Preventive Education Series **2**

DRUG EDUCATION: PROGRAMMES AND METHODOLOGY AN OVERVIEW OF OPPORTUNITES FOR DRUG PREVENTION

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DRUG EDUCATION : PROGRAMMES AND METHODOLOGY

AN OVERVIEW OF OPPORTUNITIES FOR DRUG PREVENTION

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NOTE

This report is addressed to drug prevention officers, health educators, health managers and policy makers as a guide to setting up drug prevention programmes adapted to their own particular situations. Its aims is to give an overview of strategies, processed methodologoies, guidelines in drug prevention and drug education along with examples of programmes.

The premise is that preventive education against drug abuse can only be effective if it is considered as an activity, as asocial process, and is arried out in a planned and systematic way. The goal of prevention must be set in terms of what is realistic both for the individual and for society at large, and in terms of possibilities offered by environmental context and lifestyles. In other words, a good, carefully prepared prevention programme with clearly formulated and attainable goals, selected techniques and realistic planning will contribute to rendering education effective.

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INTRODUCTION

For more than thirty years the goal of people in the field of drug prevention has been to develop educational programmes, and educators, scientists and prevention specialists have been working to design comprehensive and effective programmes to prevent or reduce drug abuse. It was long believed that a supply reduction approach promised the best results, and several international conventions were drawn up in an attempt to slow down production and curb the supply of illicit drugs. At national levels, this predominantly judicial approach has sometimes caused friction with health policies, especially as regards contacting and helping drug users. In recent years, allowance has gradually been made for both the judicial-criminological and the health oriented standpoints. Generally speaking, however, this has not produced a comprehensive, unequivocal drug policy, both politically and socially acceptable at the international level.

As of the seventies, professional thinking turned towards prevention which, (1) at that time was centered exclusively on concepts of primary prevention to discourage the initiation of non-drug users, especially children and adolescents. Primary prevention had for a long time been synonymous with public education on drugs, inspired by concepts of health education, and later, of health promotion. Professional drug education as an instrument of drug policy has always encountered difficulties in that too much was expected of it, and it had to contend with sensational, high profile, "common sense" approaches (media, public opinion, etc.)

One major problem was that evaluation studies repeatedly showed that the effects of educational programmes are frequently weak, often with a mixture of positive (intended) and Negative (undesired) results (2).

If we admit that the impact of education is still limited today, this impact could, we believe, be much greater if some of the following observations - based on a long experience with drug education practice - were taken into consideration:

- information does not unconditionally lead to changes in attitude and in behaviour;
- young people who are the main target group of drug prevention need guidance in learning to solve problems of adolescence much more than they need drug information and drug education (3);

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1) Buisman, W. R. Demand Reduction Strategies. WHO, Copenhagen. 1990

2) Goos, C. J. M. Drug Education, is it any good? In: Proceedings 13th ICAA Institute on the Prevention and Treatment of Drug Dependence, Oslo. 1983

3) De Haes, W. F. M. Looking for Effective Drug Education Programmes. In: Health Education Research, 1987 Vol.2. No. 4.pp.433-438

- drug education and information might be of more use to parents, educators, teachers and other key-persons in contact with young people, than for the adolescents themselves;
- drug use prevention will only be credible to young people if placed in the broader context of licit substances, such as alcohol, tobacco and psychopharmaceuticals.

Preventive education against drug abuse is vital in shaping and developing the personality of young people because it seeks to inspire life goals, a challenge which endows it with much broader implications than the prevention of health problems.

UNESCO is the United Nations agency with a specific mandate in education and is, thus, the main partner of the international community in the domain of education. Under the coordination of the United Nations International Drug Control Programme ({JNDCP), the Secretariat participates in global efforts to reduce the demand of drugs through its Preventive Education Programme.

In Chapter I a model of drug abuse prevention is described, which poses the basic question of what kind of preventive efforts should be undertaken: efforts to persuade young people not to take drugs, efforts to withdraw drugs from the community, or efforts linked to the social environment of potential drug users, aimed at discouraging drug-taking by, for example, offering positive and healthy alternatives?

Chapter II describes the basic planning steps in the development and implementation of drug prevention programmes and contains an overview of different target groups and formal settings for drug abuse prevention. Methods and techniques of drug education, why, when and how to apply them, are discussed and illustrated.

Chapter III looks at methods and techniques of drug education; Chapter IV provides examples of successful drug education policies and programmes in four European countries; Chapter V deals with evaluation of drug education programmes, and Chapter VI contains conclusions and suggestions for model drug education programmes.
For the purposes of this publication, the word "drug" (unless otherwise specified) is used to refer to all psychoactive substances, that is, "any substance that, when taken into a living organism, may modify its perception, mood, cognition behaviour or motor function".

"Abuse" is defined, in the first place, as harmful to the human consciousness, and in the second, as harmful to the human body.

A distinction is made between three levels of prevention:
Primary Prevention, aimed at preventing the occurence of a disorder, process or problem.
Secondary Prevention, aimed at recognising a disorder, process or problem and then suppresing it or modifying it in a positive, way and as quickly as possible.
Tertiary Prevention, aimed at delaying or preventing the further development of a disorder, process or problem and its after effects, even while the situation that gave rise to it is still present.

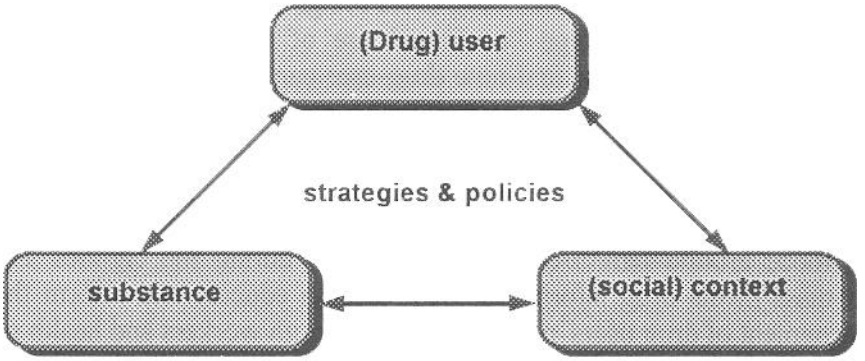
I. DRUG ABUSE PREVENTION STRATEGIES

• Supply reduction or demand reduction?

It is worth mentioning first of all the distinction made between types or models of prevention, namely, prevention of the supply of drugs (supply reduction) and prevention of the demand for drugs (demand reduction).

Supply reduction can be achieved by national and international legal measures (of the Single Convention), police action and law enforcement. Within demand reduction strategies, drug education can function as an important tool if is applied adequately and appropriately. Both strategies can only be successful and effective if they are combined in a balanced and comprehensive approach.

The combined approaches of supply reduction and demand reduction can be demonstrated in the following model:



MODEL 1: THE EPIDEMIOLOGICAL TRIANGLE

The epidemiological triangle of prevention is a useful framework within which to illustrate relationships and determinants in drug use. The basic question it implies is that of the route through which we should channel our policy or strategy of prevention. Through that leading to the substance? That leading towards the person using drugs? Or, through that passing via the social context or environment?

Several Western, and non-Western, countries strongly emphasize substances; this stems from a concept that the substance is the main cause of the problem. Whilst probably true, the target

of this focus, which is to achieve a world without drugs, seems rather unrealistic. Nor does this approach make any allowance for the beneficial effects of some mind-altering drugs for recreational, medical or therapeutical reasons. These, whether licit or illicit, have multiple effects which vary according to the dose, the individual and the context. Furthermore, the personal and social effects of drugs are influenced by the legal status of the drug, its pharmacological characteristics and patterns of use. Therefore, a compromise should probably be sought whereby availability of drugs is restricted to circumstances where the use presents only limited risks.

The second group of preventive efforts focuses on the people using or intending to use a substance, rather than on the substance itself, and is directed at discouraging people Som taking drugs. The most common method used to achieve this aim is communication: information, education and health promotion. As stated, opinions concerning the effectiveness of these measures as a means of prevention still range from optimistic to rather sceptical and are often connected with divergent views on how one should inform and educate and which methods are best suited to drug education. Politicians, police officers, media people and the general public, often claim that the only adequate approach is a warning approach, using highkey scare tactics in the media to discourage young people from experimenting with drugs. In contrast, professionals in drug prevention and health education consider this a counterproductive 4) approach.

The third group of preventive activities tries to mould the social environment in such a way that drug problems cannot evolve, or will be reduced. In other words, to influence or change the environmental conditions favourable to the onset and development of drug abuse. A look at the social environment of potential drug users brings to light a number of mechanisms that encourage rather than discourage continued use of drugs Firstly, many people in the entourage of an experimental or first-time drug-user panic when first discovering that a son, daughter or pupil, is using drugs. A reaction which runs the risk of leading the situation from bad to worse. Another widespread belief is that it is practically impossible to do anything about a drug problem unless one is an expert in the field. Such notions are detrimental because they block what is left of the normal means of communication between the drug taker and those around him. Bearing this in mind, during the eighties The Netherlands initiated a mass media drug information campaign to educate and inform those within the social environment of drug users parents, teachers, youth workers and health professionals. It was thought that this campaign would have a positive impact and produce more realistic attitudes, and open up and improve communication between educators and youngsters about drug use, and result in a reduction of related taboos 5).

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4) Advisory Council on the Misuse of Drugs. Prevention Report. Home Office, London. 1984

5) Van Berkum,G. W. R. Buisman, G. J. Kok. Mass Communication and Drug Education: Evaluation of the Dutch National Campaign "What everybody ought to know about drugs". In: Journal of Alcohol and Drug Education. 1991. Vol. 36, pp. 65-74

• Dilemmas of drug prevention

It seems obvious that drug education practitioners will be confronted with more than one dilemma in their daily work. In a recent article, Goodstadt '6) describes the numerous dilemmas inherent in drug prevention - abstinence versus responsible use, drug education versus skills training, individual education versus environmental education, education versus legalization - with which many prevention workers are unfamiliar or have not thought them through.

In his explanation of the supply reduction approach versus the demand reduction model Goodstadt makes a number of comments on the supporters of these approaches and on the combination of demand and supply reduction. He writes *The demand reduction component is most commonly addressed through educational strategies. The assumption is that social problems, including discrimination, war and drug abuse can be reduced through changing the minds and hearts of the people. It is of interest to notice that those who have traditionally put most emphasis on supply reduction, are increasingly concerned that supply reduction has been ineffective in stemming drug use. These agencies have begun to emphasise demand reduction through their involvement in the development and implementation of educational programmes. However, among those traditionally concerned with demand reduction through education, pessimism has been growing that drug education is ineffective.* He concludes: *As with most of the dichotomies and other simplifications of the real world, it is likely that the choice between supply and demand reduction is only resolvable through a marrying of the two objectives: reducing the motivation for drug use and abuse, at the same time as reducing the availability of the drugs.*

Against the background of the earlier observation that no coherent, operational and effective model for drug prevention has been developed, Goodstadt's remarks imply that:

- All faith should not be pinned on demand reduction alone.
- Drug abuse prevention must not be limited to drug education.
- Availability of drugs constitutes an essential element in the prevention of drug abuse.

It can be concluded that limiting availability and discouraging abuse of drugs and other psychotropic substances are the main strategies to produce an effective drug abuse prevention policy.

The most important tools of prevention at our disposal are a well-balanced control-policy to limit the availability of substances, information and education to discourage drug abuse and treatment and care to solve drug abuse problems. This report focuses mainly on the two communication tools information and education.

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6) Goodstadt, M. S. Drug Education: The Prevention Issues. In: Journal of Drug Education. 1989. Vol. 19(3), pp. 197-208

II THE PLANNING PROCESS OF DRUG EDUCATION

After reviewing and discussing some of the main issues involved in drug education and prevention, this Chapter will deal with planning educational processes leading to the implementation of drug education programmes. Education can only be successful if it is considered as an activity and a social process, which has to be undertaken in a planned and systematic way. This part of the report highlights some important planning steps to be considered before developing any educational programme (7). Figure 1 shows an overview of the basic planning stages:

PLANNING STEP	BASIC PLANNING QUESTION
Drug problem assessment	What drug problem does the community need to address?
Development of prevention goals	What do prevention workers want to achieve?
Identification of resources and funding sources	What resources does the program need to achieve the objectives? Where will the money come from?
Determination of content and selection of methods and techniques	What does the target group already knows about drugs, how do they behave, communicate about drug users)
Implementation	How will the program be introduced, executed and continued
Evaluation	How can be determined whether the goals are met?

FIGURE 1: BASIC PLANNING STAGES IN PREVENTION

7) Prevention Plus II: Tools for Creating and Sustaining Drug Free Communities. U.S. Department of Health and Human Services, 1989.

• Drug abuse assessment

Needs assessment is the part of the planning process that has to reply to the question: "What kind of drug problems does the target group and the educational institution need to address"? The answer is not always obvious, because there may be very different perceptions and definitions of"drug related problems" within a community. However, a complete assessment will try to determine:

- What kind of substances are being used, by whom, in which situations and resulting in what kind of problems (health, social, judicial, criminal etc.)?
- Are selected target groups motivated to change existing consumption practices?
- What skills and strategies are needed to change practices and obstacles that could inhibit the appli cation of such strategies and skills
- What other prevention programmes and aid services already exist to tackle drug problems?

Several needs assessment techniques exist. The preferred methods will depend upon factors, such as time available, funds and other resources. Some examples are:

- case studies;
- social indicators (statistical documentation available in the community);
- service provision surveys;
- key persons studies;
- target population surveys.

Selecting the most appropriate technique requires a balanced consideration of advantages and disadvantages in terms oftime, money, staff, reliability oftechnique, etc.

• Developing prevention goals and objectives

After completing the needs assessment, the second step is the determination and formulation of prevention goals or objectives which must be realistic, specific and attainable. For example the goal of a drug free community within the next two years could be considered very unrealistic.

A more attainable goal would be, for example, to reduce drug consumption in a local community by 30% within a two year period. One good way to develop prevention goals is to assign this task to a small group of experts familiar with needs assessment, thus creating a task force comprising key-persons from the community - school counselors, teachers, health educators, local researchers, representatives of the municipality - who would prepare a "white paper" and a plan of preventive action, to be subsequently discussed and accepted by
the local community.

A small group would then prepare a plan to educate and train primary health care officers in the early recognition of drug health education and drug use problems and how to deal with young people. Another group could formulate objectives for inclusion in a school curriculum.

Here, it is very important to involve teachers and school counselors in the early planning stages, in order to ensure greater support once the programme begins.

Finally, it is important to monitor and evaluate goals during the implementation of the prevention programme, changing the initial goals if these prove to be unrealistic.

• Identification of resources

A whole range of resources, besides money, educational materials etc., are needed to meet the goals of prevention programmes. Expert knowledge of specific issues is required, as is cooperation with media and press officers, support of local community boards and councils and collaboration with rehabilitation and treatment services. It is recommended that a checklist of needs and available resources be drawn up.

An essential part of the planned prevention programme is, of course, the identification and collection of funds and grants. Sometimes the latter are already at the disposal of a prevention organisation, for example, because they have been requested by a local government to initiate a prevention programme. In many cases money is not available or funds are insufficient to start the programme. There are several sources of finance foundation grants, government grants and community fundraising, the latter probably being best known to local prevention organisers. Beside fundraising and requesting grants, beneficiaries of the prevention programme could be asked for a contribution, either to cover all or some of the costs involved, for instance, purchasing educational materials.

• Determining the content and selecting methods of the prevention programme

As pointed out earlier, a prevention programme needs well formulated goals. Once these are defined, the content of the programme has to be determined and the methods and techniques which will be used to communicate the content of the programme selected. Before the content of a prevention programme can be determined an analysis has to be made of:

- What the target audience know about drugs and what kind of prejudicial mis-information they have received. On this basis, the programme organizers should indicate what additional, new information the target audience needs.
- The target audience's attitude towards drug use and drug users. Once this is known, it is necessary to determine what should be more appropriate attitudes after the end of the prevention programme.
- The actual behaviour vis-a-vis drug use of the target group; how do they cope with drug users in their own daily situations.
- How do the target groups perceive their contribution to drug abuse prevention. On the basis of this information, a prevention programme might learn of new and better ways of handling preventive activities.
- What the target group knows about existing community prevention efforts might provide suggestions on how to contribute to them.

Answers to these important questions are essential to determine the content of the prevention programme, whether it be an education or information programme, training, or a mass media campaign. Once goals and content are chosen, then the most appropriate communication methods and techniques to implement it can be selected. (See Chapter III).

• Implementation

Once the goals, content, methods and activities of the prevention programme have been determined and the support and cooperation of the community has been assured, the programme can begin. In the case of formal education, it is important that a prevention programme should be implemented adequately, because to develop a prevention programme and to integrate it in the general school curriculum requires time and effort on the part of the programme defenders and the school. Again, it should be stressed that all staff and other personnel have to be involved and committed to the prevention programme from the outset. They have to feel that it is their programme and their responsibility to strive for good results.
Implementation will be more successful if the following conditions are met:

- The school has indicated that it will adopt the prevention programme.
- The school has been involved in the initial development stage.
- The conditions (time, costs, content of the programme, educational materials, training facilities etc.) are favourable to the organization or target group.
- The school agrees on the goals, content, methods, location, and time schedule of the programme.

Outside formal education settings, the timing of a fixed-term or continuous prevention programme within the community involving youth clubs, sport or leisure clubs, community citizen centres is very important. For example, inviting citizens to join a drug education programme during holiday periods or high media coverage of sporting events will result in a low attendance. Advertising about the programme in a medium they do not use, or selecting an unfamiliar location, will also result in minimal attendance.

• Evaluation

There are several reasons to include an evaluation at the end of a prevention programme First, curiosity of those involved in the programme as to how successful their programme has been. Second, funding resources usually require some form of assessment in order to determine whether their money has been wisely invested. Third, and perhaps most important, an objective evaluation is the only credible method available to determine the effectiveness of preventive activities and programmes.

There are two kinds of evaluation: process evaluation and effect - or outcome evaluation. The central question in process evaluation is: did we accomplish our goals? Why or why not? Has the prevention programme been carried out in the way we intended and planned? Have resources been utilized as initially planned? Have we used the funds appropriately? Was the target group satisfied with the way the prevention programme was carried out? What has been the opinion of the community (local council, key-persons, the media, etc).

The second kind of evaluation deals with the effects of the prevention programme. Whilst, it is not always possible to determine or measure the intended effects or outcomes of prevention efforts, attempts should be made to discover if there is any evidence of reduction of drug use or drug problems in the community, or whether the community is more aware or better informed about drug use and drug problems.

• Programmes, target groups and intermediaries

There is no general standard drug education model or drug prevention programme suitable for the whole population or community. Distinctions must be made between different communities and target groups, each population group in a country or local community needing its own prevention programme, often with different goals, content and communication techniques.

There is also a difference in the ways preventive education can reach target groups, not all of whom need to be contacted directly by drug education workers. Some intermediary groups, community key persons or community communication channels (local radio and TV), have regular contacts with specific target groups and can play a crucial role in preventive education 8). Informing, educating and training these intermediaries to carry out educational activities, sometimes referred to as the two-step model of communication 9), can be a very efficient and cost-effective strategy. For example, it is possible to directly provide different risk groups school-leavers, school drop-outs, unemployed youth - with drug information by means of mass media communication. However, this approach is rather time consuming, cost intensive and it would be more appropriate to train key persons who have close relationships and personal contacts, or who are able to communicate in other ways, to inform and persuade groups at risk of the harmful effects of drug abuse. Another approach would be to train and educate primary health care professionals like family doctors, social workers, district nurses who, through daily contacts with families and groups in the local community, can play an important role in drug education and prevention.

Figure 2 shows several possibilities of intermediary groups and professions and educational contacts with target groups.

Besides strategical questions of addressing drug education programmes via intermediaries or directly to population target groups, a choice has to be made about the level of prevention at which the intervention will take place: primary (no use of drugs or slight experimentation), secondary (experimentation with drugs, for example, by risk groups) and tertiary prevention (relapse prevention or risky use of new dangerous drugs).

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8) Buisman, W.R. Drug Prevention in The Netherlands. In: Ghodse, H. A. et.al. Drug Misuse and Dependence, Parthenon. Lancs. 1990

9) Rogers, E.M. Diffusion of Innovations. New York. Free Press. 1983

INTERMEDIATE PROFESSION—CONTACT WITH—TARGET GROUPS	
•Youth/street workers	Risk groups, school leavers drop outs, unemployed etc.
• Teachers, counselors	Primary school children, secondary school children, adolescents
• Community workers	Citizens, parents, youth groups, out-of-school children
• Local community organisation, sport and cultural	Peer leaders in sport, leisure volunteers
• Primary health care professionals	Patients, partners, parents, families

FIGURE 2:/NTERMEDIARIES AND TARGET GROUPS

Figure 3 gives an overview of the three levels of primary, secondary and tertiary prevention 10). Different types of intervention and educational activities that could be applied to a great number of different target groups are indicated. As previously mentioned in this report, prevention programmes can have a unique, one-time character, or can be carried out several times for different target groups in a community. They might also be carried out over a long period, for example, a mass media programme on radio or television running for several months.

On the other hand, especially in the context of formal education a prevention programme might be conducted over a two-year period. An example of a long-lasting drug prevention programme at secondary school level, is the "Skills for Adolescents" programme (11). This educational programme has a broad focus and is very much person and peer group oriented. Beside providing basic facts and information on drugs, it emphasizes values and attitudes, awareness of social influences and the development of personal and social skills like critical thinking, decision-making, etc. The rationale behind the programme is that positive and healthy choices about drug behaviour are much more likely to be made within the context of self-confidence, critical thinking and decision making and an individual's awareness of (negative) social influences he or she is exposed to. However, schools and teachers who decide to carry out this well-tried prevention programme need an average of 8 hours a week at their disposal.

10) See Note. 8

11) Skills for Adolescents. Columbus, Ohio. The Quest National Centre. 1985

TARGET GROUPS	PREVENTION LEVEL		
	PRIMARY	SECONDARY	TERTIA-RY
Primary school children			
Secondary school children	X[1,2]		
Adolescents (left school)	X[1,2]	X[3]	
Migrant children	X[4]	X[5]	
Community (children)	X[6]		
Cannabis users	X[7]	X[8]	
Vulnerable groups		X[9]	
Hard drug users	X[10]	X[ll]	
		X [11]	X [12]

1. Curriculum education.
2. Teacher training.
3. Teacher counselling training.
4. Part-time classes education.
5. Teacher counselling training.
6. Migrant (youth) leader training.
7. Community leader training.
8. Early intervention training.
9. Video and manual training packages.
10. Alternatives to prevention programmes (like Survival tracks
11 . Early intervention programmes.
12. Rehabilitation programmes.

FIGURE 3. PREVENTION LEVELS AND TARGET GROUPS

Examples of intensive, comprehensive education and training courses for health professionals can be found in several medical education training programmes in the USA and the Netherlands (12). At the start of medical training, attention is paid to factual knowledge on drugs and drug use and to the development of adequate attitudes. In later years, students are trained in skills of early recognition of drug problems and care and treatment (13).

The next Chapter describes methods and techniques of drug education in more detail.

12) Buisman, W. R. & P. J. Geerlings. The Amsterdam Substance Abuse Programme for Medical Students. Bilthoven, Amsterdam. 1985

13) See Note.

III METHODS AND TECHNIQUES OF DRUG EDUCATION

A number of communication methods and techniques can be applied to attain the goals and objectives of drug education. In general, a distinction is made between education using group methods and education using mass media techniques.

Education using group methods refers to a wide range of techniques and methods, for example:

- Classroom teaching, *e.g* effects of drugs on the brain in biology-classes;
- Lectures, *e.g* << drug use by adolescents >> for an audience of parents;
- Small group discussion, *e.g* "how to cope with a drug user in a family";
- Training, *e.g* general practitioners how to detect drug problems early;
- Role playing, *e.g* counsellors teach communication with a pupil;
- Panel or forum discussions, *e.g.* community-leaders and citizens on prevention plans and policies;
- Demonstrations, *e.g* how to work with a drug information kit;
- Exhibitions, *e.g* of educational materials: posters, leaflets, videos;
- Symposia and study conferences on a wide range of drug prevention matters.

Education using mass media signifies several types of mass communication methods and approaches. For example:

- Mass media campaigns at national, regional, local levels, broadcasting anti-drug spots on television and/or radio;
- Television and radio programmes: drug information series, drug education, drug treatment, interviews with drug users, ex-addicts, drug experts; - Newspaper advertisements (or in weekly, monthly magazines); - Magazines for young people with background information, interviews, prevention and education materials;
- Educational materials containing drug information distributed house-to-house;
- Posters, booklets, stickers, leaflets, distributed to the general public in the streets, stations, markets, etc;
- Audio or audio-visual material (audio tapes, videos); - Information services using public telephone numbers.

A decision about which educational method or technique is the most appropriate very much depends on the goals of the prevention programme or educational action, the target group to whom the programme is addressed and the funds available. Generally speaking, the first choice to be made is between an approach using group methods or one in favour of mass media techniques and, in this respect, a very important question is the desired influence on the target group. What does one want to change, strengthen or confirm? Education using group

methods essentially has more impact on attitudes, social norms and behaviour like "stay drug free", learn peer refusal skills, etc. Moreover, the relationship between an educator or change agent and the selected target group is close, especially if the educator is considered both credible and expert.

An educator applying group methods can also pay more attention to specific cultural and social psychological factors presumed to have great impact on attitudes and social norms in respect of drugs and drug abuse.

To illustrate this point, in the Netherlands as in many other countries, there live several ethnic minority groups who are considered to be at higher risk of involvement in drug abuse. The introduction and spread of heroin among the young Mollucan community (originally living in Indonesia), for example, indicates a specific pattern, rather different from that in other community groups. It might be argued that heroin use is seen as a symbolic expression of the confirmation of solidarity of the group members in the Mollucan community and aimed at strengthening cohesion of specific clusters of young people within this community (I4). A mass media campaign to communicate a message with strong emphasis on the dangers of heroin use would run the risk of denying the socio-psychological function of drug use in this community and would, therefore, probably be ineffective. A more effective strategy would be to educate and train the minority community leaders in discussion techniques to heighten the awareness of youth in their community to the dramatic impact and counter effects of heroin use on cohesion and solidarity.

Education utilising mass media channels has a potentially wider range of public exposure, but the relationship between the source (educator or educational organisation) and the target audience is often rather weak. It is hardly possible to discuss social norms and behaviour with the target audience in these circumstances, and we cannot therefore expect dramatic changes in attitudes or behaviour through mass media education. On the other hand, mass media could serve to raise awareness of the existence of drug problems by offering correct information and news about the latest methods of treatment and research findings. Another important function of mass media can be to support drug education activities initiated in a community by using the "news and agenda setting" function to announce information on those activities, to interview key persons involved in the programme and broadcast statements of opinion by community leaders about their attitudes towards drug education programmes.

The next paragraph describes the possibilities, advantages and disadvantages of mass media in drug education, as well as concepts and methods of group drug education (mainly in formal education).

• Drug Education and Mass Media

Television, radio and magazines play a major role in forming the perceptions, attitudes and opinions of people, many of whom are strongly influenced by television programmes or

(14) Buisman, W. R. Educational Messages in Alcohol and Drug Education. In: Proceedings of the 34th ICAA International Congress on Alcoholism and Drug Dependence, Calgary, Canada.

articles on illness - and health related issues, like HIV/AIDS and psychoactive substances, such as medicines or drugs. Often they are exposed to advertising messages that try to persuade them to buy a specific medicine to prevent or to cure a certain disease.

People are also influenced by television programmes such as movies, soap operas or detective series that dramatise or glamorize drug use and drug users and which have a great impact on opinions and behaviour of which most people are unaware.

Over the past twenty years, drug education has been making increasing use of the possibilities of mass media to pass on educational messages to a large audience. Superficially, the only similarity between all these types of campaigns seems to be that they all make use of mass media based on the assumption that mass media campaigns greatly influence people's behaviour. On many other points, such differences exist as to make much more difficult any qualitative comparison between campaigns. Furthermore, especially in the older campaigns, clearly formulated, operational objectives in terms of hoped-for changes in attitude, social norms or behaviour are sadly lacking. Mostly there is nothing more than "awareness of the damaging effects of drug abuse" or "change of mentality", "influencing social norms"
goals that can hardly be measured scientifically. A positive development has, however, recently been observed, which is probably linked with newly acquired insights in mass communication studies. Previous campaigns were particularly characterised by untargeted bombardments of information, based on the then popular "hypodermic needle theory" of the effects of mass media (15), whereas over the past 15 years many more campaigns have been aimed at specific target audiences.

The National Institute on Alcoholism and Alcohol Abuse (NIAAA) in the USA, has run separate mass media campaigns for specific social groups, such as drivers ("If you drink, don't drive, if you drive don't drink"), pregnant woman ("Pregnant? Before you drink think!") and young people. Relevant opinion leaders are selected and local support provided for the campaigns. Use is made of recently acquired scientific insights, for example, fear arousal techniques (slow motion replay of a drunk driver knocking down a child), and the latest research findings on the use of media, and the mechanisms of selectivity and exposure are taken into account (16).

• Principles of Mass Media

To most people mass media means television, radio and newspapers. This is partly correct, but education makes use of a much wider arsenal of media, such as posters, leaflets, brochures, videos, etc. A general characteristic of mass media is that, in principle, nobody is excluded, mass media are public, accessible to everybody. But there are also many differences. The best-known, that is, television and radio, reach virtually everybody, contrary to a poster in a station, whose message is seen only by train passengers. Television exerts a great influence, not only because this powerful medium reaches many people, but also because it has an aura of authority. Television is also a penetrating medium because it has an

(15) Klapper. J. T. The Effects of Mass Communication. New York. Free Press. 1960

(16) See Note. 7

audio as well as a visual dimension which can be used to great advantage given the present level of television technology.

The printed media, and radio in particular, rather trail behind this development. In the world of the media and in drug and health education circles, a distinction is often made between high-key and low key use of mass media. These concepts apply to the medium of choice, as well as to the way in which media are used. Television is the most frequently used high-key medium because it is so large-scale, is generally considered to be authoritative and reliable and offers many possibilities. Printed media, like newspapers, weeklies and brochures are much more low-key. Not everybody is literate, reads the same newspaper, or the same weekly. Besides, exposure to an educational message or an advertisement is much more indirect; it is part of a number of other messages and so there is selectivity on the part of the reader.

The following example of a recent high-key American mass media campaign can serve to illustrate this somewhat theoretical point (17). The United States of America has contended with probably the largest drug problem in the Western world, and for some years a "War on drugs" has been declared. Recently, instead of strong emphasis on tracing and prosecuting drug traffickers, there is now more stress on discouraging Americans to use drugs, with slogans like "Using is losing".

At the end of 1986, more than 200 American advertising agencies set up the "Media Advertising Partnership for a Drug free America" (MAPDA) (18). The largest anti-drug campaign ever initiated was begun in 1987 involving a total budget of about 3 billion dollars. The organizers of this tremendous campaign first carried out wide-range market research on the basis of which about 50 different campaigns were developed. The campaign was split into three main target groups - youngsters, adults between 18 and 35 and older people. Youngsters were chosen because they are curious and have strong experimental instincts. Adults aged between 18 and 35 are often indifferent to drug abuse, are not aware of the risks and often assume the attitude: "Some use drugs, some drink too much". The third large target group of older people is furthest away from drug abuse, having very little knowledge of drugs and many misconceptions. The anti-drug campaigns set up are very varied. Besides those already mentioned, there are separate campaigns for numerous target groups such as sportsmen and women, show business personalities, opinion leaders, educators. Special campaigns were run for marijuana, cocaine, crack and heroin. There is no general emphasis on the damaging long-term effects of drug abuse but, particularly in the campaigns for youngsters, much stress is laid on the short term adverse effects. The campaigns are very high-key, using a dramatic tone, a double vocabulary, a language couched in teenage slang. TV commercials are as shocking as they are oversimplified to pound home messages to the public, such as "Drugs are a dead end". Full page advertisements are printed in well-known papers and magazines like Playboy and include emotional slogans such as "Cocaine, it can cost you your brain".

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(17) Strategy and Research Task Force Campaign Recommendation. The Media Advertising Partnership for a Drug Free America (MAPDA). New York. 1986

(18) See Note. l7

• Drug Education utilizing Group Methods and Techniques

There are many different kinds and types of group methods: methods and techniques that stress transfer of knowledge (lectures, classroom teaching), attitude change (discussion, role playing), development of social skills (training, modelling) or exploration and exchange of opinion (panel, forum). The best way to elaborate and illustrate group methods and techniques in drug education, is to refer to school drug education. The main arguments for choosing this formal educational context are:

- It is within formal education that most children and young people can be reached for preventive education;
- School settings have a clear organisational structure, with opportunities to develop links with parents, community groups, etc;
- School settings are, in spite of many cultural and societal differences, present in all countries and regions in the world;
- Most drug educational experiences have been acquired within a formal education context during the past 30 years;
- Many different school drug education methods can also be applied to other group and community settings; in most cases only a few adaptations have to be made;
- Most experimentation with drug use starts during school when children are between 14-18 years old.

•**Knowledge and drug information model.** For a long time, health and drug information education was a popular first choice strategy in prevention and it is still a commonly used method. The underlying assumption is that the presentation of factual information about drugs and the biological, social and psychological effects, the risks and dangers of drug use and its consequences, would have a sufficient preventive impact. Knowing the facts would lead directly to staying off drugs. In this model, besides techniques of fear arousal, often applied to increase the salience and impact of the message: "Drugs are a dead end" and "Using is losing" rather moderate techniques are often also used. The British "High Profile Curriculum" (19) is an example of such a low profile cognitive oriented drug education programme.

•**Affective education model**. This model was developed in the seventies and presents a rather different model of drug education where drug information plays only a minor role. The affective education model is based on the assumption that drug abuse has its main cause in the shortcomings of young personalities low self-esteem, inability to make rational decisions and express feelings and inadequate problem-solving skills. Therefore, the main goal of prevention should be enhancing self-esteem, improvement of decision-making and problem solving skills. This model IS largely rooted in the principles of humanistic psychology, the expectation being that once a young person has solved his or her basic interpersonal problems, the risk of involvement in drug abuse will be much lower. The Californian School and Community

19) High Profile Youth Work Curriculum and Consultation Materials about Drugs. ISDD London. 1988

Prevention Programme '20) is a very recent example of a drug prevention programme developed according to these principles.

•**Social influence model.** This approach is based on Bandura's Social Learning Theory which focuses on the notion that behaviour is the result of positive or negative influences. Individuals in the social environment, like parents and peers, and exposure to the media often serve as impact models, providing examples of adequate or inadequate behaviour. Prevention programmes designed within the framework of the social influence approach comprise elements such as influence resisting training (peer, media influences) innoculation against the impact of mass media (analyzing anti-health advertising), role playing, etc.

More recent is the model of reasoned action developed by Fishbein and Ajzen (21). The Dutch drug prevention programme "Talking about alcohol and drugs at school" '22) and the British programme "Facts and Feelings about Drugs, but Decisions about Situation" '23) are examples of educational programmes based on this approach.

•**Life Skills Model of Drug Education.** A most promising new approach is the life skills development model of prevention. Whilst, there is a conceptual similarity between the life skills model and the affective model, the former emphasizes balanced development of personal and social coping skills, which can be divided into five dimensions critically important for adolescent learning, thinking, feeling, decision making, communication and action. The model encompasses the improvement of positive peer influence, peer role models and peer teaching and includes teaching specific values, such as respect, compassion, responsibility, honesty and self-discipline. This programme attempts to link community groups and school groups (teachers, tutors, counselors, parents, board members), because of the belief that prevention and health education is the collective responsibility of the whole school and local community. The life skills approach is a challenging model, appropriate for both drug prevention and health promotion. The well-known "Skills for Adolescents"
programme, originally developed in the USA '24), has now been culturally adapted and introduced in many countries, including inter alia, the United Kingdom, Switzerland, France, The Netherlands, Belgium and Sweden.

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20) Towards a State of Esteem. Final Report of the Californian Task Force to Promote SelfEsteem. Cal. State Department of Education, Sacramento, USA. 1990

21) Fishbein, M. & A. Ajzen. Belief, Attitude, Intention and Behaviour: an introduction to theory and research. Reading, Mass. Addison/Wesley. 1975

22) Buisman. W. R. & J. J. van Belois. Praten over Alcohol en Drugs op School ("Talking about Alcohol and Drugs at School"). Netherlands Institute of Alcohol and Drugs, Utrecht. 1990

23) Facts and Feelings about Drugs, but Decisions about Situation. Teachers manual. ISDD London. 1982

24) See Note. 11

IV. DRUG PREVENTION IN SOME EUROPEAN COUNTRIES : A review of policies and programmes

This Chapter gives more detail about some national drug abuse prevention policies and strategies in order to propose a practical overview in some European countries during the last decade and to offer a few illustrations of how drug abuse prevention theory or philosophy can be translated into practical prevention, and into educational programmes for different target groups. The focus will be on some aspects, such as:

- background information on national drug policy;
- types of educational or prevention programmes;
- short description of some programmes;
- review of evaluation studies.

There are, of course, many types of prevention programmes being carried out in these countries. The aim is not to offer an extensive overview, but rather to give an idea of how the main programmes, targeted on segments of the national population, fit (or do not fit) into the policy framework of a country. Mass media programmes, school drug prevention programmes, training programmes for health professionals, and community prevention programmes have been selected from The United Kingdom, The Netherlands, Sweden and Germany.

• United Kingdom

•**Drug policy.** Drug policy in the UK has undergone considerable change over the last 20 years. It used to be internationally regarded as one using treatment and opiate prescription, rather than law enforcement to control and prevent drug problems. According to Dorn (25), education, once considered almost synonymous with prevention, is now seen as a supporting system. By the late 1980s, drug prevention was effectively defined as an enforcement problem first, and a medical, social and educational problem second. The main objective now is to attack the drug problem on five fronts:

- reduce supplies from abroad;
- render enforcement even more effective;
- maintain effective deterrents and tight domestic controls;

25) Dorn. N. British Policy on Prevention. In: Ghodse, H. et.al. Drug Misuse and Dependence. Parthenon, Lancs. 1990

- develop prevention and education;
- improve treatment and rehabilitation.

The first three policy objectives deal with supply, and the last two with prevention, treatment/rehabilitation and demand reduction. An Advisory Council on the Misuse of Drug established by the British Government in 1984 recommended that preventive measures be developed according to two basic criteria:

- reduce the risk of an individual engaging in drug misuse;
- reduce the harm associated with drug misuse.

Several prevention programmes have since been carried out.

Mass Media Campaign. In February 1985, the British government commissioned a London advertising agency to develop a wide-ranging and striking anti-heroin campaign, targeted at all youngsters aged 13-20 '28), especially those running a high risk of using heroin (an estimated 15% of all youngsters). The campaign "Heroin screws you up", consisted of two TV commercials broadcast regularly on Channel 4 Television. One commercial shows a boy who proudly announces that he controls his heroin use, but slowly deteriorates. The other shows a girl who, despite her efforts with make-up, looks worse and worse. Full-page advertisements in nineteen different fashion, music and girls' magazines brought the message "Heroin screws you up" to the attention of the younger generations.

A special campaign for parents, educators and intermediaries was also developed, with especially written brochures on drugs "How to act when your child uses drugs". Three different advertisements published in some weeklies and monthlies drew attention to the heroin problem and the brochures.

The goal of the first campaign was to get across the negative short-term physical and social effects of heroin use in a penetrating way. The second campaign also demonstrated through TV commercials, posters and adverts, how youngsters can turn down an offer of drugs without losing face. During recent years this anti-drug campaign has increasingly become modified into an HIV/AIDS prevention (Anti-Injecting) campaign addressed to drug users and, on a broader level, all those concerned by drugs, to meet the policy objective of reducing the harm caused by drug misuse.

The Anti-Injecting campaign "Shooting up once can screw you up. Forever" used the different media of television, posters, teenage newspapers and radio annoucements and which focused on the risk of contamination through shared use of syringes to communicate the general idea that the syringe is a deadly weapon "Screw up your blood, your liver, your life"
- even though individual use of a syringe is never discussed. The inherent risk is amplified by the advertising slogan which reduces time to a simple equation: Once = Forever.

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28) Irving. A. The Role of Advertising in the Prevention of Heroin Misuse: the UK experience. In: Proceedings of l5th ICAA Institute on the Prevention and Treatment of Drug Dependence. Amsterdam/Noordwikherhout. 1986

•**School drug prevention.** The UK has built up a long tradition of school drug education programmes, including low-level scare tactics, factual person-focused health promotion and mixed approaches. Most programmes and packages have been developed by Health Education Authorities or by agencies like ISDD, TACADE '29). There is, as argued in the Chapter V, no overwhelming evidence available to help in decisions as to what would be the most effective drug prevention approach in the school context. Probably this is the main reason for distributing a variety of drug education programmes and packages in primary and secondary schools, such as the two very different programmes, "Drug Wise Drug Education for Students, 14-19" developed jointly Health Education Council, TACADE and ISDD, '30 and the "High Profile Youth Work Curriculum about Drugs", developed and distributed by ISDD (31). The "Drug Wise" programme is a broad, factual person/skills focused prevention programme, including many educational methods (lecturing, discussion, peer support, materials etc.). The "High Profile Curriculum" is a rather traditional, cognitive based educational programme that fits into most subjects of the curriculum, whatever the type and level of education or professional training. Dorn illustrates this approach in the following table:

DRUG ISSUES IN EDUCATION CURRICULA

In subject	Drug Related Matter includes
Mathematics	Calculating spread of HIV, drug surveys
English	Drugs in literature
Biological sciences	Central nervous system and effects of drugs

The UK also pays much attention to training teachers and school counselors how to educate their pupils and students and how to deal with young people with drug problems. Since 1986 several drug education video programmes and packages are available for a variety of educational settings.

•**Training programmes for health professionals.** Most of the drug prevention programmes described so far deal mainly with primary prevention. Health professionals are often confronted with substance abuse problems at an early phase, in hospitals, or during primary care and crisis intervention. Many are not familiar with coping and intervening with drug problems, scant attention having been paid to this aspect during their medical training. There

29) Free to Choose: an approach to drug education. TACADE, Salford. IRK. 1984

30) Drug Wise Drug Education for Students, 14-l9. ISDD, London. 1986

31)See Note. 19

are several attempts to fill this gap, one of the best known being the post-graduate "Diploma Course in Addiction Behaviour", developed and taught by the Addiction Unit of the Maudsley Hospital in London (32). This very intensive, one-year training course is addressed to physicians, psychiatric nurses, psychologists and other health professionals confronted with early addiction problems in their work. It is interesting to note the high international participation in this training course, with professionals from Africa and Asia who return to their countries and train their colleagues in education and intervention with drug misusers. An international example of the "teaching the teachers" training model.

•**Community prevention projects.** So far as this author is aware, there are no striking examples of community drug prevention projects directed at primary or secondary prevention levels. What we do have, however, are examples of projects that try to reach local drug users in big towns and cities. In Manchester, for instance, a harm reduction comic called "Smack in the Eye" has been distributed to drug users (33). It uses popular cartoons to get messages across about safe drug use and safe sexual behaviour. In Brighton, a harm minimization project using local radio and telephone lines to warn young people about the dangers of mixing sedatives, including solvents, produced wrapping paper with printed messages about drugs 34).

•**Evaluation of drug prevention in the United Kingdom.** No general evaluation data is available to determine the effects of all preventive measures, either on supply reduction, or on demand reduction, to decide whether the British drug policy is a successful one. And it is virtually the same for the prevention and education programmes described above where no quantitative data is available to indicate success or failure. However, there is evidence that the British mass media campaign was successful to some extent, research findings indicating that negative attitudes of youngsters towards the use of heroin had increased by 10% after the campaign '35).

• The Netherlands

•**Drug policy.** The global objective of Dutch drug policy over the last 15 years has been the "normalisation" of drug abuse problems, which means treating drug users as far as possible as "normal " citizens, to whom "normal" demands are made and to whom "normal"
chances for living should be offered and who are considered to be responsible people, subject

32) Glass. I. B. Diploma Course in Addiction Behaviour. paper presented for WHO Consultation Meeting "Substance Abuse Education for Health Professionals". Vienna. 1987

33) See Note. 27: p. I43

34) Dorn. N. Can Local Drug Prevention Sizzle? Druglink. 1990

'35) Heroin Misuse Campaign Evaluation. Report of findings stages I-III. Research Bureau Limited. London. 1986

to the same rules as the rest of society. There should be no prosecution of drug users because they use "illegal" drugs but, on the other hand, drug users who commit crimes will have to face the consequences of their acts. This does not mean that the Dutch do not carry out any law enforcement or implement a control policy. The penalties for trafficking in heroin and cocaine, for example, have been increased from 4 years to 12 years imprisonment. New laws exist to trace, freeze and confiscate assets acquired from the proceeds of drug related crimes.

Today there is general consensus among Dutch prevention officials on the main features and principles of drug prevention which has to be developed on a broad base, not simply at the level of publicity campaigns and information. It is generally accepted that drug education should begin in primary schools, at the age of 10, with alcohol and tobacco education. These educational efforts should be repeated, and include cannabis education during the first years of secondary school, where young people are in a critical phase of their psychological development, exposed to peer pressure and media influences. In higher secondary schools, alcohol, tobacco and cannabis education should be repeated, and include other drugs.

Besides primary prevention programmes, there is now a movement towards secondary prevention programmes. This means that prevention officers are now faced with problems such as, how to contact high risk groups, how to motivate them for education and information, how to communicate with minority groups, with school drop outs etc. Those groups often have no institutional relations, and cannot be contacted through community organisations. Therefore, there is a need to develop local and regional networks of drug prevention specialists, cooperating with community institutions (schools, youth clubs, childcare centres, local police etc.) to create appropriate educational and communication techniques which will permit contact with populations at risk.

•**Mass media campaigns**. Mass media, especially media campaigns against drug abuse, have played a minor role in Dutch prevention compared to those for alcohol and tobacco prevention 36). The most striking example has been the "What everybody ought to know about drugs" carnpaign, carried out in the eighties, the main goal of which was to educate parents and educators about drugs and drug abuse. The campaign designers assumed that the social environment of experimenting drug users is usually badly informed and mostly reacts wrongly to drug abuse. The campaign was aimed at inciting parents to talk more openly with their children about drugs, and before it started, interviews were conducted with parents to determine the tonality and style of the campaign. It transpired that parents were not motivated by a campaign suggesting that their children could be involved in drug abuse and it was therefore decided to design a low-key communication campaign avoiding pictures of needles, bad-looking youngsters etc. 37).

There were two phases to the campaign. Striking headlines were slightly emotionally charged ("Fear is a bad advisor, let's talk about drugs"). The written press drew its readers' attention

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36) Buisman. W. R. Mass Media and Drug Abuse Prevention in the Netherlands. paper presented at the 1st International Drug Abuse Prevention Research Symposium. Lexington. K.Y. USAOctober 20-23 1991

37) See Note. 5

to the availability of receiving a free booklet on drugs containing objective, factual information, written in an easy, but serious style in order to eliminate fear and myths. The booklet also included two examples of discussions between parents and children to illustrate appropriate communication. Since the start of the campaign, more than 500.000 copies of the booklet have been distributed. In line with the main principle of the "What everybody ought to know about drugs" campaign, to educate the social circle of drug users, a few years later a series of six television and radio programmes was broadcast on Dutch National Educational Television (40). Part of the series has been published in a small education handbook for parents and educators.

More recently, a Cocaine Prevention Campaign was initiated by the Jellinek Treatment and Prevention Centre in Amsterdam. The main aim of this campaign was to change the attitudes of local youngsters heavily involved in disco-dancing towards cocaine-experimentation. In the first stage of the programme, a special campaign was directed towards correcting the general belief of many youngsters that cocaine is a safe drug when used carefully. Large and striking posters and information booklets were mailed to discotheques, coffee shops, trendy youth bars and youth-centres. The slogan of the campaign was "Coke, the white hammer" (copying a popular pro-milk drinking campaign "Milk, the white motor"). The second stage of this campaign tried to change the belief that cocaine use increases a youngster's status with his peer group ("Cocaine, the illusion of being strong"). In both stages of the campaign, much attention was generated in the mass media, with free publicity on television, radio, newspapers and magazines.

Three video clips were produced for risk groups frequenting youth centres, coffee shops and youth care institutions. Although no large-scale evaluation was conducted, the use of cocaine in Amsterdam decreased from 1.6% in 1987 to 1.3% in 1990.

•**School, community and other prevention programmes.** By far the greater part of drug education activities are planned and carried out by trained drug education specialists working in nearly all the large and medium-sized towns and local communities. Their main task is to train and advise key-persons or intermediaries who work with young-people-risk groups, ethnic minority groups, youth clubs, young people in care, young prisoners and, of course students and pupils in schools. The Dutch drug education system applies the "teaching the teachers" model, both in primary and secondary prevention, but in practice, courses are provided for a broad category of intermediaries in school, youth work police, prison, childcare settings. These courses last several days, and the current policy is to include drug education and drug intervention training for all these different intermediaries, who are also offered educational and audio-visual materials for use in their own prevention activities.

One important area of drug prevention is, of course, school drug prevention. To some extent a similar development can be observed as in the UK In the beginning there was strong emphasis on factual drug education "Give them the naked facts on drugs". Later the focus changed and was directed towards a person-oriented, value clarification based approach. In the late eighties the peer resistance and skills development approaches were adopted. The

40) Van Amerongen, R. Cinderella's Portrait: some observations on Dutch Drug Prevention Policy. Paper presented at the French-Dutch Drug Prevention Symposium. Paris, France. 1986

latter are still popular, but there is a tendency to offer the education market whatever they most appreciate. The main criterion is still that only qualitative materials are marketed to schools. However, this does not mean that teachers can only choose between types of materials. There are also large-scale training projects for teachers, both at primary and secondary school levels, which are developed nationally, but carried out locally, adjusted to the specific demands of local schools.

Among many other initiatives and drug education programmes, we should mention a specific "theatre drug education" project, called "Kick-seekers" which is aimed at secondary school children, aged 14-18, who are presumed to be at risk of becoming involved in drug use. Based on the assumption that many young people are looking for kicks, often to prevent feelings of depression, disappointment and disapproval, the young actors depict real-life situations and tell of their own search for friendship and acceptance in connection to drinking, smoking and sniffing. After watching the play, all schools having participated in the project were invited to join a chat show, in which the actors discuss and share their experiences and opinions with the public.

•**Training programmes for health professionals.** During the early eighties, much attention in drug prevention was paid to health professionals, especially physicians, several training courses on drug problems being offered both in undergraduate and post-graduate medical training (41). In most Dutch medical schools, courses in substance-abuse problems are taught in the second or third year. Attention is paid to knowledge and attitudes of medical students, their own use of drugs, including alcohol, aspects of early intervention and detection. In the training for general family physicians, a module of substance abuse has been integrated into the curriculum. Similar courses are being developed for the vocational training of nursing staff and social workers.

•**Evaluation of drug prevention in the Netherlands.** As with the general international situation, it is difficult to determine the results and effects of the Dutch drug prevention programmes. However, there has been some evaluation. For example, an assessment of the "What everybody ought to know about drugs" campaign indicated that 50% of the respondents reported that they had become more interested in the problem of drug use, about 75% had developed better attitudes towards open communication on drug use, and another 35% indicated that they had changed their behaviour and discussed drug problems with friends or family members 42). Another study on school drug education indicated that a

41) Lange. W. M. Alcohol Consumption and Alcohol-related Problems in the Netherlands Paper presented at the Who Working Group on the Role of Physicians in Alcohol Abuse Prevention. Oslo, 26-29 August 1986

42) See Note. 5

person-oriented approach is to be preferred to a factual or alarmist approach (De Haes, (43)). Yet another study indicated that educated pupils in primary school used less alcohol and drugs than a control group (Van de Wijngaart, (44)).

• Sweden

•**Drug policy.** Sweden has adopted a broad concept of prevention, including drugs, alcohol and tobacco. Three different levels of prevention are conceptualised and included in their prevention policy. Primary prevention is taken to mean general preventive measures (legislation, drug education) for the public as a whole. Secondary prevention aims directly at risk groups and tertiary prevention is used to provide care, treatment and rehabilitation for drug abusers. A central idea behind the Swedish approach to primary prevention is to "vaccinate" young people against starting to use drugs at some later date. According to the Swedish National Board of Health and Welfare, centralised campaigns using large-scale mass media have little or no effect. The main function of campaigns must be to support local activities at the community level. Well organized, with many social and community organizations (an excellent climate for prevention), Sweden has adopted a prevention strategy supported by large segments of the population. Consequently, many different target groups are involved in preventive activities: pre-school children, children and youth in elementary and high schools, young men in military service, students, parents, women, immigrants etc.

•**Mass media campaigns.** The modest, supporting role of mass media and large scale campaigns in Sweden has already been mentioned. In the early eighties, the Swedish Ministry of Health conducted two national campaigns against alcohol and drugs. " *Action mot droger2'* (Action against drugs) started as a continuation of an earlier campaign to stop the sale of alcohol to minors (45). *"Action mot droger'* was aimed mainly at cannabis abuse, trying to stimulate discussion about lifestyles and forces underlying drug abuse. To meet this goal, a snowball strategy was developed in which mass media were the starting point for local activities. This required a strong link between the central coordinating body and the many target groups, which at the regional level, consisted in social advisors to the largest county councils, as well as county school boards. In cities and local communities the link was forged by coordinating the social service, schools, police and sports and cultural organisations. The supportive role of the mass media consisted of two television and radio programmes in which parents discussed their opinions about drug use with young people. Six programmes called "Teenagers need parents" were later broadcast by Swedish radio. The campaign included press conferences, advertisements in newspapers and magazines.

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43) De Haes. W. F. M. & J. H. Schuurman. Results of an Evaluation Study of Three Drug Education Methods. In: International Journal of Health Education. 1975. 18 (Suppl) pp. I -16

44) See Note. 36

45) Alcohol and Narcotics. Preventive Measures in Sweden. Socialstyrelsen. Stockholm. 1987.

•**School and community drug prevention.** As a result of the mass media campaigns, a wide variety of instructional materials on drugs and alcohol were developed and distributed through national, regional and local channels. These materials not only dealt with drug information, but were more broadly designed to encourage pupils to face up to feelings of inferiority, insecurity and fear of expressing emotions and values. Different materials were published for elementary and primary schoolchildren and for junior and senior high school students. It was later decided to organise a special campaign on hashish use in cooperation with the National Association for Home and School. Parents of 14 year olds in Sweden were chosen as the target group of this campaign, and a small but striking book called "The Hash Book", was produced and mailed to them (46). To facilitate work with the book a school curriculum was developed and the material sent to key persons in education. To support the campaign, and to improve its effectiveness, the National Association for Home and School arranged a major national conference, followed by local conferences for school class representatives. The idea was that all ninth grade classes should hold discussions with parents and teachers about drugs in general and hash in particular.

•**Education and training for health professionals.** For many years, Sweden has developed research in the field of substance abuse at the major universities. As a result of a curriculum reform in 1983, a two-week training course is now given four times a year at the Karolinska Institute in Stockholm, in which attention is paid to all substances, including psychoactive medicines. For one week medical students are introduced to clinical and ambulatory treatment settings, and meet self-help groups. At the pre-clinical level, introductory information on substance abuse is given during the basic courses on social medicine and medical psychology. Sweden also has specific training programmes for public health professionals (psychologists and social workers) who can participate in certain non-medical parts of training programmes for physicians. Opportunities for education and training in substance abuse problems in Sweden are still increasing.

•**Evaluation of drug prevention in Sweden.** Unfortunately, no quantitative data is available to show that drug prevention in Sweden is successful. On the other hand, there has been no marked increase in drug consumption during the last decade. Seven hundred thousand (700.000) of the "Hash Book" have been mailed to Swedish families. As in most other European countries there is no strong prevention-evaluation tradition in Sweden, as is the case in the USA.

•Germany

•**Drug Policy.** In Germany it is estimated that the current (hard) drug problem concerns more than 60.000 drug addicts, equivalent to 0,6% of ex-West Germany. Some time ago, a national survey indicated that nearly 25% of young people between 14 and 25 reported

46) The Hash Book. Socialstyrelsen. Stockholm. 1987

having used cannabis once in their life, of whom about 1 million continued to use it. There is no reliable picture of the drug consumption situation in the Eastern part of Germany. The central Government has laid strong emphasis on supply prevention efforts: detection of illegal substances, law enforcement, customs control. The situation in the Bundeslander (Niedersachsen, Bayern, Schleswig-Holstein, Berlin etc.) is different, with more emphasis on demand reduction: education, care and treatment, rehabilitation. The regions (11 + 5 EastGerman) have autonomy to develop their own prevention policies, especially in the area of education, health care and drug prevention. The Federal Government only develops general guidelines and laws.

•**Mass media campaigns.** The German prevention strategy can best be characterized as a public information and community oriented strategy, which makes little use of high key mass media like television and advertising, with the exception of mass media campaigns to prevent the spread of HIV/AIDS. Drug abuse prevention is very much integrated in general health promotion and is primarily focused on healthy life styles, not on substances. The prevention of drug abuse is considered as a long-term public health education process involving children, young people, parents and adults, professionals and key-persons. Nevertheless, Germany has a long experience with specific use of television - their Suchtwoche (Addiction Week) '47),
when for a whole week (often in Autumn), information and discussion programmes and films focusing on addiction are broadcast. This Addiction week is aimed at raising the awareness of millions of people to substance abuse in their own environment, and programmes offer a lot of information on methods, institutions for treatment and self-help groups. Beside its information function, an important agenda setting effect of the Addiction Week Programs might be expected.

•**School and community drug programmes.** German drug prevention policy is mainly based on a health education strategy using dissemination of written materials, and, some general objectives have been formulated for specific target groups. For young children in school, it is important to strengthen competence in interpersonal contacts, enabling them to resist counter-healthy influences from media stars and heroes, to enable them to make informed decisions in conflict situations. Positive, recreational activities to strengthen interpersonal relations in peer groups are promoted. For parents, educators, youth leaders and teachers, materials are available containing information and advice on how to communicate with young people. Parents are approached with creative materials, reflecting their own social situations, convincing them that it is their responsibility to speak up on health problems with their children. A well known campaign has been the *"Alltag Scenen einer Clique"* (Everyday life: scenes from a clique) '48). The brochure used in this campaign analyses everyday situations of young people, illustrating peer group mechanisms, problems like negative feelings and how to express feelings of anxiety, and lack of self-esteem, but also

(47) Suchtwoche in Zweites Deutsches Fernsehen. Abhangige, Angehorige. ZDF Press Spezial.

48) Buismani W.R. Mass Media Drug Campaigns in Europe. Report for the Council of Europe.Utrecht . 1987

illustrating the importance of having strong positive relationships with friends, parents and school.

Germany has developed a long tradition of health and drug education in schools. In the Bundeslander (for example, Niedersachsen), training courses are organized in cooperation with some universities to inform and train all secondary school teachers to give lessons on health and substance abuse. It was recently decided that education specialists will be employed in most regions in Germany to support and initiate all kinds of preventive activities in the local communities, including prevention at the workplace, in churches, youth centres, schools, sport and leisure clubs. A national and regional infra-structure to train and educate health professionals in drug abuse prevention is now under development (Institut fur Therapieforschung OFT, Munchen, Hamburg).

•**Evaluation of German drug prevention.** Germany has a broad concept of prevention, with no strong emphasis on drug education. On the other hand, much attention is paid to health promotion and alternatives to drug use (youth theatre, art projects in Berlin) '49), but insufficient data and information is available to decide whether the German prevention concept is effective in reducing drug abuse.

49) See Note. 26. p. 49

V. EFFECTIVENESS OF DRUG EDUCATION

According to the way in which drug education and prevention programmes are carried out, three kinds of effects can be distinguished:

First, the intended effects - after undertaking a drug education programme, fewer drugs are used, or people know more about their damaging effects.

Second, unintended or unwanted effects might occur, especially in high-key campaigns which have great impact on the public. A well-known unintended effect is the arousal of curiosity about drugs amongst youngsters although the opposite is intended. Another can be that, through the influence of a campaign, drug addicts find themselves even more socially isolated.

And, finally there are the unexpected effects. For example, since the start of the British antiheroin campaign, private fundraising activities for drug education projects have increased considerably 50)

This Chapter will describe the results of evaluation studies carried out over the past 20 years. Firstly, drug education utilizing mass media will be evaluated, and secondly a number of evaluation studies undertaken to determine the effects of group and community drug education will be reviewed.

• Evaluation of Mass Media Drug Education

A fair number of studies have been carried out to determine the intended effects of mass media campaigns against drugs. These studies centre on determining how widely known these campaigns are on the one hand, and the impact they have had on the knowledge, attitudes and behaviour of population groups on the other. Most campaigns, especially those that make use of television and radio, are very well-known. As many as 95% of English youngsters had heard of the anti-heroin campaign. Research on its effects showed that there was a significant increase in knowledge of the negative effects of heroin use (51) and that negative attitudes towards the use of heroin had increased by ten percent.

These results confirm the findings of many other studies that mass media campaigns can usually affirm an attitude that already exists or strongly increase attention on a problem but rarely have much impact on behaviour. Because a negative attitude can easily be put aside in a situation in which a youngster is offered drugs in the presence of his friends, the organisers of an earlier British campaign attempted to make it clear that refusing drugs in such a psychologically.tricky situation does not necessarily mean losing face.

50) See Note. 35

51) See Note. 5

In comparison, the results of the rather low-key Dutch Mass Media Campaign "What everybody ought to know about drugs", showed that about 50% of respondents became more interested in the subject of drugs and about 75% found that their knowledge about drugs had increased as a result of reading the booklet distributed during the campaign. Thirty (30%) of respondents had changed their ideas about drugs and drug use and their attitude became more favorable with regard to talking about drugs and with drug users in their environment 52).

In drug abuse prevention and health education literature, there is evidence that carefully coordinated mass media campaigns to support community prevention programmes are probably the most effective and most promising approach 53). Essentially this is the main strategy of the Swedish drug prevention and is also the current Dutch policy in the field of -alcohol abuse prevention. Mass media campaigns (slogan: "Drinking can break your heart") are aimed at the general drinking population and specific sectors, for example, the 700 municipalities in the country. Recently, a large-scale campaign was targeted at all secondary schools (slogan: "Do you know, do you care'), with educational programmes on Dutch school television, and training and instruction courses for teachers 54).

Is there a point to anti-drug campaigns using mass media? Campaigns can influence attitudes and opinions with regard to drug abuse in such a way that the chance they will ever start using drugs decreases. To achieve this goal the right media must be used to pass on a clearcut message and, in peer groups, an attempt must be made to increase the effects of prevention at schools.

• Evaluation of Drug Education through Group Methods

Most literature suggests that almost all methods of drug education which have been applied and evaluated in the past 20 years have had no more than marginal effects on attitudes and behaviour in relation to drug use. According to a review by Hanson (55), it can be concluded

52) Alcalay, R. The Impact of Mass Communication Campaigns in the Health Field. Soc. Sco. Med. 1983. Vol. 17. pp. 92-97

53) Van Ginneken, S. The Dutch Alcohol Education Project. Paper presented at the 36th ICAA Institute on the Prevention and Treatment of Alcoholism. Stockholm, Sweden. 1991

54) Hanson, D. J. The Effectiveness of Alcohol and Drug Education. In: Journal of Alcohol and Drug Education. 1982. Vol. 27, pp. 1-13

55) Schaps E. et. al. Review of 127 Drug Abuse Prevention Programme Evaluations. In: Journal of Drug Issues. 1981. Vol. 11. pp. 17-43

that *Research has demonstrated that while it is relatively easy to increase drug knowledge, it is more difficult to modify attitudes. By far the largest number of studies have found no effects of drug edu - cation upon use.* About ten years ago Schaps *et al* published a review of 127 drug abuse prevention programme evaluations. They concluded: *Overall, the 127 programmes produced only minor effects on drug use behaviors and attitudes. The best of the available evaluations are tentatively encouraging about the efficacy of "new generation prevention programmes" 56).*

Instead of informing and warning young people about the risks of taking drugs, it seems more effective to place a stronger emphasis on the development of social skills, on peer programmes and on improving factors such as the self-esteem of young people (61). In 1986 Tobler published a well known meta-analysis of drug education programmes in which she compared the results of 143 drug education programmes. The author divided these programmes into five categories.

- Knowledge only (Informing and warning approach).
- Affective only (Affective approach).
- Peer programmes (Psychosocial approach).
- Knowledge plus affective.
- Alternatives (to drugs) programmes.

Tobler divided the research findings into 5 variables: influence on knowledge, attitudes, drug use, skills and behaviour (including school performance, contacts with police etc.). Her analysis led to the following conclusions: Affective.only scores low on all 5 variables. Knowledge plus affective shows an increase of factual knowledge and a slight positive effect on the other variables: attitude, use, skills and behaviour. Peer programmes score very high on all 5 variables and higher on each individual variable in comparison with any other approach. Moreover, only peer programmes result in behavioural change. Tobler concludes: *Peer programmes are dramatically more effective than all other programmes. At* the same time, she states that these results have only been shown in middle-class groups, other community groups scoring considerably lower on peer programmes.

In 1991, drug education experts of 16 European countries met to consider and evaluate the present state of drug education, mainly in the context of formal school education. Based on an extensive review of evaluation research and on their practical experiences in their countries *(a/o.* East-European), after three days of exchange of information and discussion they reached the following conclusions (57):

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56) Tobler, N. Meta-analysis of 143 Adolescent Drug Prevention Programmes: quantitative outcome results of programme participants compared to a control or a comparison group. In: Journal of Drug Issues. 1986. 16(4) pp. 537-567

57) Drug Prevention in Schools. Final Report. European Conference on Drug Prevention. Lubeck Germany, 1991

- Drug education is essentially effective; it should be implemented in all schools and adequate resources (funding, staff) must be provided.
- Appropriate drug education programmes should be provided for all age groups from the beginning of school attendance, including preschool.
- The methodology of drug education should be well structured and drug education programmes should employ participatory learning methods which acknowledge young people's needs and support the development of young people's responsibility for their own health.
- Peer group involvement and life-skills training should be enhanced.
- Drug education in schools should be integrated in a community approach involving parents, youth and sports clubs.
- In view of cultural differences, drug education programmes have to be designed for, or adapted to, each individual country and local situation.
- Drug education needs international quantitative and qualitative evaluation at different levels.

VI. CONCLUSION AND SUGGESTIONS FOR MODEL PROGRAMMES OF DRUG EDUCATION

This report has described the principles, strategies, planning stages, methodology and techniques of drug education and a number of national drug prevention programmes have been analyzed. Chapter IV outlined evaluation studies conducted during the past twenty years.

On the basis of the reviews of national drug prevention policies, what conclusions can be reached?

National drug policies differ both in terms of goals and objectives, and in the implementation of preventive activities and programmes. Compared with other national drug policies, for example those of Spain, Italy, France and Greece, the differences are even greater. Not to mention the lack of drug policies in the Eastern part of Europe. On the other hand, the situation in Europe today is changing favourably with a tendency to create more convergence between national drug policies and with more exchange of experiences and programmes in the field of prevention. As mentioned in Chapter IV, in the area of school drug prevention, a number of countries have adopted adaptations of the Skills for Adolescence programme. The Health Career Prevention Programme '58), developed in the United Kingdom, has been now introduced with some changes in Denmark and Sweden. Another example is the '59) European Drug Prevention Week initiated by the European Commission, when all European Union member states participate in the preparation of a Prevention Week including national and international projects of drug abuse prevention. The first European Drug Prevention Week was organised in the autumn of 1992, with an international two-days Flag Event in London to draw public, media and political attention to. the drugs issue. The second Drug Prevention Week took place in 1994, starting again with an international Flag Event in Aachen, Germany and national drug abuse prevention events in the 12 European Union member states mass media campaigns, national conferences, press meetings, TV-programmes etc. A final example of the process of international exchange of knowledge and expertise, are the international summer schools to train health professionals (Cambridge, Amsterdam). As a model of continental cooperation in the field of drug abuse prevention, there is reason to be optimistic that this process will probably bear fruit, both for Europe and for other continents.

A **general conclusion** in this report might however be that, under certain conditions, drug education is effective. These conditions depend upon a number of important factors, such as:

- The current drug abuse situation in a country;
- The actual drug (prevention) policy in a country;

'58) Dorn. N&B. Norcroft. Health Careers. Teachers Manual. ISDD. London. 1983

'59) Getting the Message across, a report on the Drug Professionals' Conference, Dep. of Health, London, I994

The current social infra-structure (school system, media network) and funds and resources available; - The support of government, decision makers, community - and opinion leaders and the public to develop and carry out preventive activities.

Young people are the main focus and the most important target group for preventive education against drug abuse. In this respect it should be emphasized that drug education has to be rooted within a realistic perspective vis-a-vis young people. According to De Haes, young people explore different aspects of the world around them and test the values and norms of adult society. Young people, in common with adults, are not "empty vessels" with regard to drugs. They already have knowledge, attitudes and behaviours with regard to risk substances. Some young people are in contact with criminal groups, where they pick up their information on drugs. Young people are very sensitive to social conformity pressures, but neither at home, nor at school do they learn to resist these pressures. In other words, it is not only important for people working on drug education to know the facts about drugs and use of drugs, but also to be familiar with (pre)adolescent psychology and pedagogy.

Against the background of the experience acquired in Western countries with regard to drug education, what policy can be recommended to countries intending to formulate and organize preventive activities in their towns and communities?

Drug education programmes that have proven successful in Western countries should be introduced in other countries in a socially and culturally adapted fashion. Possibilities should be studied of adapting two well-known drug education programmes: Health Careers (UK) and Skills for Adolescents (USA). Both programmes have been tested and undergone international and cultural adaptation. The rationale of the Health Career Programme is to regard all health related, including drug-related, behaviour as a facet of young people's responses to their life situation and that some traditions and customs which contribute towards maintaining or improving health are contained in each social grouping. It is emphasized that neither the environmental nor the individual attitudes and behaviour approaches can stand alone, but that both aspects are important. A teacher's manual describing the programme and guiding teachers through the units of the programme, is available. The Skills for Adolescents programme, described in Chapter m, is appropriate because it is probably the most elaborated example of a peer and skills training approach that according to empirical evidence is presumed to be effective in drug prevention. Moreover, this programme has a general impact on prevention of (mental) health problems and on (mental) health promotion. The possibilities of adapting these programmes to other, different national cultures or at least, if elements of them can be culturally adapted in a flexible manner, should be studied.

An **international meeting** should be organised in order to present drug education programmes that have proved effective in a number of countries (for example the Health Career and Skills for Adolescents Programmes). Plenary presentations should clarify under what conditions these programmes or components of them can be adapted for introduction into other countries. In complementary workshops, the programmes might be demonstrated in more detail to the participants, who would come from prevention organisations.

A**Sourcebook** of Prevention Ideas, should be produced listing creative and effective prevention activities which have been enthusiastically received, for example a play, a project week on drug abuse in school, a drawing contest etc. Main criteria for selecting those prevention ideas and activities are that they should be attractive, appropriate and applicable. In situations unfavorable to common drug education programmes, this might be a good alternative. Belgium published such a sourcebook in 1987. Sometimes working with a sourcebook starts the development of a common drug education programme within the formal curriculum.

It would be worthwhile collecting a limited number of **standard educational materials**, for example fact sheets on drugs and model programmes of drug education, including a short description of basic elements of a drug education programme. Because a big problem in drug education tends to be the availability of materials and programmes, attention has to be paid to the selection of appropriate organizations to ensure widespread and active distribution.

Special attention should be geared to drug education training, especially in countries and regions where there is a complete lack of preventive education. Application of the "teaching the teachers" model that has proved its worth in a number of countries merits serious attention. Besides training in methods of drug education, students or teachers have to be familiarized with existing educational materials. Training should not focus only on knowledge, but also on improvement of discussion and communication skills. More attention should be paid to these issues in undergraduate, graduate and postgraduate training prograrnmes. It is important that, from the start of their training, educators are aware that they are also responsible for the health and well-being of their pupils and students. This includes drug education.

Most suggestions so far have dealt with group education methods, educational materials and programmes, training, etc. Another, more comprehensive and much broader approach to drug education, is a multimedia and multimethods approach with the characteristics of a campaign, and a **planning guide** to this multimethods approach could be prepared and published. Some of the main elements and stages in this approach are outlined below.

First of all, a mass media campaign is organized to heighten public awareness about a drug problem. The campaign establishes a relationship between the "quality of life" and a life-style free of drug abuse, for example, along the lines of the Scottish campaign "Be all you can be, choose life, not drugs". The main target groups would be school children, out-of-school youth, parents and community leaders. The media used to convey the message would be TV spots, radio commercials, posters, leaflets, a parents' drug information booklet "How to talk with my child about drugs". Support activities would be a press conference at the start of the campaign, drug education articles, free publicity. Main features of the total campaign would be straight messages, high quality educational materials, relating drug education in a peer and social pressure context, offering appropriate alternatives to drug use.

Finally, international organisations should participate fully in providing countries where preventive education is non-existent, or where such education needs to be enhanced, with drug education programmes that have proved effective in other countries. In this respect, it is important to bear in mind that conditions often vary widely between countries and continents. International organisations and drug education experts should therefore assist, support and facilitate the identification of existing resources and local possibilities of education for the prevention of drug abuse in countries where such assistance is needed.