

TAKING AN EVIDENCE-BASED APPROACH TO CLASSROOM DRUG EDUCATION

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This paper addresses the question “What constitutes effective school drug education?” It draws on research that has identified the characteristics of those classroom drug education programs that have demonstrated reductions in harmful use of drugs. The paper argues that classroom drug education programs should exemplify both good pedagogy and good health promotion practice and be informed by the evidence-base relating to effective drug education. It cautions against the common pitfalls associated with intuitive approaches to drug education.

This paper does not encompass a discussion of the provision of early intervention responses for those young people requiring additional support to assist them to deal with problems associated with their own or others use of drugs.

Have we any evidence that drug education can work to reduce or prevent drug-related harm?

Extensive research has been conducted into the efficacy of drug education programs (Dielman 1994, Dusenbury and Falco 1995, Midford 2000, Tobler 2000). Some programs have made a discernable difference in reducing the incidence of risky use around alcohol, cigarettes and cannabis. Others have shown no impact on behaviour and others again have been associated with an increased use of drugs or increased delinquency amongst the target participants (Dishion and Andrews 1995, Withers and Russell 2000). It is known then, that some programs are a good investment as a prevention strategy, others make no discernable difference, and others again have worked against the goal of reducing drug-related harm.

What do we know about programs that don't work?

Scare tactics

Intuitive approaches have led in the past to the use of scare tactics in drug education. Scare tactics are based on the assumption that *if we could just show how risky it is - they wouldn't do it*. Students, parents and teachers are often convinced that confronting young people with the most severe harms will deter them from using drugs. However, programs that rely on scare tactics have not shown reduction in the incidence of harmful drug use (Tobler et al 1997). There may be a number of reasons why this is so. These include a tendency to believe in one's own invulnerability – *this is not going to happen to me*, and a poor fit between the young person's observation or experience of drug use and the consequences shown in the scare tactics program – *this is not what I have seen happening to others*. Many students have observed parents, peers or community members using drugs such as cigarettes, alcohol and cannabis without appearing to come to harm.

A health education program can work against its overt message by inadvertently reinforcing the behaviours it aims to work against. Scare tactics, for example, can inadvertently *glamorise* risky behaviours. The ‘survivor’ or ex-addict can gain a heroic status in the telling of their story. Thus scare tactics may make certain behaviours more attractive or compelling, especially to those with something to prove, those with an adventurous streak, or to those who are driven to cause themselves harm.

Understanding normative approaches in drug education

Normative education strategies have been identified as critical in the context of effective school-based drug abuse prevention programs (Dusenbury & Falco 1995). Students often over-estimate the proportion of their age group who used drugs, and it has been argued that normative components may play a critical role in activating students to utilise peer resistance strategies (Hansen and Graham 1991).

In constructing our drug education programs, we should be aware of a cultural tendency to problematise youth (Wyn & White, 1997). In Western culture, adolescents are often stereotypically represented as victims, potential criminals or agents of social disorder (Bessant and Watts 1998). Ideas about what is the norm may come from the media, from soap opera, advertising or the news and lead to the belief that risky drug and alcohol use is an inevitable part of youth culture. If the educator frames the entire conversation about drugs inside of the assumption that students will or do use them, this assumption can become a hidden agenda, sending the message that it is the norm to use or use in a risky way. Young people can conclude that there is something ‘wrong’ with them if they don’t follow this pattern.

Less successful drug programs have inadvertently normalised drug taking as a rite of passage or a universal adolescent behaviour – thus pushing a hidden expectation that it is a behaviour for all. To counteract this tendency, drug educators need to be informed by prevalence statistics and think critically about the way in which they construct the stimulus scenarios that are the focus of classroom discussion or role-play activities.

Is knowledge enough?

Educators can easily make the assumption that it is *knowledge* that children need to keep them safe around drugs. *If they just knew more about drugs – then they would make rational choices not to use them.* Whilst young people do need to be informed, it has been demonstrated that knowledge alone is not enough to influence behaviour, and information-only approaches to drug education have not demonstrated reductions in harmful behaviours.

An effective program asks students to *apply* their knowledge about drugs to specific contexts. In applied approaches, as well as considering risk in association with the drug type, amount, and the frequency of use, the students are asked to consider contextual risks associated with when, where and with whom the use will take place, the reason for use or the desired effect of the drug.

Students can also benefit from investigating those other factors that can influence choices about drug use, such as the desire to have fun or to celebrate, the need to belong or to fit in, the desire to forget, the urge to impress and the attempt to cope with stress or distress.

Building self-esteem and withstanding peer pressure

Following the lack of success of scare tactics and information-only approaches, the notion of self-esteem building was used to guide drug education. The intuitive assumption here was that *if only children felt better about themselves, and had good*

communication skills, they would withstand peer pressure and be strong enough not to use drugs. These purely affective approaches to drug education, in the guise of personal development programs, have also not, on their own, demonstrated changes in behaviours. (Tobler et al 1997)

The underlying assumption that drug abuse occurs due to lack of self-esteem or lack of capacity to withstand peer pressure now appears too simplistic. Research has demonstrated that some of those with high esteem may use drugs in harmful ways.

Mental Health Perspectives Inform Drug Education

There is an increasing awareness of the correlation between mental health problems and problematic drug use. As with adults, some young people use drugs to help them cope with stress or challenge. Those with mental health problems are more likely to use drugs. For example 52% of those with a high level of emotional problems smoke as compared with 11% of those with a low level of problems (Sawyer et al 2000). The risk of drug use disorder is estimated to be doubled if there is a prior depressive or anxiety disorder (Reiger, Farmer et al, 1990). This awareness prompts consideration of the impact of risk and protective factors on choices relating to drug use. More recent approaches to drug education tend to work towards the broader goal of enhancing the resilience of young people and their capacity to deal effectively with challenge or adversity.

Resilience, risk and protection

Research in the fields of resilience (Benard 2004, Luther 2000, Burns 1996, Fuller 1998), social capital (Cox and Caldwell 2000, Hughes et al 2000) and the structural determinants of wellbeing (Marmot and Wilkinson 1999, Stansfeld 1999, Lynskey et al 2001) have led to an increasing awareness of the importance of an environmental approach to enhancing wellbeing. This research has distinguished that drug use, rather than being simply an individual behaviour, is multifactorial and tends to be shaped by a range of macro-environmental factors including the economic, social and physical environment (Lynskey et al 2001).

The range of community risk factors which impact on mental health and drug use include poverty, economic disadvantage, social or cultural discrimination, isolation, neighbourhood violence, and lack of facilities and services. Conversely, protective factors at a community level include a sense of connectedness and attachment to networks within the community, participation in community groups, strong cultural identity and ethnic pride, access to support services and community norms against violence. (CHAC 2000).

Risk factors at a family level include parental drug use, family disharmony or break up, and violence or mental health problems in family. Protective factors at a family level include supportive caring parents, family stability and harmony, responsibility within the family and strong family norms and morality (CHAC 2000). Young people living in high risk families within high risk communities can be seen to be at greater risk of developing mental health or drug use problems and may require additional levels of support in relation to the provision of pastoral care and early intervention programs.

School is the organization of most relevance to young people, and a sense of connectedness or belonging to school is in itself distinguished as a key protective factor for young people (Resnick 1997, Fuller 1998). School protective factors, associated with positive school climate, include the presence of caring relationships, high expectation messages, and opportunities for meaningful participation and contribution (Benard 2004) as well as required responsibility or helpfulness, opportunities for success and recognition, school norms against violence and pro-social peer groups (Sawyer et al 2000). School risk factors include bullying, peer rejection, poor attachment to school, inadequate behaviour management, deviant peer group and school failure (CHAC 2000). Cognisant of the importance of the school environment, a greater focus is now placed on locating health education programs within integrative whole-school frameworks that promote belonging, participation, learning and wellbeing (Bond et al 2001, Wyn et al 2000). This entails an augmented focus on school climate, organisational health, policy review, teacher development, and effective partnerships with family, community and services.

Individual risk factors include low intelligence, low self-esteem, alienation and poor social skills. Individual protective factors include attachment to family, easy temperament, school achievement, above average intelligence, adequate nutrition, social competence, problem-solving skills, optimistic habits of thought, internal locus of control and positive self-related cognitions. (CHAC 2000). Bonnie Benard distinguishes the key attributes of resilience in young people as *social competence, problem-solving skills, autonomy and a sense of purpose and a bright future*. She defines social competence as incorporating *responsiveness, cultural flexibility, empathy, caring, communication skills, and a sense of humour*. She defines problem solving as including the skills of *planning, help-seeking, and critical and creative thinking*. Autonomy is defined as including a sense of *identity, self-efficacy, self-awareness, task-mastery, and adaptive distancing from negative messages and conditions* and a sense of purpose and belief in a bright future encompasses *goal direction, educational aspirations, optimism, faith and spiritual connectedness* (Benard 2004). An effective health promotion program, which has the broader aim of enhancing resilience, should use methods, which work towards enhancing these attributes in its participants.

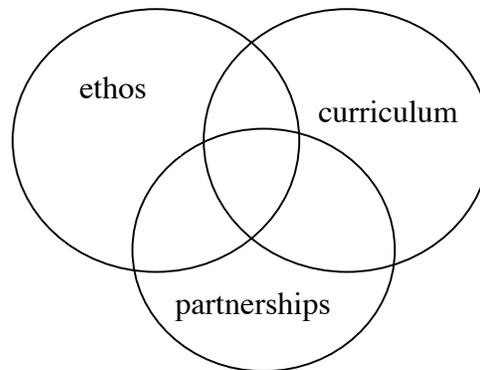
Environmental Approaches Inform Drug Education

More recent approaches to drug education are cognisant of the importance of positive school and classroom climate in the promotion of student wellbeing. This is acknowledged in school guidelines such as *The Framework for Student Support Services in Victorian Government Schools* (DOE 1999). This framework recommends a whole-of-school approach to ensure effective provision of a continuum of support encompassing primary prevention, early intervention, intervention and post-vention strategies.

Whole school approaches

Much work has been done to research the ways in which schools can best provide supportive environments for young people and work proactively to influence the

wellbeing and learning of the students through the curriculum program (Glover et al 1998, Wyn et al 2000, Bond et al 2000). The World Health Organisation (WHO) model of the Health Promoting School invites schools to address the ethos, curriculum and partnerships that can be brought into to play to promote wellbeing (WHO 1994). A health promoting school places priority on creating an environment that will have the best possible impact on the health of students, teachers and school community members. (See Figure 1)



(Figure 1: Framework for the Health Promoting School, adapted from WHO 1994)

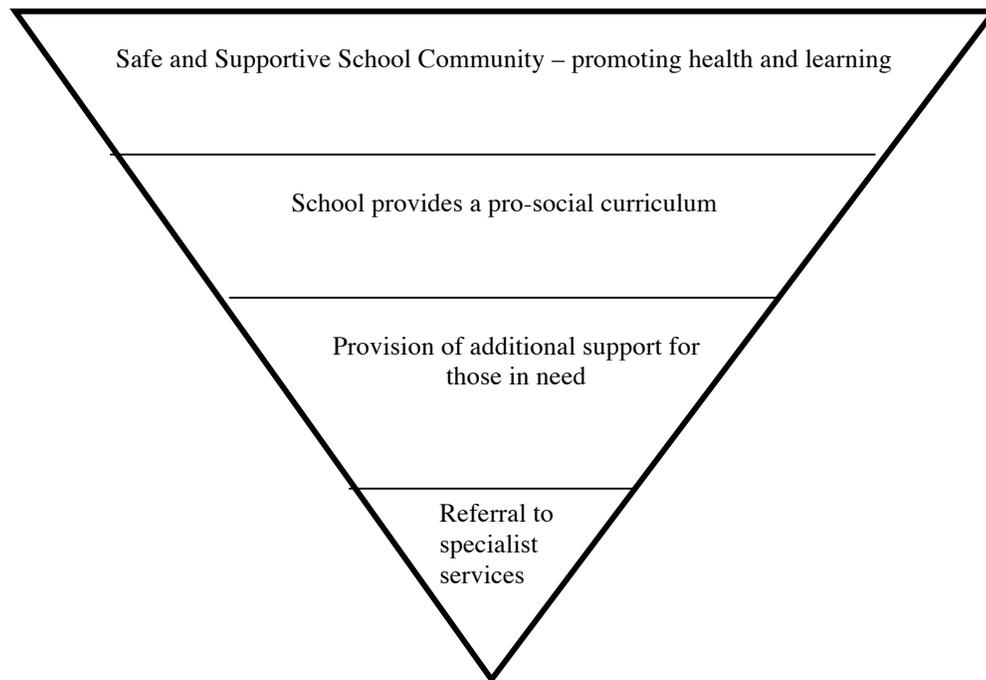
Also offered is the WHO (1994) model of mental health promotion in the school setting, which incorporates promotion, prevention, early intervention and referral (see figure 2). At the base it identifies the importance of providing a safe and supportive environment and an ethos conducive to mental health and learning. This level can termed mental health promotion. It involves all teaches in teaching for mental health and includes an emphasis on effective pedagogy and positive relationships.

The second level of the triangle depicts the provision of curriculum programs designed to promote mental health via the development of communication, help-seeking and problem-solving skills. This activity can be termed primary prevention as it aims to prevent or reduce the incidence of harmful or unhealthy attitudes or behaviours. It may include a comprehensive health education curriculum and pastoral care program and can be understood to include drug education.

The third level of the triangle indicates the need for early identification and intervention. This involves detecting a problem at an early stage and providing effective support. Targeted programs, individual counselling, consultation with parents and effective management of drug use incidents should be offered at this level.

The fourth level of the triangle indicates the small percentage of students who require professional assessment or treatment for drug use or mental health problems. This level can involve referral and in some instances crisis management. The school can play a critical role in referring students and families dealing with substance use problems,

Whilst this level of treatment is not usually provided by school personnel, the school will nonetheless play a role in referral and be required to continue to support the student undergoing treatment or to assist with reintegration into school life. (MindMatters Consortium 1999)



(figure 2 adapted from WHO 1994)

So what does the drug education evidence-base suggest?

The available evidence-base suggests that drug education programs that include knowledge, social and life skills, and refusal skills can produce significant reductions in licit and illicit drug use (Tobler 19976). These programs are best positioned within a broader health and personal development curriculum that focuses amongst other things on mental health issues such as stress and coping (Dusenbury and Falco 1997). They employ highly interactive pedagogies, engage students in problem-solving and critical thinking and assist students to relate their learning to real life situations. Quality resources model and guide such approaches. Research identifies however, that teachers are the key resource in the classroom and benefit from a strong grounding in the rationale of the program and are best supported by robust professional development which models effective practice. Effective programs occur in a school context of care and high expectation and are supported by coherent and consistent policy and practice. They are responsive to the cultural and social needs of the school community and ideally are supported by community initiatives enlisting parental, community and media support. Teachers should not be daunted if it is not within their range to involve all elements of a community support strategy as some programs which focus on the classroom program as the key intervention have also demonstrated good results (see McBride et al 2000, 2004).

From theory to classroom practice

Once equipped with an awareness of the evidence base informing effective drug education, the teacher is faced with the challenge of translating the theory into practice. The following section explores the question: What does a harm minimisation approach look like in the classroom (For examples of education programs see SHAHRP: School Health and Alcohol Harm Reduction Project on line at <http://www.ndri.org.au/shahrp/>, and Get Wise: working on illicit in school education: drug education resources for schools and their communities <http://www.sofweb.vic.edu.au/wellbeing/druged/>).

Rationale and Teacher stance

In introducing a harm minimisation approach in the classroom, the teacher may need to inform students about the intent or purpose of the drug education unit and how it fits within the broader health program. This is recommended because students may assume that the teacher will take an advisory, judgemental or moral stance. In a harm minimisation approach, the teacher takes an ‘investigatory’ stance, raising the question – *What does a young person need to know and be able to do in order to live a safe, healthy, happy and useful life in a social world in which drug use occurs?* This stance can provide a broad educative framework within which to structure a range of problem-predicting and problem-solving activities designed to equip students to prevent or minimise harms associated with drug use.

Teacher as architect of a positive relational climate

There is a need to approach the generation or maintenance of a positive class climate in a purposeful way. At the foundation this entails ensuring a *freedom from* stigma, isolation, ridicule and undue competition or hierarchy. Rules such as no putdowns can assist with this. There is also a need to generate the *freedom to* participate. Mixing and grouping devices will assist to bridge communication beyond usual friendship sub-groups. Interesting and relevant paired and small group problem-solving tasks facilitate participation and engagement with the task. Playful activities and game structures that employ some humorous elements or introduce a level of fun can also entice students to participate in a co-operative way (Cahill 2002).

Interactive and experiential approaches to learning enhance engagement in learning in the middle years of schooling (Cummings 1996). They can assist students to generate skills and to move from experiential to reflective and meta-cognitive thinking modes (Henton 1996). However, group tasks call for a high level of communication and co-operation and some teachers may be reluctant to employ such activities either due to unfamiliarity with such approaches or if they fear that that some students will subvert the activities and become difficult to manage (Hansen and McNeal 1999).

Teacher development

Dusenbury and Falco (1995) identify that failure to include interactive skills components is a key area of breakdown in the implementation of drug education programs. Successful programs have placed an emphasis on teacher development. The SHAHRPS project included a professional development component in which all teachers delivering the

program received specific training in the rationale and pedagogical approach used in the teaching materials. The Hansen and McNeal study (cited in CHAC 2004) into how drug education programs are implemented by teachers found that teachers tended to focus on the knowledge components of the drug education program and were less likely to engage students with the skills development components.

It is important that the challenge of teacher development is addressed. A strong case can be made for the provision of teacher professional development that identifies the conceptual and the pedagogical approach to be taken. Collegial support in the form of consistent behaviour management approaches, and school-wide adoption of active learning techniques, may assist the health or personal development teacher to work in this way. Professional development that models the use of such activities may support the teachers to adopt these types of activities. Without the inclusion of these skill development activities, the classroom drug education program may amount to little more than a knowledge-only approach and as such may produce limited results both as an education strategy as a health promotion strategy.

Timing and Developmentally appropriate curriculum

The research indicates that drug education should take place before young people are routinely exposed to making choices about drug use. In addition, further education should be provided when young people are engaging with the decisions in their social contexts. As with any education program, the focus and tasks should be developmentally appropriate. The best time to begin the education program seems to be late primary or early secondary school so as prevention work can occur before experimentation occurs. Age appropriate booster sessions are also needed in the middle to later years in secondary school, or around the time when adolescents are making drug-use decisions in their social contexts (McBride et al 2004).

A substantial review of the evidence related to drug education has been conducted as a component of the 2004 monograph entitled *“The Prevention of Substance Use, Risk and Harm in Australia: A Review of the Evidence.”* This work, funded by the Australian Government Department of Health and Ageing, was conducted by The National Drug Research Institute and the Centre for Adolescent Health. This comprehensive analysis of the available evidence base includes a review of parenting programs, school drug education programs and targeted programs for high needs youth. The authors of this suggest that “drug education programs may be less effective where they are initiated too early.” (p 14 Chapter 7). They recommend that drug education be targeted as the late primary and early secondary years.

“The consensus is that the optimal time for introducing youth preventive programs is late primary school or early secondary school, when experimentation often begins. This may also help to capture higher-risk individuals who may leave school early. Junior programs should be generic as the most effective programs for reducing cannabis use at this stage are also effective in reducing tobacco and alcohol use”. (CHAC 2004 chapter 8, P17)

Early years of Primary school

The authors of this report cite a range of studies that identify parent education and the development of parenting skills as a source of support for families with young children and argue that they may be the most appropriate prevention strategy to use in relation to children in the pre-school and early years.

This serves to remind those looking from a school perspective that parents have a key role to play in shaping children's attitudes, expectations and behaviours. Clearly many families stand to gain from assistance with parenting skills and the school can be a site through which to offer such support.

Though learning *about* drugs is not clearly indicated for younger children, there is strong argument for the need for the development of social competence. A broad prevention approach to drug education could include a focus on enhancing resilience or attributes associated with resilience including social competence, problem-solving, autonomy and a sense of purpose and optimism (Benard 2004). A social skills curriculum in the early and middle years of primary school may be the most appropriate foundation to support a later investment in a drug education curriculum.

Later years of Primary school

This monograph makes an extensive review of drug education programs targeted at later primary or early secondary years. The authors assert that effective primary school programs "have tended to address social influences and the development of positive peer relationships" CHAC 2004 chapter 7, P 15) and recommend that at this age "the curriculum should focus more on building relationships and social-emotional skills than on drug use. (p17)"

Lower secondary school

The SHAHRPS Drug education program is an Australian study that illustrates the beneficial outcomes that can arise from a targeting of the early years of secondary school, with booster sessions delivered in subsequent years.

Program Intensity

A review of the literature also identifies that the intensity of the intervention may also be important in its success. It appears that most of the successful programs are intensive and long-term (including booster sessions). Of the 10 soundly evaluated effective programs reviewed by White and Pitts, eight had 10 or more sessions devoted to delivery of the program and booster sessions (White and Pitts 1998). The SHAHRPS program entailed 8 sessions in first year of high school, five booster sessions in second year of high school and a further four sessions in the fourth year of high school.

This has implications for school delivery. Competing pressures in a crowded curriculum may mean that teachers only dedicate a few lessons to drug education and thus the efficacy of the program may be jeopardised.

Pedagogy

The role of interactive activities

As with any education program, effective pedagogy is employed to generate high levels of engagement with the tasks. The scenarios offered for class focus should be attuned to the contexts that the children encounter and be cognisant of the differing expectations and challenges that arise for children, adolescents and adults. A focus on context can assist with this. A primary student is more likely to encounter the challenge of avoiding the cigarette smoke of an adult caregiver or family member, whereas a 16 year old may be considering how to deal with invitations to use within a peer group. An invitation to drink, delivered by a parent at a family function, is very different from a peer expectation that everyone in the team will get drunk to celebrate a sporting victory.

Measuring and pouring standard drinks, or reading containers to discover the relative strength of their contents, are skills that can best be acquired through practical engagement with measures, containers and liquids. On the other hand, communication skills, such as asserting a choice when it differs from that of peers, or negotiating with friends for a safer travel arrangement, may best be acquired in discussion and role-play. It is in the social domain that social skills can best be applied and developed, therefore, providing opportunity for peer interaction is not an optional extra, but a central design feature of drug education.

Problem-predicting and problem-solving

A harm minimisation or harm reduction approach invites the use of problem-predicting and problem-solving techniques. *Problem-predicting* activities are prompted by the question: *Could this drug use be harmful in any way?* Useful subsidiary questions include: *What might these harms be and who may be affected?* Students can be invited to consider financial, physical, emotional and relational harm. Shorter term relational harms, such as loss of trust or reputation, and more minor physical harms, such as being vomited on or diminished performance at work, school or in sport, may be of greater interest and immediacy than the most severe harms such as death or disability. Some young people may be more motivated to construct ways to avoid or minimise these small-scale problems just because they seem more immediate and more likely to occur within their worlds.

Problem-solving activities can be generated around the questions: *How could these harms have been prevented?* or *Once they have occurred, how could these harms be minimised or alleviated?* These questions can be used to position the learners in an active problem-solving mode around particular scenarios. Lateral thinking is invited to generate a list of possible strategies. The strategies that the students themselves identify can become a form of peer education or peer endorsement and can have a different currency to those transmitted by external authorities.

Rehearsal

Solutions can be easy to identify but much harder to enact. Certain skills and abilities will be required to carry out the harm prevention or harm minimisation strategies identified by

the class. Taking an *applied* problem-solving approach gives students a chance to ‘reality test’ their solutions. To move into an applied mode the educator can use questions such as: *What would that sound like or look like?* Role-play is useful device to rehearse for or examine the challenge. It allows the students themselves to invent the sort of lines that may be useful if they want to save face, or the negotiation techniques that may work with their friends.

Deeper thinking

Role-based activities can also be used to assist students to locate and name the ‘invisible barriers’ that can impede the enactment of solutions (Cahill 2002, 2003). In role, students can be asked to give voice to the ‘hidden thoughts’ of characters, or to personify the competing voices heard in an internal dialogue as a character struggles with a decision. The educator can deepen the enquiry through questions such as: *What is she/he afraid of here? What is he/she hoping will happen? What is stopping him/her from doing what he/she knows is right or necessary? What would assist him/her to get on and do this?* These questions assist students to bring ethical and relational considerations to the fore. Further, in response to evaluative questions, such as *What would it take to... get help for a friend / stand your ground / apologise...?*, young people often identify that courage is a central feature of effective problem solving. In such instances, peer endorsement and valuing of the ‘courage’ it would take is an important part of generating health promoting attitudes.

What do normative strategies look like?

Normative strategies give students opportunities to identify that most people choose not to use drugs, or in the case of alcohol, choose to use in ways that minimise risk to themselves or to others. Learning activities position students to notice that safer choices are the norm and to identify the reasons why most people prefer not to risk harm to themselves or others. In this process students get to legitimate safer choices. When safer choices are perceived to be the norm, it is easier for students develop refusal strategies or to imagine the possibility of withstanding peer pressure. The use of quizzes and guessing games around the prevalence statistics can surround such endeavours with an atmosphere of fun.

When working with statistics it is important to distinguish between statistics relating to ever-used, which incorporate the one-off or experimental user, as opposed to those relating to recent use or regular use. Often the statistics cited are those relating to ever-used. In alcohol programs this is particularly deceptive as many young people have tasted or tried alcohol as part of family life. It is important to seek out statistics that distinguish different levels of use and distinguish between use levels at different age groups.

At a less direct level, normative approaches guide the educator to critically consider the hidden agendas in the material they are teaching and to actively involve students in critical analysis of the messages they encounter in the media. The teacher may choose not to use audio-visual discussion triggers which play into common stereotypes, perhaps by casting all the non-users as less attractive and all the high-users as the most attractive physical or fashion types. In addition, the stories within the scenarios should be selected

on the basis that they reflect more commonplace situations. For example, a scenario for early high school students about smoking may show one person suggesting to a group that they try a cigarette. This is quite different from a scene in which four or five thirteen year olds who are all smokers set about 'pressuring' one person into trying smoking. As the majority of young teenagers don't smoke, it is more relevant and accurate to reflect this numerical balance in the scenario. (Examples can be found in the SHAHRPS program and in Get Wise referenced above.)

Principles of Drug Education

The Revised Principles of Drug Education (in publication) developed by DEST as part of the National Drug Strategy offer twelve key pointers to inform the development of effective drug education (DEST in publication). They form a useful evidence-based guide to planning for effective school drug education.

At the broader conceptual level, Principles 1-3 recommend a comprehensive and evidence-based approach incorporating school practice based in evidence, a whole school approach, and clearly identified educational outcomes.

At the relational level, Principles 4-5 emphasise the importance of positive climate and relationships with an emphasis on provision of a safe and supportive school environment, positive and collaborative relationships.

At a contextual level, Principles 6-8 challenge the school to take account of the local context and needs of the community. This encompasses an understanding of the risk and protective factors at play, and informs the development of culturally appropriate and targeted drug education. It also locates the importance of school policy and practice in sending consistent messages to the school community.

At the classroom level, Principles 9-12 focus on the importance the classroom teacher in the provision of drug education. The Principles recommend that the classroom teacher uses interactive and inclusive strategies to promote knowledge and skills development. The program should be designed so as to deliver credible and meaningful learning activities as part of a broader curriculum framework addressing health and social development.

These principles are informed by and consistent the recommendations that come from the broader review of the drug education field and as such can be seen as a useful tool in guiding the development of approaches to drug education.

Selecting Resources

The Commonwealth National Initiatives in Drug Education released a set of guidelines for selecting drug education resources (Commonwealth Department of Human Services and Health 1996). These guidelines contain advice that remains pertinent.

Recommendations include reviewing a resource to ensure that it reflects a harm minimisation philosophy, provides a range of harm minimisation strategies, addresses patterns of use likely to occur in the target group, and focuses on the effects and consequences most relevant to youth. It suggests that appropriate resources avoid exaggerating the dangers of drug use, are free from bias and stereotypes and use appropriate terminology, avoiding subjective and emotive terms. In relation to the teaching and learning criteria it recommends age-appropriate activities that are designed to help students develop their social skills and which provide for a balance between

knowledge, attitudes and skills development. In addition, this document recommends that resources be offered within a broader health curriculum as part of a comprehensive school approach to addressing drug issues. It includes recommendations that schools work with parents, community group and specialist health care agencies to ensure a comprehensive approach.

Conclusion

An effective drug education program is supported by a school-wide approach to generating pro-social attitudes. Added value is obtained if community and parental standards and expectations reinforce the positive health promotion messages delivered by the school and if there is integrity of message between the classroom program and the school policy and practices. The drug education program should be housed within a broader health and social education curriculum, be attuned to the cultural and developmental needs of the students, and conducted within an atmosphere of high expectation and support. The interactive learning tasks provide opportunities for students to enhance their knowledge and skills and to predict, problem-solve and 'rehearse' for a range of challenges they may encounter in relation to drug use.

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SHAHRP: School Health and Alcohol Harm Reduction Project on line at

<http://www.ndri.org.au/shahrp/>

Get Wise: working on illicit in school education : drug education resources for schools and their communities <http://www.sofweb.vic.edu.au/wellbeing/druged/>