Community Drug Summit

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Prevention And Early Intervention Strategies, Including School, Parent And Public Education And Action In Local Communities.

Issues Paper Number 4

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1.0 Introduction

Historically there have been two identified perspectives on drug problems and their cause: abstinence and harm reduction. The Temperance Movement, which had its origins in the early 19th century, came to view drugs, particularly alcohol, as having a degenerative influence on consumers. The drug was the problem and the solution was prohibition. The Movement was initially very successful in mobilising community opposition to alcohol, tobacco and 'other narcotics' (Beck, 1998). The notion of individual addiction as the root problem is intertwined with the disease concept of drug addiction. Individuals who develop problems with alcohol or other drugs suffer from a disease process, which if fully manifested, makes them incapable of control.

The 'medicalisation' of drug problems has meant that, until relatively recently, the focus of prevention efforts has been on early identification and treatment of addiction, with the ultimate goal being total abstinence. In the early 1970s an appreciation emerged in the public health area as to the range of community problems created by drugs. This shift in focus from an individual medical disorder to a broader view of drug problems has been important in recognising the role of the community in both producing and responding to the problems.

More recently the concept of harm reduction has become intertwined with this 'new' public health perspective (Erickson, Riley, Cheung and O'Hare, 1997). Harm reduction involves a pragmatic, problem focused response to drug use and has gained credibility because of its success in combating the transmission of Human Immuno Virus (HIV) among intravenous drug users. Harm reduction, together with demand and supply reduction has formed a key plank of national drug policy in Australia for a number of years (Ministerial Council on Drug Strategy, 1998).

2.0 Western Australian Context

Prevention strategies in Western Australia have focussed on education in schools, for parents through public campaigns and community action and partnerships. Most development has occurred in the latter half of the 1990s.

The School Drug Education Project involves professional development for schools and teachers, drug education curriculum, drug policies in schools and strategies for parents and community involvement. There are a range of parent education options although they have varying success in engaging parents' participation and do so best when they are well integrated with school and other community strategies.

Illicit drug media campaigns began in 1996 under the *Drug Aware* banner and have targetted heroin, marijuana, psychostimulants (amphetamines, LSD and ecstasy) drugs and driving. The campaigns have used youth press, radio, convenience advertising and posters for your people and mainstream press for parents and have generally achieved high rates of awareness, credibility and relevance. The WA Police Service has also implemented a youth education strategy for late primary and early secondary school aged children, known as GURD. It has involved some media advertising together with school community education by trained police officers.

Community action and partnership strategies have included the establishment of about 80 Local Drug Action Groups. These involve community volunteers providing support for public education campaigns, activities for youth and support for parents as well as working with local schools and police. The range of community partnerships, involving varying degrees of activity, has extended from night venues and dance party promoters to sports, local businesses participating in the *Drug Aware* business program, TAFE and university campusses, local governments and community pharmacies.

Public Health Units in the metropolitan and regional areas are active partners in the statewide campaigns and complement these activities through locally designed initiatives. In several areas, alcohol and drug programs have evolved in these Units, whose staff have developed and implemented local plans. Initiatives have included policy development, organisational development (through education and training, business planning, targeted funding, etc), research and local partnership projects (alcohol accords, venue programs, community mobilisation, etc).

Early intervention specific to drug strategy, has included the *In Touch* school drug counselling program to support schools to address drug abuse incidents and link them with Community Drug Service Teams.

Community Drug Service Teams, the Alcohol and Drug Information Service and the Parent Drug Information Service focus on early intervention. Beyond specialist drug strategies, the 'Building Blocks' program integrates the child health services provided by Health and Community Development. It provides assistance and home visits to families and supports them through specific services.

3.0 Issues For Consideration

3.1 Early Childhood Intervention Strategies

Early intervention refers to active intervention in a child's early development, prior to the onset of problem behaviours. In the course of developing early intervention drug prevention programs, researchers have developed a framework for better understanding the causes and consequences of drug use. This framework is

still evolving, but the core elements comprise risk factors and protective factors and the interplay between the two during the social development of a child (Brounstein and Zweig, 1999; Catalano, Kosterman, Hawkins, Newcomb and Abbott, 1996). The literature indicates that certain factors in a child's life predict a range of health and social problems, including problems with drug use. Hawkins, Catalano and Miller (1992) identified the following 17 groups of risk factors as preceding substance abuse. Four of these they considered societal and cultural contextual factors. The other 13 they considered to be either individual or interpersonal factors.

Contextual Risk Factors:

- laws and norms favouring drug use;
- availability of drugs;
- extreme economic deprivation; and
- neighbourhood disorganisation.

Individual and Interpersonal Risk Factors:

- physiological factors, such as sensation seeking, poor impulse control, and genetic predisposition;
- family drug behaviour and attitudes;
- poor and inconsistent family management practices;
- family conflict;
- low bonding to family;
- early and persistent behaviour problems;
- academic failure;
- low level of commitment to school;
- peer rejection in elementary grades;
- association with drug using peers;
- alienation and rebelliousness;
- attitudes favourable to drug use; and
- early onset of drug use.

A recent study found that many of these risk factors were associated with early initiation of drinking, which in turn was associated with alcohol misuse (Hawkins, Graham, Maguin, Abbott, Hill and Catalano, 1997). These findings have important implications for alcohol misuse prevention, because they indicate that prevention approaches, which delay initiation of drinking, are likely to reduce later problems of misuse. On the basis that a similar relationship exists between early initiation of drug use and subsequent problems with misuse, prevention programs which seek to delay onset of drug use are equally likely to reduce later misuse problems.

The relationship between risk factors and drug use is not linear (Brounstein and Zweig 1999). Exposure to even a considerable degree of risk in childhood does not mean that drug use or other problem behaviours will necessarily follow. Many children grow up in high risk environments, but still emerge with few problem behaviours. The reason is the presence of protective factors in the lives of these young people. Protective factors essentially comprise the positive, healthy aspects of a child's life and these act to balance and reduce the impact of the risk factors. Continuing identification of protective factors is very important for future prevention policy.

In Australia, a comprehensive assessment of a range of psychosocial health risk and protective factors was undertaken with Victorian secondary school students (Bond, Thomas, Toumbourou, Patton and Catalano, 2000). The researchers found that there was an association between the number of risk and protective factors and licit and illicit drug use in this group of young people. In the case of illicit drugs, in particular cannabis, use remained low in students experiencing nine or less risk factors, but rose dramatically once 10 or more risk factors were present. Even a small number of protective factors can reduce drug use. Alcohol, cigarette, cannabis and other drug consumption reduced by approximately 50% with the presence of two to three protective factors.

This study suggests that well targeted programs can produce considerable prevention gains and that even limited programs that aim to reduce risk factors below this threshold are likely to produce substantial benefits.

The interaction of drug use risk and protective factors can be better understood within a framework, comprising five life domains. The individual is at the core of this model and is influenced by five environmental domains: society, family, community, school and peers. The interplay between the risk and protective factors, both within and between the individual and environmental domains determines the degree to which drug use occurs.

The concepts of resilience and successful adaptation, despite risk and adversity, are also important. The Hazeldon Foundation (1996) identified the following key factors:

- a strong caring relationship with a parent or another adult;
- feelings of success and a sense of mastery in at least one area of the child's life;

- social skills and ability to consider personal safety when making decisions;
- problem solving skills;
- a sense that hard work and perseverance will bring reward;
- surviving previous stressful situations; and
- strong personal and environmental resources, such as good health and a supportive family.

Brounstein and Zweig (1999) identified three unifying themes in effective early intervention programs:

- the programs promoted supportive caring relationships between youth and members of their families, their communities and their peer groups;
- the programs provided several interventions specifically tailored to the needs of the target group; and
- the programs were successful in either reducing the onset or use of drugs, or in reducing risk factors and /or enhancing protective factors related to the future drug use.

Early intervention is a promising approach, because it can effect a range of problematic areas, such as school retention, crime, mental health, sexuality and suicide as well as alcohol and drug use. However, further research is still needed to determine how risk, protective and resilience factors relate to drug problems, rather than drug use per se.

Important Questions

- Should there be a commitment to early intervention programs as a way of preventing later drug use problems?
- What proportion of the resources available for addressing drug use problems should be directed to early intervention?

3.2 Parent Education and Engagement Strategies

The major influence that parents have on the drug taking behaviour of their children is consistently identified in the literature (McCallum, 1996). Parents have a major influence on their children's drug use behaviour through modelling, attitudes and family relationships, although many parents were unaware of their degree of influence and how this could be used to bring about better choices. The first step in getting parents more involved in drug education is to make them more aware of their influence. Many parents feel ill equipped to discuss drug matters with their children or make representations about drug education policy, because of a lack of knowledge. Accordingly, programs that inform, engage and support parents are a useful start in tapping their potential to contribute to the drug education process.

Parents see drugs as a major issue of concern in relation to their children. Mallick, Evans and Stein, (1998) concluded that parents need drug education themselves, so they can effectively assist in the drug education of their children. Many parents are receptive to this idea, but the views and motivation of hard to reach parents were not gauged even though the involvement of this group may be particularly beneficial. Ways of involving parents in supporting school based drug education include:

- facilitating peer led education among parents, as this is more interactive and less intimidating than being talked to by experts;
- learning communication skills;
- setting limits; and
- providing consistent support.

Important Questions

- How can parents be more effectively engaged in supporting drug education programs?
- What can be done to engage 'hard to reach' parents in parent education activities?

3.3 School Based Strategies

Drug education programs have traditionally been based on the social influence model, which holds that young people begin to use drugs because of social pressure from a variety of sources, such as the mass media, their peers and even idealised images of themselves. In order to resist these pressures, young people need to be 'inoculated' by prior exposure to counter arguments and trained in the skills necessary to implement non-use choices.

Botvin (1986) added a general set of skills for enhancing individual competence in his Life Skills Training (LST) program, because he considered these would enhance a young person's ability to deal with the indirect pressures to use drugs. The LST program has been implemented extensively in the United States and in 10 separate evaluation studies was found to reduce alcohol, cannabis and tobacco use in young adulthood (Dusenbury, Falco and Lake, 1997).

Hansen and Graham (1991) have identified beliefs about drug use and drug related behaviour as having a crucial role in effective school based drug education programs.

They found that students over estimated the proportion of their age group that drank alcohol. This erroneous belief, that more of their peers drank than was actually the case, acted to increase the likelihood that they themselves would drink. Hansen and Graham's study only looked at alcohol education programs, but their findings are likely to be applicable to education programs for illicit drugs, where in most cases actual prevalence is very low.

The use of peer leaders in drug education is another strategy for which there is considerable evidence. This approach is based on the view that young people can more usefully explore controversial issues with others of the same age and social background. Botvin (1990) considered that peer leaders should be:

- credible with high risk young people;
- have good communication skills;
- show responsible attitudes; and
- at the same time be somewhat unconventional.

However, even ideal peer leaders are likely to lack the organisational and management skills possessed by effective professional teachers. Accordingly, the best of both worlds could be achieved by using teachers and peer leaders in combination.

According to a number of researchers the timing of drug education is likely to be critical. Kelder, Perry, Klepp and Lytle, (1994) commented that primary prevention is most effective if instituted before behavioural patterns are established and more resistant to change. The general consensus in the literature is that the optimal time for initiating youth drug interventions is during the late primary/early high school years, as this is when experimentation starts.

In a review of 120 school based drug education programs, Tobler and Stratton (1997) found that the most important factor was interactive process, whereby students were actively engaged in discussions, role plays and games. In a comparison of those programs that measured knowledge, attitudes and use behaviour, only the interactive programs produced significant change in attitude and drug use. The interactive programs were equally successful with cigarettes, alcohol and cannabis and extremely successful with illicit drugs other than cannabis.

3.3.1 Whole of School and Community Wide Approaches

An important recent trend in drug education is the increased emphasis given to whole of school and community approaches (Perry, Williams, Veblen-Mortenson, Toomey, Komro, Anstine, McGovern, Finnegan, Forster, Wagenaar and Wolfson, 1996). This acknowledges that drug education occurs within a broader social setting and that greater benefit is likely to occur if there is contextual support for classroom programs. These approaches need to have the following elements:

- school policy and practices that complement the education message;
- services for at risk students; and
- involvement of the local school community, particularly parents, in the education process.

Schools capacity to adopt a comprehensive approach to drug education is challenged by the number of education issues vying for a place on the school agenda. Schools that have had little drug education will probably be best served by broad based teacher training, which will create the skill base and motivation for further development. In contrast those schools that have reached a certain level of accomplishment in drug education are more likely to have the capacity to undertake a more intense, whole of school approach.

3.3.2 Future Directions in Drug Education

In some ways, drug education is at a crossroads in terms of future development. There is an increasing body of evidence that indicates not just which programs work, but which features consistently appear in the more effective programs (White and Pitts, 1998; Dusenbury, Falco and Lake, 1997). This allows new programs to be developed which can distil the best practice features of past interventions and develop new approaches. Drug education programs should not be selected simply because they do not threaten conventional community views on drug use. Drug education programs should be selected on the basis of features, which research indicates most likely to change behaviour and have a beneficial impact on youth drug use and youth drug problems.

Important Questions

- Are school based strategies currently in place in WA effective?
- How can WA further develop realistic, effective illicit drug education, which is supported by the broader community?

3.4 Community Based Prevention

In recent years there has been increasing recognition that the community is an appropriate setting for preventing drug problems. Holmila (2000) asserts that

'curing' or removing the individual problem user will not result in a reduction in drug related harm, because the community dynamics, which caused these problems, are unchanged. In order to change the aggregate level of drug related harm, environmental changes have to occur.

3.4.1 Community Based Drug Programs

Probably the largest and most rigorous community alcohol prevention program was the Community Trials Project (CTP) conducted by Holder and his colleagues in six locations in California and South Carolina over a five-year period (Holder, Saltz, Grube, Voas, Grueneward, Treno, 1997a). This is also of relevance to addressing illicit drug problems. This project differed from many of its predecessors in that it aimed to reduce harms associated with drinking rather than drinking itself. The project consisted of the following five interacting components, each with its own set of actions and goals:

- **community mobilisation:** develop community coalitions to address local alcohol problems, increase awareness and gain public support for project activities by way of media advocacy;

- **responsible beverage service:** reduce the likelihood of customer intoxication on licensed premises by training bar staff in responsible serving practices;

- **drinking and driving:** reduce drinking and driving by increasing both perceived and actual police enforcement;

- **underage drinking:** reduce alcohol involved trauma among underage youth by curtailing retail sales to this groups and restricting other methods of access; and

- **access to alcohol:** assist communities to increase restrictions on the availability of alcohol.

The report by the National Institute on Alcohol Abuse and Alcoholism, (2000) indicated that the CTP was successful on a number of measures. Alcohol involved traffic crashes decreased by 10% per annum. There was significant community support for the interventions. Media coverage of alcohol related trauma and prevention policy initiatives increased. Sales of alcoholic beverages to underage decoys were reduced. However this success needs to be measured against the cost of the project, which was considerable.

The Community Mobilisation for the Prevention of Alcohol Related Injury (COMPARI) was a WA demonstration project, designed to show that alcohol related injury could be reduced by mobilising a whole community to take an active role in changing individual drinking behaviour and the environmental factors that influence alcohol related harm (Midford and Boots, 1999). The project operated over three years in Geraldton and undertook 22 major component activities, involving community development, local networking and support, provision of alternative activities, health education, health marketing and policy institutionalisation.

Three major insights about community prevention approaches emerged from the COMPARI experience:

- externally initiated community alcohol projects need to engage in extensive local consultation and alliance building prior to their public launch;

- pure community mobilisation processes need to be supplemented by a range of practical, high profile prevention activities. This gives the prevention project a positive profile in the community and mobilisation occurs as a by product; and

- community prevention projects can have an impact on specific measures of alcohol related knowledge and behaviour but demonstrable, community wide change will take longer.

3.4.2 Community Policing and Harm Reduction

A pilot program involving local level harm reduction policing has recently been completed in Australia (Canty, Acres, Loxley, Sutton, James, Lenton, Midford and Boots, 2001). This program utilised a model of drug strategy coordinated in the United Kingdom (Lord President of the Council et al, 1995; Resource and Service Development Centre, 1996). In the UK model, local community agencies, police, health and other government service organisations would meet to identify and discuss local patterns of illicit drug use and the associated problems for both drug users and the community. These groups are known as Drug Action Teams or DATs (Lord President of the Council et al, 1995). Having identified the local pattern of problems, these groups would look at what could realistically be achieved to deal with these problems. They would then implement a range of local programs specifically designed to reduce the identified problems.

A vital aspect of the UK model is that the DATs are part of a "Whole of Government" approach, where reducing drug related problems is seen as the overriding goal and objective of the agencies involved (Lord President of the Council et al, 1995). As such, the DATs are overseen by a Drug Reference Group (DRG), which comprises senior representatives from the organisations with a stake in the DAT. The DRG provides a high level support function to facilitate collaboration at an operational level, promote the action of the DAT, remove barriers and generally maximise the likely success of DAT initiatives. This model has been piloted in four sites across Australia, including Mirrabooka and Geraldton in WA (Canty et al, 2001).

3.4.3 Prevention Can Work in a Range of Communities

In one sense the term community indicates geographical proximity of people, as in a town or neighbourhood. In another sense it can refer to social proximity, brought about by shared experience and heritage, as with an ethnic community or by a shared purpose, such as in a workplace. The needs of more specialised communities should be considered when developing prevention policy and evidence of effective practice should similarly be the determining factor in program selection.

There is increasing acknowledgment of the strengths of communities, the importance of their knowledge base and a growing consensus that successful community prevention projects have to incorporate communication between different community sectors.

Important Questions

- How can well resourced, long term, collaborative, community based prevention programs be developed?
- Should the needs of 'special' communities be considered in developing prevention policy?

4.0 Summary

Bureaucratic boundaries have meant that in the past, prevention programs have tended to be provided through major jurisdictional systems, such as education, criminal justice and health, and they have tended to be assessed in terms that have meaning within each of these arenas. Increasingly, however, there is recognition that prevention is best served by a common set of goals, which can best be achieved by a coordinated, cross agency approach. Overall:

- examination of effective prevention approaches should not just be confined to prevention of use, because other beneficial changes may be overlooked. A focus on preventing harm may also minimise the stigmatisation of drug users, can empower communities by allowing them to identify the most salient harms and can make prevention more cost effective by allowing the targeting of major harms;
- effective prevention planning requires cross agency collaboration in gathering, disseminating and using up to date information on local drug use trends across agencies;
- early intervention is a promising approach worthy of further investigation in the WA context. The literature suggests that targeted support beginning in early childhood provides prevention dividends across a range of problematic areas such as school retention, crime, mental health, sexuality and suicide as well as alcohol and drug use;
- involving parents in prevention programs is likely to provide substantial benefit, but effective engagement strategies need to be developed;
- while there is now good evidence as to what type of school drug education programs work best, this is unlikely to be enough in itself to sustain the implementation of effective mass drug education programs. Decision makers often select drug education programs on the basis of what they would like to see happen, rather than on the evidence of what can realistically be achieved. Education may not 'drug proof' young people, but it can equip them with the skills to make safer decisions in a world where drug use is a reality; and
- community prevention programs can be successful in changing patterns of drug use and harm, but they require considerable resource support, collaboration between local stakeholders and implementation over a substantial period of time to be effective.

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