of all students and staff. Policies and procedures to manage drug-related incidents and support students who are at risk are best determined through whole school consultation and implemented through well-defined procedures for all school staff. Vulnerable students may require additional support from the school and relevant community agencies. Retaining students in an educational pathway should be a priority of care for students who are at risk.

Some key considerations**The importance of policies and procedures for the management of drug-related risks**

- It is important for each school to develop drug prevention policies and procedures as part of its strategy for minimising drug-related harm within its school community. These provide opportunities to articulate clearly the school's values and expectations in relation to drug issues and contribute to a safe and supportive school environment.
- Schools need to provide clear guidance and information about possible drug use at school and the consequences if a student or staff member is involved in a drug-related incident.
- Within legislative requirements and school jurisdiction guidelines, each school needs to develop and determine its own policy and procedures for responding to drug-related issues. It is best if a collaborative approach, which involves student representatives, staff, families and the broader community, is used to develop drug education policies and procedures.
- Schools need to have in place well-developed structures for identifying and supporting at-risk students. The school health and welfare policy should address the management of drug-related incidents. Schools need to consider the wellbeing and safety of the school population in managing the interplay between welfare, support and disciplinary responses.
- The classroom teacher has an important role to play in the early identification of troubled students and in making referrals to specialist staff or school authorities. School staff, including generalist teachers, may need professional development and/or support to assist them to identify and respond effectively to the management of drug-related incidents. Precipitate action may label and marginalise a student, increasing the risk of alienation, truancy or early school leaving, each in its own right a risk factor.

Understanding the needs of at-risk students

- Drug use occurs on a continuum from abstinence through to exposure, experimentation, occasional use, problematic use and addiction. Much drug use by adolescents is of an experimental nature, influenced by peer and social factors. In general, most students who experiment with drugs do not go on to problematic drug use. Ongoing and escalating drug use is associated with a multiple risk profile affecting the individual, the family or the group. Students may be at risk of drug-related harm as a result of their own drug use or that of family, friends or community members.
- Some responses to drug use can marginalise and stigmatise students. Punitive-based school policies and responses to drug use are not productive and can lead to negative consequences. Schools can provide effective support to those who are at risk by working in cooperation with families and community support agencies to retain or reintegrate students who are experiencing difficulties related to drugs. Continued participation in education is a key protective factor for young people; those who leave the school system face additional risks.

Evidence base

The importance of policies and procedures for the management of drug-related risks

The National Health and Medical Research Council (NHMRC) (1996) notes that policies can play a major role in supporting and reinforcing educational and structural elements of a health program. The keys to effective school policies are clarity, coordination and consistency. A school policy with a clear rationale that is enforced by staff, made known throughout the school and community, and is consistent with policies in the surrounding community, is most effective (Hawkins, Catalano and Miller 1992).

Midford, Snow and Lenton (2001) note the importance of disciplinary responses that are consistent with education messages on drug use in a school and the need to balance legal responsibilities with student welfare/pastoral care. A clear evidence base of the role of policy and effective incident management has not yet emerged within Australia. Given the *National Framework for Protocols for Managing the Possession, Use and/or Distribution of Illicit and Other Unsanctioned Drugs in Schools (National Framework)*, agreed to by all Australian Governments in 2000, and the shift to more comprehensive drug education, it is expected a research base will begin to develop.

Galla et al. (2002) suggest that teachers and non-teaching staff be provided with professional development in understanding the complexity of detecting problematic drug use in students and managing drug-related incidents. They propose that staff be able to identify the physical and mental characteristics of drug use in order to recognise real problems and avoid making false judgements about a student's behaviour. They recommend that staff deal honestly and directly with students, making clear what is and what is not able to be confidential, and that access to safe counselling is provided within the school and/or referred to community services.

Understanding the needs of students at-risk

Pagila and Room, (1998, p 26) note that punitive school policies have not been found to curb substance use. Imposing sanctions may alienate those already on the periphery of the school community, as well as discourage help-seeking by those with drug-related problems (D'Emidio-Caston and Brown 1998).

Munro (1997) notes that the literature suggests punitive action can escalate drug use as an adolescent seeks to live up to his/her new identity, and suggests that there is strong therapeutic argument for schools to treat instances of drug use discretely, with an emphasis on support rather than punishment. Carroll's Reputation Enhancement Theory suggests that different adolescents are concerned about sustaining different kinds of reputations and those involved in substance use problems are likely to be concerned with achieving (and maintaining) a non-conforming reputation (noted in Ballard, Dawson and Kennedy 2002b).

Pennington (1999) suggests that given data on student experimentation with marijuana by age 17, it is inappropriate to expel a student based simply on known use. Davies and Coggins (1992) also argue that a punitive focus is a limited strategy as the vast majority of students who experiment with drugs will not encounter serious health consequences.

Thorsborne (2000) also notes the importance of non-punitive measures in addressing at-risk students and that a philosophy of restorative practice is beneficial to managing drug incidents. A preliminary evaluation (Armstrong, Tobin and Thorsborne 2002) of community conferencing as a tool for restorative practice suggests that this may provide a useful approach for the management of drug-related behaviour in schools.

Effective pedagogy

Timely programs within a curriculum framework

Principle 9: Locate programs within a curriculum framework, thus providing timely, developmentally appropriate and ongoing drug education.

Drug education programs are best provided within a clear curriculum framework for achieving student learning outcomes. Drug issues should be addressed within a broader health context relevant to students concerns and stage of development. The timing and continuity of drug education across students' schooling is critical. Programs should commence before young people start to make decisions about drug use, be developmentally appropriate, ongoing and sequenced, and provide for progression and continuity.

Some key considerations

The need to place drug education within a broader health context

- Drug education is best taught within a broader social, cultural or health curriculum rather than as a discrete subject. Isolated and *ad hoc* programs that lack progression and continuity are less effective.
- Drug education should be founded on an holistic view of health that encompasses attention to physical, social, mental, emotional, environmental and spiritual wellbeing.
- Drug education should not focus on drug issues in isolation, but investigate these choices in a way that is meaningful to students, addressing the lifestyle concerns and priorities in young people's lives.
- Drug education need not be compartmentalised by drug type, although consideration does need to be given to providing targeted programs for particular drugs, especially with older or at-risk students.

The critical importance of the timing of interventions

- Drug education should be provided before problematic behavioural patterns become established and more resistant to change. Program commencement dates should be adjusted to meet the needs of particular target groups. The onset of experimentation and the types of drugs used can vary within and between school communities. The timing of drug education is best optimised for a particular student population by reference to appropriate prevalence data.

- Australian data on students' drug use show that there are changing patterns across the school years. Schools need to focus drug education on those drugs that are most prevalent and likely to cause students most harm, and in a manner that is relevant to the students' stage of development.
- Early use of drugs is predictive of continued and progressive use. Preventing, postponing or reducing levels of drug use has important long-term health benefits.
- The effects of drug education tend to be evident immediately following delivery, but then diminish. It is recommended that programs include follow-up and are complemented by additional health promotion messages.
- Adolescent attitudes and beliefs about drug use and risk tend to change and become more tolerant with increasing age. Older adolescents tend to minimise the risks associated with their own substance use and males tend to do this more than females. This suggests that schools need to ensure drug education is not only ongoing, but is appropriate to the developmental stage and gender of the target group of students.
- For drug education to be effective it needs to be relevant to the students. Given that the interests and experiences of young people change over time, the program content and design need to reflect these changes and be relevant to their needs and priorities.

Evidence base

The need to place drug education within a broader health context

Roberts et al. (2001) advise that a broader life skills approach, relevant to a range of health related behaviours, is likely to lead to better results than a narrow focus on information and skills for resisting drugs.

The National Health and Medical Research Council (NHMRC) (1996) notes that school health programs need to be comprehensive in both concept and content. They need to be comprehensive in terms of content, moving beyond narrow health problems and adopting a broader social skills approach that is relevant to promoting positive health outcomes for students.

The critical importance of the timing of interventions

Research suggests the timing of drug education is critical. Kelder et al. (1994) state that prevention is more effective before behavioural patterns have been established and have become more resistant to change. This is based on the concept of 'social inoculation' or intervening with the target group prior to onset of risk behaviours. Cuijpers (2002) states that prevention programs based on the 'social influence model' of inoculating students against active or indirect social pressures to use drugs are the most effective.

Hawks et al. (2002) identify the timing of interventions as a critical consideration for school drug education programs. They note that there are three important times for interventions that are most likely to impact on behaviour. First is what is called the 'inoculation' phase before drug use begins. Second is 'early relevancy' when students are experiencing early initial exposure. Providing programs at this time is when information and skills are likely to have the most meaning. Third, recent research is indicating that there is another important phase known as 'later relevancy' when prevalence of use increases and the context for use changes; for example when young people drink and drive (p. 40). This WHO report on what works in the area of prevention recommends that school-based programs address these phases, guided by local prevalence data for the school community.

Midford, Snow and Lenton (2001) note that the general consensus in the literature is that the optimal time for initiating youth drug interventions is during late primary/early teens when experimentation starts. Onset can vary in different populations and with different drugs (Spooner, Hall and Lynskey 2001). Hence the timing of programs needs to take into consideration appropriate prevalence data and be responsive to the particular target groups and drugs. Dusenbury and Falco (1995) found that adequate coverage and sufficient follow-up featured in the 11 critical components of effective drug education programs. In a British summary of findings from USA-based research on important factors in creating effective drug programs, Evans and Bosworth (1997) note that:

- programs should proactively challenge students' views on drug use
- prevention programs need to be tailored to the age of the student, as drug-use behaviours, and perceptions about and perspectives on drug use are sensitive to one-year changes in age.

In a meta-analysis conducted by Tobler et al. (2000) it was found that higher intensity interactive programs were significantly more effective than lower intensity programs. Cuijpers (2002) confirmed that interactive delivery methods are a critical component and found that intensity and booster sessions in and of themselves, are not critical to effectiveness. The evidence base suggests that schools need to implement sequential, progressive and continuing programs that meet students' developmental and contextual needs and address the potential for the decay of program effects.

Effective pedagogy

Programs delivered by teachers

Principle 10: Ensure teachers are resourced and supported in their central role in delivering drug education programs.

Teachers are best placed to provide drug education as part of an ongoing school program. Effective professional development and support enhance the teacher's repertoire of facilitation skills and provide current and accurate information and resources. Appropriately trained and supported peer leaders and visiting presenters can complement the teacher's role.

Some key considerations

The importance of supporting and developing teachers in the delivery of drug education

- A teacher who knows the class, the individuals and the context of the school is best positioned to tailor programs to meet the needs of the students.
- The ongoing relationship of the teacher with the class provides the best context within which to identify and work with those students who may need additional support from the school. The teacher is well placed to access the appropriate school personnel to ensure follow-up.
- The teacher who provides drug education within an ongoing health or social skills curriculum can ensure that the program is embedded in and complemented by other elements of the school curriculum.
- Teachers require skills and support at both professional and systemic levels to ensure programs can be fully implemented. Teachers can face a range of challenges, including competing curriculum demands and tight resources.
- Programs are most successful when teachers receive adequate resourcing, training and support, particularly in the use of interactive teaching strategies, which are a key component of the social skills elements of the curriculum.

The possible use of peers/external leaders

- The teacher, guided by school policy and informed about additional school health promotion or student leadership initiatives, might complement the program with the judicious use of peer leaders, visiting presenters and other health promotion activities.
- Research suggests that peer leaders may be effective in prevention education but only when carefully selected, properly trained and well supported with management skills provided by professional teachers.

Evidence base

The importance of supporting and developing teachers in delivering drug education

There is clear evidence in the literature that resourcing and supporting teachers is critical to the effective implementation of drug education (Hawks et al. 2002). Professional development of teachers is a key component of the implementation strategy of a range of mental health promotion and drug education projects (Gatheouse Project: Glover et al. 1998; MindMatters project: Wyn et al. 2000; SHAHRP project: McBride et al. 2000).

Dusenbury and Falco (1995) found that drug prevention programs are most successful when teachers receive training and support and that a major emphasis on interactive teaching techniques is essential. Botvin (1995) also found that programs were more effective when teachers received formal training and ongoing support and consultation. Tobler (2000) notes that a key consideration in determining the effectiveness of a program is the capacity of the leader to conduct a truly interactive group. Teachers were found to require training in interactive teaching to be more effective.

Hansen and McNeal (1999) propose that when designing programs, full consideration be given to research-based prevention strategies and supporting teachers' conceptual understanding of drug use and common patterns in the onset of drug use and experimentation.

The NHMRC (1996) found pre-service training; ongoing professional development; teacher support (from experts, principals, other teachers and community agencies); in-service training; and teacher autonomy and commitment to be key factors in allowing teachers to have confidence in adapting, developing and implementing programs successfully.

In a literature review of leadership and management in drug education, Ballard, Dawson and Jackson (2002b) note that the impact and sustainability of drug education can be affected by a range of professional development and support issues. A summary of their findings on the components needed for teacher support includes:

- involvement of a significant mass of teachers (ie teachers working in isolation have less chance of initiating change than a team of teachers empowered to work on producing curriculum change);
- provision of in-service training (training seminars provide opportunities to develop abilities);

- adequate resources to support programs (inadequate guidelines, professional development and curriculum materials may constrain the effectiveness of implementation);
- continued support and follow-up after training and opportunities to exchange learning and participate in collaborative decision-making (new programs are more successful when there is the opportunity to review and reflect on experiences and develop a continued sense of common purpose);
- effective leadership of the school principal at every stage of implementation;
- opportunity for regular feedback on student learning outcomes; and
- informing and being supported by non-participating staff who may not be delivering a particular program but who can reflect the key messages across the school.

Ballard, Jackson and Kennedy (2002b) also note that an evaluation of teacher training in drug prevention from Canada by Dewit in 1996, indicates that benefits that can occur from professional development include:

- expansion of repertoire of skills for delivery methods,
- increased comfort and confidence in using a range of methods, and
- flow-on benefits occurring for students.

The possible use of peers/external leaders

Cuijpers (2002) notes that peer leaders may strengthen the short-term effects of a prevention program. Midford, Snow and Lenton (2001) suggest that peer leaders are likely to lack organisational and management skills and so drug education programs could look to using them in combination with teachers, where the peer leadership role is structured and credible.

Hawks et al. (2002) state that further research is required to determine if peer leaders can be recommended as a standard component of drug education programs. They note that studies are not conclusive and that there are difficulties associated with peer leaders including selection, adequate training time and opportunities for their use in an already demanding curriculum.

Effective pedagogy

Interactive strategies and skills development

Principle 11: Use student-centred, interactive strategies to develop students' knowledge, skills, attitudes and values.

Skills development is a critical component of effective drug education programs. Inclusive and interactive teaching strategies have been demonstrated to be the most effective way to develop students' drug-related knowledge, skills and attitudes. These strategies assist students to develop their problem solving, decision-making, assertiveness and help-seeking skills. Inclusive methods that ensure all students are actively engaged are the key to effective implementation of interactive strategies.

Some key considerations

The importance of using interactive strategies

- Research has consistently identified interactive strategies as a critical component of effective programs. Interactivity involves students having the opportunity to be involved in the exchange of ideas and experiences as well as to practice new skills and receive feedback.
- Interactive strategies work best within a climate of respect. Teachers need to acknowledge and affirm diversity and actively discourage processes that stigmatise or marginalise groups or individuals. Inclusive methods that ensure all students are actively engaged are critical to effectiveness.
- Failure to use interactive teaching strategies is the area in which breakdown in delivery of effective drug education is most likely to occur. This appears to be because facilitating interactive learning can be challenging, particularly in content areas that can involve sensitive and controversial issues.
- Interactive programs do require teachers to have specialised skills in facilitating student-centred learning, group techniques and classroom management. Teachers need to be able to facilitate strategies such as small group activities, discussion and role-play; and to promote constructive feedback on views and skills.
- Effective programs use student-centred and collaborative teaching methods to develop students' critical thinking, problem solving and decision-making skills. They incorporate rehearsal strategies to enhance assertiveness, help-seeking and refusal skills.

The need for knowledge and skills development

- Skills development needs to be a central element in programs. Programs that focus only on information do not bring about change.
- A knowledge component is appropriate, however information should be factual and balanced, and relate to the needs and interests of students, supporting their capacity to clarify their values and to make healthy decisions.
- Based on social learning theory, it is recommended that students develop broad life skills related to drug issues and other health and lifestyle concerns. The types of skills that need to be addressed include decision-making, goal setting, stress management, assertiveness and communication. Importantly, it has been found that these skills will not lead to positive results in and of themselves but need to be related to relevant drug and health concerns for young people.

Evidence base

The importance of using interactive strategies

In a meta-analysis of 120 school-based drug education programs, Tobler and Stratton (1997) found that the most important factor was the use of an interactive process in which students were engaged in discussions, role-plays and games. In the study, non-interactive programs were those that relied on lecturing, video viewing and completion of worksheets. Interactive programs were just as important in any program whatever the type of substance (ie they were equally successful with tobacco, alcohol and cannabis, and extremely successful with illicit other than cannabis).

Interactive methods provide the opportunity for students to examine their personal beliefs and foster critical reflection of their values, attitudes and behaviours (Hansen 1997). Interaction is not expected to be sufficient in itself for an effective program. Highly interactive programs that do not address drug-related information and issues are not effective (Tobler and Stratton 1997). Tobler et al. (2000) and Cuijpers (2002) confirmed the critical importance of interactive programs. Tobler et al. (2000) found that the success of interactive programs could be affected by the size of the program. Large-scale programs appeared to reduce the opportunity for students to express ideas and participate with peers.

The intention is that interactive programs provide opportunities for students to acquire, practise and refine prevention skills in a supportive environment so they are then equipped to respond effectively to real world situations (Midford, Snow and Lenton 2001). Large scale programs, discomfort on the part of teachers in using interactive techniques such as role-play, or lack of understanding of the value of interactive techniques can reduce a program's effectiveness (Tobler 2000).

Hawks et al. (2002) note that research has confirmed the importance of teachers having sufficient skills to be competent in interactive teaching techniques to enable a program to be effective. That most importantly, 'teachers are required to be able to engender adequate student interaction that is task oriented and positive, while managing group interaction, providing appropriate feedback and ensuring a safe learning environment' (p 51). The literature (Hawks et al. 2002; Roberts et al. 2001) recommends that teachers are trained in using interactive teaching techniques and provided sufficient time to practise these skills.

Helen Cahill from the Australian Youth Research Centre quoted in *REDI for Practice*, (Meyer 2002, p 4) notes that,

Teachers are critical to effective drug education. They are the people who guide the process with the students, which involves them in not only gaining the knowledge they need but far more challengingly guiding them through a set of activities which are designed to enhance their skills and problem solving capacities in such a way that they can take those skills beyond the school gate with them into social situations.

The need for knowledge and skills development

Roberts et al. (2001) recommend that skill development needs to be central to program delivery and accompanied by accurate and objective information. They note that providing programs in which students can be actively engaged in skill development activities and peer discussions offers them valuable opportunities to clarify their beliefs and practise important helping, problem solving, decision-making and communication skills.

The social influence model has placed a strong emphasis on including the development of resistance skills within programs. Recent research (Flay 2000; Paglia and Room 1998; Cuijpers 2002) suggests that the effectiveness of resistance skills within programs is limited. It would appear that the role of peer influence and peer preference is more important than peer pressure in determining attitudes and behaviours towards drug use.

Tobler (2000) identifies key features for what works in drug prevention. They include:

- knowledge of short term effects and long term consequences of drug use;
- analysis of media and social influences;
- understanding of peer drug use and perception adjustment on drug use;
- development of interpersonal refusal skills including assertiveness, communication and safety; and
- delivery techniques including active involvement, participation by peers, student generated role plays, supportive comment from peers, rehearsal of drug refusal skills, sufficient practice time, peer modelling of appropriate behaviour, and developmentally appropriate activities to promote bonding between younger adolescents.

Effective pedagogy

Credible and meaningful learning activities

Principle 12: Provide accurate information and meaningful learning activities that dispel myths about drug use and focus on real life contexts and challenges.

Students need credible and relevant information about drugs and the contexts in which choices about drugs are made. They need to engage in meaningful activities with their peers, examine the social influences impacting on drug use and encounter normative information about the prevalence of use, which is typically lower than students expect.

Some key considerations

The need for credible and relevant information

- Programs that provide biased or inaccurate information and use 'scare tactics' as a deterrent are bound to fail. Focusing on fear may glamorise or enhance the status of risky drug use behaviours.
- Accurate, relevant and credible information is an important component of an effective drug education program. Providing knowledge is not sufficient in itself. Delivery of information in a drug education program needs to be part of a skills development approach.
- Both the explicit and implicit messages delivered in a program need to be viewed by students as realistic and credible.

The value of normative information in drug education

- Recent research confirms the importance of including normative education as part of an effective drug education program. Normative information gives young people an accurate indication of the extent of drug use in their peer group, which is typically lower than expected.
- Drug education programs should include the debunking of myths associated with drug use, including common assumptions that use or risky use is the norm.

The role of utility information in drug education

- Utility knowledge should be included within a drug education program. Students need information that is relevant and applicable to their life experiences and of immediate practical use to them.
- A focus on strategies that reduce harm acknowledges that some students may use drugs and provides them with useful knowledge for minimising harm to themselves and others. Including utility information linked to harm reduction strategies for negotiating risk and minimising harm is particularly appropriate for students who may already be using drugs such as alcohol or cannabis.

Evidence base

The need for credible and relevant information

Roberts et al. (2001) suggest that both the explicit and implicit messages within a program need to be viewed by young people as realistic and credible and delivered by credible messengers. They suggest that the most important principle for any program 'is that the drug information provided is scientifically accurate, objective, non-biased and presented without value judgement' (p 40). They advise that programs for adolescents acknowledge the reasons for people using drugs and the appeal of risk-taking, while offering reasonable alternatives.

Recent research suggests that in some contexts, peers in leadership roles in a program may support the program's credibility and promote positive student norms (Cuijpers 2002; Hansen 1992). Peer education is based on the view that young people can explore controversial issues with others of a similar age and background. Evans and Bosworth (1997) found peer leaders can add credibility to a program and their presence can alter perceived norms concerning drug use. Coggans and Watson (1995) found that peer led approaches can support positive normative values and attitudes, but suggest that peer leaders need to be carefully selected.

The value of normative information in drug education

Hansen and Graham (1991) found that normative beliefs about drug use and drug-related behaviour have a crucial role in effective school drug education programs; and that students overestimated the proportion in their age group who would drink and that this erroneous belief increased the likelihood of students drinking. Providing normative information on drug use corrected student overestimation of peer drug use.

Research has consistently shown that providing accurate normative information is an important component in effective drug education programs (Cuijpers 2002; Dielman 1994; Dusenbury and Falco 1995; Hansen and Graham 1991). The research suggests that presenting age-related drug use norms helps students to gain a realistic understanding of use among their peers. Findings suggest that young people often have exaggerated notions of drug use and that presenting accurate normative information can assist in modifying behaviour if these norms are relatively low (Midford, Snow and Lenton 2001).

Hawks et al. (2002) recommend that normative information, guided by local prevalence data, be included in programs. They note that as the prevalence of use increases, normative education becomes less effective.

Cuijpers (2002) notes that providing a focus on norms within a program is part of a social influence approach and that information should include development of knowledge on social prevalence, social acceptability, normative expectations and friends' reactions to drug use.

The role of utility information in drug education

Certain content is essential for effective drug education. Programs should provide information on the health and social consequences of drug use that is of immediate and practical relevance to young people in terms of their decision-making. Dusenbury and Falco (1995) note that young people are more interested in the here and now than in information about possibilities in the distant future.

McBride et al. (2001) suggest that students need information that is applicable to their life experiences and is immediately practical. This is known as 'utility knowledge' (Cross 1997 cited in Hawks et al. 2002). Hawks et al. (2002) recommend that programs provide utility knowledge that is directly related to the needs of young people and linked to practical skills development.

Glossary

Connectedness

A person's sense of belonging and connectedness with others. There is evidence that connections with family, school or a significant adult can reduce the risk of problematic substance use for young people. Connectedness within a school community has been linked to enhancing health and wellbeing.

Drug

A substance that produces a psychoactive effect. Within the context of the National Drug Strategic Framework, the term drug is used generically to include tobacco, alcohol, pharmaceutical drugs and illicit drugs. The National Drug Strategic Framework also includes strategies to address the harmful use of other substances, including inhalants and kava. (As defined in *National School Drug Education Strategy 1999*.)

Drug education

All the planned and interrelated policies, programs and practices that are designed to enhance students' health and wellbeing and provide them with the capabilities to make informed decisions to minimise drug-related harm for themselves and others.

Engagement

The process of being actively involved and purposeful in learning processes and programs.

Evaluation

The process of measuring the value of a program or intervention. This is a structured, staged process of identifying, collecting and considering information to determine goals, progress and outcomes. Evaluation is central to good practice and to ensuring an evidence-based approach to drug education to meet school community needs, priorities and constraints.

Evidence-based practice

The process of drawing on and using the best available research evidence, curriculum practice and professional judgement to inform and evaluate drug education decisions.

Early intervention

Strategies that target those students who are at risk of ongoing social, emotional and/or physical harm, with the aim to reduce the intensity, severity and duration of the risk behaviour.

Experimentation

Substance use that might or might not continue. Many who experiment do not go on to habitual use or dependence.

Factors

The determinants of health and wellbeing. The terms 'protective factors' and 'risk factors' are often used to identify aspects of a person and his/her environment that make the development of a given problem less (i.e. protective factor) or more likely (i.e. risk factor). A combination of individual, family, school and community related factors contribute to the likelihood of substance use problems. This is a complex and dynamic process where the factors can help buffer against harm – 'protective factors', or increase vulnerability – 'risk factors'.

Harm minimisation

Harm minimisation refers to policies and programs aimed at reducing drug-related harm. Harm minimisation aims to promote better health, social and economic outcomes for both the community and the individual and encompasses a wide range of approaches. Both licit and illicit drugs are targeted. Harm minimisation includes preventing anticipated harm and reducing actual harm and involves a balance between demand reduction, supply reduction and harm reduction strategies. A comprehensive approach must take into account three interacting components: the individuals involved, their social, cultural, physical and economic environment, and the drug itself (*National School Drug Education Strategy 1999*).

Health promoting school

A place where all members of the school community work together to provide students with integrated and positive experiences and structures that promote and protect their health and wellbeing. The Health Promoting Schools model proposes three core domains for promoting health and well being in a school:

- School ethos and environment
- Partnerships and services
- Curriculum, teaching and learning.

Illicit drug

A drug for which the production, sale, possession or use is prohibited. An alternative term is 'illegal drug'.

Interactive and inclusive strategies

Refers to teaching techniques that promote student inclusion and active participation in learning activities. These include student activities such as paired work, small group learning, role-play and whole group discussion.

Intervention

Involves access to appropriate support and treatment services for students in crisis.

Normative education

Refers to teaching accurate prevalence data about drug use and reinforcing the norm that most people choose not to use drugs in a harmful manner.

Policy and procedures

Policy is the overarching statement, position and/or principles on the approach to be taken to a particular issue. Procedures, strategies, guidelines and/or action plans are the action-oriented measures that implement and aim to achieve the stated policy.

Prevention

Prevention in drug education refers to seeking outcomes that prevent or delay uptake and reduce drug-related harms for students and the school community.

Principles

The Principles are statements that encapsulate fundamental concepts to guide schools in effective drug education practice. They provide a framework to support schools in their contribution towards the prevention and reduction of drug-related harm to young people and the broader community. The Principles represent a consensus, based on the available evidence, on what constitutes effective drug education practice in school communities.

Protective factors

The factors in a young person's life which lessen vulnerability to social, behavioural and health problems. (Adapted from Human Services Victoria 2000.)

Risk factors

The factors in a young person's life which increase vulnerability to social, behavioural and health problems. (Adapted from Human Services Victoria 2000.)

Resilience

Is defined as the capacity to 'bounce back from adversity.' (Wolin and Wolin 1999.)

Safe and supportive school environment

Provides for the physical, psychological, social, cultural, aesthetic and intellectual development of students. (As defined in *Creating Safe and Supportive Learning Environments: What's working in Australian schools*, Australian Council of State School Organisations, November 1998.)

School community

The school community is generally considered to comprise students, school staff (for example teachers and other professionals, administrators and other support staff) and parents/guardians and other carers.

Unsanctioned drug

A drug whose use is restricted by law, school authorities and/or school policies/ guidelines. It includes illicit, licit and prescription drugs.

Wider school community

The *wider* school community includes individuals, groups and agencies who work together with the school community to achieve the best educational and personal outcomes for students, for example health, youth and welfare professionals and agencies, community groups and the police.

References

- Armstrong, M, Tobin, M and Thorsborne, M 2002, 'Community Conferencing In Victorian Schools: Maximising protective factors', *The Role of Schools in Crime Prevention Conference*, Melbourne, Vic., 30 September–1 October 2002, Australian Institute of Criminology and DEET, Melbourne.
- Australian Department of Education, Training and Youth Affairs 1999, *National School Drug Education Strategy*, DETYA, Canberra.
- Ballard, R, Dawson, J and Kennedy, L 2002a, *Curriculum And Teaching: Literature review one*, Queensland School Drug Education Service.
- Ballard, R, Dawson, J and Kennedy, L 2002b, *Leadership And Management: Literature review two*, Queensland School Drug Education Service.
- Ballard, R, Gillespie, A and Irwin, R 1994, *Principles For Drug Education In Schools*, University of Canberra, Faculty of Education, Canberra.
- Beckett, D and Hager, P 2002, *Life, Work And Learning: Practice in postmodernity*, Routledge, London.
- Benard, B 1995, *Fostering resilience in children*, ERIC Digest, available at <http://resilnet.uiuc.edu/library/benard95.html>
- Benard, B 1997, *Turning It Around For All Youth: From risk to resilience*, Bonnie Bernard Resiliency Associates, ERIC Digest, available at <http://resilnet.uiuc.edu/library/dig126.html>.
- Benard, B and Constantine, N 2001, 'Supporting Positive Youth Development In Our Schools: A research-based guide to approaches that work', viewed 23/3/03 <http://crahd.phi.org/AASA_Summary.PDF.
- Bond, LS, and Glover, S 2001, 'Building Capacity For Systems Level Change In Schools: Lessons from the Gatehouse Project', *Health Education and Behaviour*, Vol 28, pp 368-383.
- Bond, L, Thomas, L, Toumbourou, J, Patton, G and Catalano, R 2000, *Improving The Lives Of Young Victorians In Our Community: A survey of risk and protective factors*, Centre for Adolescent Health, University of Melbourne, Melbourne.
- Botvin, G 1995, *Prevention Update*, Institute of Prevention Research, Cornell University Medical College, Cornell.
- Brown, J, D'Emidio-Caston, M and Pollard, J 1997, 'Students And Substances: Social power in drug education', *Education Evaluation And Policy Analysis*, Vol 19, pp 65-82.
- Brounstein and Zweig 1999, *Understanding Substance Abuse Prevention – Toward the 21st Century: A Primer on Effective Programs*, US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, Rockville.
- Catalano, R and Hawkins, J 1996, 'The Social Developmental Model: A theory of anti-social behaviour', in J. Hawkins (ed.) *Delinquency And Crime: Current Theories*, (pp 149-197) Cambridge University Press, Cambridge.
- Cohen, D and Linton, K 1995, 'Parent Participation In An Adolescent Drug Abuse Prevention Program', *Journal Of Drug Education*, Vol 25, No 2, pp 159-169.

- Coggans, N and Watson, J 1995, 'Drug Education: Approaches, Effectiveness And Delivery. Drugs: Education', *HEBS Working Paper No 1*, Edinburgh: Health Education Board for Scotland.
- Commonwealth Department of Education Science and Training (DEST) 2000, *National Framework For Protocols For Managing The Possession, Use And/Or Distribution Of Illicit And Other Unsanctioned Drugs In Schools*, available at <<http://www.detya.gov.au/schools/publications/2000/index.htm>>.
- Commonwealth Health and Aged Care 2000, *Promotion, Prevention And Early Intervention For Mental Health – A Monograph*, Mental Health and Special Programs Branch, Canberra.
- Cuijpers, P 2002, 'Effective Ingredients Of School Based Drug Prevention Programs: A systematic review', *Addictive Behaviours*, Vol 27, pp 1009-1023.
- Davies J and Coggins, N 1992, 'Does Drug Education Work?', in Plant, Ritson, and Robertson (eds), *Alcohol and Drugs: The Scottish experience*, Edinburgh University Press, Edinburgh.
- D'Emidio-Caston, M and Brown, JH 1998, 'The other side of the story: student narratives on the California Drug, Alcohol, and Tobacco Education Programs', *Evaluation Review*, 22:95-117.
- Dielman, TE 1994, 'School-Based Research On The Prevention Of Adolescent Alcohol Use And Misuse: Methodological issues and advances', *Journal Of Research On Adolescence*, Vol 4, No 2, pp 271-293.
- Dusenbury L 2000, 'Implementing A Comprehensive Drug Abuse Prevention Strategy', in *Increasing Prevention Effectiveness*, pp 213-222, viewed 14/03/2003 <www.tanglewood.net/projects/teachertraining/Book_of_Readings/Dusenbury.pdf>.
- Dusenbury, L and Falco, M 1995, 'Eleven Components Of Effective Drug Abuse Prevention Curricula', *Journal Of School Health*, December, Vol 65, No 10, pp 420-431.
- Eraut, M 1994, *Developing Professional Knowledge and Competence*, The Falmer Press, London.
- Evans, A and Bosworth, K 1997, 'Building Effective Drug Programs', *Research Bulletin*, No 19, Phi Delta Kappa Centre for Evaluation, Development and Research.
- Flay, B 2000, 'Approaches To Substance Abuse Prevention Utilising School Curriculum Plus Social Environment Change', *Addictive Behaviours*, Vol 25, No 6, pp 861-886.
- Fuller, A 1998, *From Surviving To Thriving: Promoting mental health in young people*, ACER Press, Melbourne.
- Fuller, A 2001, 'From Surviving To Thriving In The 21st Century', Keynote address, *National Biennial Conference*, Hole Economics Institute of Australia, 11-13 January 2001.
- Galla, M, Aertsen, P, Daatland, C, DeSwert, J, Fischer, U, Hablis, K, Jaspers, D, Koller, M, Lee, H, Michaelis, T and Sannen, A 2002, *Making Schools A Healthier Place: Manual on effective school based drug prevention*, Trimbos Institute, Netherlands Institute of Mental Health and Addiction, International Affairs Unit, Nederland.
- Glover, S, Burns, J, Butler, H and Patton, G 1998, 'Social Environments And The Emotional Wellbeing Of Young People', *Family Matters*, No 49 Autumn, pp 11-16.
- Hansen, W 1992, 'School-Based Substance Abuse Prevention: A review of the state of the art in curriculum', 1980-1990, *Health Education Research*, Vol 7, No 3, pp 403-430.

- Hansen, W 1997. 'Prevention Program: What are the critical that spell success?' *National Conference on Drug Abuse Prevention Research: Presentations, Papers and Recommendations*, National Institute on Drug Abuse U.S. Department of Health and Human Services, viewed 16/01/2003 <<http://www.nida.nih.gov/MeetSum/CODA/CODAIndex.html>>.
- Hansen, WB and Graham, JW 1991, 'Preventing Alcohol, Marijuana, And Cigarette Use Among Adolescents: Peer pressure resistance training versus establishing conservative norms', *Preventative Medicine*, Vol 20, No 3, pp 414-430.
- Hansen, WB and McNeal, RB 1999, 'Drug Education Practice: Results of an observational study', *Health Education Research*, Vol 14(1), Oxford University Press, pp 165-176.
- Hawkins JD, Catalano RF, Kent LA, 1991, 'Combining Broadcast Media And Parent Education To Prevent Teenage Drug Abuse', in Donohew, L, Sypher, HE and Bukoski, WJ (Eds.), *Persuasive Communication And Drug Abuse Prevention*, pp. 283-294, Lawrence Erlbaum Associates, Hillsdale, New Jersey.
- Hawkins, JD, Catalano, RF and Miller, JY 1992, 'Risk And Protective Factors For Alcohol And Other Drug Problems In Adolescence And Early Adulthood: Implications for substance abuse prevention', *Psychological Bulletin*, Vol 4, pp 64-105.
- Hawks, D, Scott, K, McBride, N, Jones, P, and Stockwell, T 2002, *Prevention Of Psychoactive Substance Use: A selected review of what works in the area of prevention*, World Health Organisation, Mental Health: Evidence and Research, Department of Mental Health and Substance Dependence, Switzerland.
- Health Department of Western Australia, 2001, *Issues Paper Number 4: Prevention And Early Intervention Strategies, Including School, Parent And Public Education, And Action In Local Communities*, Community Drug Summit Office, Health Department of Western Australia, Perth.
- Henderson, N and Milstein, M 1996, *Resiliency In Schools: Making it happen for students and educators*, Corwin Press, California.
- Howard, S and Johnson, B 1999, 'Resilience, Definitional Issues', Paper presented at the AARE Conference, Melbourne, December 1999.
- Howard, S and Johnson, B 2000, 'Young Adolescents Displaying Resilient And Non-Resilient Behaviour: Insights from a qualitative study, can schools make a difference?', University of South Australia, AARE Conference Papers, viewed 18/03/2003 <<http://www.aare.edu.au/00pap/how00387.htm>>
- Howie, A 1997, *Guidelines For Planning And Evaluating Drug Education*, Edinburgh: Health Education Board for Scotland.
- Human Services Victoria 2000, *Improving the Lives of Young Victorians in Our Community: A Summary Report*, Community Care Division, Victorian Government, Department of Human Services, Victoria.
- Kelder, S, Perry, C, Klepp, K and Lytle, L 1994 'Longitudinal Tracking Of Adolescent Smoking, Physical Activity And Food Choice Behaviour', *American Journal Of Public Health*, Vol 84(7), pp 1112-1116.
- Letcher T and White V 1998, 'Australian Secondary Students Use Of Over-The-Counter And Illicit Substances In 1996', AGPS, Canberra.

- Lowden, K and Powney, J 2000, *Drug Education Context And Approaches: A review of the literature*, Scottish Council For Research In Education, viewed 17/03/2003 <<http://www.scre.ac.uk/scot-research/lowdendrug/index.html>>.
- Luthar, S, Cicchetti, D and Becker, B 2000, 'The Construct Of Resilience: A critical evaluation and guidelines for future work', *Child Development*, Vol 71, No 3, pp 543-562.
- Marmot, M 2000, 'Multi-Level Approaches To Understanding Social Determinants', in Berkman, LF and Kawachi, I (eds), *Social Epidemiology*, Oxford University Press, pp 349-368.
- McBride, N, Midford, R, Farrington, F and Phillips, M 2000, 'Early Results Of A School Alcohol Harm Minimisation Intervention: The School Health And Alcohol Harm Reduction Project (SHAHRP)', *Addiction*, Vol 95, No 7, pp 102-42.
- McCallum, T 1994, 'Parents Or Peers: Who influences adolescent drug use the most?', *Youth Studies Australia*, Vol 13, No 3, pp 36-41.
- Meyer, L 2002, 'Tips On Using Interactive And Inclusive Strategies In Drug Education', *REDI for Practice*, part of *REDI Professional Development*, Department of Education, Science and Technology, Commonwealth of Australia, available at <<http://www.redi.gov.au/>>.
- Midford, R 2000, 'Does Drug Education Work?', *Drug And Alcohol Review*, Vol 19, pp 441-446.
- Midford, R, Munro, G, McBride, N, Snow, P and Ladzinski, U 2002, 'Principles That Underpin Effective School-Based Drug Education', *Journal Of Drug Education*, Vol 32, No 4, pp 363-386.
- Midford, R, Snow, P and Lenton, S 2001, 'School-Based Illicit Drug Education Programs: A critical review and analysis', RFT 637, 1-80, Department of Employment, Education, Training and Youth Affairs, Melbourne.
- Munro, G 1997, *School-Based Drug Education: Realistic aims or certain failure*, Centre for Youth Drug Studies, Australian Drug Foundation, pp 2-4, viewed 20/03/2003 <<http://www.adf.org.au/cyds/papers/sded.htm>>.
- National Health and Medical Research Council 1996, *Effective School Health Promotion: Towards health promoting schools*, Commonwealth Department of Health and Family Services, ACT.
- O'Donnell, J, Hawkins, J, Catalano, R, Abbott, R, and Day, L 1995, 'Preventing School Failure, Drug Use, And Delinquency Among Low Income Children: Long-term prevention in elementary schools', *American Journal Of Orthopsychiatry*, Vol 65, No 1, pp 87-100.
- Paglia, A and Room, R 1998, *Preventing Substance Use Problems Among Youth: A literature review and recommendations*, Centre for Addiction and Mental Health, Canada.
- Patton, G 1999, *The Scope For Youth Health Development, Briefing Paper*, The Public Health Partnership (Nov 1999), Centre for Adolescent Health, Parkville, Victoria.
- Patton, G, Glover, S, Butler, H, Godfrey, C, De Pietro, G and Bowes, G 2000 'The Gatehouse Project: A systematic approach to mental health promotion in secondary schools', *Australian And New Zealand Journal Of Psychiatry*, Vol 34, pp 586-593.
- Pennington, D 1999, 'Drugs In Our Community – Taking Stock', *In Review*, Discussion Paper No. 3, Trust for Young Australians, Melbourne, Victoria.

- Penz, A, Brannon, V, Charlin, E, Barrett, D, MacKinnon, D and Flay, B 1989, 'The Power Of Policy: The relationship of smoking policy to adolescent smoking', *American Journal Of Public Health*, Vol 79, pp 857-862.
- Perry, C and Kelder, S 1992, 'Prevention', *Annual Review Of Addictions Research And Treatment*, pp 453-472.
- Perry, CL, Williams, CL, Veblen-Mortenson, S, Toomey, TL, Komro, KA, Anstine, PS, McGovern, PG, Finnegan, JR, Forster, JL, Wagenaar, AC and Wolfson, M 1996, 'Project Northland: Outcomes Of A Community-Wide Alcohol Prevention Program During Adolescence', *American Journal Of Public Health*, 86, 956-965.
- Resnick, M, Bearman, P, Blum, R, Bauman, K, Harris, K, Jones, J, Tabor, J, Beuring, T, Sieving, R, Shew, M, Ireland, M, Bearinger, L and Udry, J 1997, 'Protecting Adolescents From Harm: Findings from the longitudinal study on adolescent health', *Journal Of The American Association*, Vol 278, pp 823-832.
- Roberts, G, McCall, D, Stevens-Lavigne, A, Anderson, J, Paglia, A, Bollenbach, S, Wiebe, J and Gliksman, L 2001, *Preventing Substance Use Problems Among Young People: A compendium of best practices*, Health Canada, Ottawa, Ontario.
- Rohrbach, L, Hodgson, C, Broder, B, Montgomery, S, Flay, B, Hansen, W and Penz, M 1994, 'Parental Participation In Drug Abuse Prevention: Results from the Midwestern Prevention Project', *Journal Of Research On Adolescence*, Vol 4, No 2, pp 295-317.
- Sanci, L, Toumbourou, J, San, V, Rowland, B, Hemphill, S and Munro, G 2002, 'Drug Education Approaches In Secondary Schools', *Prevention Research Report No 3*, Australian Drug Foundation, November 2002.
- Sawyer, MG, Arney, FM, Baghurst, PA, Clark, JJ, Graetz, BW, Kosky, RJ, Nurcombe, B, Patton, GC, Prior, MR, Raphael, B, Rey, JM, Whaites, LC and Zubrick, SR 2000, *The National Survey Of Mental Health And Wellbeing: The mental health of young people in Australia*, Commonwealth Department of Health and Aged Care, Canberra.
- Schon, D 1987, *Educating The Reflective Practitioner: Towards a new design for teaching and learning in the professions*, Jossey-Bass, San Francisco.
- Stansfeld, S 1999, 'Social Support And Social Cohesion', in Marmot, M and Wilkinson, R (eds), *Social Determinants Of Health*, Oxford University Press, New York.
- Stuart, GL and Price, LH 2000, 'Recent Developments In Populations At Risk For Substance Abuse', *Current Opinion In Psychiatry*, 13 (3) 315-320.
- Spooner, C, Hall, W and Lynskey, M 2001, *Structural Determinants Of Youth Drug Use: The scope for youth health development*, Australian National Council on Drugs, ACT.
- Thorsborne, M 2000, 'A New School Of Thought: Non-punitive approaches to drug incidents in schools', *Drugs In Society*, 12-15, March 2000.
- Tobler, NS 2000, 'Lessons Learned', *The Journal Of Primary Prevention*, Vol 20, No 4.
- Tobler, NS and Stratton, HH 1997, 'Effectiveness Of School-Based Drug Education Prevention Programs: A meta-analysis of the research', *The Journal Of Primary Prevention*, Vol 18(10), pp 71-128.
- Tobler, NS, Roona, M, Ochshorn, P, Marshall, D, Streke, A and Stackpole, K 2000, 'School-Based Adolescent Drug Prevention Study', *Adolescence*, Vol 31, pp 159-166.

- White, V 1999a, 'Australian Secondary Students' Use Of Over-The-Counter And Illicit Substances In 1999', Department of Health and Aged Care, Canberra.
- White, V 1999b, 'Australian Secondary Students' Use Of Alcohol In 1999', Department of Health and Aged Care, Canberra.
- White, D and Pitts, M 1998, 'Educating Young People About Drugs: A systematic review', *Addiction*, Vol 93, pp 1475-1487.
- Wragg, J 1986, 'Drug And Alcohol Education: The development, design and longitudinal evaluation of an early childhood programme', *Australian Psychologist*, Vol 21, No 2, pp 283-298.
- Wragg, J 1992, 'An Evaluation Of A Model Of Drug Education', *National Campaign Against Drug Abuse, Monograph No 22*, Australian Government Publishing Service, Canberra.
- Wyn, J, Cahill, H, Carson, S, Holdsworth, R and Rowling, L 2000, 'MindMatters, A Whole School Approach Promoting Mental Health And Well-Being', *Australian And New Zealand Journal Of Psychiatry*, Vol 34, No 4, pp 594-601.
- Yen IH and Syme SL 1999, 'The Social Environment And Health: A discussion of the epidemiologic literature', *Annual Review Of Public Health*, 20, 1999, pp 287-308.
- Wolin and Wolin, 1999, *Project Resilience*, <http://www.projectresilience.com>

