'Best' Practices in Prevention for Youth

Literature Review

A Follow up document to the Vancouver School Based Alcohol and Drug Prevention Working Group: Final Report on Community Engagement Process, June 2004

Prepared by: Lu Ripley, Prevention Coordinator

Vancouver Coastal Health, Youth Addictions and Prevention

December 2005

TABLE OF CONTENTS

Introduction

This document is a synopsis of 'best practice' evidence in relation to alcohol and drug prevention for youth, based on a review of recent literature from Canada, Australia, UK and US. The purpose of this literature review is to situate the results of a Vancouver consultation process, conducted by the Vancouver Coastal Health Authority and Vancouver School Board,[1] in a broader context and ensure that any actions resulting from the consultation are in keeping with recent evidence. As a result, the focus is on *demand reduction*, and doesn't significantly address supply reduction.[2]

Too often, prevention for youth is wholly associated with school-based drug and alcohol education; however, prevention entails all "policies and practices that protect and promote healthy development, prevent or delay the onset of substance use, or prevent or reduce the negative consequences associated with the use of psychoactive substances" (Ministry of Health, 2005). Prevention for youth includes, but is not limited to, the following components:

- School based drug and alcohol education
- Programs that target academic and social learning to address risk factors such as aggression, academic failure and dropping out of school
- Social and recreational programming
- Programs that enhance youth, family and community assets
- Health interventions, such as screening and education from school nurses
- Building parent knowledge and assets through education and support
- School policies regarding drug use
- School environments that enhance vulnerable students' connection to school, emotional and social well-being
- Social marketing and mass media
- Peer education and mentoring programs
- Employment and training

The attention in this report to school based education is not meant to suggest that classroom education is the most important aspect of prevention, but rather that school-based drug and alcohol education tends to be the mostly widely studied aspect of prevention. Prevention literature is shifting focus to other prevention components, such as school environment, however less research exists in these areas.

This document begins with a brief, but important, discussion of some of the limitations of 'best practice' research in the domain of substance use prevention. Following this, broad based prevention principles will be discussed, followed by a review of distinct prevention strategies, such as school-based education and parent education. Finally,

[1] Vancouver School Based Alcohol and Drug Prevention Working Group, *Final Report on Community Engagement Process*, Prepared by Maria Hudspith, VCH and Teya Greenberg, Josephine Tcheng and Mardi Dauphinee, Kinex Youth Initiative, June 2004.

[2] This is not to suggest that supply reduction is not an important aspect of prevention, however it is beyond the scope of this literature review.

the main recommendations from the consultation are discussed in relation to 'best practice' literature.

'Best' Practice Limitations

General principles outlining 'best practices' in alcohol and drug prevention exist, however it must be acknowledged at the onset that there is a lack of evidence firmly substantiating "what works". The Monograph (Loxley et al, 2004) is considered the leading comprehensive analysis of substance use prevention to date, and its authors conclude that further research is warranted in almost all areas.[3] Although principles and information gleaned from 'best practice' research is valuable, it is useful to bear in mind limitations of the currently available evidence:

- Methodological limitations are notorious within health promotion and education due to a number of factors such as a reliance on self-reporting, a difficulty in accessing participants for follow-up research, and inappropriate choice of outcome measurements (Canning, et al, 2004).

- Programs that target "higher risk" youth are difficult to evaluate and are rarely included in larger reviews and meta-analyses (Canning et al, 2004).

- Programs and projects most often included in larger reviews and meta-analyses are those that utilize and correspond within "traditional evidence hierarchies." Other methodological approaches, such as qualitative research, tend to be under-represented (Canning, et al, 2004 p. 2).

- Most of the research has been conducted in the US, with programs have abstinence as an ultimate goal. Some argue that this is an unrealizable goal resulting in the "ineffectiveness" of most prevention programs (McBride, 2003).

3 An exception is laws and regulations regarding minimum age for purchasing or using substances has shown evidence for outcome effectiveness (Loxley et al, 2004).

Prevention Principles

1. Build a Strong Framework

- Address protective factors, risk factors and resiliency: Focus on the factors that most directly promote resiliency or, conversely, contribute to substance use problems in the population of interest.
- Seek comprehensiveness: complementary efforts through inter-agency efforts. Given the link between many psychosocial problems – such as mental health, crime and alcohol/drug use - there is strong support for inter-sectoral approaches.
- Ensure sufficient program duration and intensity (Health Canada 2001).

2. Strive for Accountability

- Utilize accurate information: use reliable and local information on the nature and extent of youth substance use, problems associated with use and user characteristics
- Set clear and realistic goals
- Monitor and evaluate
- Address sustainability from the beginning (Health Canada, 2001).

3. Address Risk and Protective Factors

- The terms 'protective' and 'risk' factors are used to describe aspects of a young person and their social environment that either reduce or increase the likelihood of the development of harmful substance use. Examples of protective factors include: strong parental monitoring, social skill development, the availability of and participation in social/recreational activities, and positive connection to school.
- As a result, prevention approaches should be grounded in an integrated approach to addressing psychosocial problems and be integrated into a larger health promotion framework (ADAC, 2002).

4. Understand and Involve Young People

- Recognize youth perceptions of substance use.
- Involve youth in program design and implementation (Health Canada, 2001).

5. Relevant Universal, Selective and Indicated Programs

- Universal preventive interventions are intended for the whole population group (i.e. school) that has not been identified on the basis of risk.
- Selected preventive interventions are targeted to sub-groups whose risk of developing a problem with substance is significantly higher than average.
- Indicated preventive interventions are targeted to individuals in high-risk environments.
- In assessing the suitability of universal, selected and targeted prevention approaches, it is useful to consider the 'prevention paradox.' An epidemiological term, the prevention paradox demonstrates that the greater number of lower risk individuals means that collectively they contribute to the largest bulk of preventable illness.
- Research from Australia indicates that the prevention paradox holds true for youth who consume legal substances, such as alcohol and tobacco, but it is not the case for illicit substances.[4] These findings suggest "that prevention strategies for legal substance (and potentially cannabis) should be universal in their application and relevance to young people, and prevention strategies for illicit substances be targeted to high risk populations" (Ministry of Health, 2005).

Advantages and Disadvantages of Universal Programs (from Canning et al, 2004)

Advantages	**Disadvantages**
• Avoids labeling/stigmatizing individuals • Prepares way for targeted programs • Provides a possibility for focusing on community –wide factors • Behaviourally appropriate (i.e. high-risk children are not expected to change their behaviour when they are living among children who have high levels of same behaviour)	• Might be unappealing to decision makers • Small benefit to individual • Might have greatest effect for those at lowest risk • Might be perceived by low-risk population as being of little benefit • Difficult to detect overall effect

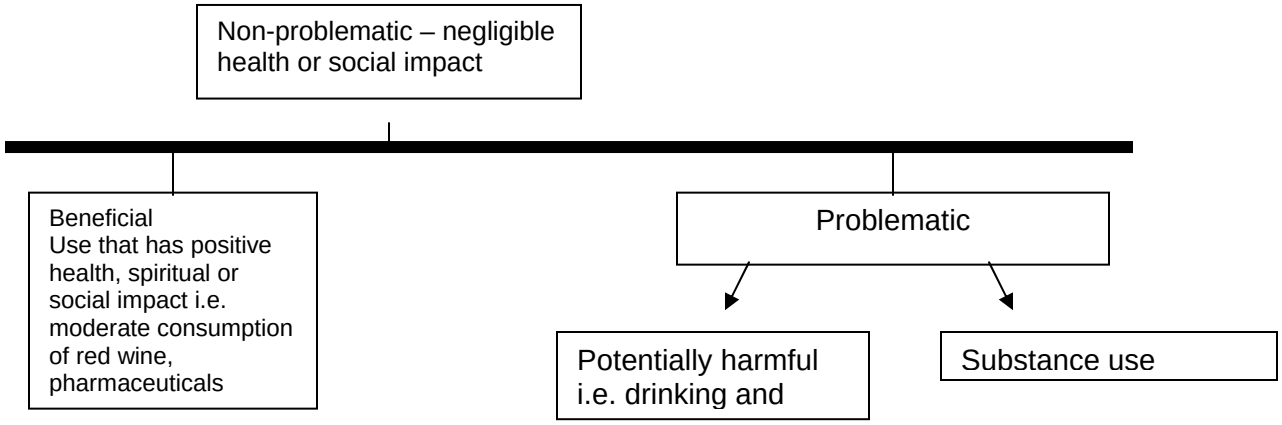
6. Spectrum of Substance Use

- Throughout history and across cultures humans have used substances to alter consciousness, thus the ultimate goal of prevention cannot be to *eliminate* substance use completely (Ministry of Health, 2005).
- In terms of substance use among adolescents, research shows that use of any substance can be problematic because young people are in a critical period of growth (Ministry of Health, 2005). At the same time, it is important to

[4] Given the relatively high usage rates and normalization of cannabis use in British Columbia (see Adlaf et al, 2005), it is worth questioning where cannabis fits into the prevention paradox.

acknowledge that many youth experiment with substances without developing addiction issues or experiencing significant harm. In fact, substance use may play a functional role as risk taking and experimentation can be part of "normal" and healthy youth development (McCall, 2004).

- It is useful to integrate harmful substance use with other risk behaviours such as tobacco smoking, sexual risk-taking and other sensation-seeking behaviours (McCall, 2004).
- A model for understanding substance use is offered by the Ministry of Health (2005) that allows for a complex and realistic understanding of substance use problems and acknowledges a broader analysis of the harm that can emerge from substance use. Such an analysis is particularly useful in the context of youth substance use as the harm that emerges from use is rarely associated with a substance use disorder, but with harmful activities such as motor vehicle accidents and violence.



7. Developmentally and culturally appropriate

- Prevention should be ongoing from kindergarten to the final year of high school, and especially intensive just prior to the age of first use (CAMH, 1999). Developmental factors such as social development, mental health, and self-awareness and control need to be considered.
- Prevention programs should be long-term with repeated interventions. Research shows that the benefits from middle school prevention programs diminish without follow-up programs in high school (NIDA, 2003).

8. Focus on key transition points

- Prevention programs aimed at general populations during key transition points. The Alberta Alcohol and Drug Abuse Commission (2004) identifies key developmental transition points in grades 4, 7, 9 and 11.
- Efforts targeting 'at risk' populations should be made to ensure that such interventions do not single out risk populations and, therefore, attempt to reduce labeling and promote bonding to school and community (NIDA, 2003).

9. Combine two or more strategies

- Using two or more strategies is more effective than a single approach, for example combining student education with parent education. Most effective are those initiatives that reach populations in multiple settings – i.e. schools, clubs, faith based organizations and media – are most effective when they present consistent, community wide messages in each setting (NIDA, 2003).

Prevention Strategies

The following section reviews several of the most common substance use prevention strategies: school-based education, parent education, interventions for high risk youth, school organization and environment, primary health interventions, social marketing, school policy and multi level community initiatives.

A. School-based Education

To date, school education has been the most commonly evaluated alcohol and drug prevention strategy. According to recent literature and meta-analyses (Desenbury, 1997; McBride, 2003; Loxley et al, 2004), evidenced-based prevention education in schools incurs short-term reduction in both drug use and progression to frequent drug use; however prospects for longer-term behaviour change are still uncertain.

An example of a school-based drug education program that has received quite a bit of evaluative attention, particularly in the US, is the Drug Abuse Resistance Program (DARE). DARE is an education program delivered by police officers and is a component of prevention programs in many school districts[5]. Evaluations of DARE have consistently shown that it is *not* effective in preventing or delaying drug use, or affecting future intentions to use (Health Canada, 2001). Method of instruction and lack of peer interactivity, among others factors, have been cited as possible reasons for lack of effect. However, any criticism of DARE should take into account that many education programs fail to demonstrate long term behavioural outcomes (Health Canada, 2001). On a positive note, evaluations of DARE have shown the program to boost anti-drug attitudes[6], increase knowledge about drugs and foster positive police community relations (Health Canada, 2001).

The following aspects are highlighted in the literature as impacting the effectiveness of school-based alcohol and drug education:

i. Goal of school based alcohol and drug education

Research concerning the effectiveness of programs is skewed as the majority of evaluated programs come from the US, where non-use and delayed use are almost universal program goals (McBride, 2003: 734). As a result, other behavioural effects (such as using substances in a less harmful way) have not been evaluation to the same degree (McBride, 2003).

[5] DARE is not a regular component of alcohol and drug education within the Vancouver School District.
6 Note that increasing anti-drug attitudes may not be a desired outcome, but rather to increase understanding regarding factors that increase the likelihood of problematic substance use.

Harm reduction or minimization has been advocated as an alternative goal to abstinence. An example of a harm minimization behavioural effect would be a change in a drug-using experience resulting in less harm (i.e. drinking alcohol but not driving a car). The results of a US cannabis program evaluation illustrate the potential promise of harm minimization goals – in this case an education program was found to be successful in averting regular cannabis use, but not in preventing initial experimentation (Toumbourou, 2003).

Two recent studies focusing on alcohol further demonstrate the promise of a harm minimization approach. The *Alcohol Misuse Prevention Study* and *School Health and Alcohol Harm Reduction Project (SHAHRP)* both demonstrate the benefit from a change in paradigm to harm minimization, although there is a need for further research, in particular longitudinal studies (McBride, 2003).

In conclusion, recent literature points to the effectives of that program objectives with goals that "encompass a range of strategies, including non-use, and which aim to reduce harmful consequences of drug [and alcohol] use (Midford et al, 2000). Goals emanating from such an approach include:

- Delay age of first use
- Reduce (rather than eliminate) overall drug use
- Lessen effects of use
- Promote responsibly for self and others through knowledge about: signs of abuse and dependency; how to approach and assist people showing signs of problematic use, awareness of resources (Skager, 2001).

A framework for school based alcohol and drug education based in the above goals is something that needs to be further researched and discussed, as it would need to be utilized appropriately according to developmental level of the target audience.

ii. Timing and intensity

Appropriate educational strategies are identified at all grade levels, however there is general consensus that drug and alcohol education is most effective when delivered *immediately prior* to initial experimentation and during the period when **most** students are *experiencing initial exposure* to substances (McBride, 2003; CAMH 1999, Loxley et al, 2004). Onset of use varies in different populations and with different types of drugs, thus timing of programs needs to be adjusted according to local prevalence data (Stockwell et al, 2003). Literature also suggests the importance of targeting youth during *a later relevancy stage*, e.g. when the majority of young people are using substances.

An additional feature of effective programs relates to the time devoted to curriculum. The majority of soundly evaluated programs recommend 10 or more sessions (Canning, 2004), although time devotion in and of itself does not determine success.[7] Effective programs reinforce and build upon messages through the use of *booster sessions* and/or additional elements (such as community or mass media component). Like all education, booster sessions need to be tailored to appropriate developmental levels. The number of sessions identified in the literature varies, but usually involves a

[7] Note that intensity alone does not guarantee effectiveness, as many intense programs are found to be ineffective in a recent review by the UK's National Health Service (Canning et al, 2004)

greater number of sessions in the initial year and fewer sessions in subsequent years (McBride, 2003).

iii. Programs based on needs/developmental level of target group

Within 'best practices' literature there is overwhelming agreement that school drug and alcohol education programs should be *engaging*, *relevant to the young people who are likely to participate* in the program, and that they be developmentally appropriate. To address substance use effectively, this requires "a preparedness to step outside traditional ways of thinking about and organizing substance use education and appreciating that this education may look different from the curriculum as a whole" (Commonwealth of Australia, 2003).

There are various means that enhance a curriculum/program meaningfulness to young people - for example by involving youth in program planning and delivery, including a formative phase in program planning prior to implementation, and utilizing surveys or other data collection devices to assess youth usage rates and attitudes to alcohol and other drugs (CAMH, 1999; Health Canada, 2001; McBride, 2003; Midford et al, 2000). Policy makers and educators involved in developing education programs need to be especially astute to potential adult biases regarding youth substance use, and create opportunities to include young people's varied perceptions (Midford et al, 2000).

In terms of developmental appropriate, NIDA (2003) and Health Canada (2001) recommends that following guidelines:

Elementary school students

- Aims to improve academic and social-emotional learning in order to address risk factors such as early aggression, academic difficulties, and poor social skills.
- Education should focus on building emotional awareness, communication, social problem solving and social control skills.
    - Grades 1-3 – Focus on safety concerns and sensible use of medications and other hazardous household products.
    - Grades 4 and 5 – Basic prevention education aimed at smoking, alcohol and cannabis.
    - Relationship building and social-emotional skills rather than drug and alcohol use information.

"Middle" and Secondary School Students

- Increase academic and social confidence by targeting communication skills, study habits and academic support, peer relationships, self-efficacy and assertiveness, as well as substance use education.
    - Grades 7 and 8 – These are particularly important years for substance use education and prevention as this is the time drug use experimentation generally begins and when students are most vulnerable due to developmental changes and changes in school, friends, and academic pressures.
    - Grades 9 - 12 - Preventative activity for these grades needs to be aimed at reducing risk of harmful effects arising from potentially harmful substance use patterns (particularly grades 10-12).

- To be relevant to young people, it is agreed that:

- Drug and alcohol education should be more than teaching and learning about 'drugs.' Rather the intention should be about "building students' engagement and connectedness through a variety of approaches and strategies that target their individual needs" (Commonwealth of Australia, 2003).
- Take into account a range of student knowledge, attitudes and behaviours.
- Learning through 'real life' applicability and through the experiences of others (i.e. utilizing dialogue).

iv. Content and Delivery

Social Influence Approach

The most promising prevention education approaches are based on social learning theory[8], utilizing the social influence model that combines information, resistance skills training and normative education (CAMH, 1999; Canning et al 2004; McBride, 2003; Loxley et al, 2004).

It is worth noting skepticism regarding the usefulness of resistant skill training, at least within particular contexts. Duff (2004) suggests that resistance training may not gel with youth culture and decision-making as there is a growing tendency for young people to question scientific "expert" information that contravenes their own experience. As well, Skager (2003) points out that a focus on resistance training may be based on the false association of problematic substance use as a result of "poor decision-making", rather than a result of a complex interaction of social, emotional and environmental factors (Skager, 2002). While resistance and decision-making skill training are worthwhile aspects of an A&D education program, it is worth taking into account the potential pitfalls of an extensive emphasis on resistance training.

A variation on skill training is offered by an Australian harm minimization education program call SHARHP, which provides skill training in harm minimization rather than resistance skills (saying no) training. The results of SHARHP demonstrate that behavioural change is equal to or greater in harm minimization informed programs, as opposed to those that use resistance training exclusively. Further research in the usefulness of both resistance skills training and harm minimization influenced training is warranted (McBride, 2003: 736).

Normative education - reinforcing that contrary to popular opinion drug use is not a norm among young people - is often considered an important component of school based substance use education. Skager (2003) also offers a different approach to normative education by emphasizing that even if prevalence data demonstrates low levels of use, dismissing youth estimates of high levels of drug use ignores youth perception of how things are "and it is this perception that establishes what is normal or ordinary" (p. 14).

[8] Social learning theory focuses on the learning that occurs within a **social context**. It considers that people learn from one another, including such concepts as observational learning, imitation, and modeling.

The following criterion indicates the content of both successful and unsuccessful alcohol and drug prevention programs:[9]

Unsuccessful	Successful
Provide information only or which focus exclusively on the affective – personal problems such as low self-esteem and poor values.	Currently circumstances that build student engagement and connectedness. Strategies and skills appropriate to the student's own context and life situations. Safe and supportive environment for discussion. Engage students at the emotional level[10], with planned and sustained follow-up teaching and learning strategies. Increases understanding of variety of pressures to use substances, such as the media, peers, drug taking culture.
Provides information on negative health risks and long term consequences of substance use	Credible and honest information about substances, including both the benefits and dangers of using and not using. Information that is useful and relevant, students will dismiss information that they perceive as contradictory to their personal experiences Free of moralizing or scare tactics
Lecture format	Interactive, activity oriented that engages students

v. Interactive, activity oriented and engaging curriculum

Substantive research exists to demonstrate that interactive programs are at a minimum twice as effective as non-interactive programs (Mc Bride, 2003). Key to successful programs is peer interaction (cited in McBride, 2003), open dialogue between the leader/teacher and students, and interactive teaching techniques, such as discussion, role plays and games, that allow for active learning (CAMH, 1999;

[9] This table combines information from CAMH, 1999; Midford et al, 2000; Commonwealth of Australia, 2003.

[10] It is important to stress that emotional connection does not infer emotional manipulation or hysteria created by the use of scare tactics.

Canning et al, 2004). "Learning about drugs is for many students an immediate and pressing lifestyle need…..this requires learning that is real-life, genuine, credible and includes life skills such as problem solving, decision-making and assertiveness" (Commonwealth of Australia, 2003).

For a curriculum to be engaging there is a need to address specific areas, such as a gender perspective or strategies to engage those who are vulnerable or at-risk (Commonwealth of Australia, 2003).

Multi-drug focus or single drug focus

Prevention programs should address all forms of problematic drug use, alone or in combination (NIDA, 2003). There is limited research on the effectiveness of single or multi content focuses. Based on the research from tobacco programs, Tobler (cited in McBride, 2003) recommends single drug focused programs, particularly for youth older than 12 years.[11] Midford et al (2000) echo this sentiment with the recommendation that prior to grade 9 generic programs focusing on tobacco, alcohol and cannabis are most relevant, while from grade 9-12 separate programs or well-differentiated programs have most success.

Developing programs that focus on the differentiated experience with various substances is indicated. The tendency to treat all "drugs" as equally harmful is questioned by some within the prevention field as this approach tends to negate differing experiences with substances and increases the likelihood for the audience to dismiss the source of information (Duff, 2004). At the same time, it is important not to succumb to a hierarchy of "good" and "bad" substances, as in reality all (or at least most)substances have both positive and negative effects.

Messengers/Leaders: Peers, teachers, health professionals

Qualities, background and training effective 'messengers' for A&D education is important for effective delivery of alcohol and drug education curriculum. Research indicates that regardless of age or status of the educator, it is important that students trust the person or people who deliver the material and that it is presented factually, in an unbiased manner that doesn't appear as propaganda (CAMH, 1999)[12].

Evidence strongly indicates that classroom teachers are important 'messengers' for drug and alcohol education, as they have first-hand knowledge of student needs and developmental level, and the ability to integrate drug/alcohol education at appropriate times (McBride, 2003). Classroom education can incorporate peer educators, health professionals, those who have experience with problematic substance use, and police; however it is important to have teacher led involvement before, during and after guest speakers.

Recent studies investigating the effectiveness of peer vs. non-peer programs indicates rather varied results. In general, evidence leads to the conclusion that that peer-led

11 McBride (2003) points out that single drug programs focus on tobacco and alcohol, thus it is suggested that the benefits of focusing on commonly used substances.
12 Best means for information not to appear as propaganda is to be open to youth lived experiences with substances, including the potentially "positive" effects.

interventions are at least as, or more, effective than adult led interventions (Mellanby et al, 2000). At the same time, Mellanby et al (2000) cautions against the naive acceptance of peer education as the pinnacle of effectiveness, by pointing out that in-depth analysis of research on peer programs indicates a "variety of analytical and methodological problems" (p. 543).[13] A tremendous benefit of 'peer' education models is assisting youth in developing skills and leadership roles, particularly for 'at-risk' young people.

Tobler (cited in McBride, 2003) compared the effectiveness of several types of classroom leaders and her results suggest no significant difference between different types of classroom leaders. Rather, the primary benefit of peer-led programs is the increase in structured *classmate interaction* rather than the direct impact of the peer leader (McBride, 2003).

While there are important opportunities for "peer" education models in drug and alcohol education, Stockwell (in Loxley et al, 2004) suggests the *judicious use of peer leaders*. "Peer leaders need to be selected carefully and supported, be credible with high-risk young people, have good communication skills, demonstrate responsible behaviour but simultaneously be unconventional"(p. 120). Those considered appropriate peer leaders by adults are not necessarily regarded as such by the target group. Effective peer education requires significant support resources, a factor that is often overlooked.

Research is lacking on the pros and cons of utilizing messengers who have direct experience with alcohol and drug problematic use. It is clear that while there is some benefit to this approach it is recommended that the speaker be part of a broader curriculum.

Teacher training/skills of teacher and/or other facilitators

Fidelity of implementation and dissemination of education programs can be an issue, particularly when implemented by teachers or others who haven't been part of creating the curriculum (Loxley et al, 2004; McBride, 2003). Beneficial education for teachers and other school staff focuses on increasing teachers' conceptual understanding of drug use and prevention, of normal patterns of drug use onset and experimentation, as well as training on research-based prevention strategies (Loxley et al, 2004: 121).

13 Examples of analytical and methodological programs include the definition of peer programs (is it peer interaction or facilitated by peers).

Examples of Best Practices in Student Education

- *School Health and Alcohol Harm Reduction Project* – SHAHRP (Australia) School curriculum to reduce alcohol related harm among secondary school students. Lessons are conducted by trained teachers in three phases with eight lessons in the first year of the program, five booster lessons in the following year and four additional booster lessons in phase three, two years later.

- *Alcohol Misuse Prevention Study* – AMPS (United States) The AMPS curriculum, for students in grades five through eight, focuses primarily on teaching peer-resistance skills and on clarifying students' misperceptions of their peers' alcohol use.

- *Midwestern Prevention Program* (United States) – The school component of this multi-faceted program is based on social learning theory, provides grade 6 and 7 students 10 classroom sessions and 10 homework sessions.

- *Illawarra Program* – (Australia) – Based on social learning theory. Conducted in the last year of primary school, involved peer and parent education component. School component focused on decision making strategies, information on problems associated with drug misuse, alternatives to drug misuse, social pressures to take drugs, issues relating to conformity, assertiveness and peer resistance skills. Following the teaching phase of the program, the students engaged in groups to develop various drug-related materials/drama.

- *Life Skills Training- (*United States) Three-year prevention curriculum for students in middle and junior high. 15 sessions the first year, followed by 10 and 5 sessions in the following years. Demonstrates success five years post program (Canning et al, 2004).

- *Lions-Quest Skills for Adolescence* – Curriculum delivered to grade 6 students based on social influence and social cognitive approach

- *Project Alert* – 14 lesson drug prevention curriculum for middle school students that focuses on alcohol, tobacco marijuana and inhalants. Uses participatory videos to help establish non-drug norms, develop reasons not to use, and resist pro-drug pressures.

- *Here's Looking at Youth – (*US) K-12 prevention program that includes parental involvement. http://www.chef.org/prevention/looking.php

- *CAMH Alcohol and Drug Curriculum* (Canada) outlines curriculum content for grades 1-8. http://www.camh.net/education/curriculum_gr1to8intro.html with accompanying website www.virtualparty.org (not formally evaluated)

Alcohol – Drug Education Service - Making Decisions (Canada) – curriculum for grades 6 and 7 students. (not formally evaluated)

B. Parent Education & Support

Parent education, with the aim of encouraging healthy family development, is a component of effective substance use prevention programs. "There is evidence that parent education may be a potentially useful strategy to assist families facing a high number of risk factors for harmful drug use…. parent education using behavioural or social learning principles can be useful in preventing further escalation of problems related to illicit drug use" (Loxley et al, 2004, p. 116). There is evidence that this strategy can contribute to the healthy development of young people, independent of socio-economic status (Toumbourou et all, 2003), although it is also apparent that risk factors, such as poverty and problematic substance use among parents, affect parental capacity (Dishion et al, 2000).

Much of the 'best practice' literature in parent education focuses on university-based programs designed for selected/indicated groups. However, Dishion et al (2000) argues for community based universal, selected, and indicated interventions – that supplement existing service delivery programs and reach a large number of individuals.

'Best Practices' in parent education and support point out the following suggestions:

- **Include a range of services along a continuum of intensity** (NIDA, 2003).
  a. *Universal*
     - Reaches all parents within a setting.
     - Include services such as establishing an infrastructure for collaboration between school staff and parents; support norms for protective parenting practices; disseminating information encouraging family management practices that promote school success and prevent the development of early on-set alcohol and drug use (Dishion et al, 2000).
     - Conducted in a variety of means, including: interactive and skill development workshops, print materials, videos, media awareness, newsletters, and home visits.
     - Involving parents specifically as part of their child's homework has been found beneficial.
  b. *Selected*
     - Identify and support families at greater risk by providing information and interventions specific to their needs.
     - An example of a selected intervention is the *Family Check Up* that provides assessment and parenting skills for parents who have adolescents experiencing problems at school (Dishion et al, 2000).
     - Should occur in a manner that does not target or label participants.

  c. *Indicated*

- Direct professional support to parents: intense assistance and information for parents of children who are exhibiting behavioural problems.
- Includes brief family intervention, school monitoring system, parent groups, behaviour family therapy and case management services.
- Most often occurs in small group settings or through telephone counseling.

Dishion et al (2000) strongly encourages the integration of all three levels of parent education in order to address the related problems of identification and motivation to participate.

- **Integrate parent education within school context**. The most effective means to reach high-risk youth and parents is to integrate parent education and support within the school context. Examples include: increasing collaboration and communication between school staff and parents, engagement of parents, establishing norms for parenting practice, and disseminating information regarding risks for problem behaviour and substance use (Dishion et al, 1995).

- **Innovative means to engage parents.** Parent education and support programs are notorious for low participation rates and an inability to reach the intended populations. Universal programs are useful as they are often more effective at engaging parents because less embarrassment is associated with attending these programs. At the very least, all parent education programs need to be innovative in engaging parents, for example: providing food and childcare, utilizing a range of settings and established channels (such as parent-teacher nights, media, and community groups), and involving parents in child's homework.

- **Programs that support parents by helping them build and develop "authoritative" parenting styles**. Evidence strongly suggests that *authoritative* parenting, as opposed to exceedingly harsh or permissive parenting, can lead to lower substance abuse and improved adolescent competencies (Ausinet, 2005; Dishion et al, 1995). Authoritative parenting is defined as:
    - Prioritizing straightforward, direct, open and honest communication
    - Valuing warmth, closeness and intimacy along side independence and self-confidence
    - Maintaining clear parental authority and responsibility for making decisions while ensuring children are consulted and listened to (Ausinet, 2005).

- **A broader focus on health family development**, rather than exclusively providing substance use information.

- **Bring parents *and* children/youth together to build skills using interactive approaches** (Etz, 1998)

- **Utilize a pragmatic, safety-first approach.** Reality based education that supports parents by helping them understand and respond to youth substance use and other problematic behaviour, without employing scare tactics and misinformation (Rosenbaum, 2004).

- **Appropriate timing**. Programs that are delivered to parents of early secondary school students have reported significant impacts across a range of risk factors (Ausinet, 2005). Dishion et al (2000) points out the benefits of targeting parents of early adolescent children as problem behaviour escalates around age 13 and puberty presents a critical period for adolescent-parent relationships.

Programs that attempt to reduce the negative peer attachment risk factor by helping parents influence and better manage their child's peer relationships have *not* been successful (Loxley et al, 2004).

Examples of Best Practice in Parent Education and Support

- *Strengthening Families Program* (US) is a 14-session, science-based parenting skills, children's life skills, and family life skills training program specifically designed for high-risk families, although it has universal application.

- *Parenting Adolescents a Creative Experience* (*PACE)* is a targeted program for parents of early adolescents, which seeks to build parent hope and optimism. Facilitated sessions focus on adolescent development, conflict resolution, adolescent communication, and teaching an "authoritative" parenting approach. Unlike many other parent programs, *PACE* has been successful in reaching disadvantaged and sole parent families (Loxley et al, 2004). Evaluation results indicate the following: reported reduction in family conflict, reported increased maternal care, and decreased delinquency and poly-drug use.[1] As well, evaluation demonstrates increased benefits among all families in the schools that participated, even if the family did not participate in PACE.

- *Creating Lasting Family Connections* (US) Skill building program for parents and youth in universal, selected and indicated contexts utilizing risk and resiliency theory. http://www.copes.org/

- *Guiding Good Choices (formerly Preparing Students for the Drug Free Years),* a US program that educates parents on how to reduce risk factors and strengthen family bonding. Includes five- two hour sessions.

- *Oregon Social Learning Centre (US*) is a resource for information on the impact of parent education and support approaches. *http://www.oslc.org/parent97.html*

- *Triple –P Positive Parenting Program* is a multi-level secondary school intervention that tailors information, advice and professional support to the needs of individual families. It is currently undergoing evaluation. Triple P interventions range from the provision of brief information resources such as tip sheets and videos at Level 1, through to brief targeted interventions (for specific behaviour problems) offered by primary care practitioners at Levels 2 and 3, to more intensive parent training programs at Level 4 and Level 5 programs targeting broader family issues such as relationship conflict and parental depression and stress. http://www.triplep.net/02_model/model.htm

- *Family Resource Centre* – embedded within school setting that provides a range of universal, selected and indicated parent/family programs and supports. Include a parent self assessment tool called "Parenting in the Teenage Years." (see Dishion et al, 1999).

C. Interventions/Programs for Youth at Risk

Evidence indicates that universal prevention programs are more effective for 'lower-risk' adolescents and less successful with 'higher risk' youth (Canning et al, 2004). Differing levels of risk among adolescents suggests the benefit of targeted prevention programming designed to meet unique needs. As mentioned earlier, research from Australia regarding the applicability of the 'prevention paradox' youth and substance use recommends universal programs for legal substances (and possibly cannabis), and targeted approaches for illicit substances.

Preventative case management usually involves a coordinated delivery of services for youth with multiple risk factors, such as assessment of need, identifying relevant services, coordination of service delivery and monitoring outcomes. This approach appears feasible for assisting youth with a high number of developmental risk factors although there have been no evaluations assessing impacts on harmful drug use (Loxley et al, 2004, p. 133).

Some preliminary findings suggest that peer interventions for identified 'high risk' youth may be indicated, however findings must be interpreted cautiously (Loxley et al, 2004). Research on interventions targeting high risk pregnant or parenting females found that social and life skills training either had no benefit or actually increased participants drug use. "It may be that improving global social skills in the context of prevalent drugs use may not be a useful prevention strategy" (Loxley et al, 2004, p. 132). However, if one utilizes harm minimization goals, peer programs for high-risk youth may positively affect factors (such as self worth), thereby potentially impacting harmful drug use over time.

Examples of Best Practices in Intervention for High Risk Youth

- *Multisystemic Treatment* - is a unique treatment methodology proven to have positive effects on serious, violent, and chronic juvenile offenders. http://www.mstservices.com/

- *Children at Risk* – Drug and delinquency program for high risk youth 11-13 residing in socially marginalized communities. Included: case management (recruitment, assessment, treatment, planning), family intervention, social and recreational programming, mentorship, education support (i.e. after school tutoring). http://www.ncjrs.org/pdffiles1/nij/178914.pdf An identified risk of this program includes aggregating high-risk youth in selected prevention programs.

- *Personal Growth Class* – Grade 9-12 students who are actual or potential school dropouts that uses an intensive school-based social network prevention approach. A key component of the program is the avoidance of openly labeling targeted students as "high-risk" in an effort to reduce the possibility of self-fulfilling prophecies. Fundamental elements of the classes include experiential learning opportunities, study-skills training, peer tutoring, resistance skills training, and systematic decision-making skills training. Both peers and teachers implement these elements. (Health Canada, 2001). Evaluation results have demonstrated less entry to potential harmful drug use (Stockwel et al, 2004).
http://www.ncset.org/publications/essentialtools/dropout/part3.3.05.asp

  Advocacy Program – the development of an ongoing relationship between a teacher and student to help improve learning outcomes and other supports.
http://www.advocacy.gsat.edu.au/advocacy/advocacy.htm

D. School Environment and Organization

Recently, there has been increasing attention on the role of school environment in mitigating individual and environmental risk factors, although "researchers and program developers are still sorting out the best mix, duration and type of interventions" (McCall, 2004: 10). The Alberta Alcohol and Drug Abuse Commission (2004) cites the importance of youth "connection" to school, and identifies specific ways that schools can increase protective factors of the students, the family and the local community. A well-defined and communicated policy regarding substance use is significant in creating a positive school environment (AADAC, 2004).

Specific school protective factors include:

- Caring and supportive school environment that undermines negative, disorderly and unsafe school climate
- High teacher expectations
- Clear standards and rules re: substance use policies
- Youth participation, involvement, and responsibility in school tasks and decisions.

This premise is further supportive in other literature, for example in Loxley et al (2004) the authors demonstrate the significance of interventions aimed at improving overall school environments and addressing risk factors such as academic failure and lack of connectedness.

Examples of Best Practices in School Organization

Victorian Gatehouse Project, from Australia, builds the capacity of schools to promote emotional well being, coping skills and connectedness among youth through improving school environments, policies, practices and programs. Early indications have associated the program with reductions in youth drugs use (Loxley et al, 2004).
http://www.rch.org.au/gatehouseproject/about/index.cfm?doc_id=176

Vancouver School Board- Community Schools Model – (Canada) The work of the Community School Teams in engaging vulnerable students in school and community programs and connecting them to positive older role models, fosters the development of assets that contribute to their ability to make healthy choices about substance use. (not formally evaluated re: substance use)

E. Primary Health Interventions

Strategies that improve the accessibility and effectiveness of existing health services appropriate to young people is a strategy often excluded from prevention 'best practice' documents, however The Monograph (Loxley et al, 2004) indicates that this is a promising early intervention strategy. Components of primary health interventions include screening and referring adolescents to services, which may require added training for health care professionals. Further research is required to encourage program innovation and evaluation of universal health service strategies targeting youth (Loxley et al, 2004).

Examples of Best Practices in Primary Health Interventions

- *Adolescent Prevention Services* – developed a computerized approach to preventative screening and health education. (http://xnet.kp.org/permanentejournal/winter04/model.html)

- *STARS*, based on multi-component motivational stages theory, a program utilizes nurse consultation with parent awareness raising and take-home education for parents and children. http://modelprograms.samhsa.gov/worddocs/FactSheets/STARs.doc

F. Social Marketing/Mass Communications

Recent studies – primarily focusing on tobacco and alcohol - reveal that mass media campaigns – using print, radio, TV, billboards, magazines – can be effective in increasing knowledge and awareness, and has modest success in affecting attitudes and behaviours (CAMH, 1999; Loxley et al, 2004). Most promising results combine mass media with other strategies, such as school-based education, parent education and/or community mobilization (Loxley et al, 2004).

Factors to consider:

- Radio appears as effective as other more expensive media outlets; there is a dearth of research on utilizing Internet or teen magazines (Loxley et al, 2004).

- Community based initiatives that utilize pamphlets to inform from a harm reduction approach have not been evaluated (such as DanceSafe), thus the effectiveness as a stand-alone approach is not known (Loxley et al, 2004).

- Harm minimization/reduction presents challenges for the development of effective social marketing campaigns due to the complexity of messages (Loxley et al, 2004).

Examples of Best Practices in Mass Media/Social Marketing

- *Speed Catches Up with You* in Australia was shown to be effective in increasing knowledge and in decreasing amphetamine use, however once the campaign ended, usage returned to baseline levels (Loxley et al, 2004)

- *National Illicits Drug Campaign* – incorporated a range of media including television, newspaper, magazine, billboard, a website and a phone contact line, as well as parent booklets. Evaluation demonstrated effectiveness in increasing family communication and substance use prevention knowledge (Loxley et al, 2004).

- Various Australian social marketing initiatives aimed at reducing harm – such as *Drink Drunk the Difference is U (*demonstrated high awareness and some intention toward change in binge-drinking behaviour) and the *National Alcohol Campaign* – Australia (demonstrated increased awareness and knowledge but no substantial difference in behaviour) (Loxley et al, 2004).

G. Policy

i. School policy

A uniform school policy on substance use and possession is an important component of a comprehensive alcohol and other drug prevention strategy, and can have a positive effect on student relationship to substances and improve school environment (ADAC, 2004; CAMH, 1999).

School policies tend to be informed by *zero tolerance* (punitive consequences such as expulsion) or *harm minimization* (detention, in-school suspension), or a combination of both. The theoretical premise of a zero tolerance approach is deterrence - that substance use is reduced due to punitive penalties. Within a zero tolerance approach all offenses are treated equally severe in an effort to send a message that any behaviour associated with substances is unacceptable (Skiba, 2000). Zero tolerance is the basis of the US National Drug Control strategy.

Conversely, an approach informed by harm minimization strives to reduce/prevent substance use, while pragmatically acknowledging that some youth will use drugs (Beyers et al, 2005). Harm minimization tends to be less confrontational and more caring in its application than zero tolerance (Munro and Midford, 2001). Harm minimization has been the basis of Australia's National Drug Strategy for a number of years.

Policy Violation Consequences

A research project comparing US and Australia approaches to school policy provides an overview of the similarities and difference in the practical implementation of zero tolerance and harm minimization approaches (Beyers et al, 2005).

Both states utilized the following consequences fairly frequently in relation to alcohol and illicit drug use:

- Call to parents
- Refer to administrator
- Suspension
- Recommendation to program
- Referral to counselor/nurse

The Australian example was more likely to utilize the following consequences for alcohol and illicit drug use:

- Restricted independence
- Detention
- In-school suspension
- Written warning

As well, Australian policy setting processes were found to be more democratic (Beyer, 2005).

The US example was more likely to utilize the additional consequences for alcohol and illicit drug use:

- Referral to police
- Expulsion

Research is inconclusive as to the effectiveness of each approach *in relation to behavioural change*. A few researchers indicates that zero tolerance is associated with lower rates of tobacco and alcohol use (Evans-Whipp, 2004), however a cross-national comparison of school drug policies in the US and Australia did not link severe school penalties with reduction in student substance use (Beyer et al, 2005). The more severe consequences of zero tolerance, such as expulsion, have been linked to a negative impact on the health and well being of youth who use substances and may serve to further alienate students at-risk (CAMH, 1999). Positive, longer term outcomes are associated with harm minimization as "policies aimed a remediation and responsible use may help prevent students who use drugs from progressing toward more harmful patterns of use through permitting their continued access to school related services and informal support" (Beyers et al, 2005: 139).

A longitudinal study from the International Youth Development Study is underway that will compare the strategy of harm minimization, common in Australia, with zero tolerance policies in the US. When available, the report will provide more information on the impact of school policies on student drug use.

Principles for School Policy

The United Nations, Office on Drugs and Crimes, puts forth the following principles (2002):

- Ensure that behaviours associated with possession or dealing substances at school are **detected** and that the **consequences for detection** are serious enough to discourage that behaviour.
- Particular behaviours should not be encouraged by being explicitly or implicitly condoned. Deterrent effects are most potent when detection and punishment are **followed-through**.
- Values that guide policy and procedures on drug related incidents should be identified and developed in **consultation** with students, teachers, parents and wider community.
- **Solely punitive approach is limited**; a strategy of democratic discipline, as opposed to authoritarianism, should be developed.
- Policy should **not marginalize users** or exacerbate issues such as alienation or emotional distress.
- Rather than removing students from the school, education authorities should retain students at school and confront them with the consequences of their actions as offenders and victims.
- The **messages** that students receive in the classroom and from the school in response to a drug related incident should be consistent with the values articulated in the drug policy.
- Harmful behaviour is an **opportunity** for positive change – i.e. presents an opportunity to use restorative justice/community conferencing, engagement in support (i.e. drug education, stress management, alternatives to drug use and techniques for safer drug use.

Best Practices in School Policy

The following have not been evaluated, but do represent a positive trend in dealing with drug related incidents at school and at school events:

Alberta Alcohol and Drug Abuse Commission – Outlines steps for creating a school policy and the importance of involving representatives from all groups affected by policy – such as students, parents, school staff, and community.

Alternatives – North Vancouver – A program for students caught using substances at school that replaces suspension.

Informed Decisions: An Alternative for Substance Using Youth (Cynthia Voo at Pacific Community Resources Society) – a directed studies curriculum that supplements or replaces suspension.

As well, several school districts are examining and implementing a restorative justice approach.

Various school districts in BC have utilizes restorative justice principles in dealing with substance use i.e. Sunshine Coast.

The following supply reduction strategies are worth mentioning:

ii. Minimum drinking age/deterring sales to minors

Setting and enforcing laws regarding the minimum age of use appear to be effective in delaying initial use.

iii. Other – taxes and health warning labels

Laws and regulations enforcing minimum age for purchasing or using substances appear to be effective in delaying initial use. To be effective, regulation approaches usually require a coordinated approach with other strategies.

H. Multi-level Community Approaches

Community prevention programs that reach populations in multiple settings – such as schools, clubs, faith-based organizations, and the media – are most effective when they present "consistent, community-wide messages in each setting" (NIDA, 2003:19).

Benefits of community mobilizations include:

- Short term reduction in tobacco, alcohol and other drug use has been demonstrated in some community based programs
- The ability to reach "the unidentified high-risk population of early drug users in an anonymous fashion and at an early state when their patterns of drug use may be more easily influenced" (Loxley et al, 2004: 133).

Loxley et al (2003) suggests that modest reductions in tobacco, alcohol and marijuana use can be achieved through school-based education supplemented by community based mobilization effort. However, the following caution is worth: "The available evidence suggests that further evaluation should investigate whether outcomes are superior compared to simpler interventions that are limited, for example, to a single component such as school-based education or enforcement laws." The Monograph also cautions community based education programs for high-risk youth as evidence suggestions risks in "bringing together high risk young people for drug education programs" (Loxley, et al, 2004: 24).

Best Practices Examples in Multi-level Community Initiatives

- *Midwest Prevention Program (*United States) Combines school curriculum, parent involvement in school prevention policy, parent education and training and community mobilization aimed at reducing the availability of alcohol and drugs)

- *Project Northland* (United States) Alcohol focused school curriculum for grades 6-8 based on interaction and experiential learning, incorporates peer education, information booklets for parents and involvement of local businesses in promoting drug and alcohol free students)

- *Parent Programs – such as Triple P* – utilizes mass media, parent education and support groups.

Conclusions and Recommendations

This literature review highlights factors that enhance the outcome of substance use prevention initiatives. An interesting finding in this research is that behavioural change, such as reducing substance use, is not always the *immediate* goal of prevention programs. Rather, it is most useful to aim toward minimizing risk factors and enhancing protective factors and resiliency. A focus on immediate behavioural change runs the risk of neglecting important work within the communities, for example with parents and youth, that builds assets and demonstrates promise for longer term impact on substance use.

Best practices in prevention echo many of the recommendations from the Vancouver school consultation report, in particular:

- Education should facilitate dialogue and interaction with respect to the issues, rather than proscriptive "don't do drugs, drugs are bad, drugs are harmful".
- Prevention efforts need to be culturally relevant to students, and utilize education and marketing techniques that appeal to young people. The most effective means of doing this is to incorporate youth leadership and contribution in planning and implementing prevention efforts.
- Consistent drug and alcohol messages within a comprehensive approach are required, that combine a variety of strategies, such as school based education and parent education and support, community education, "social marketing". (i.e. within malls etc).
- Research strongly supports a "messenger" who can facilitate discussion, utilize active learning and incorporate a range of perspectives within the classroom. While "peer" models show great promise, there is no concrete evidence that peer programs are in and of themselves more "effective" in producing behavioural change. Education that taps into students as an emotional level is recommended, although this requires suitable follow-up by the classroom teacher. In general, it is recommended that teacher integrate drug and alcohol into their curriculums, which are supplemented by components others, such as peer programs, and the use of outside experts such as police and addiction professionals.
- Recent literature in substance use prevention supports a school policy that incorporate a safety net for youth using substances, rather than being solely punitive. As well, it is extremely important that a school policy be well defined and communicated.

Summary: Best Practices and Consultation Report

The following section situates the main recommendations from the Consultation report (School Based Prevention Project: Final Report on the Consultation Process) in a broader 'best practice' context:

Consultation Report Recommendations	**Best Practice Findings**
Need for consistent drug and alcohol messages	**Supported** ▪ *Consistent* messages are crucial. ▪ School policies should reinforce the objectives of drug education programs and vise versa. ▪ Prevention is best achieved when prevention messages are echoed within family and larger community.
Need for consistent prevention infrastructure	**Supported** ▪ At a minimum, school prevention program should include: 1. Prevention/education 2. Brief intervention 3. School policy ▪ All need to be informed by the same conceptual framework and reinforce each other.
Need for smaller, intimate settings that encourage discussion *Use of creative curriculum i.e. forum theatre*	**Supported** ▪ Interactive teaching techniques are one of the most effective means of creating a successful A&D education program. ▪ Effective teaching strategies incorporate: · 'real life' learning · engaging youth at an emotional level · learning through dialogue and hearing the experiences of others · sharing beliefs · acknowledging different experiences and beliefs · exploring issue and reinforce information through skill acquisition. ▪ Examples of interactive strategies include role-play, group work, structured games, and forum theatre. ▪ Focus is not about 'teaching about drugs' but on building student engagement and connectedness.
Youth to youth conversations without authority figures	**Not discussed** ▪ This is not usually possible/advisable within

Consultation Report Recommendations	Best Practice Findings
	school system, but could be something initiated in community. ▪ Education needs to engage youth and speak to their lived experience.
Safe environments for questioning and asking for help	**Supported** ▪ Provide opportunities for students to *share beliefs and attitudes* with each other and with trusted adults. ▪ Include opportunities for young people to discuss the *benefits* of substance use, without fear of reprisal or labeling. ▪ Fear arousal techniques and scare tactics are **not** supported. ▪ School policy that allows young people to ask for help without fear of suspension or other reprisal.
Use of "credible messengers" i.e. younger people, people with life experience re: A&D, non-judgmental person whom students have relationship with	**Somewhat supported** ▪ It is not so important *who* the messenger is, but *how* the curriculum is implemented. Credible messengers are those who are able to use interactive teaching techniques and who have the ability to present information honestly. ▪ Substance use education needs to be part of the school curriculum; *teachers should play a critical role.* ▪ Prevention delivered by outside "experts" – i.e. police or individuals with previous addiction problems - is not effective as an exclusive strategy. Rather, it should be part of broader education and follow-up by teacher. This is particularly true for education that engages at an emotional level. ▪ Literature not clear on whether messenger should have lived experience, this can be problematic. Learning that is *meaningful* and which connects with students on an *emotional level*
Messenger: peers	**Somewhat supported** ▪ Peer educators/leaders are valuable, and are best implemented as one component of a broader prevention program. Peer leaders need to be selected judiciously. ▪ Youth respond positively to peer education ▪ Consider developmental level (i.e. perhaps peer education most effective with older youth. ▪ Consider use of peer mentoring (older youths)

Consultation Report Recommendations	Best Practice Findings
Drug education/prevention programs need to start in elementary school and be tailored to the developmental abilities of students	**Supported** ▪ Effective prevention/education requires a long-term, sustained approach that addresses the students' needs at each stage of development and builds on what has gone before. ▪ Prevention approaches, tactics and intensity of messages vary depending upon age of the target audience. ▪ One size does not fit all – prevention needs to take into account gender, culture.
Creation of culturally relevant and youth driven prevention approaches	**Supported** ▪ Prevention initiatives, including education, needs to speak to the lived realities of youth. ▪ Involving youth and including a formative phase in program planning helps ensure that the program is based on the needs and relevant to young people who will be participating in the program. ▪ Needs to reflect youth culture and young people's conceptions of substance use.
Parent Education *Includes non-threatening and culturally appropriate contexts*	**Supported** · Continuum of services from universal education to targeted support groups. · Utilize innovative means to engage parents. · School programs that are implemented and initiated in consultation with parents are more successful. · Should provide support in parenting, as opposed to simply facts about substances.
Teacher Education: *Includes information as well as how to facilitate D&A education with student; how to assess problem situation*	**Supported** · Education is more effective when teachers receive formal training and ongoing consultation and support. Objectives of teacher education can include: · Assistance with planning, developing and implementing a drug education program for their classroom · Identifying students who may be at risk for A&D problems and the steps to assist them in getting help · Increasing comfort level with the content and process of drug education, including interactive teaching techniques · Increase teacher level of knowledge of the facts of student drug use and related

Consultation Report Recommendations	Best Practice Findings
	issues; · Increase the competence, confidence and commitment of teachers toward substance use education
Use of mass media to counteract positive messages about drugs/alcohol	**Supported** · Social marketing is most effective as part of a broader prevention strategy – for example, in combination with school education.
School policy: *Implemented consistently, not solely punitive, communicated with all parties, involves intervention that aims to assist student, collaborative*	**Supported** · Should be well defined and communicated · Involve those affected by policy i.e. staff but also students, parents, broader community · Should not be solely punitive, but function as a means to engage 'youth at risk.' · Consistently implemented and communicated to all relevant parties. · Community conferencing, similar to restorative justice, is indicated as having potential in the area of drug related incidents.

Bibliography

Adlaf, E. M., Begin, P., and Sawka, E. (Eds.) (2005). *Canadian Addiction Survey: A national survey of Canadians' use of alcohol and other drugs: Prevalence of use and related harms: Detailed report*. Ottawa: Canadian Centre on Substance Abuse.

Alberta Alcohol and Drug Abuse Commission (2004). *Developing substance use and gambling policies for Alberta schools*. http://teacher.aadac.com/prevention/school_resources_policy_manual/policy_manual.asp

Auseinet - Australian Network for Promotion, Prevention and Early Intervention for Mental health (2005) *Building Resiliency in Australian Families: A Pace Approach*, Issue 10. http://auseinet.flinders.edu.au/resources/auseinet/netter10/netter05.php

Beyers, Jennifer M.; Tracy Evans-Whipp, Megan Mathers, John W. Toumbourou, Richard Catalano. (2005) *A Cross-National Comparision of School Drug Policies in Washington State, United States, and Victoria, Australia*, Journal of School Health, vol. 75, no. 4.

Canning, Una; Louise Milward; Thara Raj; Daniel Warm. (2004). *Drug use prevention among young people: a review of the reviews*, 1st Edition, July, NHS: Health Development Agency, UK.

Centre for Addiction and Mental Health. (1999). *Alcohol and Drug Prevention Programs for Youth: What Works?* Toronto: Centre for Addiction and Mental Health.

Commonwealth Department of Education, Science and Training. (2003). *Creating an Engaging Curriculum*, A report from the national school drug education innovation and good practice project.

Dishion, T.J., Kavanagh, K., & Kiesner, J. (1999). Prevention of early adolescent substance use among high-risk youth: A multiple-gating approach to parent intervention. In R. S. Ashery (Ed.), *Research meeting on drug abuse prevention through family interventions.* NIDA Research Monograph, 177.

Dishion, T.J., Kavanagh, K. (2000). *A multilevel approach to family centred prevention in schools: process and outcome* in Addictive Behaviours, vol. 25, no. 6, p. 899-911.

Duff, Cameron. (2002). *The importance of culture and context: rethinking risk and risk management in young drug using populations* in Health, Risk and Society, vol. 5, no. 3, p. 285-299.

Dusenbury, Linda and Mathea Falco. (1995). *Eleven Components of Effective Drug Abuse Prevention Curricula* in Journal of School Health, December, vol. 65, no. 10, p. 420.

Evans-Whipp, Tracy et al. (2004). *A review of school drug policies and their impact on youth substance use*, Health Promotion International, vol. 19, no. 2, June, p. 227-234.

Farringdon, Fiona, Nyanda McBride and Richard Midford (1997) *It works: combining research and education to achieve change in secondary school student's alcohol related behaviour,* http://www.aare.edu.au/01pap/far01097.htm

Greenberg, Mark T. et al (2003). "Enhancing school-based prevention and youth development through coordinated social, emotional, and academic learning" in *American Psychologist*, June/July.

Hawthorne, Graeme. (2001). *Drug education: myth and reality*, in Drug and Alcohol Review, vol. 20, p. 111-119.

Health Canada (2001). *Preventing Substance Use Among Young People: A Compendium of Best Practices*, www.cds.sca.com

Loof, Rudi and Hettie Rensink. (2000). *The Healthy Schools Handbook*, Utrecht, Holland: Trimbos-Institute.

Loxley, et al (2004). *Monograph: The Prevention of Substance Use, Risk and Harm in Australia: A review of the evidence*, The National Drug Research Institute and The Centre for Adolescent Health.

McBride, Nyanda (2003). "A systematic review of school drug education" in *Health Education Research*, vol. 18, no. 6 p. 729-742.

McCall, Douglas (2004). *School Health Research Network*, prepared for Health Canada, March 30, 2004 (draft).

Midford, Richard and Simon Lenton, Leanne Hancock (2000). *A Critical Review and Analysis: Cannabis Education in Schools*, NSW Department of Education and Training.

Ministry of Health Planning (2005) *Addressing Psychoactive Substance Use: A Prevention Planning Framework*, Government of BC (DRAFT document).

Munro, Geoffrey and Richard Midford. (2001). 'Zero Tolerance' and drug education in Australian schools," in *Drug and Alcohol Review*, 20, p. 105-09.

NIDA (2003). *Preventing Drug Use among Children and Adolescents: A Research Guide for Parents, Educators, and Community Leaders*, Second Education, US Department of Health and Human Services.

Paglia, Angela and Robin Room (1999). "Preventing Substance Use Problems among youth: A Literature Review and Recommendations," in *Journal of Primary Prevention,* 20:3-50.

Resnick, MD, PM. (2004). *Influencing Behaviour: The Power of Protective Factors in Reducing Youth Violence.* Centre for Adolescent Health and Development, University of Minnesota. Minneapolis, MN.

Rosenbaum, Marsha. (2004). *The Safety First Approach to Teens and Drugs*, Maps Rites of Passage: Kids and Psychedelics, vol. Xiv, no. 2.

Skager, Rodney. (2002). "On Reinventing Drug Education: Especially for Adolescents", in *The Reconsider Quarterly*, vol. 1, no. 4.

Toumbourou, John W. and Bosco Rowland, Dr. Joanne Williams, Dr. Sheryl Hemphill. (2003) "Preventing drug related harm through community mobilization," *Drug Info Clearinghouse*, Prevention Research Evaluation Report, No. 5, February.

Toumbourou, John W., Bosco Rowland, Bronwyn Lee, Sherry Hemphill, Jann Marshall, Mary Dimovski (2003). "Parent Education in the prevention of drug related harm," *Drug Information Clearinghouse*, Prevention Research Evaluation Report, No. 6, June.

United Nations (2004). *Schools: school based education for drug abuse prevention*, Vienna: Office on Drugs and Crime.

World Health Organization (2005). *Alcohol and Interpersonal Violence*. World Health European Centre for Environment and Health, Rome EU.