STRENGTHENING DRUG EDUCATION IN SCHOOL COMMUNITIES

BEST PRACTICE HANDBOOK FOR DESIGN, DELIVERY AND EVALUATION YEARS 7-13

FOR PRINCIPALS, HEALTH TEACHERS, DRUG EDUCATION PROVIDERS AND FUNDERS OF DRUG EDUCATION

STRENGTHENING DRUG EDUCATION IN SCHOOL COMMUNITIES

BEST PRACTICE HANDBOOK FOR DESIGN, DELIVERY AND EVALUATION

YEARS 7-13

FOR PRINCIPALS, HEALTH TEACHERS, DRUG EDUCATION PROVIDERS AND FUNDERS OF DRUG EDUCATION

Published by
Ministry of Youth Development
PO Box 10-300
Wellington
New Zealand

www.myd.govt.nz

ISBN 0-478-25020-7

MINISTRY OF YOUTH DEVELOPMENT
TE MANATŪ WHAKAHIATO TAIOHI

Administered by the Ministry of Social Development

The Ministry of Youth Development recommends that schools use a curriculum-based approach to drug education, which is delivered by qualified teachers, and only use external providers or programmes if those providers or programmes can provide evidence that:

- demonstrates how their drug education session plans are linked to the *Health* and *Physical Education in the New Zealand Curriculum*; and
- the programmes have had an acceptable independent, external evaluation according to the evaluation guidelines in this handbook; and
- the 16 principles of best practice have been fully implemented in the design, delivery and evaluation of the drug education programme by the provider; and
- the enhancement of students' social skills, knowledge and safe attitudes towards preventing and reducing drug-related harm has taken place as a result of these programmes.

Disclaimer: Please note that the information in this handbook is the best advice and guidance at the time of printing, but anybody seeking to use an external provider or external programme should still seek independent advice as appropriate to ensure that the programme meets all necessary requirements.

ACKNOWLEDGMENTS

The Ministry of Youth Development acknowledges the valuable contribution of everyone involved in the development of this handbook. In particular, we wish to thank:

- Allen & Clarke Policy and Regulatory Specialists Ltd for its work on the development of the best practice principles from the findings of *Effective Drug Education for Young People: A Literature Review and Analysis.*
- Pauline Dickinson for her work on the draft handbook and practical guide.
- The expert reviewers for the Ministry of Youth Development who provided valuable feedback on the draft handbook. These were: Chris Cunningham, Lita Foliaki, Andrew Waa (Health Sponsorship Council), Gillian Tasker, Jenny Robertson and Paul Duignan.
- Staff at the Ministries of Youth Development, Education, Health and Justice, ALAC, the New Zealand Police and Te Puni Kōkiri who commented on the draft handbook.
- Those people who participated in the consultation groups and who made submissions as part of the consultation on the draft handbook.

CONTENTS

CONTENTS

INTRODUCTION

As part of the Government's *Action Plan on Alcohol and Illicit Drugs*, the Ministry of Youth Development (MYD) was directed in 2002 to identify and to encourage evidence-based best practice for drug education. The drug education initiative was led and co-ordinated by MYD in consultation with the Ministries of Education, Health and Justice and the Alcohol Advisory Council of New Zealand (ALAC).

MYD undertook a literature review in 2003, called *Effective Drug Education for Young People: A Literature Review and Analysis* (MYD's literature review). While there are still some questions about the effectiveness of school-based drug education, there is growing evidence that well-designed and well-implemented drug education units of learning can have beneficial effects, especially when these are co-ordinated with family and community initiatives.

This handbook for school-based drug education was developed from the literature review findings. The best practice principles are intended to help schools provide drug education that is effective in improving young people's drug-related knowledge, skills and safe attitudes.

Strengthening Drug Education in School Communities is for people who:

- plan, develop, deliver and evaluate school-based drug education
- use or fund school-based drug education from external providers.

The purposes of the handbook are:

- to improve the effectiveness of the curriculum-based approach to drug education
- to complement *Drug Education: A Guide for Principals and Boards of Trustees* (drug education guidelines) published by the Ministry of Education
- to encourage best practice principles in the design, delivery and evaluation of school-based drug education
- to provide guidelines on how to plan and evaluate drug education over time to ensure it is consistent with best practice
- to provide schools with a checklist to guide their decisions about using drug education offered by external providers.

School-based drug education can be covered in many subject areas such as Social Studies, English, Science, Media Studies and Technology. This handbook contributes to the key area of mental health in the *Health and Physical Education in the New Zealand Curriculum* (health and physical education curriculum), and specifically to providing learning opportunities for students to develop knowledge, understanding and social skills so they can make informed, health-enhancing decisions about drug use. All schools are required to teach the health and physical education curriculum to Year 10. This basis can then be used to plan units of learning in the senior school (Years 11-13). The place of drug education in the health and physical education curriculum is explained on page 20 in the drug education guidelines.

The handbook supports and should be read in conjunction with the drug education guidelines. The principles of best practice in this handbook reflect the principles described on page 21 in the drug education guidelines. It is essential that schools have policies and procedures in place to

address drug-related incidents that are in keeping with the drug education guidelines and support curriculum-based drug education.

This handbook expands on the drug education guidelines by providing processes for evaluating drug education and for assessing external providers for their ability to provide drug education based on evidence-based best practice.

DEFINITIONS

Drug includes legal drugs (such as coffee, tea, tobacco and alcohol), illegal drugs (such as cannabis, opiates, ecstasy, methamphetamines and mushrooms), volatile substances (such as petrol, solvents and inhalants) and other substances used for psychoactive effects, recreation or enhancement ('legal highs'), culturally significant (such as kava) as well as prescription and pharmacy-only drugs used outside medical or pharmaceutical advice. In this handbook, the word 'drug' encompasses all of the substances listed above. This definition is consistent with the one used in the drug education guidelines (page 6) and comes from the Ministry of Health's *National Drug Policy 1998-2003.* All drugs are potentially harmful.

School-based drug education includes units of learning that support and are based on the health and physical education curriculum, the core statement for the essential learning area, health and physical wellbeing. Drug education in schools needs to take place as part of student learning about mental health, body care and physical safety.

Effective drug education implements the following principles of best practice in the design, delivery and evaluation of school-based drug education and enhances young people's skills, knowledge and attitudes to prevent and to reduce drug-related harm.

FOR FURTHER INFORMATION

MYD's website has details on the drug education initiative (www.myd.govt.nz/pag.cfm?i=358) and the literature review on which this handbook is based (www.myd.govt.nz/pag.cfm?i=394).

Schools may also find it useful to refer to a New Zealand School Trustees Association (NZSTA) publication called *Information for Boards of Trustees: The Issue of Drug and Alcohol Use in Children.*

HOW TO USE THIS HANDBOOK

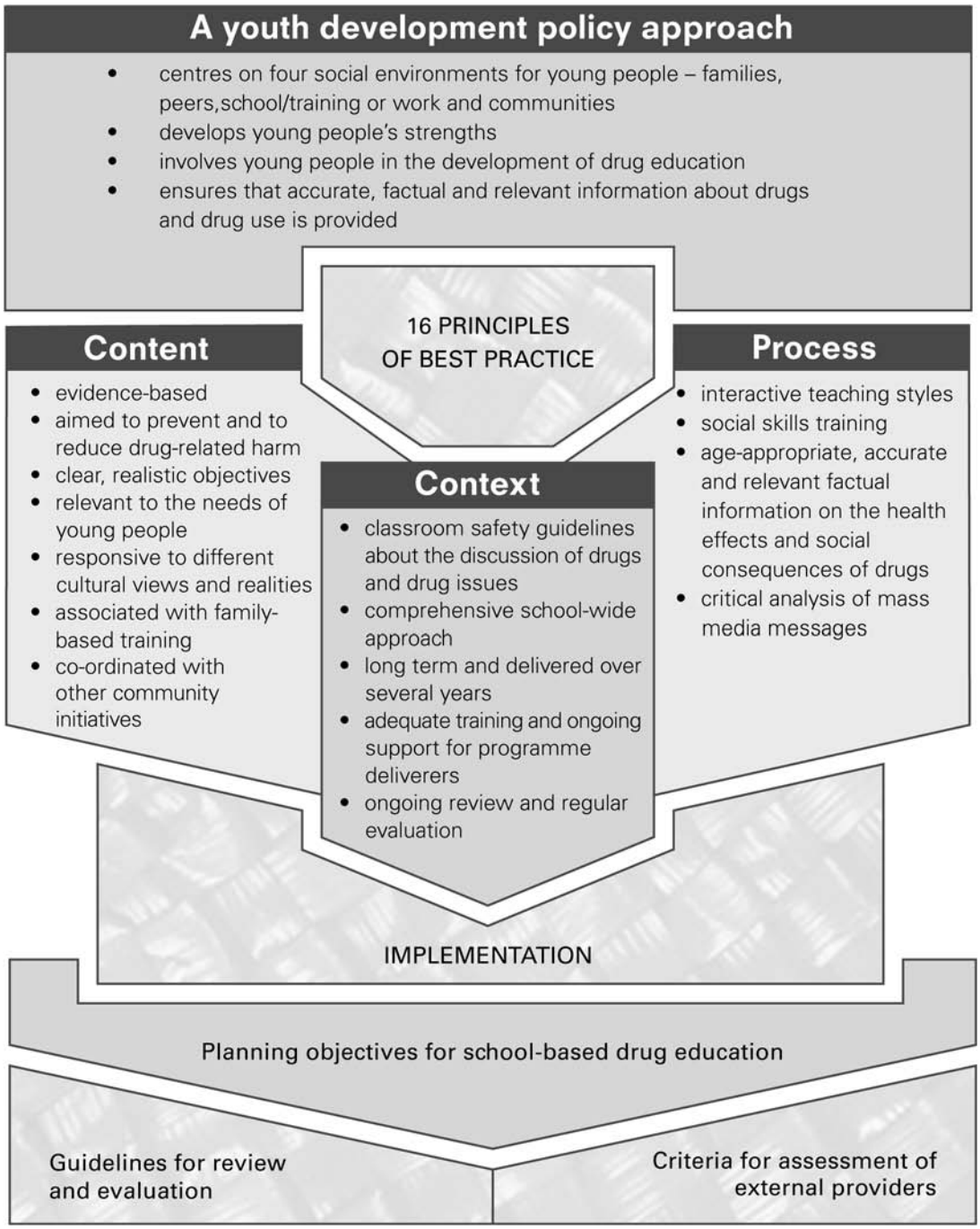
School-based drug education can be effective when the principles of best practice are implemented in the design, delivery and evaluation of drug education programmes. Given that young people are exposed to situations where legal and illegal drugs are used, it is essential they have the opportunity to experience effective best practice drug education that aims to enhance their social skills, to improve their knowledge and to enable them to examine and, if necessary, to change their attitudes towards drugs and drug use.

This handbook recommends schools deliver their core drug education units of learning as part of the health and physical education curriculum using qualified health education teachers. External providers may be used to support this curriculum-based approach but they should not be the primary providers of drug education in schools.

The handbook has been written to guide drug education for Years 7-13. It has three sections:

1. A description of the **principles of best practice** can be found on pages 8-30. Examples and suggestions about the ways these principles can be applied to lesson plans are given in boxes.
2. **A programme plan and evaluation guidelines** on pages 31-39 are included for schools, drug education providers and funders of drug education. These incorporate the principles of best practice for the design, delivery and evaluation of school-based drug education.
3. **Quality expectations for external providers** are described on pages 40-42. External providers should be able to show evidence their drug education sessions are based on best practice principles. A checklist is provided for schools that choose to use external providers to enhance the curriculum-based approach delivered by qualified teachers.

OVERVIEW OF BEST PRACTICE FOR DRUG EDUCATION IN SCHOOLS



A YOUTH DEVELOPMENT APPROACH TO DRUG EDUCATION IN SCHOOLS

The approach to school-based drug education in this handbook is consistent with the *Youth Development Strategy Aotearoa* (Ministry of Youth Affairs 2002). It describes a positive, holistic youth development approach, informed by an understanding of what young people need. The strategy identifies four social environments that influence youth development: families, peers, school/training or work and communities. This approach has six key principles:

1. Youth development is shaped by the 'big picture', including the wider social and economic contexts and dominant cultural values which impact on young people as they grow up.
2. Youth development is about young people being connected, fostering young people's positive connections with many social environments.
3. Youth development is based on a consistent strengths-based approach, addressing both 'protective' and 'risk' factors, as well as the range of skills young people need.
4. Youth development happens through quality relationships, supporting and equipping people for successful relationships with young people.
5. Youth development is triggered when young people fully participate, providing opportunities for young people to increase their control of what happens to them and around them, through their advice, participation and engagement.
6. Youth development needs good information drawn from effective research, evaluation and information gathering.

The findings from MYD's literature review are consistent with the youth development approach and show the following:

1. Young people's drug use is shaped by social, cultural and economic contexts. These contexts are also important in developing effective education about drugs for young people. Effective drug education requires the co-ordination of messages from a number of sources, and active support by all levels of government and the community.
2. The development of young people's strengths is likely to reduce their chances of experiencing drug-related harm. Development of strengths is one element of effective drug education.
3. Drug education is most effective when it reflects the needs and attitudes of young people, and when it is delivered using interactive strategies. Young people should also be involved in the development of drug education to make sure the units of learning are relevant.
4. Information about young people's drug use is essential for developing effective drug education. Effective drug education sometimes involves providing factual and relevant information about drugs and drug use.
5. Young people are more at risk of drug-related harm if they have poor relationships with their families, communities, school or peers. Improving these relationships is another element of effective drug education.

BEST PRACTICE PRINCIPLES FOR DRUG EDUCATION

PRINCIPLES OF BEST PRACTICE

MYD's literature review shows that student outcomes are greater when drug education:

CONTENT

1. is evidence-based
2. aims to prevent and to reduce drug-related harm
3. has clear, realistic objectives
4. is relevant to the needs of young people
5. is responsive to different cultural views and realities
6. is associated with family-based training
7. is co-ordinated with other community initiatives

PROCESS

8. uses interactive teaching styles
9. teaches young people social skills
10. provides age-appropriate, accurate and relevant factual information on the health effects and social consequences of drug use
11. critically analyses mass media messages

CONTEXT

12. follows classroom safety guidelines about the discussion of drugs and drug issues
13. is supported by a comprehensive school-wide approach
14. is long term and delivered over several years
15. provides adequate training and ongoing support for programme deliverers
16. includes ongoing review and regular evaluation.

The following section explains each of the 16 best practice principles. It includes examples of suggested learning opportunities for Years 7-13, where appropriate. Each example is linked to the appropriate level, strand and achievement objective of the health and physical education curriculum (for example, 4A3 indicates Level Four, Strand A, Achievement Objective 3).

1. DRUG EDUCATION IS EVIDENCE-BASED

Drug education should be based on sound evaluation studies and evidence on what works and does not work. One-off sessions or sessions that only use ex-addicts, scare tactics or 'just say no' approaches, have shown not to work. Drug education that does not apply the best practice principles, may be ineffective and unsafe.

Evidence must be drawn from sound research that uses clear questions and methods that produce objective information, and shows the way the data collected measures up against the research questions. Objective methods include using a range of information sources, independent researchers, unbiased samples and interviewing methods or well-designed questionnaires.

To reduce any sampling biases, the research should have a sufficient and identified number of participants representative of their population group.

At times, new or innovative drug education initiatives will be required because existing approaches to drug education are inappropriate or have diminished effectiveness. These initiatives should be piloted and comprehensively evaluated.

Information from sound evaluation studies is likely to be available from universities, peer-reviewed journals specialising in alcohol and drug topics, Colleges of Education, government websites, government-funded information websites, and alcohol and drug clearing houses such as ALAC, the New Zealand Drug Foundation and Alcohol Drug Association New Zealand (ADANZ).

An example of using the evidence base is MYD's literature review finding that social skills training is an important element in best practice drug education.

2. DRUG EDUCATION AIMS TO PREVENT AND TO REDUCE DRUG-RELATED HARM

The approach to drug education outlined in this handbook aims to prevent and to reduce drug-related harm and is consistent with the youth development approach described on page 10 of this handbook. It recommends an inclusive approach where all young people, whether they use drugs or not, are able to access, enhance and gain knowledge and skills so they can make informed choices about drug use.

This approach is not permissive towards drugs nor does it normalise their use. The approach, in its inclusiveness, supports those young people who choose not to use legal or illegal drugs as well as providing young people who do use drugs with the opportunity to examine their current drug-use behaviour and to consider a range of options, including abstinence, which can reduce the potential harm associated with their drug use.

A harm-prevention and harm-reduction approach treats all drugs (legal or illegal) as potentially risky and offers strategies to prevent and to reduce drug-related harm. It promotes the safety and protection of young people and includes a wide range of objectives such as:

- To promote wellbeing, hauora and other cultural health outcomes.
- To strengthen the resilience of young people.
- To promote and to support the non-use of legal and illegal drugs.
- To teach age-appropriate social skills, information and safe attitudes.
- To educate young people on current drug laws.
- To educate about the benefits of avoiding, delaying or reducing the initial use of commonly used substances such as tobacco and alcohol.
- To educate students on the safe use of alcohol.
- To critically analyse the reasons why people may be using legal or illegal drugs.
- To provide social skills and information about reducing the progression from experimental drug use to regular drug use.
- To provide young people likely to use drugs with age-appropriate strategies for avoiding or reducing drug-related harm (such as help-seeking strategies).
- To educate students on the correct use, and the risks related to the use, of such things as prescription drugs, steroids and diet pills.
- To foster safe, supportive environments.

An age-appropriate mix of these objectives will be necessary in any particular drug education unit of learning. Harm prevention and harm reduction is achieved through an increase in social skills and knowledge and the development of safe attitudes. This means a sole focus on abstinence is not a sufficiently comprehensive approach for drug education for young people.

Drug Education: A Guide for Principals and Boards of Trustees, *available from the Ministry of Education, promotes the harm minimisation approach on pages 26-27.*

Different types of drugs need different drug education objectives. For example, drug education on alcohol may aim to promote safe drinking levels in safe environments, and to avoid drink driving and binge drinking. Drug education on tobacco may aim to reduce the number of young people trying cigarettes or to support the ones who are experimenting to prevent them from becoming addicted.

Possible learning opportunities using a harm-prevention and harm-reduction approach to drug education:

The use of scenarios, either developed by the students or provided by the teacher, enables students to explore issues related to drugs without having to focus on their own experiences. Students could work in small groups to identify different scenarios and describe ways they could assess the situation and take action to minimise possible harm. Students could then role play their responses to the situation and/or prepare a visual presentation such as a cartoon strip, bumper sticker or poster to share with the class.

Years 7-8 (4A3; 4C3)
Scenarios should only include drug information relevant to this age group, for example, it is likely young people in this age group will have some knowledge of legal drugs such as cigarettes and alcohol and some illegal drugs such as cannabis.
Suggested scenarios:

- *being offered a ride home by a friend's parent who has been drinking beer for several hours*
- *being offered cigarettes by a group of peers*
- *being offered medication to try out.*

Years 9-10 (5A3; 5C3; 6A3; 6C2)
Suggested scenarios:

- *becoming aware a friend has brought alcohol to school*
- *leaving a friend alone who has passed out after drinking alcohol.*

Years 11-13 (6A3; 6C2; 7A3; 7C2)
Suggested scenarios:

- *arranging safe transport before a party*
- *setting up and operating a buddy system at a party*
- *communicating that you do not want to drink, and handling pressure to drink*
- *drinking moderately*
- *refusing a ride from a driver who has been drinking.*

3. DRUG EDUCATION HAS CLEAR, REALISTIC OBJECTIVES

The overall goal of drug education is to prevent and to reduce drug-related harm. Clarifying drug education objectives, achievement objectives, learning opportunities, and learning outcomes is important for assessment and evaluation purposes.

The objectives for drug education will depend on the age of the students, their attitudes, knowledge and social skills, and the community they live in. All drug education objectives must:

- be SMART: sensible, measurable, achievable, realistic and time-bound
- have input from students and, where appropriate, from families and communities
- relate to the evidence base.

Be SMART

Each drug education objective should focus on enhancing the social skills, knowledge and healthy attitudes of students. School-based drug education programmes can be evaluated by measuring the changes in students' drug-related social skills, knowledge and attitudes. However, it is usually not possible to measure the changes in students' drug-use behaviour due to the outside factors that affect their choices, such as their access to alcohol, tobacco and other drugs in the community. This underpins the need for sound and rational programme plans and well-planned evaluations.

Each drug education objective must have a related achievement objective, learning outcome and success measure. Developing realistic drug education objectives involves identifying and agreeing on learning outcomes and success measures that can be achieved within the timeframe of the unit of learning and evaluation.

If a similar unit of learning is delivered elsewhere (for example, another school), it would be useful to use similar learning outcomes and success measures so the results can be compared.

Objectives for a drug education unit of learning could be:

- To increase student awareness of personal and social factors that influence drug use.
- To increase students' knowledge about the short-term and long-term effects of drugs, the legal and negative social consequences of drug use, and the potential harm from drug use.
- To explore students' attitudes towards drink driving, intoxication and other risky behaviour associated with drugs and drug use.
- To develop students' skills for seeking help for themselves and others (for example, friends and family members), for refusing offers of drugs, or for managing situations where there are potential harms associated with drugs and drug use.
- To create a supportive, safe school environment.

An example of a clear, realistic overall drug education goal, achievement objective and learning outcome is:

Years 7-8
Overall goal: *to strengthen students' abilities to resist pressure to use drugs*
Achievement objective: *students will demonstrate knowledge and skills to make safe choices about drugs (4A3)*
Learning outcome: *students will demonstrate refusal skills through skills practice and/or visual/written responses to three different scenarios involving pressure to use drugs.*

Years 9-10
Overall goal: *to focus students' thinking on the links between drug use and injury or crime*
Achievement objective: *students will identify the ways drug use can impact on their personal safety and the safety of others (6C2)*
Learning outcome: *students will describe research findings and media reports related to drug use and the ways these can result in injury or crime.*

Years 11-13
Overall goal: *to influence and reduce student cannabis use through better-informed choices and decisions*
Achievement objective: *to familiarise students with the cannabis debate (6D3; 7D3; 8A3)*
Learning outcome: *students will gain knowledge of the key findings of the Cannabis Inquiry Committee.*

Have input from students

The drug education programme objectives must address the risks the students face concerning drug use. These include the attitudes, knowledge and social skills that need affirming, enhancing, developing or changing. It is essential drug education objectives are relevant and based on students' needs. Therefore, in the development of drug education units of learning, the developer must:

- Involve the students themselves in identifying their needs and in developing drug education objectives – ask them what social skills they need to prevent or to reduce drug-related harm. Student input will vary depending on whether it involves a new unit of learning or an adapted unit of learning for a different or a similar group of students.
- Have a clear understanding of the local community and of the needs of particular groups such as students with high and complex needs.
- Clearly identify students' knowledge, social skills and attitudes about drugs and drug-related behaviour that will be supported, influenced and possibly changed through drug education.

Relate to the evidence base

The drug education objectives must take into account the known facts about drug use and attitudes to drugs in New Zealand and in the school community. They should also be based on current New Zealand research about teaching and learning processes that promote effective learning. These are described in *Quality Teaching for Diverse Students in Schooling: Best Evidence Synthesis* by the Ministry of Education and are relevant for all communities.

National surveys show that alcohol, tobacco and cannabis are the most problematic drugs for young people in New Zealand. Drug education should focus primarily on these drugs.

Useful information is available from:

- *ALAC's surveys and research on the drinking patterns of young people which can be accessed on www.alcohol.org.nz .*
- *Russell Bishop's research on best practice for teaching Māori students. An example of his work is* Te Kotahitanga *(2003) which can be accessed on www.minedu.govt.nz .*

4. DRUG EDUCATION IS RELEVANT TO THE NEEDS OF YOUNG PEOPLE

Students should have an input into the design and delivery of the units of learning to ensure drug education is relevant to their needs.

Some groups may require specially developed drug education to meet their needs. Drug education must also be designed so the needs of Māori, Pacific and Ethnic students are met. In addition, young people with multiple and complex problems may require specially-designed programmes/interventions and services. These include the homeless, young offenders, truants, those in special care, those with learning disabilities, those with mental health problems and those living in families where family members use drugs.

Young people who took part in MYD's consultation groups, highlighted the importance of having drug education delivered by a person they relate to and who is a credible information

source for young people. Students' learning depends on the quality of their personal relationship with this person (health teacher or drug education provider). Young people also discussed the need for youth-friendly delivery methods for drug education, for example, through the use of music, visual images and real-life scenarios. Teachers and providers should have expertise in how to engage young people and to respond to the diversity of young people.

Drug education is more relevant to young people when it deals with the short-term consequences of drug use, including social consequences, as well as the long-term consequences. Young people should be encouraged to consider the need for environmental changes and to increase their social skill level. Drug education is also more relevant and useful when it provides information and social skills that are of immediate practical use. Skill training for young people may cover how they can look after themselves, for example, how to keep safe at parties and in clubs, developing refusal skills, and how to keep friends safe who over-use.

Drug education is also more relevant to young people when it reflects their reality and the specific drug-related issues in their community. The input of their community may be valuable to ensure the drug education provided fits the wider context of the students' lives.

Students and the community can have input into the development of school-based drug education through:

- *conducting a school-wide 'post-box' exercise* so young people, school staff, parents/caregivers and community groups can provide anonymous information guided by a series of four or five global questions such as "What are the important things that need to be included in school-based drug education?" – these ideas can be collated and used to stimulate further discussion*
- *using the 'post-box' findings to access additional ideas from young people from different year levels, through workshops or focus groups*
- *meetings with the school community, including parents and caregivers*
- *a hui with rangatahi and whānau*
- *fono with Pacific communities*
- *arranging a translator, if necessary, and a facilitator with appropriate intercultural skills for discussions with Ethnic communities*
- *consultation with youth workers*
- *the school getting feedback from young people on the ways the programme could be improved*
- *discussions with local health-care professionals about local issues.*

Drug Education: A Guide for Principals and Boards of Trustees *suggests various ways on page 22, including networking with other schools in the district, to learn what other forms of drug education have been successful, and adapting these if appropriate.*

**An example of how to conduct a 'post-box' exercise is provided on pages 21-23 of* Caring for Yourself and Others: An Alcohol Resource for Secondary Students.

5. DRUG EDUCATION IS RESPONSIVE TO DIFFERENT CULTURAL VIEWS AND REALITIES

Patterns of, and attitudes towards, drug use vary among cultures, and certain drug education approaches may be more appropriate for some cultures or communities than for others. For example, kava use is an integral aspect of some Pacific communities, and khat use is traditional in some African communities. In some New Zealand communities binge drinking or cannabis use has been normalised. Religions may hold definite views on the use of drugs. Cultural views are shaped by shared history, experiences, customs, values and beliefs, and also by ethnicity, gender, sexuality, ability and age.

Drug education should reflect various cultural views about drugs, where appropriate. Exploring these views with students will help them to better understand the social and environmental factors that affect drug use in their communities, in New Zealand or overseas. For example, drug issues may not be openly discussed by some communities.

To design and deliver effective drug education, it is important to understand the particular drug-related issues young people from various cultural groups may face.

It is important drug education is delivered in a culturally sensitive way. Teachers should be aware of their own cultural beliefs and values when teaching children from Ethnic groups different from their own. The cultural competency of an external provider should be considered.

Responsiveness to cultural views and realities means ensuring ongoing input from relevant cultural groups into the design, delivery and evaluation of drug education.

Responsiveness to Māori

The principles of the Treaty of Waitangi (partnership, participation and protection) are a fundamental guide to managing relationships with, and responsibilities to, Māori. (See *April Report* (1988) published by the Royal Commission on Social Policy and *The New Zealand Health Strategy* (2000) published by the Ministry of Health.)

Alcohol and tobacco use are major causes of poor health outcomes among Māori. These causes of health inequalities do not necessarily lie at an individual level.

In 2001, 14.7 percent of the total population identified themselves as Māori. Māori communities are diverse and hold a range of traditional and contemporary perspectives on health. Drug education that uses Māori health models such as Te Whare Tapa Whā, Te Pae Mahutonga and Te Wheke, may be more effective for some Māori communities. These health models may help schools in meeting their obligations to work in partnership with Māori communities and to reduce educational inequalities. It may be useful to identify Māori customs important to your students, for example, the use of karakia or not sitting on tables. However, some young Māori people may respond to messages delivered via non-Māori specific means such as hip-hop music. Young Māori people are diverse and will have different needs.

One of the underlying concepts in the health and physical education curriculum is wellbeing/hauora. The four dimensions: physical wellbeing/Te Taha Tinana, mental wellbeing/Te Taha Hinengaro, social wellbeing/Te Taha Whānau and spiritual wellbeing/Te Taha Wairua are described in the curriculum on page 31. All four dimensions are needed to strengthen wellbeing or hauora.

Responsiveness to Pacific and Ethnic communities

In the 2001 census, 6.25 percent of the total population identified themselves as Pacific people. There are six major Pacific groups in New Zealand: Samoan, Cook Island Māori, Tongan, Niuean, Fijian and Tokelauan.

The term 'Ethnic' is used for people whose ethnicity distinguishes them from the majority of other people in New Zealand, including Māori and Pacific people. Ethnic group affiliation is self-determined. Ethnicity is a broad concept that includes elements of race, language, religion, custom and traditions as well as geographic, tribal or national identity. (For further information see www.ethnicaffairs.govt.nz .)

Approximately 10 percent of the population are identified as being Ethnic, including people who identified themselves as Asian (6.6 percent of the population). It includes people from Continental Europe, Africa, Latin America and the Middle East.

Pacific and Ethnic communities are diverse. For example, some students' parents may have been born overseas or the students may be recent arrivals. Some of the young people might struggle with reconciling two worldviews while adapting to New Zealand life and respecting family values.

Traumatised young people (for example, refugees), may use drugs to alleviate mental health issues. Students from a migrant background new to New Zealand may also be at risk, especially when they are away from the influence of their extended family and not used to the relatively easy access to legal and illegal drugs.

Cultural responsiveness can be achieved by:

- *exchanging and adapting materials from schools with a similar mix of students*
- *involving cultural advisors to identify different cultural perspectives*
- *ensuring your teaching material and delivery methods are culturally appropriate for your students*
- *discussing customs and issues around alcohol and drugs in your local community*
- *understanding the diversity of your local Māori, Pacific and Ethnic young people*
- *identifying various cultural health models relevant to your community*
- *getting input from Māori and Pacific health services and local Māori communities; also from Ethnic-specific health services and school support staff who work with Ethnic communities*
- *involving Ethnic-specific organisations such as Refugees as Survivors, Multicultural Learning and Support Services, Regional Migrant Services (see Multicultural Services Centre http://msc.wellington.net.nz)*
- *implementing the processes for communicating with Māori communities as described on pages 27-28 of* Drug Education: A Guide for Principals and Boards of Trustees

- *using resource books on Ethnic communities such as* New to New Zealand *by Daphne Bell.*

Culturally responsive learning approaches can include:

Years 7-8 (3D1; 4D1)

- *Students could use the Te Whare Tapa Whā model to gain an understanding of the effects of drugs on the physical, social, mental, emotional and spiritual wellbeing of individuals and groups.*

Years 9-10 (5D1; 6A1; 6C1)

- *Students could be involved in a process of identifying and inviting relevant speakers from the community to provide different cultural perspectives on drugs and drug issues. Students could also generate questions that seek answers about drugs and drug issues.*

Years 11-13 (6A1; 6C1; 7C2; 8A4)

- *Students could research historical and contemporary customs and issues relating to alcohol and drugs in Aotearoa/New Zealand and elsewhere, and describe the ways these have influenced wellbeing.*

6. DRUG EDUCATION IS SUPPORTED BY FAMILY-BASED TRAINING

Drug education is more likely to be effective if it includes family-based training that focuses on good communications and dynamics within families/whānau. Facilitators need to have the skills and the credibility for the community they work with.

Families need information and skills on how to discuss drug-related topics with their children, how to reinforce classroom messages, how to set safe boundaries, how to recognise drug-related problems and where to go for help. For example, a possible topic could be the safe supply of alcohol to young people by family members. It may be useful to consider which media and language would be the most effective.

At times, families will have different views from what is taught in the classroom. They may not want to talk about legal or illegal drugs or acknowledge drug-related problems. In some rural areas, there may be a strong link between drug use and/or supply and low socio-economic status. It is possible that, for various religious and cultural reasons, families are unsupportive of any form of drug education.

Family-based training should at least be made available to the families of students who are more at-risk of drug-related harm. MYD's literature review found students are likely to be more at risk if they have some of these factors:

- they have low involvement in activities with adults
- they think drug use in the community is higher than it actually is
- they are in conflict with their parent(s)
- their parents have alcohol and drug problems
- there is poor family management
- they are failing at school
- they or their friends have delinquent behaviours
- they have favourable attitudes to drugs.

These factors, though, may not necessarily be indicative of legal or illegal drug use by young people. Where students have been identified with drug-related problems, it will be useful to access services that can provide family-based interventions.

Factors that can reduce the risk of drug-related harm include: having strong family bonds, having a commitment to schooling, having strong adult role models, and having the ability to be assertive and to stand up for oneself. Young people's resilience can be strengthened by a youth development approach, for example, by a strengths-based approach that helps young people to make stronger, positive connections with their families/whānau, peers, school/training/ work and their community.

Schools may be able to work in partnership with local community agencies and initiatives that provide family-based training.

Schools can promote an inclusive family-based approach to drug education by:

- *updating families on what is taught through information sheets*
- *consulting communities about health education, as required every two years by the Education Act 1989 (section 60B) – the health and physical education curriculum describes consultation guidelines for schools on pages 50-55*
- *organising family information meetings*
- *promoting drug-free school-based activities with family and Māori, Pacific and Ethnic community involvement such as Stage Challenge and Rock Quest*
- *learning about local whānau development programmes and how an alcohol and drug component may fit in*
- *involving Pacific churches or radio stations to deliver information to families*
- *using an Ethnic family liaison person in your school*
- *using interpreters to facilitate communication with Ethnic families as outlined in* Let's Talk*, Ethnic Affairs' guidelines for hiring interpreters*
- *making resources available to family/whānau in take-home packaging*
- *identifying potential mentors and support people for young people*
- *helping to introduce family-based education programmes in the district*
- *establishing partnerships with agencies who can facilitate family group conferences, including Special Education, Child, Youth and Family and Youth Justice*
- *maintaining links with CYFS, Police Youth Aid, RTLB, GSE, Public Health, Housing New Zealand and WINZ*
- *linking up with the Strengthening Families initiatives in your local community, and identifying options for working with at-risk families*
- *considering* Information for Boards of Trustees: The Issue of Drug and Alcohol Use in Children *published by the NZSTA which covers family-based drug education on pages 26-32.*

7. DRUG EDUCATION IS CO-ORDINATED WITH OTHER COMMUNITY INITIATIVES

Drug education is much more effective if its messages are reinforced by broader community interventions such as ALAC's Youth Access to Alcohol campaign. Drug education should be co-ordinated with other community initiatives aimed at reducing or controlling the supply or availability of drugs, or the treatment and support of drug users.

Many organisations in the community support the messages provided through drug education, including:

- *the Police, through youth education officers and enforcement activities*
- *youth organisations and youth workers*
- *counselling services*
- *the Safer Communities activities*
- *Māori and Pacific health services*
- *alcohol and drug treatment agencies funded by the local District Health Board*
- *public health services*
- *voluntary community groups*
- *ALAC's community action projects*
- *LTSA's drink-driving campaigns*
- *local community action programmes on alcohol and drugs*
- *local and national drug-free events, for example, Stage Challenge and Rock Quest.*

8. DRUG EDUCATION USES INTERACTIVE TEACHING STYLES

Interactive teaching approaches are student-focused, involve small group activities and enable relationship building between teachers and students. The teacher's role is to facilitate a co-operative, supportive learning environment in which students can interact safely and positively with each other. Various activity-based teaching methods and accelerated learning techniques are used to respond to the different learning styles students may have such as visual, auditory and/or kinesthetic learning styles. However, some overseas students may be more familiar with rote learning.

Methods of interactive teaching include:

- *getting students to design advertising campaigns using available multi-media*
- *developing a documentary-style video*
- *using structured debates on alcohol and drug issues*
- *developing 'safe school' recommendations and initiatives from student perspectives.*

Examples of interactive learning approaches include:

Years 7-8 (3D1; 4D1)
Students could work in small groups to identify the ways legal drugs such as coffee, cigarettes and alcohol are advertised and promoted within the community. Students could then take part in a structured class debate relating these ideas to the use of legal drugs.

Years 9-10 (5D1; 6D4)
Students could suggest a range of speakers who represent different viewpoints about drugs and drug use, to debate a drug-related topic as a discussion panel.
Students could work in pairs or small groups to prepare their questions before the panel session. All questions would be agreed on by the students and the teacher as appropriate for the range of invited speakers.

Years 11-13 (6D4; 7C2; 8D1)
Students could work in small groups, with each group representing a different interest group related to alcohol and drugs, for example, ALAC, abstinence, harm prevention and harm reduction, ACC, emergency hospital staff and Police, to prepare media material (news reports, newspaper articles, visuals, a video) that represents the messages their groups are promoting in the school and in the community.
Students could then analyse the messages, assess their appropriateness to young people in Aotearoa/New Zealand and develop appropriate messages for their age group.

9. DRUG EDUCATION TEACHES YOUNG PEOPLE SOCIAL SKILLS

Drug use is influenced by social and environmental factors as well as personal factors. Teaching social skills can help students to avoid harm in situations that involve legal and illegal drugs such as celebrations, parties or sport events. The skills taught should be relevant to avoiding or safely managing drug-use situations, and should be of immediate practical use to students. Social skills are culturally defined and should be culturally appropriate. There are also intergenerational differences.

The health and physical education curriculum identifies essential skills on pages 48-49, including self-management and competitive skills, communication skills, problem-solving skills, social and co-operative skills. These generic skills apply to all aspects of health education. In a comprehensive programme, there will be many opportunities for students to rehearse these skills in a variety of situations. For example, providing opportunities for students to rehearse refusal skills is essential given the lack of these skills has commonly been seen as a risk factor for drug use, particularly tobacco use.

Teaching social skills is an essential part of drug education and social studies. Skills practice is ideal for rehearsing drug-related situations within safe environments to develop the students' confidence, assertiveness, decision-making and refusal skills. It enables students to practice interpersonal skills and get feedback from other students on how they approach situations like refusing drugs.

The New Zealand Qualifications Authority has various unit standards covering a range of health topics and life skills such as communication, assertiveness, problem solving, stress management and team skills. Health education units at Level 3 can contribute towards the requirements for University Entrance.

Friendship, *part of the* Curriculum in Action *series, provides examples of how to teach relationship skills for Years 9-10.*

Students can also be provided with information about personal wellbeing and social attitudes towards drugs. They can explore the relationship between drugs and sport, and the use of alcohol, cannabis and ecstasy in social settings.

The development of students' social skills is an important goal of the harm prevention and harm reduction approach:

Years 7-8 (3C3; 4C3)
Students could prepare drug-use scenarios that involve the need to make a healthy decision, to demonstrate assertiveness skills, and to use 'I' statements. Students would then role play the situations.

Years 9-10 (5C1; 5C3; 6C2; 6C3)
In groups, students work with scenarios related to drugs and drug use to identify the potential risk and the possible harm that could occur. Students work with a decision-making model to explore the consequences and options related to the scenario. Students then work in pairs to rehearse the ways different response behaviours (for example, passive, aggressive, assertive) impact on their decision making.

Years 11-13 (6C2; 6C3; 7C2; 7C3; 8C1)
In groups, students work with a range of drug-use scenarios to demonstrate their skills in being able to refuse drugs and to minimise the possible harm associated with drug use. Scenarios could focus on the availability of drugs in social and sporting situations.

Students could also critically analyse social attitudes towards drugs and the ways attitudes towards drugs and drug use have changed over time.

Note: When working with scenarios, it is helpful if students receive ongoing feedback from their peers and the teacher about how they have approached situations such as refusing drugs. This ongoing relationship of students with their teachers is an important feature for school-based drug education.

10. DRUG EDUCATION PROVIDES AGE-APPROPRIATE, ACCURATE AND RELEVANT FACTUAL INFORMATION

Students need age-appropriate, accurate and relevant information on the health effects and social consequences of drug use, drawn from sound research rather than guesswork or personal beliefs. Regional differences in the prevalence of drugs and community attitudes towards legal and illegal drugs need to be taken into account.

The information must:

- be relevant to the students' age group, clarifying what they already know and what they need to know
- describe the prevalence of drug use among similar age groups, which is generally lower than students realise

- be of immediate practical use to students, focusing on the short-term health and social effects of drug use
- be related to students' values, attitudes and perceptions, and be based on a knowledge of the prevalence of drugs and the broad school community
- be provided in a credible manner that takes into account students' beliefs about and experiences of drugs
- be drawn from robust research and not exaggerate or use scare tactics, which will undermine the credibility of the information and alienate existing drug users.

National surveys have shown the drugs most commonly used by young people are alcohol, tobacco and cannabis. Most drug-related problems occur for young people while using these drugs.

Note: Information should not be provided about solvents if students are not already using them. There is only a small proportion of the total population (0.1 percent in 2001) that uses solvents and there was no change in this proportion between 1998 and 2001. The distribution of information about solvent inhalants may alert non-users to the wide range of household and readily available products that may be obtained and misused. However, if some students are using solvents, they must receive information to help them to avoid harm and ideally to stop using them. If students handle solvents in class, safe handling needs to be taught as part of the health and safety regulations.

National figures on alcohol and drug use for different age groups are available from the Ministry of Health, the Adolescent Health Research Group, the Alcohol and Public Health Research Unit (APHRU) and the Centre for Social and Health Outcomes Research and Evaluation (SHORE). Information on local use may be available from Police education officers.

Relevant information may be found on the following websites:

New Zealand Drug Foundation
www.drugfoundation.org.nz
ALAC
www.alcohol.org.nz
ADANZ
www.adanz.org.nz
Urge/Whakamanawa
www.urge.org.nz
National Drug Policy
www.ndp.govt.nz
Ministry of Health
www.moh.govt.nz
Health Sponsorship Council
www.healthsponsorship.co.nz

MYD's website *(www.myd.govt.nz/pag.cfm?i=391) provides information on solvent abuse by young people.*

Suggested learning opportunities for students to gain relevant factual knowledge about drugs and drug use:

Years 7-8 (3D1; 4D1)

- *Students could be provided with statements describing the effects on wellbeing of legal drugs commonly used in society such as tea, coffee, chocolate, alcohol and cigarettes. In groups, they organise the statements under physical, social, mental, emotional and spiritual effects on wellbeing.*

Years 9-10 (5D1; 6D1)

- *Students could be provided with age-appropriate statements relating to drugs and drug use. They could work in pairs, groups or as a whole class to decide which statements are true and which are false.*
- *Students could also work in groups with each student receiving a different set of factual information about drugs and drug use which they read, identify key points and share these points with the rest of the group. Each group could then share their findings, as a class, to check for consistencies in the interpretation of factual information.*

Years 11-13 (6D1; 8A1; 8A3)

- *Students could analyse dilemmas and ethical issues related to drugs and drug use that influence their personal health and that of others. For example, students could work in pairs or individually to research a dilemma or ethical issue, prepare a report and present a summary of the report to the class. There are links with the English, Science and Social Studies areas and achievement standards for Research and Presentations.*
- *Students could also collect existing data about drugs and drug use in Aotearoa/New Zealand, identify the key findings, make recommendations and create strategies to meet the current and future needs of young people in their age group.*

11. DRUG EDUCATION CRITICALLY ANALYSES MASS MEDIA MESSAGES

Drug education in schools is more effective if it is supported by mass media messages such as Smokefree advertising. This includes ethnic and language-specific media such as radio, printed media and websites. If media messages are inconsistent with drug education principles, drug education needs to address this inconsistency. For example, advertising may glorify drinking a specific product, while ALAC promotes moderate drinking. Analysing these messages provides an opportunity for young people to develop and apply critical analysis skills while exploring this type of inconsistency. Students may explore how tobacco is promoted, even though tobacco advertising is banned in New Zealand.

Topics could include:

- *various attitudes towards legal and illegal drugs*
- *messages and strategies used by the advertisers of alcohol*
- *themes and messages of Smokefree promotions*
- *the use of drugs in the popular media, such as cigarette smoking in movies, drinking in television programmes or drug references in song lyrics.*

The food and nutrition learning area of the curriculum encourages young people to think about how to make healthy decisions about food. Curriculum in Action: Making Connections *gives examples of learning activities for Years 9-10. The framework of the lessons can be used when teaching young people how to make healthy choices about drugs. Links are possible with the Science and Technology areas.*

Suggested learning opportunities for students to explore attitudes, values, messages and strategies about drug use in society, and the ways different media portray these:

Years 7-8 (3D1; 4D1)

- *Students could explore the messages and themes of Smokefree promotions and the relevance of these messages for their age group.*

Years 9-10 (5D1; 6D1)

- *Students could explore the use of drugs in the popular media, such as cigarette smoking in movies, drinking in television programmes or references to drugs in song lyrics. There are links with the English, Media Studies and Social Studies areas.*

Years 11-13 (6D1; 7D1; 8D1)

- *Students could participate in a values continuum that explores various attitudes towards legal and illegal drugs. This learning activity links to Social Studies.*
- *Students could critically examine the ways both individuals and groups may be persuaded and enticed by the advertisers of legal drugs.*

An example of how to facilitate a values continuum is provided on pages 24-26 of Caring for Yourself and Others *(1998).*

12. DRUG EDUCATION IS SUBJECT TO CLASSROOM SAFETY GUIDELINES ABOUT THE DISCUSSION OF DRUGS AND DRUG ISSUES

Schools need clear guidelines about classroom discussions on drugs and drug issues. The safety guidelines should be designed so drugs and drug issues can be discussed generally in a positive and supportive environment. Disclosure of personal drug use or the drug use of other people such as family members should be avoided. This is to prevent unwanted legal or personal consequences from revealing information, and to ensure drug use is not modelled by peer-group leaders, teachers or external providers. The drug education guidelines (page 19) discourage schools from using ex-addicts.

The safety guidelines need to describe how much professional discretion a teacher may use, what course of action to use when a personal disclosure is made or problems have been identified, the procedures for follow-up from issues raised in the classroom, when to refer students and when to initiate disciplinary actions. Most schools may already have a policy on disclosure which deals with a wide range of topics, such as sexual harassment. Young people who are experiencing drug-related problems will need an intervention approach with a clinical focus. Contact details for the school counsellor, the school health nurse and helping agencies should be made available to staff and students.

At times, external providers are brought in by schools to create a safe environment for students to discuss drug use in confidence. External providers must work within the school's classroom safety guidelines. It is important external providers have quality teaching skills, know how to deliver drug education within the health and physical education curriculum and have an ability to

assess students' progress according to the best practice principles.

Schools may consider incorporating other factors into the safety guidelines that influence classroom safety, such as cultural safety. The safety guidelines may sit under umbrella policies such as a safe school policy, or they may be documented with a curriculum department statement that sits under a teaching and learning policy.

It is useful to discuss confidentiality issues and classroom safety guidelines at the start of the unit of learning, clarifying what these mean and why are they necessary.

Years 7-13 (the following comments are relevant to each year level that takes part in drug education)
It is important for students, at each year level drug education is being implemented, to have the opportunity to clarify the ways drugs and drug issues will be discussed. Suggestions for this include:

- *Make a statement that is inclusive of both young people who are not currently using drugs and those who are. It is also important to acknowledge that, while the young person may have chosen not to use drugs, they may have family members who currently use drugs and/or whose wellbeing has been negatively influenced by their drug use. Students also need to know about local alcohol and drug services and telephone services such as Youthline or Alcohol and Drug Helpline.*
- *At the start of the drug education unit of learning, emphasise to students that they are not expected to share personal information about themselves or others in relation to drug use. Instead, learning will be based around simulated scenarios of real-life events.*
- *Highlight the fact some students may recognise, as a result of participating in a unit of learning, their drug use or the drug use of others has become problematic for them. It is important they know who they can disclose this information to in a way that is confidential and enables them to access the support they need.*

At each year level, the establishment of class safety guidelines is essential if students are to be able to work together in a safe, supportive environment. Students should spend time in small groups generating safety guidelines which can then be discussed and agreed on by the whole class. The teacher and/or drug educator should also participate in this process. Examples of the way safety guidelines can be negotiated are provided on pages 13-15 of Caring for Yourself and Others, Volume One.

Case studies can be used to depersonalise discussions around drug-related topics.

Drug Education: A Guide for Principals and Boards of Trustees *discusses the role of the classroom teacher on page 21, the need for privacy and confidentiality when working with young people on page 24 and recommended approaches in responding to drug-related incidents on page 32.*

13. DRUG EDUCATION IS SUPPORTED BY A COMPREHENSIVE SCHOOL-WIDE APPROACH

School policies and practices must support the objectives of drug education. This means schools should adopt the harm prevention and harm reduction principle for policies, for example for dealing with drug-related issues. Schools can also support the objectives of drug education through implementing multi-levelled, comprehensive health education programmes that are supported

by a whole-school approach. Health education teachers need to be supported to attend relevant professional development courses which reflect best practice principles for drug education. They must also receive adequate resourcing to run drug education programmes.

Health Promoting Schools provides a model for a school-wide approach. It was developed by the WHO and introduced in New Zealand in 1996. Health Promoting Schools are schools which display, in everything they say and do, support for and commitment to enhancing the emotional, social, physical and moral wellbeing of their school community.

Health Promoting Schools aims to:

- foster the healthy development of children and young people in their settings of school, community and peer group so they can learn, grow and contribute now and in the future
- offer schools a framework for developing health-promotion initiatives in a way that supports and enhances their existing structures, programmes and practices
- help schools to evaluate the range of health-related activities they are currently involved in, identifying areas of need and setting goals for future action
- enhance the links between schools and their communities in promoting positive health and learning outcomes for young people
- raise the awareness of the importance of promoting health for all.

There is a national Health Promoting Schools' Association and a network of regional Health Promoting Schools co-ordinators to support school initiatives. The website www.hps.org.nz gives examples of how New Zealand schools are applying the Health Promoting Schools approach.

Health Promoting Schools in Action in Aotearoa/New Zealand: A Resource to Assist Schools in the Implementation of Health Promoting Schools *is a practical resource for schools.*

A comprehensive school-wide approach may cover:

- *the mental health of the whole school community, including staff*
- *legal and illegal drug use on the school grounds, including the use of these drugs by staff, Board members and visitors*
- *the safe handling and administration of prescription drugs*
- *access to health services*
- *partnerships between schools and communities.*

The health and physical education curriculum is an integral part of the conceptual framework for Health Promoting Schools. Suggested learning opportunities could include:

Years 7-8 (3D3; 4D3)
Once students are familiar with the school's drug policy, they could work in small groups to develop a range of visual information to be displayed around the school and in classrooms that promotes safety in relation to drugs such as:

- *where and who to go to for help*
- *ways to manage situations where they may be confronted with drugs or where the drug use of others may impact negatively on their safety.*

Years 9-10 (5D1; 6D2)
Students could work in small groups to discuss how the school drug policy addresses situations such as:

- *student drug use at school*
- *school and community support structures for students who experience problems related to their drug use*
- *ways students can seek help at school and/or in the community for concerns about their own drug use and/or the drug use of others.*

Years 11-13 (7D2; 8A1; 8D3)
Students could work in small groups to develop and conduct a school-wide survey to:

- *find out the numbers of students and staff who are aware a policy about drugs and drug education exists, and their knowledge of the content of the policy.*

Students could then:

- *present the results of the survey and key recommendations from their findings to the Health Promoting Schools team, Board of Trustees, student council, parents and community representatives*
- *work in groups to develop an action plan to address the key recommendations.*

14. DRUG EDUCATION IS LONG TERM AND DELIVERED OVER SEVERAL YEARS

One-off drug education sessions are unlikely to have any significant effect. Drug education is more effective when it is implemented as multi-levelled units of learning over several years that build on and reinforce learning over time.

Ideally, drug education should not only take place during Years 1-10, the compulsory years for health education, but also during Years 11-13, when more young people are likely to be exposed to drugs. The programme objectives will need to be different depending on the student age group. There should be six to 10 sessions a year, revisited in successive years as young people progress through adolescence.

Education on alcohol, tobacco and illegal drugs will require a specific focus in different sessions. Initial drug education will need to focus on preventing use and delaying first use. Delaying first use has been found to reduce the degree of misuse in later years. Subsequent sessions will address ways to prevent experimentation from developing into regular use, and later sessions will provide strategies for managing real-life situations that involve alcohol and drug abuse.

15. TEACHERS GET ADEQUATE TRAINING AND ONGOING SUPPORT

Teachers and drug educators need to be competent in their ability to deliver programmes in a manner consistent with the drug education objectives and the achievement objectives of the health and physical education curriculum. They need to use the appropriate interactive teaching approaches and relevant resources to meet the students' needs.

Teachers and drug educators also need regular feedback and evaluation on their performance from students and other health teachers.

It would be useful for teachers to examine their own attitudes towards and practices of using legal and illegal drugs.

Training for peer educators

Peer education involves a person of a similar age and background to the students providing information about drugs and drug use to students. Peer education should not be used unless the programme provides full training, support and clinical supervision to peer educators, and conforms with the guidelines for peer education published by the Australian National Centre for Education and Training on Addiction (McDonald et al 2003).

Teachers delivering drug education should take advantage of professional development opportunities in mental health provided by the Colleges of Education for teachers delivering the health curriculum. Other sources of information include conferences on youth drug issues and workshops presented by the SHORE research centre at Massey University in Auckland or the PPTA. Using mentoring or support networks with health teachers and taking part in email discussions may also help keep ideas and content up to date.

16. DRUG EDUCATION HAS REGULAR EVALUATION

Self-review and evaluation are integral parts of drug education and are planned before a unit of learning starts. They provide essential feedback about students' achievement of learning outcomes and what has worked and not worked in relation to content and teaching strategies. The information gained from this feedback will show how drug education can be improved.

External drug education should be evaluated against the school's overall programme plan after the first year, and then at least once every three years after that.

Evaluation ensures that:

- units of learning are based on the health and physical education curriculum
- units of learning use best practice principles and are delivered appropriately
- each objective is achieving its learning outcome (the results of the evaluation will show this)
- the unit of learning and learning opportunities are effective in enhancing students' knowledge, social skills and safe attitudes towards drugs and drug-related behaviour in ways that are healthy and safe for them.

Self-review by teachers is part of a continuous cycle of improvement that focuses on questions such as:

- *what did we plan to do?*
- *are we doing it?*
- *is it working or not?*
- *how do we know and what is the evidence?*
- *what needs improving?*
- *what action is needed?*
- *how and when will we review whether the action is successful?*
- *did we achieve what we set out to do, and what is the evidence?*

THE PROGRAMME PLAN

For the purpose of this section, 'drug education programme plan' refers to the development of multi-levelled units of learning that integrate drug education into the overall plan for a comprehensive health education programme in a school. This section provides a draft drug education programme plan for schools and external providers to complete when developing drug education. The draft drug education programme comprises units of learning that will occur from Years 7-13.

Using the programme plan will ensure the drug education programme is developed methodically and carefully and is consistent with best practice principles. It will also ensure that review and evaluation are part of the programme delivery.

The programme plan has three purposes:

- for a school to complete when developing a drug education programme
- for a school to require an external provider to submit when the school is deciding whether to use the provider's sessions
- for a government agency to require an external provider to submit when the agency is considering funding the provider.

Sometimes a school shares the delivery of a drug education programme with an external provider. In these cases, both the school and the provider should complete a programme plan, to ensure all parts of the programme have consistent objectives and relevance.

A programme plan needs to cover the following 11 areas.

1. A WHOLE-SCHOOL APPROACH

A statement about how the programme is supported by a whole-school approach, including:

- whether the programme is harmonious with school policies on drug issues
- how well informed members of the school community are about the programme
- how the Board of Trustees, school administration, and teaching staff support the programme and its messages.

External providers must show how their services will fit in with the school community and school policies.

2. COMMUNITY CO-ORDINATION

A statement about the ways the programme links in with local initiatives such as those targeting under-age tobacco sales, and with other agencies and organisations working in drug education in the school's community.

If the programme takes a different direction from these, a statement must be included explaining why.

A statement about how the programme will address mass media messages and conflicting views from different sections of society.

3. CULTURAL RESPONSIVENESS

A statement about how the programme contributes to meeting the needs of the students who are Māori, Pacific people or from Ethnic groups. The statement must show how:

- the needs of these students will be identified
- the cultural diversity of the local community will be assessed
- the families and communities of these students will be informed about and involved in the programme
- the programme will actively work to reduce inequalities and demonstrate partnerships with Māori, Pacific and Ethnic families and communities.

4. TRAINING AND SUPPORT

A description of the qualifications of the drug educators who will deliver the programme, including their teaching qualifications, training and experience in drug education and what ongoing support they will have. External providers must show they are working from sound education principles.

5. RELEVANCE TO YOUNG PEOPLE

A description of:

- how a representative focus group of students has helped identify the learning outcomes
- how the focus group has pre-tested the programme, and how the programme has been adapted if necessary following pre-testing
- how young people will have ongoing input into the content and delivery.

6. CONSISTENCY WITH THE HEALTH AND PHYSICAL EDUCATION CURRICULUM

A description of the way the drug education programme links to the health and physical education curriculum. The description must include details about how the programme will address these three learning strands:

- developing and maintaining personal health and physical development
- enhancing interactions and relationships with others
- creating healthy communities and environments.

7. PROGRAMME OUTLINE

A full outline of the programme content, detailing the content for units of learning including six to 10 sessions each year over several years. The outline must:

- be consistent with the objectives and learning outcomes
- state what age group is targeted and show how the learning outcomes are relevant for this age group
- show how the programme will meet differing needs (for example, the needs of students who abstain from drug use, students who are curious about drug use, students who use drugs, students who are having difficulty with their own or others' drug use)
- show how the programme will address attitudes to drugs and drug use
- show how the programme will help the students develop social skills for drug-related situations
- state the number and frequency of sessions
- describe the resources and interactive teaching strategies that will be used.

External providers must show they have the financial and organisational viability to support the delivery of the sessions for three years.

8. GOALS, OBJECTIVES, LEARNING OUTCOMES AND SUCCESS MEASURES

A statement of the programme's high-level goals, and a statement of its objectives, learning outcomes and success measures, and how these interrelate.

Goals are the long-term issues the programme aims to contribute to. Objectives are what the programme aims to achieve.

The objectives are chosen on the basis of the students' needs and must cover a mix of drug-related social skills, knowledge and attitudes and show what social skills, knowledge and healthy attitudes the students will gain from the programme. A description of the strategies of how these objectives are expected to be achieved, needs to be included.

The learning outcomes must show what harm prevention and harm reduction the programme aims to achieve.

9. CLASSROOM SAFETY

A description of the safety guidelines on the disclosure of drug use and confidentiality, and a statement that these safety guidelines will be explained to students taking part in the programme.

10. FACTUAL INFORMATION

A list of the research sources for the information provided in the programme.

A description of how the information will be delivered so that it:

- is relevant to the students' age group
- describes the prevalence of drug use among similar age groups in New Zealand and in the school community
- is of immediate practical use to students
- is linked to students' values, attitudes and perceptions
- is provided in a credible manner
- does not exaggerate or use scare tactics.

11. SELF-REVIEW AND EVALUATION

A description of the process for self-review, ensuring that continual improvements are made to the programme. The more the self-review mirrors the evaluation processes as described in this handbook, the more reliable this information will be.

A description of the process for evaluating the programme, including:

- the number of students who will participate, and their age and ethnicity
- what mix of and change in social skills, knowledge and attitudes will be measured, and how
- evaluation methods and a timetable

- a summary of previous evaluation findings (if any) on the impact or effectiveness of the programme, and how they have been used to adapt the programme.

External providers must show they have the financial and personnel resources for the ongoing and robust evaluation of their sessions.

EVALUATION GUIDELINES

The following evaluation guidelines have been developed from the findings of MYD's literature review. They describe how schools, external providers and funders can assess whether the drug education programme is working well, and whether it is being implemented as set out in the programme plan. The evaluation will provide qualitative and quantitative information in a robust way. To date, drug education programmes implemented in New Zealand have lacked a robust evaluation of their effectiveness.

Evaluations should aim to develop and critique the programme plan in terms of formulating goals, objectives and strategies, reviewing the process of implementing the programme and assessing any short to medium-term impacts. Evaluation activities should include assessing the ways the principles of best practice have been integrated into the design and delivery of the drug education programme. Measuring programme effectiveness involves assessing the students' achievement of learning outcomes. Typically, this would include the assessment of any increases in young people's drug-related social skill levels, knowledge and safe attitudes. The review may also cover relevant school policies and the assessment of other teachers/staff views on the programme.

The evaluation must include:

- A **questionnaire** at the beginning of the drug education unit of learning to assess students' prior knowledge and attitudes, and at the end of the sessions to assess the increase in students' knowledge and changes in safe attitudes. The questions will relate to the drug education objectives, achievement objectives and learning outcomes.
- An **assessment/observation** of students' social skill levels, through written and/or oral responses to scenarios about drugs and drug use at the beginning and at the end of the unit of learning. Assessment should relate to the drug education objectives, achievement objectives and learning outcomes. The information from the observations is used to assess the students' learning of social skills.
- **Feedback** from students and teachers should be collected at the end of sessions included in the unit of learning. Additional feedback can also be accessed from other school and community members, including family and whānau. This feedback will provide qualitative information on the effectiveness of the programme.
- A **record** of students' participation and response during sessions, including how many students participated, how many didn't participate and what percentage of students provided feedback. It will provide information on how reliable the findings from student satisfaction surveys are.
- An **implementation review** of sessions against the session plans. It will provide information on how well the session plans have been implemented and the principles of best practice have been applied in the delivery of the drug education. It also covers the teacher's reflection on their practice.
- A **report** setting out the results of the evaluation. The report is a way to record evaluation findings and to communicate them to the school management, Board members, parents, students and funding organisations. The recommendations from the report can then be translated into an action plan and changes to the drug education programme can be monitored.

Progress can be reported in the two-yearly consultation meetings with the local community on health education.

Evaluation is essential to assess the effectiveness of a drug education programme and to improve it on an ongoing basis. Evaluation processes should be an integral part of the drug education unit of learning plan and can be carried out effectively in class time. Make sure the evaluation is carefully planned within the scope of the available resources (expenses, time and personnel) to carry out the evaluation.

BEFORE THE SESSIONS

1. Determine the needs of the students and the community, guided by the 16 principles of best practice.
2. Identify drug education objectives, achievement objectives and learning outcomes, for the unit of learning. This should be done when the unit is developed.
3. Plan the evaluations so they are integrated into the overall programme plan. Ensure there are sufficient resources (expenses, time and personnel) to carry out the evaluation at the appropriate times.
4. Questionnaires for pre and post testing of the effects of drug education should be developed in consultation with students. Develop a draft questionnaire and trial this with the students who will be taking part in the drug education units of learning. Ask the students to provide feedback on the structure and wording of each question and how straightforward it was for them to answer it. Make changes to the questionnaire where necessary. This questionnaire can become a standard questionnaire.

Get help from people with experience in questionnaire design, if necessary.

5. Obtain the baseline data for the evaluation:

- Give the final version of the assessment questionnaire to all students taking part in the sessions. Make sure they know the questionnaire is confidential.
- Observe and record the skill levels of students, as they relate to the drug education objectives, through their written and/or oral responses to scenarios about drug use. This will provide teachers with evidence of the students' prior knowledge and skills.

Collecting this baseline information is essential for you to assess the ways the sessions have contributed to changes in the students' social skills, knowledge and attitudes.

DURING THE SESSIONS

Record participation rates for each session, and regularly summarise student participation and responses:

- Are all students participating and finding sessions useful?
- Which students, if any, are not participating? Why are they not participating?
- Is there any verbal feedback from students, parents or teachers about the value of sessions?
- Do the sessions appear to be meeting the needs of Māori, Pacific or Ethnic students?
- How could future participation be improved?

AFTER THE SESSIONS

1. Collect results data by giving students the same questionnaire you used before sessions began. Identify what progress students have made.
2. Observe the social skill levels of the students, through their written and/or oral responses to scenarios, and compare them to your observations at the beginning of the sessions.
3. Assess whether the changes in students' social skills, knowledge and attitudes exceeds, meets or fails to meet the relevant learning outcomes. These are related to specific strands, levels and achievement objectives from the health and physical education curriculum.
4. Ask students what changes they have noticed in themselves in relation to their skills, knowledge and attitudes towards drugs and drug use as a result of taking part in the programme. Which specific changes have occurred and what was it in the programme that contributed to those changes. Students could provide this information through reflective diary writing or written/oral exercises. It will ensure the drug education programme has been relevant to the needs and experiences of the students.
5. Get feedback on how well sessions worked from students and teachers. Board members, families/whānau and community members could also be invited to provide feedback where appropriate. Use a written survey, personal interviews or an open feedback session. If you use a survey or personal interview, make sure people know their responses are confidential.

Develop feedback questions based on these suggestions:

- Were there sufficient sessions to cover the drug education objectives, the achievement objectives and the learning outcomes for the programme?
- Was the content suitable? Were the important and topical issues dealt with?
- Was the information relevant to students, their whānau/family and their community?
- Was the information presented in a way students could understand it and relate to it? If not, why not?
- Were the activities appropriate?
- How could the sessions be improved?

6. Reflect on your practice: what worked, what didn't work, what can be improved and how?
7. Review how well the sessions were implemented according to the session plans.
8. Record and give out the evaluation information.

EVALUATION REPORT

An evaluation report covers the following areas.

Background
Describe the programme and the evaluation aims.

Method
Describe how you conducted the evaluation and how you obtained the information and data. Attach a copy of the session plans.

Knowledge and attitudes
Summarise any changes from the baseline data. State whether the changes exceeded or met the stated objectives, learning outcomes and success measures.

Social skills
Summarise any improvement in the students' social skill levels that shows they could respond in ways that could prevent or reduce harm in different drug-related situations. State whether this improvement exceeds or meets the stated learning outcomes.

Feedback
Summarise the positive and negative feedback about the session, and suggestions for improvement.

Implementation review
State whether the sessions were implemented as set out in the session plans, and the reasons why not, if necessary. Identify and address any risks to the implementation of future programmes. State whether any parts of the session plans need revising or changing.

Changes
Describe the changes you will make to the sessions as a result of the evaluation findings, and what consultation, actions or resources these changes will require.

EVIDENCE FROM THE EVALUATION

An evaluation provides evidence on how effective a programme is, based on how:

- the programme is linked to the health and physical education curriculum
- all the principles of best practice have been implemented into the design and delivery of the programme
- the programme increased young people's drug-related social skill levels, knowledge and safe attitudes
- improvements have been made to the programme over time, based on previous evaluation findings.

EXTERNAL EVALUATIONS

In addition to the self-evaluation by teachers or external providers as outlined in the evaluation guidelines on pages 35-39, evaluation should also be carried out by external and independent evaluators where appropriate. External providers, in particular, should have information on the effectiveness of their programmes from robust external evaluation. The effectiveness of the sessions should be measured in three ways: young people's increased drug-related social skill levels and knowledge and changed attitudes.

These external evaluations will ensure the lesson plans are based on best practice, fit within a larger programme plan and meet their objectives, and that self-evaluation is being carried out adequately. External evaluations should use a mixture of methods: observations of the school-based programme, qualitative information from interviews and both quantitative and qualitative information from documentation.

External evaluations need to be carefully prepared and carried out. Many such evaluations in New Zealand and overseas have had major methodological failings. Anyone considering conducting an external evaluation should get independent professional or official advice about the methodology they will use, to ensure the best use of the resources and to add value to the knowledge about drug education in New Zealand.

A report on the external evaluation should provide the following information:

- a critique of the programme plan
- the evaluation qualifications and expertise of the evaluators
- the type of robust methods for the evaluations that were used
- the appropriateness of the qualifications of the provider to deliver drug education
- the effectiveness of the needs analyses undertaken in identifying the needs of the students' families and communities
- the ways the unit of learning is based on the health and physical education curriculum
- the ways the 16 principles of best practice, as described in this handbook, have been incorporated into the session plan
- how effectively the sessions have been implemented
- how effective the sessions have been in meeting their objectives and in meeting students' needs
- the particular changes in students' drug-related knowledge, social skills and safe attitudes that can be attributed to the learning opportunities and learning outcomes of the units of learning implemented
- evidence of the provider's ongoing self-evaluation of the drug education implemented
- the ways young people and their families were involved in the evaluations, and how culturally appropriately this was done
- the use of self-evaluation findings to improve and to increase the effectiveness of the units of learning implemented.

QUALITY EXPECTATIONS FOR EXTERNAL PROVIDERS

Drug Education: A Guide for Principals and Boards of Trustees (page 21) identifies that effective programmes in schools are based on the health and physical education curriculum and delivered by appropriately trained and supported teachers. At times, schools may decide to use an external provider to strengthen their curriculum-based approach by including specific sessions within units of learning. The challenge for schools is to assess how these external providers strengthen the curriculum-based approach, how these sessions add value to the core drug education programme delivered by teachers and how effective these sessions are.

The best practice principles, the programme plan and the self-evaluation guidelines create a set of quality expectations for external providers of drug education sessions.

When deciding whether to use, purchase or fund sessions from an external provider, a school or funder should require the provider to supply:

- a completed drug education sessions plan according to the programme plan in this handbook
- a report on their self-evaluation of the sessions (if the sessions have been delivered before)
- a report on an external evaluation of the sessions (if the sessions have been delivered before).

These three documents will provide the evidence the external provider's sessions meet the quality expectations of:

- incorporating the 16 best practice principles of school-based drug education
- being based on a full and documented needs assessment of the students and their community
- including regular self-evaluations and external evaluations as part of session delivery.

External providers should meet these quality expectations.

CHECKLIST FOR SCHOOLS TO ASSESS THE EFFECTIVENESS OF EXTERNAL PROVIDERS

To meet quality standards for effective drug education, providers should be able to supply schools and funders with evidence on how their sessions meet the following criteria for session planning, self-evaluation and external evaluation.

1. SESSION PLANNING

The provider has submitted a plan for sessions as described under the programme plan in this handbook. The plan identifies that:

the sessions are linked to the health and physical education curriculum and address its learning strands, levels and achievement objectives	YES	
the 16 principles of best practice for school-based drug education as described on page 6 are integrated into their sessions	YES	
the sessions' goals, achievement objectives and learning outcomes are clearly stated and include a mix of drug-related knowledge, social skills and attitudes, and promote a harm prevention and harm reduction approach	YES	
the learning opportunities are kept relevant to young people, and how the input from young people is ensured in the design, delivery and evaluation of the sessions	YES	
cultural responsiveness and the diverse needs of students and their communities are addressed – specific information may focus on Māori, Pacific and Ethnic groups, including any consideration of religious sensitivities	YES	
the sessions are co-ordinated with local community initiatives	YES	
media messages will be addressed	YES	
research sources for the information provided in the sessions are included	YES	
this information will be delivered in a practical, credible, interactive and youth-friendly way	YES	
safety guidelines on disclosure and confidentiality to ensure classroom safety are clearly stated, and how these guidelines will be communicated to students	YES	
sessions are consistent with the school policies on drug issues	YES	
the relevant teaching qualifications, training and experience of the drug educators who deliver the sessions are stated, and what ongoing support and appropriate professional development these educators have	YES	
the sessions' outline, the number of sessions, specific details on the content of each session and the relevance of the content for various age groups are clearly stated.	YES	

2. SELF-EVALUATION

The provider has submitted a report, completed in the last three years, on their self-evaluations which assess the effectiveness of their sessions as described in this handbook. The report provides information on:

the process and timing of the needs analyses of the students' families and communities, and what needs were identified	YES	
the evaluation methods, including the gathering of baseline information, the questionnaire measuring changes in students' knowledge and attitudes and the assessment methods for measuring changes in students' social skill levels	YES	
student participation rates for each session	YES	
the positive and negative feedback about the session, and suggestions for improvement	YES	
an implementation review, showing how effectively the session plan was implemented	YES	
how effective the session was in improving students' drug-related knowledge, skill and attitudes	YES	
what changes were made and/or were intended to be made in response to evaluation findings	YES	
ongoing, adequate self-evaluation by the provider of their session.	YES	

3. EXTERNAL EVALUATION

The provider has submitted a report, completed within the last three years by independent, external evaluators, on the effectiveness of their session. The report describes and assures:

the evaluation qualifications and expertise of the evaluators	YES	
robust evaluation methods	YES	
that the provider has the appropriate qualifications to deliver drug education	YES	
how effective the needs analyses have been in identifying the needs of the students' families and communities	YES	
how closely the session plan is linked to the health and physical education curriculum	YES	
how effectively the 16 principles of best practice, as described in this handbook, have been incorporated into the session plan	YES	
how effectively the session has been implemented	YES	
how effective the session has been in meeting its objectives and in meeting students' needs	YES	
what particular changes in students' drug-related knowledge, social skills and safe attitudes have been as a result of the session	YES	
how effective the provider has been in self-evaluation on an ongoing basis	YES	
how young people and their families were involved in the evaluations, and the cultural appropriateness of this process	YES	
how the findings from the self-evaluations have lead to improvements and the increased effectiveness of the session	YES	

Schools are encouraged to provide their own drug education when a provider does not meet these quality standards.

REFERENCES AND FURTHER READING

Adolescent Health Research Group (2003) *New Zealand Youth: A Profile of Their Health and Wellbeing,* Auckland: Auckland University.

Allen & Clarke Policy and Regulatory Specialists (2003) *Effective Drug Education for Young People: A Literature Review and Analysis,* Wellington: Ministry of Youth Development.

Bell D (ed) (2002) *New to New Zealand: A Guide to Ethnic Groups in New Zealand*, Auckland: Reed Publishing.

Christchurch College of Education (1998) *Caring for Yourself and Others: An Alcohol Education Resource for Secondary Students: Volume One and Two, Additional Resources Folder, Assessment in Alcohol Education,* Christchurch: Christchurch College of Education.

Durie M (1998) *Whaiora – Māori Health Development* (2nd edition), Auckland: Oxford University Press.

Education Review Office (2002) *Drug Education in Schools*, Wellington: Education Review Office.

Health Committee of the 46th Parliament (2003) *Report on Inquiry into Health Strategies and Legal Options for Cannabis*, Wellington: New Zealand House of Representatives.

McDonald J, A M Roche, M Durbridge and N Skinner (2003) *Peer Education: From Evidence to Practice, an Alcohol and Other Drugs Primer,* Adelaide: National Centre for Education and Training on Addiction.

Ministry of Education (1999) *Curriculum in Action: Friendships,* Wellington: Ministry of Education.

Ministry of Education (2000) *Drug Education: A Guide for Principals and Boards of Trustees,* Wellington: Ministry of Education.

Ministry of Education (2000) *Health and Physical Education in the New Zealand Curriculum,* Wellington: Ministry of Education.

Ministry of Education (2002) *Curriculum in Action: Making Connections,* Wellington: Ministry of Education.

Ministry of Education (2003) *Quality Teaching for Diverse Students in Schooling: Best Evidence Synthesis,* Wellington: Ministry of Education.

Ministry of Health (1998) *National Drug Policy,* Wellington: Ministry of Health.

Ministry of Health (2000) *The New Zealand Health Strategy,* Wellington: Ministry of Health.

Ministry of Health (2001) *New Zealand Drug Statistics,* Wellington: Ministry of Health.

Ministry of Health, Auckland District Health Board, Public Health Promotion, Mental Health Foundation of New Zealand (2001) *Health Promoting Schools in Action in Aotearoa/New Zealand,* Wellington: Ministry of Health.

Ministry of Youth Affairs (2002) *Youth Development Strategy Aotearoa,* Wellington: Ministry of Youth Affairs.

New Zealand School Trustees Association (2000) *Information for Boards of Trustees: The Issue of Drug and Alcohol Use in Children*, Wellington: New Zealand School Trustees Association.

Royal Commission on Social Policy (1988) *The April Report,* Wellington: Royal Commission on Social Policy.

Waa A, F Holibar and C Spinola (1998) *Planning and Doing Programme Evaluation: An Introductory Guide for Health Promotion,* Auckland: Alcohol and Public Health Research Unit.

Wilkins C, S Casswell, K Bhatta and M Pledger (2002) *Drug Use in New Zealand: National Surveys Comparison 1998 and 2001,* Auckland: Alcohol and Public Health Research Unit.

World Health Organisation (1996) *Health-promoting Schools Regional Guidelines: Development of Health-promoting Schools: A Framework for Action,* Manila: World Health Organisation.

World Health Organisation (2002) *Prevention of Psychoactive Substance Use: A Selected Review of What Works in the Area of Prevention,* Geneva: World Health Organisation.

MINISTRY OF
YOUTH DEVELOPMENT
TE MANATŪ WHAKAHIATO TAIOHI

Administered by the Ministry of Social Development

2004