Universal Drug Prevention

LISA JONES
HARRY SUMNALL
KIMBERLEY BURRELL
JIM MCVEIGH
MARK A BELLIS
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The National Collaborating Centre for Drug Prevention [NCCDP] is undertaking a review of recent government sponsored research and policy related to drug prevention, with the aim of encouraging evidence based practice through dissemination of research evidence to practitioners and commissioners and making recommendations to policy makers.

The third¹ in a series of updates on this work considers the effectiveness of universal drug prevention interventions.

AIMS

The aim of the report is to synthesise findings from government sponsored research that has evaluated universal drug prevention programmes. This is placed in the context of current drug prevention policy and the wider academic literature in order to provide evidence-based recommendations and to highlight gaps in the research that require attention. This report is of particular importance to a wide range of practitioners and planners working across young people’s services [including schools, youth services and other community-based services], and to policy makers who wish to pursue evidence based approaches. The report is not intended to be a comprehensive review of all research evidence for universal prevention.

STRUCTURE

The report is divided into seven sections. The first section gives an overview of universal prevention approaches. Subsequent sections focus on recent government sponsored research into the effectiveness of universal prevention interventions across a number of settings including school, family, the community, mass media and generic services. Finally, a summary is provided considering implications for universal drug prevention work across these settings.

FINDINGS, IMPLICATIONS, AND RECOMMENDATIONS

School-based interventions are the most popular and widely researched method of delivering universal drug prevention programmes. Review evidence suggests that Life Skills Training [LST], or approaches based upon it, is one of the few programmes that has demonstrated a small but positive effect on reducing indicators of drug use. However, only those schools particularly dedicated to drugs education, and eager to have pupils take part in this type of education may see benefits. Research into which elements are regarded as potentially able to increase the success of drug prevention programmes has found that interactive approaches to drug education are more effective than non-interactive approaches. There is also weak evidence to support the finding that effective programmes tend to include booster sessions; and that programmes may be more effective when they are delivered to pupils between the ages of 11 to 14 years. Multi-component programmes and those based on the social influence model have shown the most consistently positive outcomes, but even these programmes are limited in their effects on reducing drug use [3.8, 3.9]. In addition, research is lacking about which components contribute to the overall effectiveness of multi-component programmes.

There is a need for evaluation and long-term follow-up of drug education programmes targeted at primary school aged children [3.11]. Review of the limited literature available suggests that primary school interventions should focus upon family intervention and parent education, and school organisation and behavioural management. In addition, families play an important role in young people’s choices around drug use and research from the US has shown that family components may enhance the effectiveness of universal programmes. Currently, UK-based evidence is lacking about which interventions work most effectively with parents and how best to engage parents in drug prevention activities.

Government funded, community-based prevention initiatives have tended to target deprived communities and universal prevention programmes delivered in this setting have not been widely assessed [5.5]. In addition, more research is required to elucidate the effectiveness of community-based programmes including mass media campaigns as a part of multi-component drug prevention programmes [5.6].

Although international research has shown early evidence that provision of generic health and educational services may have a positive effect on drug use behaviours, a lack of UK-based research in this area was identified [7.7].

Overall, a lack of robust UK-based evaluations of universal drug prevention programmes was identified. Those responsible for delivering young people’s services across a broad range of universal and generic settings including educational, health and social care should be aware of their potential role in the prevention of problematic drug use. Schools in particular have an important role to play in the delivery of universal drug prevention initiatives.

¹ Previous briefings are Drug Prevention among vulnerable young people [Edmonds et al., 2005] and Tiered approach to drug prevention and treatment among young people [Burrell et al., 2005].
Abbreviations & Definitions of Terms

**ABBREVIATIONS**

**CAF**
Common Assessment Framework

**D.A.R.E.**
Drug Abuse Resistance Education

**D[A]AT**
Drug [and Alcohol] Action Team

**DANOS**
Drugs and Alcohol National Occupational Standards

**DATE**
Drug, Alcohol and Tobacco Education

**DFES**
Department for Education and Skills

**ECM**
Every Child Matters

**LHSP**
Local Healthy Schools Partnership

**LST**
Life Skills Training

**NHSS**
National Healthy Schools Standard

**PCT**
Primary Care Trust

**PSHE**
Personal Social Health Education

**SDA**
School drugs advisor

**DEFINITIONS OF TERMS**

**CHILDREN**
People under the age of 18 years, in accordance with the Children Act [1989], and the United Nations Convention on the Rights of the Child [1989].

**COMPLETENESS OF DELIVERY**
Refers to the degree to which a replicated programme model or strategy was implemented in its entirety according to the specifications of the original.

**DRUG DEPENDENCY**
A compulsion to take a drug on a continuous or periodic basis in order to experience psychic effects and sometimes to avoid discomfort in its absence. Both physical and psychological dependency can occur.

**DRUG MISUSE**
Illegal or illicit drug taking which leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence. Drug misuse is therefore drug taking that causes harm to the individual, their significant others or the wider community.

**FIDELITY**
Refers to the degree to which a replicated programme model or strategy was implemented as planned according to the specifications of the original.

**META-ANALYSIS**
The combination of quantitative evidence from a number of studies.

**POLY DRUG USE**
The simultaneous, sequential, or concurrent use of more than one drug, often with the intention of enhancing or countering the effects of another drug, or to substitute for the effects of an unavailable drug.

**PROBLEMATIC DRUG USE**
As drug misuse.

**SUBSTANCE MISUSE**
As drug misuse, but including alcohol and tobacco.

**SYSTEMATIC REVIEW**
A method of locating, appraising and synthesising evidence from primary studies, which adheres to a scientific methodology.

**YOUNG PEOPLE**
People under the age of 25 [in line with the Drug Strategy definition]. Some data sources used, however, had alternative definitions. This is noted where relevant.
Introduction

1.1 This briefing focuses on recent [2000 to 2005] government sponsored research on universal drug prevention, and considers how this relates to current government policy and guidance. Following on from Drug Prevention among vulnerable young people [Edmonds et al., 2005] and Tiered approach to drug prevention and treatment among young people [Burrell et al., 2005], this briefing is part of a series forming a complete review of all recent evidence derived from government sponsored research and evaluation of drug prevention work.

1.2 Universal drug prevention comprises those interventions and programmes which are targeted and delivered to whole population groups [Mrazek & Haggerty, 1994]. Each member of the population is considered to have the same level of risk for drug use and equally capable of benefiting from the activity. It is often delivered to large groups without screening, and its general aim is towards primary prevention by providing drug-related skills training.

1.3 Universal drug prevention may be delivered across a number of settings such as schools, the family home, and in the community. It is the aim of this review to synthesise findings from government sponsored research in order to provide evidence-based recommendations and to highlight gaps in the research which require attention.

1.4 A full methodology, which has undergone peer review by National Institute for Health and Clinical Excellence [NICE] research specialists, is available on request from the corresponding author.

1.5 The findings here should be considered in the context of government policy. Drug prevention and treatment among young people is a key element of the Updated Drug Strategy [Home Office, 2002]. The 2004 Spending Review Public Service Agreement states that by 2008 there should be a ‘reduction in the use of Class A drugs and the frequent use of any illicit drug among all young people under the age of 25’.

1.6 The Every Child Matters: Change for Children programme aims to reform children’s services, tackling not only substance use but also the risk factors that may promote it; ‘Choose not to take illegal drugs’ is part of the ‘Be Healthy’ objective. The Every Child Matters Change for Children: Young people and drugs strategic guidance links to the Updated Drug Strategy locally, regionally and nationally, outlining a joint approach to the development of universal and other services to prevent drug related harm.

1.7 The Choosing Health agenda, while not specifically focussing on drug use, aims to reduce health inequalities and improve the provision of information and advice to vulnerable groups of young people.

1.8 The report is divided into five sections focusing on the different settings in which universal programmes of drug prevention may be delivered. Government policy relating to each setting is discussed at the beginning of each section and each section contains a summary box and subsections considering: Description of the setting; Approaches; Gaps and Inconsistencies; and Implications and Recommendations.

1.9 A summary is provided considering implications for drug prevention work across these settings.

2 In contrast to the previous two NCCDP reports, research published between 2000 and 2002 was included due to a lack of government sponsored research evaluating universal prevention programmes in more recent years.

3 See www.drugs.gov.uk/ReportsandPublications/YoungPeople/1111061244/ECM_YPD.pdf
Overview of Drug Prevention

2.1 Recent surveys of drug use in young people highlight the ongoing need for drug prevention initiatives. Although figures are down from the previous year [2004], approximately 18% of pupils (aged 11 to 15 years) had taken drugs within the last year and 10% within the last month [Department of Health, 2005]. Cannabis remains the most popular drug [11% of 11-15 year olds had taken cannabis in the last year], and around 4% of pupils report using Class A drugs [1% of 11-15 year olds had taken heroin and 1% cocaine]. However, caution should be used when assessing the number of young people using Class A drugs due to the small numbers involved and the potential for under- and over-reporting. Studies investigating false reporting and recanting [i.e. positive reporting of drug use that was later denied] indicate that young people are particularly prone to over reporting drug use [Peryg et al., 2005; Social Issues Research Centre, 2004].

2.2 A new framework for classifying prevention, based on the groups they are aimed at, was proposed by The Institute of Medicine [Mrazek & Haggerty, 1994]. It described three distinct types of prevention: universal, selective and indicated4. A description of each type is given below.

UNIVERSAL

2.3 Universal prevention programmes are designed to reach the general population or sub-sections of the general population such as individual communities or schools, regardless of the perceived risk of initiating drug use [Kumpfer, 2001]. Children and young people are usually the focus of such universal programmes, with the emphasis on the prevention of precursors of drug use or the initiation of use.

2.4 Universal prevention activities may include schools-based prevention programmes or mass media campaigns, or they may target whole communities, or parents and families. Many universal prevention programmes include more than one type of intervention. Multi-component programmes may combine school-based curricular interventions with school-wide environmental changes, parent training programmes, mass media campaigns, and/or community-wide interventions [Flay, 2000].

SELECTIVE

2.5 Selective prevention programmes target groups or subsets of the population who may have already started to use drugs or are at an increased risk of developing substance use problems compared to the general population, or both [Edmonds et al., 2005]. Children excluded from school and the children of drug users are examples of groups that may be particularly vulnerable to drug use and misuse. Selective prevention is the focus of the first report in this series [see Edmonds et al., 2005].

2.6 Selective prevention programmes are generally longer and more intense than universal programs [Kumpfer, 2001] and may directly target identified risk factors. For example, Positive Futures, a national sport based social inclusion programme5, was designed to use sport and other activities to divert young people away from risky behaviours [see Edmonds et al., 2005]. The Cannabis Youth Treatment study, a randomised controlled trial of a variety of outpatient interventions in a US population of problematic cannabis users, is another example of a selective prevention programme [Dennis et al., 2004].

INDICATED

2.7 Indicated prevention programmes target individuals who may already have started to use drugs or exhibit behaviours that make problematic drug use more likely, but who do not yet meet DSM-IV criteria for substance dependence [McGrath et al., 2005a].

2.8 Indicated prevention activities are aimed at preventing or reducing continued use, and preventing problematic and harmful use. Interventions delivered may include assistance programmes, peer counselling programmes, parent-peer groups for troubled youth, teen hotlines, and crisis intervention [Kumpfer, 2001]. One promising intervention from the US is Multidimensional Family Therapy for adolescent drug abuse, which targets young cannabis and alcohol users, and their families [Liddle et al., 2001].

The Diagnostic and Statistical Manual of Mental Disorders [DSM-IV] provides diagnostic criteria for the most common mental disorders, and is the most popular authoritative manual of its type. DSM-IV criteria for substance dependence are as follows: Maladaptive pattern of use, leading to clinically significant impairment or distress, as manifested by 5 or more of the following, occurring at any time in the same 12-month period: [1] tolerance; [2] withdrawal; [3] the substance is often taken in larger amounts or over a longer period than was intended; [4] there is a persistent desire or unsuccessful efforts to cut down or control substance use; [5] A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects; [6] Important social, occupational, or recreational activities are given up or reduced because of substance use; or [7] substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

4 Targeted prevention encompasses selective and indicated prevention.
5 For reports on the progress of this programme see www.drugs.gov.uk.
APPROACHES TO UNIVERSAL DRUG PREVENTION

2.9 Universal drug prevention programmes may be based on a number of different approaches. Information dissemination and affective education approaches were the first to emerge, prior to the 1980s [Canning et al., 2004]. Programmes based on information dissemination seek to increase young peoples’ awareness of drugs, the impact on their health, and social consequences. These hold the assumption that if young people knew the inherent potential dangers of drug use they would subsequently decide not to take them. These approaches may have a positive impact on knowledge and attitudes related to drugs as expected, but not on drug use itself and could actually increase their use [Dusenbury & Falco, 1995; Hansen, 1992; Puglia & Room, 1999; Töbner, 1992; Töbler et al., 2000]. For example, stressing the dangers of drug use may attract high-risk thrill seekers. There also exists a conflict between cognitive and affective risk assessment, that is, a young person may have good risk awareness [including drug knowledge] or be able to estimate the likelihood of an adverse outcome, but if they do not simultaneously worry about the effects of those consequences, or if it holds no personal significance [e.g. risk of dependence after experimental use of cocaine is highly unlikely], then knowledge will have no effect upon behaviour [ Gamma et al., 2005]. Simple information provision should not be confused with information provision and discussion on the real extent of drug use in the population and among peers, or information and discussion on the role of industry and publicity messages; both of which are examples of normative education.

2.10 Affective education approaches aim to reduce drug use by increasing potential mediators of drug use including self-esteem, self-understanding and self-acceptance. Activities may include values clarification and responsible decision-making [Botvin, 1999]. Whilst many professionals believe intuitively that there is a causal connection between self-esteem and drug use, this is not upheld by the evidence [Schroeder et al., 1993]. Becoming alienated from conventional role models, rebelling against conventional standards, the belief that engaging in alternatives to conventional behaviours can enhance self-worth, and becoming involved with deviant peers who boost their self-worth, can all raise self-esteem. Activities may include values clarification and responsible decision-making [Botvin, 1999]. Whilst many professionals believe intuitively that there is a causal connection between self-esteem and drug use, this is not upheld by the evidence [Schroeder et al., 1993]. Becoming alienated from conventional role models, rebelling against conventional standards, the belief that engaging in alternatives to conventional behaviours can enhance self-worth, and becoming involved with deviant peers who boost their self-worth, can all raise self-esteem. Although Kaplan and colleagues [1984] found that weak self-esteem directly affects involvement with drug using peers, there was only an indirect relationship with actual drug use. Furthermore, there are varying definitions of the term, which means that interventions targeting particular aspects of personality and behaviour in the belief that it indicates self-esteem, may in fact be targeting entirely different constructs altogether. Finally, the literature is fraught with methodological and statistical problems, which means that there is no justification for using self-esteem enhancement in prevention work.

2.11 The social influence approach grew in popularity in the 1980s [Canning et al., 2004]. These approaches hypothesise that drug use stems from direct or indirect social influences from peers and/or the media [Botvin, 1999; 2000]. There are several components of social influence approaches, but all aim to increase awareness of social influences over drug use and to teach specific skills for effectively coping with such influences or pressures. For example, normative education targets the misconception that the majority of adults and adolescents use drugs, as the theory supposes that inaccurate normative expectations can ultimately lead to drug use. Another example of this approach, resistance skills training, aims to equip young people with skills to recognise, cope with or avoid situations where there will be peer pressures to use drugs. Again, however, research into this area is confounded. In assessing the effects of peer pressure, most studies measure the participants’ friends’ behaviour, but it is known that young people often project their own behaviour onto their friends. Furthermore, young drug users often self-select into drug using peer and social groups, which hold similar values and ideals. Both of these factors will lead to an overestimation of peer influence.

2.12 Competence enhancement approaches focus on teaching generic personal and social skills, and are sometimes combined with features of the social influence approach. An example of this is the Life Skills Training Programme [LST], which teaches these skills through cognitive-behavioural skills training methods such as behavioural rehearsal and homework assignments [Coggins et al., 2003]. Resistance skills training aims to teach young people how to recognise, avoid, or cope with situations where they are likely to be pressured to use drugs, and it has been shown to be an effective component of multi-component programmes [Dusenbury & Falco, 1995]. However, as rehearsal times and skills building require displacement of classroom time and resources, other forms of delivery have been proposed. A recent evaluation of the LST CD-ROM, designed for use in home and after-school settings, showed no significant effect upon these types of skills [Williams et al., 2005].

TIERED APPROACH TO DRUG PREVENTION

2.13 The Health Advisory Service [2001] document, The Substance of Young Needs: Review 2001, sets out the four-tiered approach to young person’s service delivery. The tiers may be outlined as follows:

Tier 1 Universal, generic or primary services
Tier 2 Youth oriented services offered by practitioners with some drug and alcohol experience and youth specialist knowledge
Tier 3 Services provided by specialist teams
Tier 4 Very specialised services

[Health Advisory Service, 2001]

2.14 As the central focus of the Every Child Matters programme is on integrated commissioning and multi agency working at a local level, this links well with the young person’s substance misuse tiers [see Box 1]. A consideration of the tiered approach in relation to young people was presented in the previous briefing in this series [Barrell et al., 2003]. The aim of the tiered approach is to ensure more comprehensive and integrated service provision.
The Every Child Matters: Change for Children programme has important implications for universal drug prevention.

The overall aim of the programme is to ensure that every child has the chance to fulfil its potential. In order to achieve this aim emphasis is placed on reducing educational failure, ill health, abuse and neglect, crime and anti-social behaviour among children and young people, through the improvement and integration of universal services including schools and the health service. In achieving these aims, potential risk factors or precursors to drug use would be addressed. Interventions highlighted include promoting full service extended schools and increasing the focus on activities for children out of school through the creation of a Young People’s Fund.

Every Child Matters also emphasises the need for strong links and integration between universal and targeted services [see Figure 1], considering the needs of vulnerable young people within the context of universal service provision. It is intended that closer links between universal and targeted services will result in faster access to targeted services and less stigmatisation.

Every Child Matters stresses the importance of ensuring that the full range of substance misuse work from education through to prevention and treatment is embedded in mainstream services. The emphasis on multi disciplinary teams able to provide integrated services should ensure consistent messages and stop young people falling between services.

Beginning in 2005, joint area reviews and annual performance assessment of children’s services will judge the contribution that services have made to the five outcomes of the Every Child Matters programme [Ofsted, 2004].

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### Box 1: Every Child Matters

The Every Child Matters: Change for Children programme has important implications for universal drug prevention.

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### Figure 1: Targeted Services within a Universal Context

[reproduced from ECM 2003]
Screening & Assessment

2.15 The identification and assessment of young people who may require additional support in relation to drug use is part of a comprehensive approach to universal drug prevention. In the Every Child Matters Green Paper [DfES, 2003] it is recommended that “all professionals working with children and young people should be able to identify, assess and undertake appropriate action for addressing substance misuse issues” [p. 32]. Briefly, the purpose of services at this level is to ensure universal access and continuity of advice and care to all young people. However, there may be situations when professionals are required to identify substance-related needs, for example, when a young person seeks drug, alcohol and solvent related advice and information or, following actual or suspicion of substance use [Britton & Noor, 2003].

2.16 Every Child Matters: Change for Children [2004] introduces the Common Assessment Framework [CAF], designed to standardise the way that young people’s needs are assessed across agencies to aid multi-agency working in ensuring that all the needs are met. Using the CAF as a screening tool may help to de-stigmatise substance misuse and puts young people at the centre of service delivery, addressing all their needs.

Training across universal prevention settings

2.17 Every Child Matters: Change for Children includes the Common Core of Skills and Knowledge for the Children’s Workforce [2004], which sets out the basic skills and knowledge required for everyone working with children, young people and their families. In addition, the Drugs and Alcohol National Occupational Standards [DANOS], which specify the standards of performance to which people in the drugs and alcohol field should be working, as well as the knowledge and skills required, are relevant to all professionals working in universal prevention services. However, they may need refining to be of optimum utility for those working with young people.

2.18 Velleman and colleagues [2001] evaluated 13 training projects targeting a range of professionals who encountered drug-related issues with young people, including teachers, drugs educators, social workers, youth workers and drug trainers. They identified that two outstanding features affect the success and long-term impact of training: [1] organisations needed a strategic approach to training, that is, it was important that training was planned as part of a wider local or national drug prevention strategy; and [2] training projects needed the active involvement and support of the participants’ management in order to deliver the strategy effectively.

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7 See Burrell and colleagues [2005] for a full consideration of training and assessment needs for those delivering universal and generic services.
## School-based Interventions

**Description:** Drug education in schools is a planned component of PSHE and Citizenship.

**Policy and Guidance document[s]:**
- Every Child Matters: Change for Children [DfES, 2004a];
- Drugs: Guidance for Schools [DfES, 2004b];
- National Healthy Schools Standard: Drug Education [Batcher, 2004].

**Targeted professionals:** Head Teachers, Teachers, Youth Workers, Local Education Authorities [LEAs], School Nurses, School Drug Advisors and other health professionals.

**Key Research Areas:** Effectiveness of school-based drug education; features of effective programmes including peer-led education and external contributors.

**Research gaps:** Implementation of drug prevention programmes and policies; appropriateness of evidence-based approaches in school curricula; progression of drug education during the transition from primary to secondary education; drug education in primary school and FE institutions; use of drug testing and sniffer dogs in schools.

### DESCRIPTION OF SETTING

#### 3.1
The document, Drugs: Guidance for Schools [DfES, 2004b], outlines how schools in England7 have a role to play in the delivery of the Updated Drug Strategy. The guidance states that drug education should be delivered through Personal, Social and Health Education [PSHE] and citizenship provision, and enable pupils’ to develop their knowledge, skills, attitudes and understanding about drugs and appreciate the benefits of a healthy lifestyle, relating this to their own and others’ actions.

#### 3.2
There are statutory requirements for the delivery of drug education in schools across Key Stages 1 to 4, which are set out in the National Curriculum. Briefly, schools are expected to use the non-statutory frameworks for PSHE and citizenship at Key Stages 1 and 2, PSHE at Key Stages 3 and 4, the statutory citizenship programme of study at Key Stages 3 and 4, and the statutory requirements within the National Curriculum Science Order for all phases as the basis for developing drug education [DfES, 2004b].

#### 3.3
Drug education should be supported by a whole school approach [Tobler, 1992], such as is encouraged by the National Healthy Schools Standard [NHSS], jointly funded by DfES and the Department of Health, the NHSS is part of the government’s overall strategy to raise educational achievement and address inequalities [see www.wiredforhealth.gov.uk]. The Government’s national target is that half of all schools will be Healthy Schools by 2006, with the rest working towards healthy status by 2009 [Department of Health, 2004a]. Although achieving the NHSS is not a statutory requirement, from September 2005, Ofsted expects all schools to demonstrate how they are contributing to the five national outcomes for children outlined in Every Child Matters. Achieving healthy schools status will enable schools to show good evidence of this.

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7 Substance Misuse: Children and Young People, National Assembly for Wales Circular No.17/02 [National Assembly for Wales, 2002] provides guidance to schools, colleges and youth settings in Wales.

8 Key stage 1: aged 5 to 7 years; Key stage 2: aged 7 to 11 years; Key stage 3: aged 11 to 14 years; Key stage 4: children aged 14 to 16 years.
3.4 To achieve the drug education standard of the NHSS, Local Healthy Schools Partnerships [LHSP] must have the capacity and capability to support schools to develop a whole school approach to drug education [Butcher, 2004]. The following minimum criteria should be met:

- The school has a named member of staff and a governor who are responsible for drug education provision;
- The school has a planned drug education programme involving development of skills which starts from early years and identifies learning outcomes, appropriate to pupils' age, ability and level of maturity and which is based on pupils' needs assessment;
- The school has a policy, owned and implemented by the whole school, including parents/careers, for managing drug-related incidents which includes identifying sources of support for pupils and alternatives to exclusion;
- Staff understand the role schools can play in the national drug strategy and are confident to discuss drug issues and services with pupils;
- The school works with the police, youth service and local drug services in line with the DAAJT strategy to develop its understanding of local issues and to inform its policy.

3.5 Recently, Ofsted carried out a survey of drug education programmes in schools in England [Ofsted, 2005]. The report was based on evidence gathered from visits to over 60 schools, which involved discussions with drug education/PSHE co-ordinators, subject teachers, senior managers and groups of pupils. In addition, drug education lessons were observed, reference was made to drug policies and schemes of work, and examination of pupils' work was undertaken. Evidence was also gathered from over 200 school inspection reports in England.

3.6 Ofsted [2005] found that the quality of teaching about drugs had improved in both primary and secondary schools since 1997, as had progress in the development of policies and curriculum plans for drug education. However, the report identified that a number of primary schools had out of date drug policies. The report found evidence of a lack of understanding of the needs of secondary school children in terms of the dangers from alcohol and tobacco, and few drug education programmes made links to other related PSHE themes such as sex education. Assessment of pupils' knowledge following drugs education remains a problem. Self-reported learning is conceptually different from objective increases in knowledge or skills, as children may have simply been recalling key themes from lessons, thus reflecting memory of events. Children may also respond depending upon the way in which they perceive the question and it's meaning to them [response expectation], for example, providing a 'correct' answer [i.e. socially acceptable answers], rather than one that reflects experiences, beliefs, and attitudes [Buckett-Milburn & McKie, 1999].

APPROACHES

3.7 Cuipers [2002a] attempted to isolate the effective components of drug prevention programmes in schools. None of the programme characteristics examined was judged to have a ‘very strong’ or ‘proven’ level of evidence. This may imply either a paucity of sound evidence in the drug prevention field, a lack of effective programmes, or both. Furthermore, within particular interventions, some components were found to be highly effective, but not others. This inconsistency may mean an inappropriate application of theory into practice or a need to modify theory. Another explanation of the variability is the poor fidelity of implementation, that is, interventions were not delivered as developers intended. However, some caution is needed when inferring a causal relationship between the quality criteria and their reported effectiveness. Cuipers [2002a] acknowledged that the findings of the review were limited because of the variability in methodology and interventions used. In addition, substance use was based mainly on self-report, which can be an unreliable measure for drug use behaviour.

3.8 Other review-level evidence [Cuming et al., 2004; McGrath et al., 2005] found that school-based intervention programmes aimed at young people could delay the onset of substance use by non-users for a short time, and temporarily reduce use by some current users. In addition, universal prevention programmes appeared to be more effective in lower-risk young people than those at higher risk, which may have implications for cost-effectiveness. Review evidence suggests that Life Skills Training [LST], or approaches based upon it, was one of the few programmes that demonstrated a small but positive effect on reducing indicators of drug use. However, Coggans and colleagues [2003] noted that the programme only worked when fidelity and completeness of delivery were high, and that the longevity of the positive effect was also questionable. This former aspect means that only those schools particularly dedicated to drugs education, and eager to have pupils take part in this type of education will see benefits. This approach may therefore effectively target those individuals most at risk from initiating drug use. A recent systematic review published by the Cochrane Collaboration [Faggiano et al., 2005] found that programmes based on life skills were the most consistent at reducing some aspects of drug use in school settings, indicating that there is fairly good evidence to support drug programmes based on the social influence model.

3.9 Research into which elements are regarded as potentially able to increase the success of drug prevention programmes has found that interactive approaches to drug education are more effective than non-interactive approaches [Faggiano et al., 2005]. According to one meta-analysis [Tobler et al., 2000], there was ‘strong evidence’ to suggest that interactive methods [e.g. role-play] of delivering drug prevention interventions were more effective than non-interactive methods [e.g. a lecture] in reducing drug use. Unlike non-interactive methods, interactive methods can provide opportunities for communication among participants which might account for the apparent superiority of interactive approaches. For example, participants could receive feedback and constructive criticisms and have a chance to practice newly acquired refusal skills with peers.

3.10 There is weak evidence to support the finding that effective programmes tend to include booster sessions; most of the programmes found to have a positive impact on cannabis use had booster sessions or similar extra components that aimed to reinforce the effects of the programme [Skara & Sussman, 2003]. There is no convincing evidence to indicate that intensive programmes are more effective than non-intensive programmes. Based on weak evidence, school-based programmes may be more effective when they are delivered to pupils between the ages of 11 to 14 years [Gottfredson & Wilson, 2003]. Therefore, it may be suggested that delivering prevention programmes to primary school pupils does not have long-term positive effects that outweigh the benefit of providing such programmes to middle/high school students.

3.11 There is little supportive evidence for the effectiveness of primary school based prevention [i.e. children aged 5–10 years]. Evaluation suggests that primary school education that focuses upon family, knowledge, attitudes, and values has limited benefit [Goffrey et al., 2002]. Review of the limited literature available suggests that primary school interventions should focus upon family intervention and parent education [see Chapter 4], and school organisation and behavioural management [Toubournou et al., 2005]. There is a need for follow up in later years to determine the success of interventions at this age.

14 Quality of teaching is assessed by Ofsted according to the extent to which teachers show good command of areas of learning, and courses, plan effectively, with clear objectives and suitable teaching strategies; interest, encourage and engage pupils; challenge pupils; use methods and resources that enable all pupils to learn effectively, make effective use of time, make effective use of teaching assistants and other support; where appropriate, use homework effectively to reinforce learning; and promote equality of opportunity. [see Ofsted [2003] Framework 2003 – Inspecting Schools for further information].

11 The Cochrane Collaboration is an international non-profit and independent organisation, dedicated to making up-to-date, accurate information about the effects of healthcare readily available worldwide.
3.12 It is currently unknown whether UK schools take an evidence-based approach to their drugs education provision. However, Blueprint, the Government’s large drug educational research programme [see 3.16], is designed in accordance with the evidence base for drug education. Work from the US suggests that evidence-based curricular are rarely the most commonly used, and are much more likely to be used in middle schools [i.e. children aged 11-14 years] rather than at primary or high school levels [Pardini & Halfford, 2004]. The main barrier to diffusing evidence based curricular was identified as regional and local drug education coordinators’ lack of time and resources.

**Multi-component programmes delivered in England**

3.13 NE Choices was a school based multi-component drugs prevention programme aimed at 13-16 year olds and delivered over three years in the North East of England [Stead et al., 2000; Stead et al., 2001; Mackintosh et al., 2001]. The first year’s programme consisted of an in-school drama workshop, which was followed up by classroom teaching, as well as small group work on information and discussion, parent sessions, training for school governors, and information packs. The second year comprised an all-day out-of-school drama workshop, which was followed up by four sessions at school, together with training for teachers, and media information products. In contrast, the final year had three components including a youth work programme, parents’ programme, and a one-week residential intervention for students who were assessed as at-risk of drug use/problems. Press and public relation activities, work on its website, and information packs for governors and parents ran every year for three years. The length of each component of the programme was rather short [one hour to one day] despite the programme itself lasting three years.

3.14 Overall, after comprehensive evaluation, there was no evidence that the programme had made an impact on drug use prevalence. In fact, there was a marked increase in the percentage of students who reported having ‘ever used drugs’ in all three of the experimental conditions between the baseline and third follow-up survey [full intervention group 26% → 39%, partial intervention group 25% → 34%, and control group 22% → 35%]. This increase appeared to be consistent across all levels of the intervention. Other results were also consistent, with the exception of escalation of drug use. A small proportion [2%] of pupils reduced their drug taking by changing from harder drugs to cannabis, solvents or nitrates or to non-use. This effect was greatest among pupils at schools that received the full intervention [4% compared to 1% at partial intervention and control schools].

3.15 The Integrated Programme was a multi-component drugs prevention programme delivered to young people aged 13 and 15 years in two regions of Northern England [West Yorkshire and Northumbria] between 1996 and 1999 [Morris et al., 2002]. The programme included drama workshops, lessons by teachers, external visitors, and drugs information resources. Further outreach projects were delivered to vulnerable young people outside of school hours. The results suggested that young people who received the programme were more likely to reduce harder drug use and maintain a ‘softer’ drug-taking repertoire compared to those in comparison sites. However, these gains were small and inconsistent. The programmes had no impact on reducing initiation or “first trying” rates. One of the reasons proposed for the apparent failure of this campaign was that there were too few sites enrolled in the programme to produce a meaningful data set. It has been proposed that there should be at least six intervention sites, plus six control sites, for convincing data to be generated in a health related evaluation [Okonkwo et al., 1999].

3.16 A partnership between the Home Office, Department for Education and Skills and the Department of Health, Blueprint is a multi-component programme comprising five elements: school drug education, family and parent/carer work, media support, community support, and health policy. The aim of the Blueprint evaluation is to provide information about what works in educating 11-13 year olds about the risks of drug use and in the longer term whether the programme reduces the number of young people who become involved in drugs. The first results are expected in 2007. Further information is available on the National Drug Strategy website.

3.17 The effectiveness of different elements within multi-component programmes have not been sufficiently examined in the UK, compared to the US where the majority of the research evidence originates from. However, due to the poor methodology of the studies which have examined multi-component programmes, Flay [2000] found little evidence that combining ‘social environment change’ [such as parent training, mass media and community-wide programmes] with school-based interventions was more effective than delivering school-based interventions alone. Therefore little is known about the extent to which different intervention components may contribute to effective drug use prevention [Canning et al., 2004, McGrath, 2005a].

**External contributors including peer educators**

3.18 School nurses, police officers and theatre in education groups are the most frequent contributors to drug education in English schools and peer education has also been used for some time [Ofsted, 2005]. In Wales, the All Wales Schools Programme[20] involves Police School Liaison Officers working with PSHE teachers and schools to deliver drugs education.

3.19 Drug Abuse Resistance Education [D.A.R.E] is a popular police-led prevention programme in the US, which has been modified and offered to schools in the UK [D.A.R.E UK]. There has been no published evaluation of the effectiveness of the D.A.R.E programme in the UK, although one is currently proposed, subject to funding. Meta-analysis of US data has shown no significant overall effect of participation in the programme on drug use, and no relationship between the length of follow-up time and effect [which would have indicated longevity of effect] [Esmett et al., 1994; West & O’Nial, 2004].

3.20 White and colleagues [2004] undertook a systematic literature review of the role of external contributors including the police, theatre in education, school nurses, drug agency workers, life education centres, external peers, users or ex-users, health educators/professionals, parents, fitness instructors, youth workers, cartoon animator, songwriter/singer, basketball team, unspecified legal and health experts, and researchers. They found that much of the research was of poor quality and that there was no evidence to suggest the any of the particular contributors was more effective than the other. However, teachers and pupils valued the input of external contributors, which may suggest low expectation or lack of awareness of the potential of external visitors. Alternatively, with respect to teachers, it may suggest that they valued the opportunity to pass on responsibility for teaching an unfamiliar subject [e.g. Harris, 2001] to someone perceived as having professional knowledge. External peer educators benefited from the experience of visiting schools, but without standards of quality, teachers currently have no means to distinguish between effective and non-effective providers.

[12] The type of drugs was not reported.
[16] www.drugs.gov.uk/NationalStrategy/YoungPeople/Blueprint
3.21 O’Connor and colleagues [1999] argued that to play a more effective role in drugs education, police need to modify the nature of their input. They should offer a complementary or supportive position to schools related to their speciality and expertise. In addition, they can support and add value to school-based prevention programme by getting involved in managing drug incidents in schools, and by helping schools to develop and implement drug policies. In April 2006, the Association of Chief Police Officers will publish updated guidance for police officers working in schools and colleges.

3.22 Shiner [2000] reviewed eight peer-led drug prevention projects [including school- and community-based projects] located in Sussex, the East Midlands and West Yorkshire. Peer education was found to cover a range of approaches although there was no precise definition for the term. School-based projects tended to use peer educators from relatively socially and/or educationally disadvantaged circumstances and their role was defined primarily in terms of delivering sessions to peers. Peer education tended to be viewed positively by teachers and pupils, although assessment was limited towards views and opinions. Reinforcement formed a key theme in the accounts given by young people, i.e. among young people who did not use drugs, participation in peer education sessions encouraged on-going abstinence.

3.23 Other findings are mixed with regard to the effectiveness of peer-led education [Canning et al., 2004; McGrath et al., 2005a; McGrath et al., 2005b], and it appears that the child or young person delivering the intervention tends to benefit most from the experience. Based on results from two meta-analyses, Cuijpers [2002b] reported that the use of peer educators was another effective characteristic of multi-component programmes that had ‘strong evidence’ of effectiveness. However, this positive effect seems to be supplementary, as evidence suggests that peer educators can only help increase the effectiveness of an already successful programme. The review author noted that adding the use of peers [as well as other features] improved the positive effects of tobacco prevention programmes, but that the effect was found to be relatively short-lived. Compared to adult providers, there were no significant differences in effects on drug use [tobacco, alcohol and cannabis] at 1 year and 2 years follow-up [Cuijpers, 2002b]. Furthermore, adult-led interventions were more effective than peer-led interventions in some cases. This suggests that it may be more useful to examine what kind of skills constitute an effective programme provider and how training can improve these attributes; and what kind of prevention components [e.g. booster sessions] benefit from peer [or adult] facilitators.

Implementation

3.24 The greatest challenge to implementation of evidence based/effective school programmes is poor implementation and dissemination in busy environments [Hallifors and Godette, 2002].

3.25 Evans and colleagues [2001] evaluated four projects supporting the development of school drugs policies and identified that schools need support to enable them to develop and implement effective drug policies and education. The projects demonstrated that community-based agencies could usefully support schools and that successful implementation was linked to the whole school viewing drug education as a priority.

Teacher training

3.26 Drug education is more effective when taught by teachers who have acquired the necessary subject knowledge [DfES, 2004a]. Blenkinsop [2004] evaluated the first and second year of the Drug, Alcohol and Tobacco Education [DATE] Teacher Training Package, which aimed to improve the quality of the planning and delivery of DATE in schools across all Key Stages through funding for teaching networks, teacher observation, teacher training and school drugs adviser [SDA] training. The evaluation found that teaching networks had an impact on teachers’ knowledge, expertise and confidence but that support from SDAs appeared to be essential in order to ensure that aims were achieved and outcomes were successful. Lack of time was identified as a major issue for both teachers and SDAs, for example, teachers found it hard to find time to attend network activities and meetings. In a recent survey of 24 D[A]ATs issued by the Drug Education Forum [Ferguson, 2005], half of the respondents were worried that support for drug education would have uncertain funding, and a third reported loss of posts to support drug education.14

3.27 In a small evaluation of six pilots of the drug components of PSHE certification, Warwick and colleagues [2004] found that teachers believed participation in the programme had improved their drug knowledge, understanding and skills. However, teachers at Key Stages 1 and 2 reported special challenges, particularly in relation to producing evidence about the links between drug use and sexual practices, as themes and elements were felt to be more relevant for work at Key Stages 3 and 4.

Transition between primary and secondary school

3.28 Drugs: Guidance for Schools [DfES, 2004a] states that schools should liaise with their feeder and receiver schools to ensure continuity and progression of drug education across the phases of education, with particular respect to the transition from primary to secondary school. Drug education in Years 7 and 8 should reinforce and build upon drug education in primary schools. However, there has been no relevant work assessing whether this is either appropriate or has meaningful effects, and as the Olsted [2005] report revealed, there are significant gaps in primary school provision.

3.29 Harris [2001] evaluated drug prevention delivered through a ‘Family of Schools’ structure, which sought to establish greater consistency and co-ordination between primary and secondary schools in the provision of drug education. The research initially identified that the transition to secondary school was an anxious time for primary school children. Teachers also held little confidence in their ability to teach drugs education, and provision was based upon professional position rather than experience or interest. At the end of the project participants reported that they had a better understanding of drugs issues, and better awareness of resources and materials for drugs education. Participants perceived multi-agency working as an important development in establishing better practice. Teachers valued guidance as they viewed drug education as highly sensitive, and reported that they particularly welcomed advice on effective [i.e. evidence based] education and its delivery.
Sniffer dogs and drug testing

3.30 Headteachers are entitled to use strategies such as sniffer dogs and drug testing if they feel that such approaches are appropriate [DfES, 2004b]. McKeganey [2005] identified that there was a lack of high-quality studies which have evaluated the impact of random drug testing in schools and that the introduction of such programmes raises a wide range of concerns including undermining of trust between staff and pupils. A large scale national study of the rates of drug use in the US, comparing schools with and without testing, showed no difference in reported prevalence, indicating that the intervention was not responsible for reducing drug use [Yamaguchi et al., 2003]. In the recent review of drug education in schools by Ofsted [2005], the majority of schools reported that they did not wish to introduce the use of sniffer dogs and only a small number were considering introducing random drug testing.

Drug education in further education institutions

3.31 Young people aged between 16 and 24 years show the highest prevalence of drug use in the UK, with 27.8% reporting use of at least one illicit drug in the previous year [Chivite-Matthews et al., 2005]. The most popular drug is cannabis followed by cocaine, and ecstasy. Around 8% report using Class A drugs.

3.32 Drugs: Guidance for further education institutions [Drugscope, 2004] highlights the need for further education institutions to respond to the drug education needs of their students. In the absence of specific evidence, it is recommended that drug education should aim to provide opportunities for students to develop their knowledge, understanding, skills and attitudes about drugs to help them make healthy and informed choices. A harm minimisation or demand reduction approach might be more suitable for students who have already experimented with or are using drugs.

3.33 Only two controlled studies have examined drug prevention initiatives in the further education population [Larimer et al., 2005]. A US-based multi-component, campus-wide intervention drawing on self-regulation theory19 and designed to increase risk perceptions, was found to have a modest reduction or stabilisation on use rates of several classes of illicit drugs and some high-risk drinking behaviour compared to a control group approximately 18 months later [Miller et al., 2001]. In a second study, delivery of a 60-minute motivational interview resulted to a control group approximately reducing drug use [McCambridge & Strang, 2004].

3.34 Only two controlled studies have examined drug prevention initiatives in the further education population [Larimer et al., 2005]. A US-based multi-component, campus-wide intervention drawing on self-regulation theory19 and designed to increase risk perceptions, was found to have a modest reduction or stabilisation on use rates of several classes of illicit drugs and some high-risk drinking behaviour compared to a control group approximately 18 months later [Miller et al., 2001]. In a second study, delivery of a 60-minute motivational interview resulted to a control group approximately reducing drug use [McCambridge & Strang, 2004]. However, both studies suffered from limitations of their study design, [for example, there were potentially important differences between the intervention and control groups at baseline in both studies] and these results should be interpreted with caution.

GAPS AND INCONSISTENCIES

Research

3.34 Insufficient research has been undertaken to determine which components of multi-component programmes are the most effective.

3.35 There is a lack of evaluated drug education programmes that have targeted primary school-aged children [Canning et al., 2004] and young people engaged in further education.

3.36 Ofsted [2005] identified that schools and in particular, primary schools, may lack appropriate or updated drug policies. However, little research has been undertaken on supporting schools to develop and implement policies.

Practice

3.37 The transition from primary school to secondary school has been identified as a time of anxiety and DfES guidance [2004b] states that schools should ensure continuity and progression of education. However, there is no evidence to demonstrate that this is happening in practice.

IMPLICATIONS AND RECOMMENDATIONS

Research

3.38 Multi-component programmes based on the social influence model have been shown to be the most consistently effective prevention programmes. However, further research is needed to determine the relative effectiveness of individual components. The Blueprint evaluation should help to further build the evidence base by assessing the effectiveness of a multi-component drugs prevention programme on children aged 11 to 13 years. As reported in the NE Choices evaluation, the research design and management may play an important part in the nature of the results obtained and the Blueprint evaluation includes an assessment of fidelity of delivery by teachers as well as monitoring the effects of management issues. [3.18; 3.13; 3.26]

3.39 There is a need for evaluation and long term follow-up of drug education programmes targeted at primary school aged children. In particular, whether interventions that focus on family intervention and parent education, school organisation and behavioural management are effective. [3.17]

3.40 Peer education is widely used in schools and, for various reasons, is popular with both teachers and pupils. In addition, the use of external contributors such as police, nurses and theatre in education is positively viewed. However, there is inconsistent evidence that either approach is appropriate or effective at reducing drug use or changing behaviour, and more research in this area is needed. [3.22; 3.23]

3.41 The transition of pupils from primary to secondary school is an anxious time for children, further research is required to identify whether schools are achieving continuity and progression in drugs education during this time, and whether this approach is either appropriate or has meaningful effects. [3.28; 3.29]

3.42 Research by Evans and colleagues [2001] has identified that schools need support in order to develop and implement drug prevention policies and education. In particular, primary schools were identified as lacking updated drug policies in the Ofsted report [2005]. Such support may come from community-based groups but more research is needed to build on this work. Working towards the drug education standard of the NHSS may help schools to achieve this. [3.25]

3.43 Drug education is more effective when taught by teachers who have acquired the necessary subject knowledge [DfES, 2004b]. Accordingly, efforts should be made to ensure that motivated teachers have access to effective and relevant training packages, and that they receive sustained support. [3.26]

3.44 McKeganey [2005] identified a lack of high-quality research evaluating random drug testing in schools. Schools choosing to adopt this approach could serve as useful case studies, as long as appropriate evaluation methodology is used [cf MacVean & Lienenberg, 2005]. [3.30]

19 i.e. how people control and alter their behaviour in response to changes in the social environment.
Family-based Interventions

**Description:**
Families play an important role in young people's choices around drug use.

**Policy and Guidance document(s):**
Drugs: Guidance for Schools [DfES, 2004b].

**Targeted professionals:**
Head Teachers, Teachers, Youth Workers, LEAs, School Nurses, and School Drug Advisors.

**Key Research Areas:**
Role of the family in preventing drug use; engaging parents in drug prevention activities.

**Research gaps:**
Effectiveness of parent-orientated drug prevention interventions; the role of families in protecting and promoting risk and resilience factors against drug use.

**DESCRIPTION OF SETTING**

4.1 Family factors play an important role in young people's choices around drug use; for example, a cohesive family unit and high parental supervision have both been shown to be protective against drug use [Best & Witton, 2001; see Appendix 1]. However, parents may feel ill equipped to help their children avoid drugs. They may lack both basic knowledge about drugs, and confidence about their knowledge of drugs, inhibiting their ability to communicate clearly and effectively [Velleman et al., 2000].

4.2 Serious difficulties have been found in recruiting and retaining families in drug prevention programmes [Velleman et al., 2000], and Ofsted [2005] found that information and advice evenings for parents in schools have attracted variable and often small numbers of parents.

4.3 Drugs: Guidance for Schools [DfES, 2004b] acknowledges the important role of parents and carers in preventing problem drug use. Parents and carers should be made aware of the school’s approach and rationale for drug education, involved in the planning and review of drug education programme and policy, given information about their child's drug education and school rules in relation to drugs, encouraged to support their child’s learning at home, and be able to access information about drugs and local/national sources of help.

4.4 Multi-component drug prevention programmes commonly include a parental/carer component. Blueprint [see Chapter 3], for example, aimed to engage families and carers through activities including a home activity pack to aid parent/child communication, a booklet containing information on drugs and their use, parent workshops, and an invitation to parents to contribute to the school drugs policy review. The Blueprint evaluation, due in 2007, will report on the effectiveness of each of these components.

**APPROACHES**

4.5 The report, Drug education in schools [Ofsted, 2005], identified that parents felt that drug training should include the provision of accurate, up-to-date information on all drugs and their effects; advice on how to talk to their children about drugs; and advice on how to access local sources of advice and information.

4.6 Canning and colleagues [2004] found that British parent-orientated programmes have not been adequately evaluated. There is an indication that such programmes may be poorly attended, particularly among parents who drink and smoke more heavily.
4.7 Following evaluation of five drug prevention programmes for parents, Velleman and colleagues [2000] found that the key to successful recruitment of parents appeared to be the networks within the school or community to which a project was mostly strongly linked. Following engagement in these programmes parents reported that they were more knowledgeable about licit and illicit drugs, and felt more able to communicate with their children about drugs. Parents also reported an impact in terms of more broad support including increases in self-confidence, and in general communication and parenting skills.

4.8 Blueprint includes a family component [see Section 3.16]. This type of approach is popular in the US. For example, The Strengthening Families Program For Parents and Youth was aimed at 10-14 year olds, and provided guidance [originally rural, but now extended to other types of family] to parents on family management skills, communication, academic support, and parent-child relationships [Spoth et al., 2002]. The providers encouraged participation through flexibility in scheduling and location, and by offering conveniences such as babysitting, transportation, and meals. Evaluation found delayed initiation of alcohol and cannabis use at 6-years follow up. Other findings showed improved youth resistance to peer pressure to use alcohol, reduced affiliation with anti-social peers, and reduced levels of problem behaviours. Conservative cost-benefit calculations indicated returns of $9.60 per dollar invested.

4.9 Another type of targeted family programme with a universal component, which operated within a school setting, was the US-based Adolescent Transitions Program [Dishion & Kavanagh, 2000]. The intervention made a Family Resource Room available where information on parenting was provided. This was a tiered prevention programme and so also offered selective levels via assessment to identify and help families at greater risk by providing them with information and interventions specific to their needs. Families already engaged in problem behaviours were subsequently identified as needing an indicated intervention and provided with more intense assistance and information tailored to their needs. The assistance included individual or family therapy, intensive parent coaching, therapeutic foster care, or other family-specific interventions. The uniqueness of this particular tiered approach was that the whole school participated in the programme and all individuals or families received the appropriate level of help without being labelled in the process.

4.10 A key aim of FRANK [the Government’s communications initiative, see Chapter 6] is to ensure that parents and carers have access to the information and advice they need to deal with their concerns about drugs. A FRANK action update [Home Office 2003] suggested the following ideas for media and public awareness work involving parents and carers: family phone-in on a local radio station, gathering evidence about local concerns as a hook for local media work promoting relevant services and resources, using local networks and links to set up information and learning events for parents, including basic information on effective communication as part of parents’ awareness materials, and approaching major local employers to publicise services and information for parents.

4.11 DfES guidance recognises the important role of parents in drug education but attendance may be variable and in small numbers [Ofsted, 2005]. Research in the US indicates that family components can enhance the effectiveness of universal programmes [Tobler et al., 2000]. No government sponsored research was identified that has built upon the findings of Velleman and colleagues [2000] and British parent-oriented programmes have not been adequately evaluated [Canning et al., 2004]. The Blueprint evaluation will report on the outcomes of its family component in 2007. In addition, investigations of the prevention role of grandparents and other family members are currently being undertaken by Mentor UK [www.mentorfoundation.org/] and Adfam [www.adfam.org.uk] on behalf of the Department of Health.

IMPLICATIONS AND RECOMMENDATIONS

Research

4.12 More research is needed to identify which types of family-orientated interventions are effective in the UK. This may include interventions to promote engagement of parents in drug prevention activities, interventions that help facilitate parent/child communication, and interventions that help to build parents’ knowledge about and confidence of dealing with drug issues. The tiered approach, incorporating different levels of engagement, is useful to avoid stigmatisation of families.

Practice

4.13 The key to successful recruitment of parents may lie in the networks within the school or community to which a project is mostly strongly linked. In addition, courses with a broader health focus, flexible scheduling and those offering conveniences such as childcare or transportation, may help aid the participation of parents in projects. [4.7]

GAPS AND INCONSISTENCIES
Community-based Interventions

**Description:** Drug prevention in the wider community can help to reinforce school or family messages about drug use.


**Targeted professionals:** Statutory and voluntary organisations, Youth Workers, Employers, D[A]ATs, Crime and Disorder Reduction Partnerships, and Lecturers

**Key Research Areas:** Stimulating community drug prevention; drug education through youth work; drug testing at work.

**Research gaps:** Effectiveness of universal community-based interventions, including effectiveness as part of multi-component programmes.

**DESCRIPTION OF SETTING**

5.1 Community interventions may be described as a combined set of activities organised in a specific region or town, aimed at adolescents, as well as parents and other people and organisations, however there is a lack of a uniform concept of the term [Burkhart & Matt, 2003]. Cuijpers [2003] gives the following as examples of universal prevention delivered in community settings: mass media campaigns [considered in Chapter 6]; ‘community’ interventions; prevention in the workplace; community mobilising committees, and; educational activities in bars and discos.

5.2 The Confident Communities in a Secure Britain [Home Office, 2004a] outlines the Government’s plans to build safer communities. One of the key objectives is to reduce the harm caused by illegal drugs, supporting and building on the aims of the Updated Drug Strategy [2002] to strengthen communities through reducing drug-related crime and supply. The Building Safer Communities fund is available to support communities to tackle drugs by participating in the development and running of services. Research by Shiner and colleagues [2004] advises that the notion of community should not be tied so tightly to law enforcement and criminal justice but should focus more on welfare-based activities, such as treatment and education, with the aim of promoting inclusive forms of social cohesion. The majority of government funding for this type of community-level work is targeted at regenerating deprived communities and whilst this will have an indirect impact on drug use, is outside the remit of this review.

5.3 Targeting drug and alcohol misuse in the workplace is part of the ‘Communities’ strand of the Updated Drug Strategy [2002]. An important role for businesses was identified as maximising the potential of the workplace as a setting for awareness raising, education and support for employees through the introduction of drug and alcohol policies and the distribution of information.

5.4 Community interventions have been commonly delivered in combination with other drug prevention initiatives such as a school-based programme [e.g. Blueprint, NE Choices pilot; see Chapter 2]. For example, in addition to school, parent/carer, media and health policy components, Blueprint involves the coordination of programme delivery with the prevention activities of key partners [including D[A]ATs, Regional Government Offices, Healthy Schools Programme Coordinators, SDAs and Primary Care Trusts [PCTs]] to develop shared principles of working.
**APPRAOCHES**

5.5 Little research has been undertaken to evaluate community-based interventions, and almost none has been undertaken in the UK. Flay [2000] reviewed whether combining additional components, including community-wide programmes, with school-based programmes improved overall programme effectiveness. The review found that while there is evidence that these components can be effective, there is little evidence of the added effects of these approaches over and above the school-based programmes. Few studies have been able to separate the added effects of community interventions, and of those that have, the findings are inconclusive. For evaluations of multi-component programmes see Chapter 3.

'Community' interventions including community mobilising committees

5.6 Community mobilisation may be defined as campaigns which initiate or strengthen an explicit strategy of coordinated community action aiming to advance community conditions [Teambourou et al., 2005].

5.7 Smith [2001] examined the process of stimulating drug prevention through community action at five sites across the country. Consulting and engaging the community was found to help people feel more positive about the strength of their community and its potential to tackle problems caused by drugs. The research identified that communities may have to be creative in building effective partnerships, such as looking beyond the 'obvious routes of youth services [and] schools', in order to deliver activities.

Youth work

5.8 A survey of drug education policies and practice in the youth service in England [DrugScope, 2003] found that provision of drug education was diverse and that there were a number of different models of intervention. Most services were addressing drug issues at tier 1 and 2.

5.9 Evaluation of a drug prevention project in South London [Shui, 2001], which aimed to provide a community-based complement to formal drugs education, found that the working environments of youth workers and the responsive nature of youth work proved to be barriers to the implementation of the project in many youth work settings.

5.10 Ward and Rhodes [2001] evaluated the delivery of drugs prevention through youth work and found that 'holistic' programmes, using an interactive approach and combining health and lifestyle elements with drug issues, were the most appropriate method of drugs prevention education [although no assessment of outcome was made]. They identified that there was a limit to how much drugs education could be delivered in structured youth work. Project workers felt it was inappropriate to place too much emphasis on drug use and, in particular, schools were identified as a more appropriate setting for drugs education in younger children [8-12 years]. Respondents to a survey conducted by DrugScope [2003] echoed these findings; reporting that some workers felt that young people were resistant to the introduction of drugs education.

Prevention in the workplace, including drug testing

5.11 Guidance from the Home Office [2004b] for developing a drug and alcohol policy in the workplace states that establishing a work place policy can help businesses to fulfil their legal duty of care to safeguard the health, safety and welfare of their employees, create a more productive environment and help prevent the expense of dealing with drug and alcohol problems. It also identifies a wider role, that raising awareness of substance misuse among employees may in turn help to raise awareness in their families and friends. A guide for employers from the Health and Safety Executive [2004] suggests that employers undertake a programme of awareness for managers and supervisors, and all employees.

5.12 The use of drug testing by employers is increasing in the UK, however, the Independent Inquiry into Drug Testing at Work [IIDTW] [2004] found no clear evidence to show that drug testing in the workplace had a significant deterrent effect on drug use, or that is was the most appropriate way of identifying and engaging with staff whose drug use may be affecting their work. The IIDTW acknowledged that there was a useful role for drug testing in safety-critical industries.

Educational activities in the nightlife environment

5.13 There is a close association between the nightlife environment and the recreational use of drugs and, therefore, universal prevention approaches are unlikely to be effective in this setting. For example, a high proportion of club goers are confirmed drug users [Webster et al., 2002]. In a survey of over 2000 clubbers in the North West of England, 65% reported taking drugs alone or in combination with alcohol on their night out; only 4% reported that they neither drank alcohol nor took drugs [Parker et al., 2003]. In a survey of recreational drug use among clubbers in the South East of England [Deeham & Saville, 2003], 79% reported that they had taken drugs at some time in their lives. Levels and use varied according to the venue attended, use was highest [over 90% reported ever using drugs] at a commercial city centre pub, an established dance/gay club and at a monthly independent dance music event. Holidymakers and seasonal workers abroad also tend to report greater prevalence and frequency of drug use [Bells et al., 2003] and therefore, casual workers may be in an advantageous position to offer general health advice [Hughes et al., 2004].

5.14 Universal approaches in the nightlife environment should promote consideration of health related behaviours surrounding drug use and lifestyle [Panagopoulos & Ricciardelli, 2003]. Environmental variables play an important role in drug-related harm and so need to be regulated and monitored. There is also the potential to provide accurate information on safer drug use [e.g. secondary prevention interventions] [Webster et al., 2002], but as with other information-based approaches there is no indication that this will influence behaviour [e.g. Van de Wijngaart et al., 1999]. However, on-site facilities for tablet testing in the Netherlands have been shown to reduce the drug use of people attending organised dance parties [ibid.]; but a full consideration of approaches such as these is outside the remit of this review.

5.15 User generated approaches towards prevention, in its wider context, may include experiential learning [e.g. increasing dose and frequency in order to gauge the amount that will produce the desired effect]; observational learning through direct observation and reported drug experiences of others; database sources [e.g. learning derived from academic research], and psychopharmacological facilitated [e.g. the use of valium, or cannabis on a cocaine/ecstasy 'comedown'] to minimise sub acute adverse effects [Panagopoulos & Ricciardelli, 2003]. Database sources are of particular relevance to universal prevention, as drug naive individuals who are considering initiating drug use may access these types of resources. However, there has been no assessment made of the credibility of these sources, how they are accessed and whether they lead to changes in drug using behaviours.
GAPS AND INCONSISTENCIES

Research & Practice

5.16 Although a common additional component of multi-component drug prevention programmes, there is little evidence that existing community-based interventions have been effective. This is reflected in the academic literature [Flay, 2000]. The scope and delivery of community-based prevention in the UK needs to be considered.

5.17 Government funding for community-based drug prevention interventions has tended to be targeted towards socially excluded and deprived communities, rather than as part of a universal prevention programme.

IMPLICATIONS AND RECOMMENDATIONS

Research

5.18 Research should be undertaken to evaluate whether community-based interventions including the delivery of media campaigns, are an effective component as part of multi-component drug programmes. [5.5]

Practice

5.19 Universal drug prevention initiatives are unlikely to be an effective means of delivering drug education to the majority of those participating in the nightlife environment as drug use is already likely to be high [Deeham & Saville, 2003]. However, universal initiatives may potentially exert effects on younger individuals, new to the nightlife environment and contemplating taking drugs for the first time. Research should be undertaken with regard to targeted prevention interventions to promote safer drug usage. [5.13; 5.14]

5.20 Currently, youth work practice does not appear to be a particularly appropriate setting for universal drug prevention, especially in young children. However, it should be investigated whether combining generic health and lifestyle elements with drug issues may present a more successful and appropriate way of incorporating drug prevention within youth work. [5.9]

5.21 Drug testing in the workplace has not been shown to be an effective deterrent against drug use [IIDTW, 2004], which largely takes place outside the work environment. Work-based prevention initiatives could potentially stress the impact of acute and sub-acute drug [and alcohol] intoxication upon performance and safety. [5.12]
Mass Media Interventions

**Description:** Mass media may be used in a number of ways to educate, raise awareness and challenge attitudes related to drug use.

**Policy and Guidance document[s]:** Updated Drug Strategy [Home Office, 2002].

**Targeted professionals:** Teachers, School Nurses, School Drug Advisors, D[A]ATs, statutory and voluntary organisations and Youth Workers.

**Key Research Areas:** Evaluation of the US National Anti-Drug Media Campaign; effectiveness of different sources of media.

**Research gaps:** Effectiveness of the FRANK campaign based on its four key purposes; effectiveness of media campaigns as part of multi-component programmes.

**DESCRIPTION OF THE SETTING**

**6.1** The media is the most frequent source of drugs information for young people, however there is no clear consensus on the extent to which the media influences young people’s lives [DrugScope, 2005]. Mass media may be used in a number of ways to promote drug prevention including counteracting other messages, supporting or reinforcing other programming, altering perceptions of community norms, or demonstrating new behavioural skills [Flay, 2000].

**6.2** An aim of the Updated Drug Strategy [2002] was to introduce a communications campaign targeting young people and their parents to further raise awareness about the risks and dangers of drug taking and encourage discussion of substance misuse. This was realised with the launch of the FRANK campaign in England and Wales20 in 2003 [see Section 6.4].

**APPROACHES**

**6.3** Media campaigns may influence behaviour through three pathways [Hornik & Yanovitzky, 2003]: [1] direct exposure of individuals to persuasive messages generated by the campaign; [2] diffusion of campaign themes at an institutional and organisational level [e.g. by placing external constraints or creating incentives such as increasing taxes on cigarettes]; and [3] social interaction with family members, peers and others as a result of media campaigns.

**6.4** FRANK is a 3-year campaign, targeting 11-21 year olds and the parents of 11-18 year olds. Outputs from the campaign include national and local advertising [television, radio and press], a website and helpline, public relations and editorial, local events, and support for schools, GPs, the police and other groups. The four key purposes of the FRANK campaign are: [1] to ensure that all young people understand the risks and dangers of drugs and their use and know where to go for advice or help; [2] to provide parents with the confidence and knowledge to talk to their children about drugs; [3] to support the work of professionals working with vulnerable young people; and [4] to ensure those with drug problems get the support they need, and help prevent young people from becoming problematic drug users. These aims are being tracked through the monitoring of the performance indicators [Home Office, DH & DfES, 2004], although there has been no evaluation focussed on these four key purposes so far. Since 2005, FRANK activities have become more closely aligned with drug prevention policies set out by DfES, the Home Office, and the Department of Health, and in particular the Every Child Matters: Change for Children programme.

20 Know the Score provides a similar service in Scotland
6.5 Evaluation of the US National Youth Anti-drug media campaign [launched in 1997 and primarily targeting 10 year olds] found that although the campaign had a favourable effect on parents, it was not effective in preventing drug use, or changing beliefs or attitudes in young people [Hornik & Yanowitsky, 2003]. Media interventions have not been shown to be effective in preventing drug use if they are used as a stand-alone intervention [McGrath et al., 2005b].

6.6 In a meta-analysis that examined the relative effectiveness of different media sources in the USA, messages communicated via video were associated with the largest positive effect on three drug related outcomes; behaviour, attitudes and knowledge [Derzon & Lipsey, 2002]. In addition, supplementing the media message with other components [such as group discussion, role play or supportive services] was associated with a positive effect on these outcomes.

GAPS AND INCONSISTENCIES

Research

6.7 An evaluation of the government communication campaign, FRANK, based on its four key purposes is lacking.

6.8 There is little understanding of the role mass media interventions play in multi-component drug prevention programmes.

IMPLICATIONS AND RECOMMENDATIONS

Research

6.9 Further research is required to elucidate the effectiveness of mass media campaigns as a part of multi-component drug prevention programmes.

Practice

6.10 Stand-alone media interventions do not appear to be effective at reducing drug use in young people. [6.5]
### Generic Health Interventions

**Description:** Broader-based interventions target social inclusion and health promotion and may both directly and indirectly impact on drug use.


**Targeted professionals:** Head Teachers, Teachers, School Nurses, Youth Workers, statutory and voluntary organisations, and other health care professionals.

**Key Research Areas:** Effects of the provision of generic health and educational services on drug use.

**Research gaps:** The impact of generic and early years interventions on drug use from a UK perspective; effects of addressing health and social inclusion on drug use.

**DESCRIPTION**

7.1 Use and misuse of drugs occurs in a developmental and environmental context and many children and young people who misuse substances often have multiple antecedent and co-occurring mental health, social and educational problems [Health Advisory Service, 2001]. Factors associated with both a greater and a reduced potential for drug use have been identified [see Appendix 1] and these may impact on the psychological and social development of young people [Best & Witton, 2001]. Many of these risk factors also predict other adolescent problem behaviours and it is important that the delivery of drug prevention is set within a broader context of personal and social development, linking to other related issues.

7.2 Health promotion has been defined by the World Health Organisation [WHO] as ‘... the process of enabling people to increase control over, and to improve, their health... to reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment.’ [WHO Policy Statement, 1986]'

7.3 The practice of health promotion is based on a number of theories and models [for example, the health belief model, the theory of reasoned action, the trans-theoretical [stages of change] model, social learning theory, social cognitive theory, the theory of planned behaviour, community development and models of organisational change] with the principal intention of providing information either to improve knowledge or change behaviour. In practice, health promotion is a generic option providing opportunities for universal drug prevention messages. Its advantage is that it has a non-conflicting principle everybody can agree on.

7.4 However, within this broad framework is the question of how detailed prevention activities are and how far participants are committed to the full consequence of implementation of the WHO principle. There is a difference between including drug prevention under a broader health promotion umbrella, but still specifying its contents and objectives, and the assumption [without direct evidence] that increased well-being, safe learning, good school climate, etc. alone will have a positive effect on the social risk and protective factors for drug problems. It is important that preventive efforts should be geared not only towards pupils in the school setting, but also to their living environment, thus ensuring structural and normative conditions required for effective drug prevention, but there is no evidence that health promotion alone is sufficient to curb drug problems.22

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22 UNIVERSAL DRUG PREVENTION
There are a number of policy documents aimed at reducing health and social inequalities in young people and helping them to lead healthier lives that may contribute directly or indirectly to the reduction of problematic drug use:

- Choosing Health: Making Healthy Choices Easier [Department of Health, 2004] sets out plans to promote healthy choices early in life and provide a supportive environment for children and young people integrated with the wider initiatives in the Every Child Matters: Change for Children Programme.
- The National Service Framework for Children, Young People and Maternity Services [Department of Health, 2004] sets national standards for children's health and social care, which promote high quality, women and child-centred services and personalised care that meets the needs of parents, children and their families, providing a joined-up system to ensure health and well-being for young people from birth to adulthood.
- The National Healthy Schools Programme [see www.wiredforhealth.gov.uk] focuses particularly on key health priorities including healthy eating, physical activity and emotional health and well-being. The government vision is that half of all schools will be healthy schools by 2006, with the rest working towards healthy school status by 2009.

The tiered approach to substance misuse services outlines how Tier 1 services are concerned with improvement and maintenance of health, educational attainment, and identification of any risks or child protection issues. All young people should have access to universal interventions, including, access to general medical services [such as routine health screening and advice on health risks], housing support and/or sexual health clinics [Health Advisory Service, 2003].

**APPROACHES**

A number of prevention strategies may target drug use as one component within a broader set of prevention goals, they may target drug use explicitly or contribute to the reduction of drug use by addressing common developmental determinants [Lexley et al., 2004].

Research evidence is limited, but US evaluation of universal interventions targeted at years prior to birth, infancy and childhood have shown some promise [reviewed by Lexley et al., 2004].

Sure Start is a government programme supporting children and their families from birth up to age 14 [up to age 16 for children with special needs or disabilities]. The programme aims to increase the supply of good quality early learning, childcare and health, and family support, as well as encouraging the development of integrated and joined up services. Early evaluation of the programme indicated that when variation within Sure Start Local Programmes (SSLP) and comparison areas was considered, SSLP areas were more than twice as likely to show evidence of better-than-expected functioning across multiple outcomes related to child development and parenting [National Evaluation of Sure Start, 2004].

The National Service Framework for Children, Young People and Maternity Services sets out plans for a reorientation of services for this group. Universal services at this level can play an important role in identifying mothers with substance-related needs and/or drug-exposed children through screening and assessment. Small-scale studies have shown that pregnant women accept screening and assessment, but that no behavioural outcomes have yet been established. The international literature demonstrates a promising role for family home visiting in reducing family-level risk factors for drug abuse [Loxley et al., 2004], however intensive home visits are only cost effective when provided as a selective or indicated intervention, and may provide no benefit when applied universally. Home Start is a UK-based service providing home visitation for families with young children.

Parenting education and support for encouraging healthy child development is central to the National Service Framework for Children, Young People and Maternity Services [see Standards 1 and 3]. A systematic review of parent education programmes in children aged 0 to 4 years showed that these programmes have moderate effects, with short-term improvements observed in two thirds of participants [Mitchell et al., 2001]. These programmes focus on developing strong bonds between parents [generally mother] and child, and ensuring parenting competency to meet developmental needs. The international literature demonstrates the value of childhood parent education programmes for tackling child behaviour difficulties [Lexley et al., 2004]. Research is needed to determine whether delivering universal family interventions in the primary school setting can achieve better outcomes than may be achieved through parent education alone [Lexley et al., 2004].

Engagement in school is a protective factor against harmful drug use [Burrell et al., 2005] and international research, mainly US-based, indicates that interventions to improve the school environment may make a contribution to reducing risk factors for drug use [Lexley et al., 2004]. Preparing children for school is only a practical strategy for vulnerable families, where it has shown positive effects on indicators such as intelligence and academic readiness. The 'Enjoy and Achieve' objective of the Every Child Matters: Change for Children programme aims to encourage children and young people to attend and enjoy school. In addition, the Government's Five Year Strategy for Children and Learners [DfES, 2004] sets out plans for schools to develop an extended range of services such as sports clubs and activities, parenting support opportunities and easier referral to a wide range of support services.

Choosing Health [Department of Health, 2004a] highlights the important role for school nurses in working with children and young people, parents and carers, teachers and others. In terms of their role in delivering universal services, they provide general information on health issues and may act as a point of referral if further services are required.

The Government’s Teenage Pregnancy Strategy has two key goals: to halve the teenage conception rate, and to increase the number of teenage parents in education, employment or training. Although interventions have been successful in preventing and delaying pregnancy in young women, their outcome in preventing pre-birth exposure to drug use and drug use problems in further generations has yet to be demonstrated [Yombourou et al., 2003].

**GAPS AND INCONSISTENCIES**

Research

There is little UK-based research that has evaluated whether generic programmes targeting broader themes such as social inclusion and health have impacted on drug use behaviours.

**IMPLICATIONS AND RECOMMENDATIONS**

Practice

International research shows evidence that provision of generic health and educational services, particularly in the early years of life, may have a positive effect on drug use behaviours. [7.4]

All young people’s services should be aware of their potential role in the prevention of problematic drug use. In line with Every Child Matters all workers in young people’s services should be able to identify, assess and undertake appropriate action to address drug use issues. This should include broader issues such as the identification of problem behaviours which make problematic drug use more likely [for example, conduct disorders, anxiety, aggression].
8.1 Much Government policy and guidance, including a broad range of strategies for crime reduction, educational attainment and health, directly and indirectly targets drug use as a component within a broader set of goals. Consequently, those responsible for delivering young people’s services across a broad range of settings should be aware of their potential role in the prevention of problematic drug use.

8.2 Schools have an important role to play in the delivery of the Updated Drug Strategy [DfES, 2004b] and school-based drug education programmes are the most popular and widely researched method of delivering universal services. Programmes based on the social influence model have shown the most consistently positive outcomes [Canning et al., 2004; Faggiano et al., 2005], but even these programmes are limited in their effects on reducing drug use.

8.3 Multi-component programmes which include a number of components such as school-based programmes in combination with parent/carer work, and media and community activities have been demonstrated to be more effective than delivering these components alone. However research is lacking about which components contribute to overall effectiveness.

8.4 Community-based prevention initiatives have tended to target deprived communities and universal prevention programmes delivered in this setting have not widely been assessed.

8.5 Research gaps have been identified in each section and they demonstrate a lack of robust evaluations of UK-based universal drug prevention programmes. Particularly, there is a need for evaluation of drug education programmes targeted at primary school aged children. In addition, families play an important role in young people’s choices around drug use, yet evidence is lacking about which interventions work most effectively with parents and how best to engage parents in drug prevention activities.

8.6 The scope of universal approaches to drug prevention is large, incorporating wide-ranging messages and utilising numerous mechanisms of delivery. Young people receive messages concerning drug use through education, social interaction, television, radio, the internet, music, and these will be interpreted and responded to in different ways. According to source, intent, and delivery, some of these may be perceived as preventative, others as supporting drug use. It is because of the ubiquity of drug related discourse in society that it may never be possible to elucidate the effectiveness [or otherwise] of planned universal prevention approaches over and above those delivered in society as a whole.
### Table 1: Risk and protective factors [Best & Witton, 2001]

<table>
<thead>
<tr>
<th>CLASS</th>
<th>RISK FACTORS</th>
<th>PROTECTIVE FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental/</td>
<td>High drug availability</td>
<td>Prosocial adult friends</td>
</tr>
<tr>
<td>Contextual</td>
<td>Low socio economic</td>
<td>Prosocial peers status</td>
</tr>
<tr>
<td></td>
<td>Drug using peers status</td>
<td>High socio economic</td>
</tr>
<tr>
<td></td>
<td>Delinquent peers</td>
<td></td>
</tr>
<tr>
<td>Family factors</td>
<td>Parental substance use and deviance</td>
<td>Absence of early loss or separation</td>
</tr>
<tr>
<td></td>
<td>Low parental monitoring</td>
<td>Cohesive family unit</td>
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<tr>
<td></td>
<td>Parental rejection</td>
<td>Parent-child attachment</td>
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<tr>
<td></td>
<td>Poor disciplinary practices</td>
<td>High parental supervision and monitoring</td>
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<tr>
<td></td>
<td>Family conflict/divorce</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Familial/environmental</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Predisposition/addicted parents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low parental expectations</td>
<td></td>
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<tr>
<td></td>
<td>Family disruption including unemployment</td>
<td></td>
</tr>
<tr>
<td>Individual biography</td>
<td>Early onset of deviant behaviour, smoking, drinking</td>
<td>Late onset of deviant behaviour or substance using behaviours</td>
</tr>
<tr>
<td></td>
<td>Early sexual involvement</td>
<td>Negative expectations and cognitions about substance use</td>
</tr>
<tr>
<td></td>
<td>Early onset of illicit drug use</td>
<td>Religious involvement</td>
</tr>
<tr>
<td></td>
<td>Rapid escalation in substance use</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Positive expectations and knowledge about substance use</td>
<td></td>
</tr>
<tr>
<td></td>
<td>History of behaviour problems</td>
<td></td>
</tr>
<tr>
<td>Personality</td>
<td>Strain/stress</td>
<td>High self-esteem</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>Low impulsivity</td>
</tr>
<tr>
<td></td>
<td>Aggression</td>
<td>Easy temperament</td>
</tr>
<tr>
<td></td>
<td>Impulsivity/hyperactivity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Antisocial personality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sensation-seeking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental health problems</td>
<td></td>
</tr>
<tr>
<td>Educational</td>
<td>Poor school performance</td>
<td>Good teacher relations</td>
</tr>
<tr>
<td></td>
<td>Low educational aspirations</td>
<td>High education aspirations</td>
</tr>
<tr>
<td></td>
<td>Poor school commitment</td>
<td>High parental education expectations</td>
</tr>
<tr>
<td></td>
<td>Absence, truancy and drop-out</td>
<td>High education attainment</td>
</tr>
<tr>
<td></td>
<td>Little formal support</td>
<td>Good formal support in education</td>
</tr>
</tbody>
</table>
## Table 2: Key Policy and Guidance Documents

<table>
<thead>
<tr>
<th>TITLE</th>
<th>DATE</th>
<th>LEAD AGENCY</th>
<th>AIMS</th>
<th>INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Updated Drug Strategy</td>
<td>2002</td>
<td>DSD; Home Office</td>
<td>Sets out the government’s strategy to reduce the harm that drugs cause to society. A key priority is to prevent today’s young people becoming tomorrow’s problematic drug users. Updates the drug strategy published in 1998.</td>
<td>Key target: To reduce the use of class A drugs and the frequent use of all illicit drugs by all young people (&lt;25) and in particular the most vulnerable by 2008. Key interventions: Improving quality of schools drug use education, diversionary schemes including Positive Futures, drug testing and treatment for young offenders, FRANK communications campaign.</td>
</tr>
<tr>
<td>Every Child Matters</td>
<td>2003</td>
<td>DfES</td>
<td>The Children’s Green Paper outlining whole system reform to the delivery of children services. Aims to help children fulfil their potential by reducing levels of educational failure, ill health, drug misuse, teenage pregnancy, abuse and neglect, crime and anti-social behaviour among children and young people. The Childrens Act 2004 provides the legal framework for reform.</td>
<td>Interventions include the creation of new posts and statutory bodies, including Local Safeguarding Children Boards. Specific drug misuse interventions include training for all professionals working with children to enable them to identify, assess and respond to young people with drug use problems, funding to tackle drug misuse among the most vulnerable and ensuring that the full range of drug use services are embedded in mainstream services. Interventions contribute to the DfES/Home Office joint target to reduce under 25’s Class A drug use.</td>
</tr>
<tr>
<td>Every Child Matters: Next steps</td>
<td>2004</td>
<td>DfES</td>
<td>Sets out the purpose of the Children Bill and the next steps for delivering change in children’s services.</td>
<td>Interventions highlighted include Parenting Fund, Sure Start, Connexions and the Common Assessment Framework, with an emphasis on partnership working. No specific emphasis on drug misuse.</td>
</tr>
<tr>
<td>Every Child Matters: Change for Children</td>
<td>2004</td>
<td>DfES</td>
<td>Explains the requirements of the Children Act 2004 and how it fits with other core elements of Every Child Matters to provide a national framework for local change programmes.</td>
<td>Provides a national framework in which local authority lead change programmes can respond to local needs. A specific report on young people and drugs will explain the relationship between Every Child Matters and the Updated Drug Strategy. Specific documents have been published for those working in social care, the criminal justice system, health services and schools. ‘Choose not to take illegal drugs’, is part of the ‘Be Healthy’ objective. Contributes to DfES/Home Office target.</td>
</tr>
</tbody>
</table>

DSD - Drugs Strategy Directorate; DfES - Department for Education and Skills; DH - Department of Health
<table>
<thead>
<tr>
<th>TITLE</th>
<th>DATE</th>
<th>LEAD AGENCY</th>
<th>AIMS</th>
<th>INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children Act                                                        2004</td>
<td>DfES</td>
<td></td>
<td>The Act provides legislation for the reforms detailed in Every Child Matters. The overall aim is to encourage integrated planning, commissioning and delivery of services as well as increasing accountability. The legislation is intended to be enabling rather than prescriptive providing local authorities with flexibility in the way they implement its provisions.</td>
<td>The Act includes legislation enabling increased information sharing, establishment of an independent champion for children and young people, an integrated inspection framework.</td>
</tr>
<tr>
<td>National Service Framework for Children, Young People and Maternity Services 2004</td>
<td>DH</td>
<td></td>
<td>The framework sets standards for health and social care services for children, young people and pregnant women. It is a ten-year programme intended to stimulate long-term and sustained improvement in children’s health. The implementation of the Children’s National Service Framework is a major part of the Change for Children programme. Change for Children Health services includes details of how to implement the framework.</td>
<td>Includes 11 standards. Drug misuse features in standard 4, ‘Growing up into Adulthood’, is the most relevant. Interventions specified include: provision of school based education covering all substances to be provided to all young people; PCTs to ensure that information and advice services are provided for young people and their parents; PCTs and Local Education Authorities [LEAs] to ensure information regarding support services is accessible to all young people including those not in school; staff from all agencies able to identify young people at risk of misusing drugs or alcohol, access to a range of local prevention and treatment programmes.</td>
</tr>
<tr>
<td>Choosing Health                                                      2004</td>
<td>DH</td>
<td></td>
<td>White Paper setting out how the Government plans to assist people in taking responsibility for their health by improving information and providing support in making healthy choices. This includes how the health of children and young people will be safeguarded.</td>
<td>Although drug misuse is not a specific priority it identifies that addressing health inequalities among children and young people is as a major priority for all local agencies in order to break the cycle of deprivation. Emphasis is on information provision, in particular the role of the youth service, young people’s development programme and outreach services to provide information and advice for vulnerable young people who may be excluded from services.</td>
</tr>
<tr>
<td>First steps in identifying young people’s substance related needs     2003</td>
<td>DSD; Home Office</td>
<td></td>
<td>Highlights the responsibilities of all professionals working with young people in identifying substance related needs and ensuring these needs are addressed, with the aim of reducing vulnerability to developing substance misuse problems. Contributes to the Updated Drug Strategy young people aim.</td>
<td>Emphasises a holistic approach to needs assessment, with a framework provided for identifying substance related needs within existing assessment procedures. Tier 1 and 2 interventions highlighted include provision of information and advice, support for carers, outreach work, counselling and drug related prevention programmes.</td>
</tr>
<tr>
<td>Assessing local need: Planning services for young people              2002</td>
<td>DrugScope &amp; Home Office</td>
<td></td>
<td>To provide a framework for assessing young people’s needs for drug programmes. Aims to help DJAATs analyse the needs of children and young people, and the current resources that are available. This needs assessment forms part of Young People’s Substance Misuse Plans.</td>
<td>Advocates building a profile of the young people in the DJAAT area, highlighting; areas with particular needs, vulnerable young people, vulnerable young people in contact with children’s services and harder to reach young people. Comparison of this data with current provision to identify gaps. There is also a focus on multi-agency working and service co-ordination.</td>
</tr>
<tr>
<td>Drugs: Guidance for Schools                                           2004</td>
<td>DfES</td>
<td></td>
<td>To provide guidance to all schools in England on issues relating to drug education, schools drugs policy and supporting the drug related needs of young people. This guidance considers drugs in the widest sense: Links to the Updated Drug Strategy through contribution to the aim of ‘preventing today’s young people becoming tomorrow’s problematic drug users’ and by highlighting the needs of vulnerable young people.</td>
<td>The guidance sets out how schools have an important role to play in the delivery of the Updated Drug Strategy. Drug education should be delivered through PSHE and citizenship, and fulfil the statutory requirements of the National Curriculum Science order. States that drug education should: increase knowledge; develop personal and social skills; and enable pupils to explore their own and other people’s attitudes to drugs. In addition, all schools should have a drug policy, developed, implemented and reviewed by the whole school community.</td>
</tr>
<tr>
<td>TITLE</td>
<td>DATE</td>
<td>LEAD AGENCY</td>
<td>AIMS</td>
<td>INTERVENTIONS</td>
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<tr>
<td>National Healthy Schools Programme</td>
<td>2005</td>
<td>DH &amp; DfES</td>
<td>The aims of the programme are: 1) to support children and young people in developing healthy behaviours; 2) to raise pupil achievement; 3) to help reduce inequalities; and 4) to help promote social inclusion.</td>
<td>Comprises the National Healthy School Standard [NHSS], continuing professional development [CPD] programme for the certification of the teaching of PSHE, and a PSHE certification programme for community nurses.</td>
</tr>
<tr>
<td>National Healthy School Standard: Drug Education</td>
<td>2004</td>
<td>DfES</td>
<td>The NHSS is a national standards framework guiding the work of local partnerships between PCTs and LEAs. To become a 'Healthy School', schools need to show evidence of how they have met criteria across four core themes [PSHE, healthy eating, physical activity and emotional health and well-being]. Drug education forms part of the standard for PHSE.</td>
<td>Local Healthy Schools Partnerships must have the capacity and capability to support schools to develop a whole school approach to drug education. Sets out minimum criteria which schools must evidence in order to meet the drug education standard of the NHSS.</td>
</tr>
<tr>
<td>Drugs Guidance for further education institutions</td>
<td>2004</td>
<td>DrugScope, Alcohol Concern &amp; DfES</td>
<td>To help further education [FE] institutions: 1] respond to the drug education needs of students; 2] manage drug related situations; 3] develop and implement a college policy on drugs. The guidance supports Drugs: Guidance for Schools, drawing out areas of relevance for FE institutions.</td>
<td>The guidance identifies a role for FE institutions to integrate drugs into a holistic approach to student welfare, focusing on the boundaries of acceptable behaviour and education for personal and social development. Opportunities for the provision of drug education across college life are presented and strategies for dealing with drug related situations are explored.</td>
</tr>
<tr>
<td>Youth Matters</td>
<td>2005</td>
<td>DfES</td>
<td>Consultation document for strategy for reforming young people’s [age 13-19] services to provide opportunities, challenge and support to young people. The document builds on the system reforms outlined by the Every Child Matters Programme.</td>
<td>The 4 main areas of work are to be around engagement of young people in positive activities, community involvement and volunteering, provision of information and advice and intensive support for those who need it. One of the aims is ‘making services more integrated, efficient and effective’. Clear assessment processes are to be introduced and lead caseworkers for each individual. The document also highlights the need for strong links between universal and targeted interventions.</td>
</tr>
<tr>
<td>Confident Communities in a Secure Britain</td>
<td>2004</td>
<td>Home Office</td>
<td>Sets out the government’s plan to reduce crime and anti-social behaviour. Includes the aim to reduce the number of people’s lives that are ruined by drugs and alcohol.</td>
<td>Commitments include reducing drug-related crime by directing approximately 1,000 drug-using offenders a week into treatment; ensuring that every school reaches a good practice standard in drug education and developing further the FRANK advice campaign for young people and their families; providing drug treatment to 60,000 more drug users in England by 2006; reducing the availability of heroin, cocaine and crack; and maintaining police focus on Class A drug-users and their dealers and making greater use of new powers to close crack houses.</td>
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<tr>
<td>Guidance for developing a drug and alcohol policy - a tool for employers</td>
<td></td>
<td>Home Office</td>
<td>The purpose of the guidance is to help employers understand the importance of informing staff about substance misuse, why a robust workplace policy can help protect employees and businesses, and why a workplace policy is valuable. A drug and alcohol policy should aim to support affected employees, and should seek to help them and encourage them to seek treatment an employee admits to having a drug or alcohol-related problem.</td>
<td>The guidance states that the benefits of developing and effectively implementing a policy ensures that there is: a clear understanding of your company’s rules on drugs and alcohol; a clear definition of both employee and employer responsibilities; a greater awareness in your company of the effects of drugs and alcohol; necessary procedures in place should a problem arise; trained managers or key staff who have the skills to deal with problems when they arise; a culture whereby employees are willing to acknowledge that they or a colleague have a problem.</td>
</tr>
</tbody>
</table>

DSD - Drugs Strategy Directorate; DfES - Department for Education and Skills; DH - Department of Health
**References**


Home Office [2003] FRANK action update: We are Family. London: Home Office
National Assembly for Wales [2002] Substance Misuse: Children and Young People, National Assembly for Wales, Welsh Assembly Government
Yamauchi R, Johnston LD & O'Malley PM [2003] Relationship between student illicit drug use and school drug testing policies. Journal of School Health 73: 159-64