How effective are current drug education programs as a means of preventing illicit substance abuse in teenagers?

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The declaration

I Karen Lees-Amon declare that this thesis comprise only my original work, except where due acknowledgment has been made in the text to all other materials used. This thesis does not exceed 15,000 words in length, exclusive of bibliographies, footnotes and appendices.

Signature .................. Date 20/12/1999
Acknowledgments

I have benefited greatly from the advice and assistance of many people and organisations. The remarkable intelligence and generosity from many of the contributors has made it possible for me to successfully complete this work.

Acknowledgement and many thanks have been earned by Steve James PhD, lecturer Department of Criminology Melbourne University, for his patience, direction and time. His ready accessibility and dedication to assisting me has been a great stimulus for the completion of this thesis.

Appreciation to Stephen Wallace PhD, Department of Psychology Deakin University Burwood, for generously giving me knowledge and time.

I would also like to extend my thanks to Milton Long, Drug Education Unit Department of Education, for answering copious questions and providing me with invaluable resources.

Thanks also to Mark Brown, Training Education Manager Life Education Victoria, for his invaluable contributions in time and resources.

I would like to acknowledge a former lecturer from Deakin University, Peter Lewis, whose advice led me to study drug education.

On a more personal note, I would like to express gratitude to my wonderful family. To my beautiful children, Christopher, Sheree and Sam for their patience whilst I was locked away in my study. To Dean Amon, for his support and assistance during a very long and difficult year.

Finally to my mum, Rhonda Greenfield and dad, Graham Greenfield, for their unending love and support.

I dedicate this and any future works in the area of drug education to my brother Russell Lees who helps me appreciate life.
Abstract:

Western Governments have been obliged to tackle illicit substance abuse by focusing on health issues, this has resulted in preventative policies that direct drug education through schools. As a consequence there are hundreds of drug education programs and the majority are competing for funding under the same auspice. Victoria’s response has been to develop a prevention program known as Get Real and phase it into Victorian schools over a three year period.

The three year period ended in 1999 and due to a change of Government the Get Real program has been re-funded for another 12 months, this is despite the fact there have been no formal evaluations conducted about its success or otherwise.

This program has been examined in relation to its own objectives and juxtaposed against two other main programs operating in schools in Australia. The results suggest Get Real is on the road to achieving its objectives which are to provide students with a realistic knowledge base about drugs and their effects. However, its broader goal which is to prevent illicit substance abuse cannot be evaluated because there are no studies that show its success or otherwise.

Based on the hypothesis that drug education programs prevent illicit substance abuse in teenagers, Get Real’s curriculum was compared with other similar programs and the research done on these programs suggest drug education programs do not successfully prevent illicit substance abuse.

The best Get Real and other programs can hope to achieve, is to provide realistic information and develop children’s social skills and empower them with the knowledge and self esteem to make their own decisions. And to know that they alone are responsible for their choices and the consequences that follow from these choices.
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I. Brief overview of Victorian drug education

Governments are fundamentally concerned to not only lower the economic costs of illicit substance abuse, but to also ensure they tackle the health issues associated with illicit substance abuse. Western Federal and State Governments have long ago given up the task of trying to eliminate illicit substance use, although some contemporary laws don’t reflect their practice (Australian Illicit Drug Report, 1996).

In essence governments and particularly progressive governments, realise they face a losing battle when illicit substance abuse is driven by global demand and economic rationalism dictates that where there is demand there will be supply (Premier’s Drug Advisory Council, 1996: p. V).

The Victorian Government has spent $102.9 million on providing support services such as prevention, law enforcement, research and training and courts (Australian Illicit Drug Report, 1996). The result has had minimal impact on reducing crime and recent Federal Government changes to legislation prosecuting first time drug offenders is an example of this realisation (Herald/Sun 18/11/1999:1).

Law enforcement agencies acknowledge that their increased attempts to control drug use in any given locality simply results in relocating the problem elsewhere (Australian Illicit Drug Report, 1996). Although this may seem desirable for local communities riddled with blatant drug dealing, the universal picture is that the problem simply infests itself elsewhere (Australian Illicit Drug Report, 1996). In Victoria alone, in 1995, the recorded costs associated with illicit drugs were $457.9 million (Premiers Drug Advisory Council, 1996:9). Nearly 75 per cent of the total outlays were spent in the area of law enforcement.

Governments are therefore obliged to tackling fundamental concerns associated with illicit abuse such as health care. In line with this direction, the Australian Federal and State Governments have chosen to direct funding into preventative measures. This focus was partially the result of research conducted by the National Campaign against Drugs Abuse. Hence, Howat et.al’s 1987 study found “the emergence of prevention as
a key issue in (drug education) in Australia and other countries” (cited in Wragg, 1992: 1).

Instead of trying to tackle the issue solely from a criminal justice perspective that involves a reactive approach, the Victorian Government became proactive and directed funding into health issues related to drug use. They also focused on preventative measures and this mainly involved making funding available for drug education programs, particularly in schools. On the advice from Premier’s Drug Advisory Council 1996 (P.D.A.C) and under the direction of Federal Government campaigns such as the National Campaign against Drug Abuse, the Victorian Government followed suit and also adopted a harm minimisation approach to illicit substance abuse.

**The Drug Education Debate**

The policy of harm minimisation is a direction that “developed largely because of the spread of HIV/AIDS among injecting drug users in England in the late 1980’s, when the threat of HIV/AIDS was seen as a greater risk to society than illegal drug use” (Drug Education Support for Schools Team 1999:3). Pennington stated that “in view of the intersectoral and interdisciplinary nature of the problems associated with drugs of dependence, a multifaceted approach was needed.” He foreshadowed the involvement of Health and Community Services, Education, Police, Corrections, and the courts (PDAC, 1996:9).

This new direction ensured that policies were delivered under a bipartisan arrangement that attempted to include an onus of responsibility on the individual and a wider health support service aimed at preventing and minimising the harm associated with illicit substance abuse. It is possible to argue that it is realistic given the increasing globalisation of the illicit drug trade (Munro, 1997: 1). Professor Pennington headed a team of consultants advocating a harm minimisation approach through the Victorian Premier Drug Advisory Council established in 1995.

The (P.D.A.C) “was established to conduct a detailed public investigation into the trade and use of illicit drugs in Victoria” (Department of Education, 1998:8). The Council was concerned with the “lack of information and inaccurate information”
(P.D.A.C, 1996:77) regarding drug education; it acknowledged that “there has been little planning for a comprehensive, coherent and coordinated information and education approach to illicit drugs in Victoria” (P.D.A.C, 1996: 77).

Among the Council’s key recommendations was the fact that “the Victorian Government supports a sustained and integrated information and education strategy that deals with both illicit and licit drugs such as alcohol and tobacco” (PDAC, 1996:120). In August 1996 the then Premier, Jeff Kennett announced a drug reform strategy that became known as Turning the Tide. “This strategy became the Government’s response from the Department of Human Services, the Department of Justice and the Department of Education” (Department of Education, 1998:2).

Part of the response to this strategy involved the Victorian Government allocating $14.2 million over three years to funding drug education in Victorian Schools (Department of Education, 1998:3).

School based drug education is seen by many governments as an ideal primary prevention strategy, because it offers the potential to stop the next generation from experiencing drug problems and there is certain logical appeal to using school-based drug education as means of changing behaviour (Midford, McBride & Farringdon, 1995:4).

This new found realism resulted in Victorian policies that ensure drug education and information is disseminated through the school curriculum system. Under the auspices of Turning the Tide, Victorian schools were given access to a number of specific drug education programs designed to tackle Victoria’s drug problem by focusing on children prior to the time they are likely to get involved in drugs.

Turning the Tide provided funding for organisations that could meet their criteria and as a result a number of major and minor drug education programs were funded – with the majority being implemented in schools. Turning the Tide directed the majority of its funding into three areas that it considered a priority. The first was the Background Project that focused on providing funding for schools that facilitated drug education programs for BI-lingual community workers. These community workers were charged
with designing and implementing parent drug education programs for parents in their first language.

Funding was also made available for programs under the heading of the Connect Program. In order to be successful, programs needed to demonstrate how schools worked collaboratively with a consortium of local community groups, schools, local government agencies and other services to provide on-going drug education and information resources when funding was no longer available.

The third program that was heavily funded under the same Turning the Tide Project was Get Real. The Get Real Program will be examined in great detail later in this thesis. It is sufficient here to mention its inception and the background surrounding its political development. Get Real is a drug education program that was phased into Victorian schools over a three year period between 1996 and 1999. This period has now ended and the Department of Education is in the midst of evaluating the results of these programs.

Get Real is one of a number of drug programs receiving Government funding that is currently being taught in schools in Australia. The other main programs include Life Education and Drug Abuse Resistant Education.

**Australian Federal Government’s Financial Commitment to Drug Education.**

“The Federal Government, as part of its recent ‘Tough on Drugs’ initiative has committed $17.5 to drug education over a period of 4 years (Prime Minister’s National Illicit Drug Strategy, 1999) ” (Midford, McBride & Farrington, 1995:4). There is wide spread belief that school based drug education programs are valuable and all are founded on the initial belief that their long term goals are to deter future drug use among adolescents. However, critics of these programs argue that it is not enough to want a program to work, it must adhere to certain criteria (Wallace 1999; Hawthorne, Garrard & Dunt 1995; Milton 1999). These criteria will be discussed in detail later in this thesis under the heading of methodology.

The Premier’s Drug Advisory Council believes that prevention must be one of the foundations of Victoria’s long-term drug strategy. Dissemination of accurate
information, and providing education about drugs within a health promotion framework, is a major component of the Council’s proposed strategy (P.D.A.C, 1996:77). The P.D.A.C. states that

A hierarchy of approaches exists for responding to young people’s drug use. These include broad based prevention strategies, closely linked to personal and mental health promotion, that aim to prevent the use of drugs when most people are considering experimenting. This type of program, delivered as an integrated part of the school curriculum, will be all that most young people will need (PDAC, 1996:79).

Two main programs have led the way in drug education in both Australia and the United States. Both programs are founded in the United States and consequently use American research data to justify the theory behind their curricula. These programs are known as Life Education and Drug Abuse Resistant Education and both have been the subject of frequent academic criticism stating that their effect is not only short term, but in many instances counterproductive (Wallace 1999; Hawthorne 1995).

Both D.A.R.E and Life Education have been implemented in Australian primary schools for periods long enough to allow for in-depth evaluations regarding their long term effectiveness in preventing drug use. However, despite this time frame, evaluations for both programs seem to either fail methodologically or contain some type of pre or post-test flaw (Hawthorne et al, 1995:214).
This thesis is concerned with examining *Get Real, Life Education* and *Drug Abuse Resistant Education (D.A.R.E)* as the three main programs operating in Australian schools. This thesis is more broadly concerned with examining the impact of drug education in schools in Victoria, although the emphasis will be on examining in detail the effect and evaluation of the *Get Real* program. *D.A.R.E* and *Life Education* will also be evaluated so that the results can be juxtaposed against each other. Other drug education programs will be briefly examined under the generic area of drug education.

Critics of drug education programs argue that after more than two decades:

> It is difficult to assess the effects of hundreds or thousands of programs that have been undertaken during the last two decades ... (because) when attempting to determine the effectiveness of educational programs almost no evidence exists. Very few attempts have been made to study their outcomes, and those that have been undertaken are frequently woefully inadequate (Kraus 1979: 55).

As a result of these concerns, this thesis will also be concerned with the following:

- Examining empirical data regarding drug education programs and raising questions such as which drug education program best meets the needs of primary age children.
- Examine whether drug education programs achieve their outcomes as a result of aiming their targets at pre-adolescent children.
- Examining the broader question of whether or not drug education programs are reaching their targeted audience and how could current programs be remodelled to more effectively prevent adolescent involvement in illicit substance abuse.

In answering these questions this thesis will examine in depth the trio of current mainstream programs and analyse their curriculum content and formulate a criterion to assess their programs by. It will also attempt to provide an analysis of the current status of drug education in Victorian primary schools and more broadly to determine whether or not drug education is an effective method of attempting to prevent illicit substance abuse among adolescents.
2. METHODOLOGY

The Get Real Drug Education Program has been phased into Victorian State and Catholic Schools over a three-year period. Initial phasing-in started in 1996 and has recently drawn to an end in terms of its initial goals. However, due to the recent change of Government in Victoria, Get Real has been extended for another year.

There are currently no evaluations that have been conducted on the actual Get Real Program and according to the Department of Education no formal evaluations are planned in the coming year. However, the auspice under which it was funded was recently evaluated and due to a change of political environment in Victoria, this evaluation has not been formally released.

Get Real project leaders are currently designing a blue print for the year 2000 in terms of its implementation and are taking into account budgetary cuts that have directly affected the number of project supervisors. Get Real was designed specifically for inception into Victorian State and Secondary Schools and its funding was provided by the then State Liberal Government under the auspices of Turning the Tide Program.

Get Real was assessed in this thesis by examining its curriculum content in terms of its own objectives and juxtaposed against two other main drug education programs operating in Australian schools. These two programs are Life Education and D.A.R.E. Both were chosen because of their popularity in schools around Australia and statistically this enabled a fair comparison by allowing all programs to be evaluated using a common denominator ie: the number of students exposed to the program.

Background Research

Initial background research was conducted by holding informal discussions with the Department of Education, Life Education’s Training and Education Manager, school principals, teachers in charge of implementing Get Real and project leaders in charge of managing Get Real’s objectives. A vast number of secondary research was conducted by researching various specialists in the area of drug education and these will be referred to later in this thesis under the heading Literature Review.
These informal discussions provided the basis for further investigations into the efficacy of drug education in schools because they highlighted concerns such as:

- Academic criticisms highlighting the lack of credible program evaluations.
- Curriculum changes to programs that are yet to be externally evaluated and yet are continuing to operate in schools with unknown outcomes.
- Practical concerns from teachers regarding their ability to timetable drug education into their curriculum.
- Concern by principals on their lack of control once children left school noting their inability to control external factors that may influence patterns of drug abuse.
- Lack of continuity between school and children’s home life in terms of delivery and follow up of the programs.
- Concerns by all main drug educators, particularly Department of Education that a number of programs are competing for the same funding and this could impact on the quality of the programs being delivered because less money is available.
- Academic concerns that drug education programs are not working.

**Criteria Used to Assess Drug Education Programs**

After extensive literature reviewing of both Australian and United States literature, it was discovered that there were a number of frameworks used to measure effective and ineffective curriculum. The differences in their frameworks are the result of the different inherent theories. All criteria used focused on prevention as the main objective in drug education.

The first criteria were those developed by Dusenbury and Falco in 1995 after conducting extensive primary research in the form of first hand telephone interviews with American professionals in the area of drug education and prevention research.
Dusenbury and Falco evaluated the opinions of these professionals and found there were eleven criterions that seemed to keep emerging from their discussions, they used these as a guide to assess effective drug education. This set of criteria can be found in the Appendix under Appendix A. In essence their list stressed that drug education should be based on research and be driven by a theory. They believe this would result in consistent messages. They also believe it is crucial that drug education be culturally sensitive and be taught by the classroom teacher who should received ongoing training and support.

They also recommended a number of prevention drug education programs, although their limitations lie in their origin - they are all developed and based in the United States. Although there is nothing new in this set of criteria these elements seem to be emerging in all the available literature, it therefore seemed logical to use this list as a broad basis on which to assess effective drug education. This list was also chosen because it represents the opinions of those people whose opinions are called upon by authorities in charge of formulating drug education policies in the United States.

This does not mean that their opinions or this set of criteria is given credence in this thesis, it simply recognises that there needs to be a starting point and for piecing together criteria against which Get Real could be assessed.

Another set of criteria that has been used and was written in 1995 under the policy direction of harm minimisation. This set of criteria was developed by a taskforce representing State and Commonwealth issues (Ballard, Gillespie, Irwin, 1994:3/4). This second set of criteria was included because they were developed for Australian conditions. They are ideally suited to be used as a framework to assess Australian drug education programs.

These principles include:

1. Drug education is best taught in the context of the school health curriculum.
2. Drug education in schools should be conducted by the teacher of the health curriculum.
3. Drug education programs should have a sequence, progression and continuity over time throughout schooling.

4. Drug education messages across the school environment should be consistent and coherent.

5. Drug education programs and resources should be selected to complement the role of the classroom teacher with selected external resources enhancing not replacing their role.

6. Approaches to drug education should address the values, attitudes and behaviours of the community and the individual.

7. Drug education needs to be based on research, effective curriculum practice and identified students needs.

8. Objectives for drug education in schools should be linked to overall goal of harm minimisation.

9. Drug education strategies should be related directly to the achievement of the program objectives.

10. The emphasis of drug education programs should be on drug use likely to occur in the target group and drug use, which causes the most harm to the individual and society.

11. Effective drug education should reflect an understanding of the characteristics of the individual, the social context, the drug and the interrelationship of these factors.

12. Drug education programs should respond to development gender, cultural, language, socio-economic and lifestyle differences relevant to the level of student drug use.

13. Mechanisms should be developed to involve students, parents and the wider community in school drug education program at both planning and implementation stages.

14. The achievement of drug education objectives, processes and outcomes should be evaluated.

15. The selection of drug education programs, activities and resources should be made on the basis of an ability to contribute to long term positive outcomes in the health curriculum and the health environment of the school.
It was decided that only criteria advocating prevention be used because western governments have unanimously chosen to direct drug education through preventative measures. (P.D.A.C 1996:Vi) Regardless of each government’s national policy directive, all governments agreed that prevention was seen as the ideal objective in the area of drug use. Armed with this framework, the task became a process of, firstly, questioning the overall aim of drug education and analysing whether schools were truly in a position to make valuable contributions to altering patterns of drug use. And secondly deciding which criteria could schools realistically hope to meet - given their resources and time limits.

These two frameworks were then reviewed and merged into one smaller, more practically based criteria that schools could use as a framework to develop individual drug education guidelines.

**Get Real Curriculum juxtaposed against Criteria**

The end result is a simple set of criteria that focuses on the student as an individual and takes into account issues such as age appropriateness, cultural, religious and language diversities (Freestone, Wigzell, Horacek, Taking it on Conference, session 4, 25/10/1999). A good program will tailor education to meet the specific needs of boys and then if needed change to meet the specific needs of girls.

It should be delivered by the classroom teacher in an honest manner with particular emphasis on health and statistical objectives. Students should be alluded to the fact there are various types of illicit and licit drugs and sometimes those more broadly used such as licit tobacco and alcohol do the majority of damage. Health issues should be stressed, as children are more body focused.

Parents and wider community networks should be included in discussions about curriculum before and after delivery because principals were concerned that the messages taught at school were consistent with those students were receiving at home. Part of this process meant designing a practical working drug policy document that involves not only parents and teachers, but also students and the immediate social services connected with students with drug problems.
Academic literature has shown that the most effective methods of altering patterns of behaviour include programs that focus primarily on improving self-esteem, improving social skills and goal focusing. This was seen as a priority in drug education and also very achievable considering the amount of time students spend in the classroom each day. Programs that are currently operating in schools need to be externally evaluated so that it is not possible to build any bias into the evaluation results. In essence this means a percentage of the available funding for each program should be set aside for further evaluations at the completion of each program. If programs are ongoing then a framework needs to be agreed upon to ensure the program meets its objectives.

Schools need to realise there is no such thing as blanket immunisation in drug education and buffers need to be built into the entire program. These include providing mentors for those students who need further nurturing. Get Real’s curriculum was then examined in relation to its own objectives. Its curriculum was compared broadly with Life Education and D.A.R.E to see if there was any similar content. Then its curriculum was examined in relation to the final set of criteria.

Finally the Get Real program was examined in relation to research supporting the hypothesis that drug education programs prevent illicit substance abuse in teenagers. These findings are presented in the Critical Analysis section of this thesis.
3. Drug Education Programs

Life Education

History:

Life Education is an Australian drug education program based on Chicago Health Education Centre Programs. Minister Ted Noffs started Life Education Australia in Kings Cross Sydney in 1979. “Each year more than 1,100,000 Australian students participate in the primary program in the 118 mobile and static classrooms throughout every State and Territory” (Life Education, 1997:1).

“Life Education comprises 9 affiliated members, one for each Australian state and territory” (Life Education Australia, 20/10/1999:8). The Victorian component of Life Education was founded in 1985 and registered as a charity. It currently retains the status of an “independent, non-profit, non-government, secular organisation” (Life Education Victoria, 1997:3). Theoretically this means that profits are returned into the program to fund existing programs or to provide funds for future endeavours.

After recent changes, the program “adopts the official harm minimisation framework of the National Drug Strategy” (Classroom Teachers Handbook – Life Education Victoria, 1997:11) and applies for part of its funding under the auspices of the State Governments Program Turning the Tide.

Funding:

Life Education Victoria and Life Education Australia are independent charities and are not bound by the same guidelines as those Government authorities that are wholly government subsidised. Life Education Victoria (LEV) receives 20 per cent of its funding under the auspices of State Government funded program known as Turning the Tide (Life Education Australia, 1997:3).

This year (1999) funding was given to LEV under a one off State Government Grant that totalled $400,000. Although this grant needs to be applied for each year, LEV has
successfully received funding over the past 15 years in varying degrees. For the fiscal year between 1998 – 1999, this $400,000 totalled 20 per cent of their annual budget. The rest of their budget was made up of a combination of 50 per cent from fees charged to students attending the LEV program and the remainder 30 per cent is made up of sponsorship from local communities. In total the annual budget for the last financial year was approximately $2 million and this figure has not changed substantially over the last decade. In 1991 LEV’s annual budget was $2.1 million (Personal Communication, Mark Brown, 20/10/1999).

Administration:

LEV staff work in conjunction with local community organisations to promote local businesses that in return provide funding for the LEV vans. Life Education Victoria operates under the management of a full time paid state manager, an education and training manager, a project co-ordinator, an administrative officer and a part-time accountant.

Together this team forms the administrative section of LEV and is responsible for overseeing and training the 40 paid Life Educators who visit the schools daily. These 40 Life Educators are divided into 25 separate groups and a local voluntary committee oversees each group. Together these 25 separate groups are responsible for visiting 230,000 primary school children each year in Victoria.

Goals and Objectives:

According to its literature “Life Education Australia provides positive preventative programs that develop the social skills and knowledge necessary for effective decision-making, communication, negotiation, peer resistance and refusal in drug-related situations” (Life Education, 1997: 8). Its aims are to encourage respect for the uniqueness of each individual and teaches:

The skills to assert confidently that individuality, especially in social settings with friends. In partnership with schools and the community, to help reduce tobacco use and illegal drug use among young people; encourage them to
avoid or delay alcohol use; and reduce the harms associated with any drug use (Life Education, 1997:8).

Curriculum:

The program is broken down into four components, with each component directed towards teachers, parents, primary school children and secondary school children. Although each component is separate, the overall aim is for each component to complement each other and reinforce the intended outcomes which are to increase self-esteem, provide knowledge about the body and knowledge about the impact of drugs on the body and to increase children’s social skills.

In essence the Life Education’s program vision is to provide a holistic approach to drug education by starting with the premise that knowledge and social skills lead to informed decision making. Life Education Victoria offers the following four programs to children from year prep through to year 9. Each year level receives a different program and programs can be tailored to meet specific needs. The Life Education Victoria literature states that the program meets Curriculum Standards Framework outcomes and is taught under the Health and Physical Education framework.

Life Education Victoria

1. Student and Teacher Program
2. Teacher Program - IDEAS
3. Parents Program - Talking It Over
4. Secondary School Program - up to year 9

Life Education’s public health objectives are to prevent adolescent smoking, drinking and unnecessary analgesic use. It is based on the belief that school children can have instilled in them a deep respect for the complexity and beauty of the human body … they will think it unthinkable to abuse drugs (Hawthorne, Garrard & Dunt, 1995:213).
The program is designed to be implemented in three parts – and children are exposed to a new model of the *Life Education* program each year. The classroom teacher is used to introduce the program and provide follow up sessions, while *Life Education* staff provides the actual presentation to the children. In effect the program is divided into three separate sections, with the classroom teacher being responsible for the bulk of preparatory and follow-up work.

*Life Education* staff visit the school in a mobile van and children are asked to pay a $6 fee to enter the actual mobile van session.

Presentations involve sound and light sessions in mobile classrooms aimed at promoting students’ awareness that (they are unique and special...There is emphasis on learning how the body works, which is presented using a transparent anatomical model (TAM), and using audio-visual aides of the digestive, circulatory and nervous systems (Hawthorne et al, 1997:206).

Presenters try to avoid teaching about individual drugs; instead “drugs are presented as substances that may be either “helpful” or “harmful” (Hawthorne et al, 1979:206). Children are alerted to the fact peer pressure will play a significant role in their decision to use drugs and are asked to enact a 5-minute impromptu play where they are challenged to resist alcohol and tobacco.

“*Life Education* aims to delay initiation to smoking and aims to reduce unsupervised drinking by advising adolescents it is advisable not to drink at all” (Hawthorne et al, 1979:206). This program is designed and implemented once a year in a one off session by Life Education staff in the form of an incursion. It is expected that once the program is started in prep, it will continue each year for the duration of the child’s school life up to year 9.

**Public Criticism:**

Life Education has received its fair share of criticism over the years from well-known academics such as Graham Hawthorn and Stephen Wallace. Both question the program’s success and whether or not it is preventing adolescent illicit substance abuse (Hawthorn, Garrard & Dunt, 1995:5) (Wallace & Staiger 1998:167).
Despite these very public criticisms and the fact that following reports by Hawthorn et al an obvious loss in the number of schools using LEV occurred, it has steadfastly remained prevalent in Victorian Primary Schools over the years. It has even expanded internationally and this is partly due to the fact it is politically proactive because it is seen to be doing something about a problem affecting the very core of society – our children (Life Education Victoria, 1997:8)

_Sponsorship:_

*Life Education* attracts enormous sponsorship from local businesses within the community that use the program to reach their target audience (Life Education, 1999:8). Welfare organisations such as the Variety Club of Australia and Rotary have long been advocates of the program. In conjunction with government grants which totalled nearly $2.5 million in 1991, the program rapidly expanded overseas to “the United Kingdom, the USA, New Zealand, Thailand, Papua New Guinea, India, China, Cyprus and South Africa” (Hawthorne et al, 1995:205).

In their research report into *Life Education*, (Hawthorne et al, 1995:205) estimated that one million Australian primary schoolchildren aged between 5 and 12 took part in the program up to 1995.
D.A.R.E Program

Overview:

D.A.R.E stands for Drug Abuse Resistance Education. The program is “a cooperative venture between law enforcement agencies, schools, and the local community, and it involves the use of trained, uniformed police officers in the classroom to teach carefully planned drug prevention curriculum” (Rosenbaum, 1999:2). It is currently America’s “most popular school-based drug education program, it is administered in approximately 70% of the nation’s school districts, reaching 25 million students in 1996 and has been adopted in 44 foreign countries” (Law Enforcement News, 1996:1).

The actual program is school based and involves children aged from kindergarten through to year 12. It was created in 1983 as a “collaborative venture between the Los Angeles Police Department and the Los Angeles United School District” (Rosenbaum, 1999:4).

Curriculum:

“The core D.A.R.E. curriculum ... focuses on children in their last year of elementary school (5th and 6th grade). It is based on the assumption that students at this age are the most receptive to anti-drug messages as they approach the age of drug experimentation (Rosenbaum, 1994:4). According to Dennis Rosenbaum, “D.A.R.E is solidly grounded in a body of theory and research that laid the foundation for a second generation of school-based prevention initiatives. The program is deeply rooted in the social skills and social influence model of drug education” (Rosenbaum, 1994:43).

Professor Rosenbaum identifies elements of psychological inoculation, resistance skills training and personal and social skills training. D.A.R.E. ’s Core curriculum is divided into 17 sessions. In 1998 the United States Federal Government placed pressure on local schools to implement drug education and prevention programs in order to receive special funding. Schools therefore found themselves in the
unfortunate position of having to prove that they were conducting drug education programs so many chose to deliver programs that appeared to be the most active. *D.A.R.E* certainly fitted this category.
Get Real Program

History:

Get Real is a drug education resource program for Victorian schools “developed by the Drug Education Support for Schools Project (DESS). The project has been funded by the National Campaign Against Drug Abuse (NCADA) and the Drug Research and Rehabilitation Fund (DRRF) through the Victorian Department of Health and Community Services” (Department of Education Support for Schools Project, 1995: 1).

The program started in 1993 with a brief to develop a strategic plan to improve the quality and availability of drug education and drug-related student welfare in all Victorian schools (Department of Education Support for Schools Project, 1995: 1).

A reference group representing a wide variety of interested groups and organisations was established to support and advise the DESS. Eleven members of staff were charged with working with more than “one hundred primary and secondary schools across the state to trial aspects of the developing strategic plan... The Drug Education Strategic Plan 1994-99 recommended that this resource be based on a harm-minimisation approach to drug education and support the implementation of drug education policies, practices and programs in schools” (Department for Schools Project, 1995: 1).

Curriculum:

The program consists of ten booklets, six for primary schools and eight for secondary schools. The primary school component of the program consists of two books. The first book provides guidelines for drug-related student welfare and critical incidents within schools and the second book provides lesson materials for children from prep to year 6. The materials are taught under the health and physical education key learning area of the Curriculum Standard Framework.
There are four booklets that are common to both programs and these include:

1. **A harm minimisation approach to drug education.** This booklet introduces and outlines the ideology behind harm minimisation and provides advice on how schools can develop their own policy on drug education.

2. **Drug Information for Teachers.** This is a teacher reference package for teachers to use in lessons and as part of their development of welfare response and when framing school policies.

3. **Tobacco Education Materials.** This booklet provides materials to be used in the classroom for students in year 6–8 and is based on material developed by the Quit Campaign.

4. **Parent Forums.** This gives practical advice and support for teachers when designing and implementing parent drug education forums.

*The Secondary Schools program has the following additional four booklets:*

5. **Drug-related Student Welfare: Identification, Monitoring and Intervention** puts drug related student welfare into the context of broader school and community structures.

6. **Drug-related Critical incidents** which could occur in secondary schools and provides advice on dealing with such issues.

7. **Lesson Materials for Secondary Schools** provides a program for drug education for Years 7-10 within the Health and Physical Education Key Learning Area of the Curriculum and Standards Framework.

8. **Alcohol and Education Materials** deals specifically with alcohol-related incidents and contains lesson materials relevant for Years 8-10. These materials are designed to meet learning outcomes in the Curriculum and Standards Framework.

In relation to drug use, this approach embodies the following principles:

- An understanding that many students have used, currently use and will use drugs
- A recognition of the rights of students not to use drugs.
• A recognition that non-drug using students are subject to potentially harmful situations by the behaviour of drug using people.
• A recognition that drug use provides varying degrees of risk for the user.
• An acceptance that drug use by young people is a personal choice that is not within the control of teachers or schools.

*Philosophy behind the program:*

A harm minimisation approach acknowledges that many young people will use drugs at some stage of their life, making it critical that students acquire knowledge and skills that will assist them in making informed decisions about their drug use and so minimise any harmful effects associated with that use (Department of Education Support for Schools Project, 1995:3).

The practical implementation of harm-minimisation requires schools to cover three main broad areas, which include policy, curriculum and student welfare and support:

The development of school-based policy rests with a number of parties and it is up to individual schools to determine their own process for policy development. It is clear that the roles of the Health and Physical Education Learning Area, Student Welfare Coordinator or designated welfare staff, classroom teachers and the administration are vital in constructing a comprehensive drug education policy (Department of Education Support for Schools Project, 1995:5).

The Get Real Program does not provide teachers with a daily lesson curriculum; it is designed for teachers to use as a plan when designing their classes. They are expected to use this as a guideline when responding to the needs of their students and local communities within the guidelines set out in the Curriculum Standards Framework (Department of Education Support for Schools, 1995:1).
4. Literature Review

Overview:

There is no shortage of literature regarding the issue of drug education and its effect on latent illicit substance abuse. However, there are obvious divisions with one main argument developing in favor of drug education as preventative measures and the other argument developing around the issue that some drug education programs do not achieve their long-term objectives.

Within each of these arguments there appears to be even more divisions exploring such issues as what age group is the most receptive and should drug education be taught within the school curriculum. Radical arguments revolve around the possibility that drug education is doing more harm than good and in fact producing the very problem it is trying to prevent. The following publications represent this broad range of views and have been reviewed because the authors are amongst the most outspoken in the field of drug education. These publications are divided into three broad categories starting with those in favour of drug education, those not in favour of specific drug education programs and those against drug education programs.

Those in favour of drug education:

1. Philosophical Frameworks and Models of Drug Education:
   Dr Louise Rowling (1995)
In her 1995 address to the National Initiatives in Drug Education Conference in Canberra, Dr. Louise Rowling provided a framework for drug education. Her opening remark was to remind those in charge of implementing drug education programs that they are not operating in a vacuum. She reminded them that there will be a wider national and state policy framework, their organization’s framework and their personal framework of beliefs about drug use is the most effective way of intervening (Rowling, 1995:2).

Rowling’s main point was that she wanted to remind each organization that drug education needed to include individual variables and take them into account when designing and implementing programs. Rowling stated “We need to balance drug education with broader drug abuse prevention strategies and to fit these within a health promotion framework” (Rowling, 1995:5).

She identified three group programs and approaches by dividing them into cognitive, personality deficit and psychological models. In the Cognitive Model, Dr. Rowling identified six guidelines including using credible people to deliver the information, provide information that is relevant to the target group, address the target groups’ values, provide information that is unambiguous, provide information that is accurate and balanced and that is appropriate to the audience’s developmental level. She summed up this model by stating:

> The credibility of educators is based on student’s perspective, not the beliefs of health or education professionals. Relevancy of messages means the acknowledgment that the social consequences of drug use for young people are far more effective as messages than the health consequences (Rowling, 1995:5).

Her next model, the Personality Deficit Model analysed early research models that she said, “focused on identifying individual personality characteristics that were seen to be precursors of drug using behaviour. Self esteem was identified as one such factor” (Rowling, 1995:6). Rowling states this research was not supported and the hypothesis that there was a strong relationship between low self esteem and drug use was not supported by strong research.
She advocates the need to differentiate between different behaviours in the social context in which they are carried out, for example, she says drinking alcohol in excess and car stealing are very different behaviours and they have different meanings for the individual and society in general.

Her **Psychological Model** aims to understand that “problem drug use by most youth is related to social and environmental influences, not just underlying psychopathology” (Rowling, 1995: 6). She believes this behaviour is interconnected to the wide factors affecting mental, social, physical and spiritual health. She specifically states that schools have quite specific needs in regard to drug education. Their needs are guided by a series of limitations that include limited resources that need to be stretched to cope with “a full range of young people’s problems and drugs are just one issue schools are expected to deal with” (Rowling, 1995:7).

Rowling believes that what is needed is “a focus on the whole school community and its role. This is not to state that she wants to move away from the idea of school based skills-training, moreover she suggests it be enhanced and sustained by including “community wide programs that target parents, community organizations and other elements in young people’s social environment” (Rowling, 1995:9).

Rowling targets the issue of harm minimization stating it is not a standard concept that does not change depending on the surrounding factors. She states:

> It may mean abstinence for a particular drug, if the purpose is to reduce initiation into harmful drug use. Or it may for example mean, encouraging parents to make a contract with their 18 year old to ensure the young person gets home safely after consuming alcohol...(Rowling, 1995:9).

Her **Ideal Model** of drug education aims to empower schools and community members by focusing curriculum; teaching and learning, schools organizations and ethos; and school community partnerships and service. Rowling concluded that drug education involves planned curriculum approaches to the following:

- Drug education curriculum.
• Policies for handling drug incidents that have been developed in consultation with parents, students, and local police and outside agencies.
• An awareness of what exists in the school environment that undermines or reinforces the schools drug policy and curriculum.

Rowling and the Australian Drug Foundation both endorse drug education as a means of preventing adolescent substance abuse, but Rowling has developed a very specific model that spells out pragmatic actions aimed at prevention. Where as the Australian Drug Foundation is concerned that schools have a specific drug policy in place in case students become involved in illicit substance abuse, so theirs is not so much a prevention drug education program incorporated as part of the daily curriculum, it is more broadly a policy ensuring students stay at school at all costs.

As part of this policy the ADF warn against the use of schools adopting a zero tolerance approach to drugs. According to the ADF:

> Illicit drug use is predominantly a young person’s behaviour, and frequently those experimenting with drugs are still of school age. A major factor that increases the risk of a young person proceeding from experimental to habitual drug use is dropping out of school (Munro, 1999:22).

The Australian Drug Foundation adds to the drug education debate by ensuring that schools are aware that any cut and dry approach they have as part of their drug education policy, will be likely to encourage students to feel isolated and actually encourage drug taking. They are primarily concerned that schools adhere to positive and realistic drug education and accept some students will experiment. As part of this experimentation, they urge schools to have policies in place prior to the need to use them. This ensures that when situations arise where students have chosen to break the rules and use illicit substances, the school will be in a position to act in favour of the students individual long term benefit instead of simply looking at the immediate impact that individual student has on the over all school community. (Australian Drug Foundation, 1999:22).
They are therefore concerned that schools adopting a drug zero tolerance will expel students and although they accept that this is a fair response for students who continually bring drugs and use drugs in school, they state; “where possible, it is essential that schools develop policies and strategies to help retain students within the school system” (Munro, 1999:22). In attempting to convince schools that this type of approach is not only detrimental to the school, the students and the wider community, the ADF states it is also not consistent with broader National policies that have proven effective.

They refer to “Australia’s Drug Strategy that was developed in 1997 that recognised harm minimisation as fundamental to the Strategy’s success. Using one indicator: less than 5% of Australian injecting drug users are HIV positive compared to 14% in the United States. (Munro, 1999:22). A difference that Australian researchers say can be attributed to those strategies associated with harm minimisation.

Dusenbury and Falco conducted an extensive review of school-based drug abuse prevention programs that were conducted between 1989 and 1994 in a bid to identify effective key elements. In conjunction with a broad literature review and personal telephone interviews with “a panel of 15 leading experts in prevention research” 11 key components for prevention were identified (Dusenbury & Falco, 1995:420).

Effective prevention programs were found to be based on theoretical or research foundations and included:

- developmentally appropriate information about drugs, social resistance skills training and normative education. Broader based personal and social skills training appeared to enhance program effects. Effective programs used interactive teaching techniques and teacher training, and provided adequate coverage and sufficient follow-up. Culturally sensitivity to the target population was found to be critical to program success. Additional program components were expected to enhance curriculum effectiveness (Dusenbury & Falco, 1995:420).

Dusenbury and Falco said effective drug education could involve developing

- More appealing features and packaging for promising programs, and to promote the state-of-the-art programs using aggressive marketing
techniques...Finally, an important way to promote the utilization of promising curricula would be to give schools more guidance as to how they should spend their funds for drug abuse prevention (Dusenbury & Falco, 1995:425).

The authors state a 1991 in America a Government Accounting Office report estimated that $125 million was spent on drug education curricula. They cite Hansen, Rose and Dryfo's report that state “most of that money is spent on aggressively marketed programs that have not been evaluated, or worse, have been shown not to work” (Dusenbury & Falco, 1995:423).

The report cites programs such as DARE, QUEST, Here's Looking at You, 2000, BABIES, Project Charlie, Ombudsman and Project Adventure as programs that have been aggressively marketed. They state of these only “DARE has been adequately evaluated and while DARE has been extremely successful at Diffusion and dissemination according to Clayton, evaluations including a recent meta-analysis suggest that DARE is not any more effective at reducing substance use behaviour than standard curriculum approaches” (Dusenbury & Falco, 1995:423).

In his occasional paper Munro stated that drug education is an essential component in the overall framework of drug prevention. However, he states “drug education has a long history of perceived failure due to un-realistic expectations imposed on drug education by many of its proponents” (Munro, 1997:1).

He believes drug education ought to prepare young people for living in a drug using society by aiming to develop their understanding of how drugs effect individuals and society, how problems can be avoided and how drug issues impact on the domain of public policy. Munro believes these are “educational aims consistent with the cultural role of schools and the needs of students. They do not burden drug education with fantastic objectives” (Munro, 1997:1).

Munro quoted President of the Victorian Secondary School Principals Association, Duncan Stalks who opposes drug education on the basis that it will not stop people using drugs. He states schools will be seen to fail and may be blamed for the problem they are trying to solve. Stalks believe policy makers mistakenly assume that the aim
of drug education is to eliminate drug use. This has the effect of “inhibiting the development of drug education” (Munro, 1997:1).

Instead Munro believes that drug education should be viewed as contributing to the central purpose of schooling which is to educate young people and prepare them for living and working in the world around them. In relation to secondary schools Munro states schools should have a knowledge of basic pharmacology and have a development of abilities to act to minimise drug related risks and the analysis of public policy concerning drugs.

**Those against Specific Drug Education Programs**

1. *Does Life Education’s Drug Education Program Have a Public Health Benefit?*  


Hawthorne, Garrard and Dunt attracted enormous publicity when they released their evaluation of the drug education program known as *Life Education* in 1995. Hawthorne et al succeeded in causing *Life Education* to lose some of its standing in the community by publicly evaluating and attacking its curriculum. They questioned *Life Education's* ability to deliver its intended outcomes and as a consequence *Life Education* recorded a noticeable decline in the number of schools using the program, according to *Life Education* Training and Education Manager Mark Brown.

In summation of the program, Hawthorne et al stated that “the attraction of the program is that it is a visible symbol that communities are prepared to tackle the drug issue through education” (Hawthorne, Garrard & Dunt, 1995:212). Hawthorne et al were scathing in their criticism of *Life Education* as a drug prevention program; they stated their evaluations “showed no evidence suggesting participation over a 5 year period delayed experimentation with initiation into smoking, that it persuaded students to avoid drinking or to drink less or that it reduced students use of analgesics” (Hawthorne et al, 1995:212).
They further stated that according to his evaluation there was even “some evidence that Life Education students drug use and misuse was marginally higher than non Life Education students” (Hawthorne et al., 1995: 214). He further stated that the Life Education’s experiment showed that boys and girls responded to the program differently” (Hawthorne et al., 1995:214).

Their results indicated that “the program appeared to increase girls smoking and have no effect on girls drinking or analgesic use. It appears to increase boys recent smoking and their drinking and their lifetime use of analgesics” (Hawthorne et al., 1995:214). Hawthorne et al concluded from the results of their analysis of 1500 children that “drug education programs should be both drug specific and matched with students gender and drug recruitment patterns rather than drug generic and indiscriminately delivered” (Hawthorne et al, 1995:216). They summarised the Life Education program by stating it was unlikely to achieve its stated public health aims.

Midford, McBride & Farrington question the success of current drug education programs in changing student’s behaviour. Midford et al evaluated Project D.A.R.E as part of an Australian efficacy study of alcohol and harm reduction in schools. The project was a “four year quasi-experimental evidence based intervention research study designed to explore the effects of a student focused secondary school, alcohol education intervention in reducing alcohol related harm experienced by school students” (Midford et al, 1995:2).

Unlike the majority of programs currently operating in schools, this one had its focus to decrease the harm associated with alcohol. It did not set out to change student’s attitudes by delaying use or encouraging non-use. Part of this study involved a critique of other mainstream drug education programs – the first of which was D.A.R.E. Midford et al stated that Project D.A.R.E provides drug education lecturers to approximately 50 per cent of American school districts nationwide. They refer to Ennett et al who in 1994 conducted a “meta-analysis of eight methodologically rigorous evaluations of D.A.R.E program They consequently found the effect of drug use was not statistically different and substantially smaller than that of programs emphasising social skill development and interactive teaching techniques” (Midford et al, 1995:4).
Midford et al highlighted D.A.R.E in their quest to show how most programs are similar, they state “Australia is not immune from this sort of decision making, where drug education programs with a high public profile, but no proven efficacy continue to be supported” (Midford et al, 1995:5). Midford et al also made reference to Life Education’s drug education program stating their evaluations of it found no evidence that it reduced use of alcohol, analgesics or tobacco.

In making this claim Midford et al like most critics did not favour Life Education as an effective drug education program, referring specifically to Hawthorne, Garrard and Dunts’s 1995 evaluation of 1500 Life Education students. As part of their criteria for evaluating drug education programs, Midford et al acknowledged that for the past decade the Australian Ministerial Council on Drug Strategy had provided a National Drug Strategic Framework stating that the principle of harm minimisation has formed Australia’s Drug Strategy.

Although they formally acknowledge this framework and its adherence by many drug education programs, they question the amount and results of research of the benefits of taking a harm reduction approach with drug education (Midford et al, 1995:5). Instead, Midford et al suggests the exception to this rule is alcohol-harm reduction approach. They state a “harm reduction approach was received positively by students, because it was not judgmental about their experiences and offered something useful to all students whether they started drinking or not” (Midford et al, 1995:5).

One of their outcomes according to their own evaluations was that “participating students were significantly more knowledgeable about alcohol use and consumed significantly less alcohol than non-participating controls” (Midford et al, 1995:7). Their rationale is that:

The efficacy of a particular service has not been demonstrated, there is considerable benefit in committing some of that money to finding out if current practice is achieving any meaningful change; what improvements can be made and whether there are alternative approaches which are likely to have a greater impact and represent better use of resources (Midford et al, 1995:7).
Those against Drug Education as a means of preventing adolescent drug abuse

3. This Week Online with DRCNet, Issue No 103: Interview with Dr. Joel Brown on the Status of Drug Education in the United States (1999)

Stephen Wallace condemns drug education in schools by stating that “it is incumbent on all those who wish to play a role in Drug Education to arm themselves more than a good set of intentions” (Wallace, 1993:75). In a nutshell, Wallace believes the best contribution a teacher can make is to ensure that “no child should leave the class on any day without having experienced some sense of fulfillment, satisfaction, recognition or success (Wallace, 1993:75). Wallace has attracted a reputation in the health and political arena for his outspoken and seemingly radical views on the benefits of current drug programs in schools. His viewpoint includes recommendations that the best type of drug education is “to do absolutely nothing” (Wallace, 1993:78). In support of his argument is the fact he believes continued drug education as it is being offered now, not only fails to deliver its outcomes which are to prevent adolescent substance abuse, but current programs such as Life Education and D.A.R.E actually encourage illicit substance abuse among adolescent.

Instead, he states the challenge before drug educators is to understand that drug education cannot be taught as a blanket program that immunizes everyone equally. He specifies that “one enormous challenge for researchers is presented by findings which indicate that males and females require different treatments to achieve equivalent results” (Wallace, 1993:86).

Wallace also draws attention to the types of drugs classified as illicit by legislators and educators. He states “Perhaps as Barber and Gritchig suggest in order to make the most effective use of resources, the more widely used substances ought to be targeted as a first priority” (Wallace, 1993:86). He is specifically talking about alcohol and tobacco.
Kraus joins the argument against continuing drug education programs when he states “a continued reliance by professionals on empirically invalidated educational programs based on commonsense and intuitive notions, constitutes an abrogation of professional responsibility” (Kraus, 1979: 55). Kraus’s main argument against continuing current drug education programs is that it is:

difficult to assess the effects of the hundreds or thousands of programs that have been undertaken during the last two decades ...when attempting to determine the effectiveness of educational programs, almost no evidence exists. Very few attempts have been made to study their outcomes and those that have been undertaken are frequently woefully inadequate (Kraus, 1979:56).

In developing this argument Kraus uses the example of smoking, stating that “smoking has decreased among people aged 30 and above, but it has increased not only among people in their late twenties, but also among very young non-smoking age groups which have been exposed to anti-smoking education and publicity during their whole lifetime” (Kraus, 1979:56). Kraus states this example can be taken one step further when he uses the analogy that people who should be the most informed and see first hand the results of smoking are doctors and nurses. Despite this knowledge, Kraus states “for decades it has been a truism in epidemiological research that the highest rates of drug addiction are found among doctors and nurses…” (Kraus, 1979:56).

Kraus refers to these two examples as natural experiments and he clearly states that “knowledge is not a prophylactic when drugs are available” (Kraus, 1979:56). Kraus could be classified as one of the more radical critics, particularly when he attributes drug abuse to drug education campaigns. He supports studies that show “those exposed to drug education had increased incidence” (Kraus, 1979:57).

He pinpoints the reason for this by acknowledging that more information provides more knowledge that encourages experimentation, but it also highlights the elated side effects associated with particular drugs. Kraus believes that educational drug programs call attention to the exotic risk-taking qualities of mind-altering substances. He is adamant when he states there are “well established findings that for the great
majority of juvenile drug abusers, curiosity thrill seeking, experimentation and novelty were the factors motivating their initial use of drugs” (Kraus, 1979:57).

Kraus includes media in his causes by stating they contribute to the attentive factor by apportioning part of the blame to media who have effectively “dramatised drug taking” (Kraus, 1979:57). In regard to Australia, Kraus states that, the Senate Standing Committee on Social Welfare expressed an awareness “that information alone can be counterproductive and may even contribute to an increase in the incidence of drug use” and “recommended that all drug education programs be evaluated, and that funds be withdrawn from drug-education programs which are found to be ineffective” (Kraus, 1979:57).

Kraus is clearly critical of the fact that despite money being made available under the auspices of this Senate Standing Committee on Social Welfare, almost no studies have been conducted to evaluate the effectiveness of these programs. He states quite critically that “only one evaluative study has been conducted in Australia (and) … the findings of this study indicated that children exposed to drug education had higher recruitment rate to drug use than children not exposed to it” (Kraus, 1979: 61).

Researchers from the University of Kentucky have concluded that D.A.R.E is largely ineffective after conducting a survey of 1,000 graduates of the D.A.R.E program over a ten-year period. Authors of the research project referred to D.A.R.E, as the world’s most popular anti-drug education program. The study involved taking 1000 graduates of D.A.R.E and other similar programs over a ten year period found that “in no case did the D.A.R.E group have a more successful outcome than the comparison group” (Brown, 13/8/1999: 5).

According to the authors of Drug Reform Coordination Network, the Kentucky study “is the latest of several studies over the past ten years to reach the same conclusion.” The study was overseen by the executive director of the Centre for Educational Research and Development, which is specifically designed to evaluate and research drug education programs. According to Dr. Joel Brown:

There is not a single scientifically sound, long-term study that shows that D.A.R.E prevents kids from using drugs. But more importantly, this isn’t really
about D.A.R.E. We now have at least nine recent examinations of drug education that show that the programs like D.A.R.E, Life Skills Training, Project Alert, etc., do not prevent kids from using drugs. And we have at least three recent examinations, which show that they cause a multitude of negative effects—including, but not limited to, increased drug use, exiling those kids in need of help from the school system, and cognitive dissonance. (Brown, 13/8/1999: 6)

According to Dr Brown children are emotionally disturbed by the conflict in messages. He states on the one hand children are being told to just say no as part of the curriculum in drug education and on the other hand they are seeing the results of drug use that don’t equate outside in their social circles. It is these conflicting messages that Dr. Brown believes results in a conflict in children and prevents seeing the messages as credible, in essence they believe they are only being given part of the equation and as a result are unwilling to believe what they are being told in schools. Editors of DRCNet Online questioned Dr Brown’s methodology by stating “spokespeople for DARE complain that studies showing DARE’s ineffectiveness don’t take into account the changes made to the curriculum over the years” (Brown, 13/8/1999:6).

Dr Brown’s response was that “they’re still building on an original curriculum. Ten versions of what doesn’t work in the first place will not suddenly make it effective” (Brown, 13/8/1999: 6). Dr Brown also said the broader conflict was the Federal Government’s policy that states only effective drug education programs are allowed to be implemented in schools and yet “the only program they will allow to be implemented have been found to be universally ineffective.”

Although Dr Brown is using the example of DARE to illustrate how ineffective drug education, this is not the crux of his overall argument, the broader argument is that a no-use model of drug education does not prevent children from using drugs. Instead of focusing on what he considers young people’s disabilities, he believes programs need to focus on their capabilities.
As part of this focus, Brown advocates a need to connect young people to adults by emphasising relationships over rules. This model that he refers to is known as the resilience model and it aims to emphasize emotional attachments between youth and adults. Brown states that “when those emotional attachments are present, then the educator can bring in good and honest and accurate and complete information” (Brown, 13/8/1999:7). Brown stresses that zero-tolerance policies teach young people unintended lessons about a punishing society, and the limited learning opportunities in a punitive educational system.

He does not deny that for a small number of children these policies are successful, but states these are the children who are least likely to experiment or develop drug problems in the first place. Smith raises criticisms of the D.A.R.E program in light of the above Kentucky research. Smith states the problem with D.A.R.E is it fails to make distinctions between different substances and he states it is contradictory to evidence that argues “treating marijuana the same as heroin, for instances, reduces the credibility of D.A.R.E’s message” (Smith, 13/8/1999). Smith was speaking after the graduation ceremony for D.A.R.E graduates at a Florida elementary school who were rewarded with a special performance by the Florida Highway Patrol Special Tactics Team.

Smith criticised this display stating it was “directly in line with the ethos of D.A.R.E’s founder, former Los Angeles police chief Daryl Gates, who once remarked that casual drug users should be taken out and shot.”
5. Critical Analysis

The philosophy behind the Get Real program is similar to that behind Life Education because both are based on the harm minimisation principle and both are taught under the health and physical education section of the Victorian Curriculum Standards Framework.

Both apply for and have in the past received funding under the auspices of Turning the Tide, which is the Victorian State Government three-year program.

However, Get Real aims to provide schools with an on-going resource that classroom teachers can use when planning lessons. Currently teachers have access to supervisors that are funded by the Department of Education to ensure its implementation. Teachers implementing the program are given in-service sessions and are guided through the program and given ongoing back up by area supervisors.

Get Real aims to provide a holistic approach to drug education by ensuring the school’s policy reflects the school’s practice and offers community and parental sections to ensure drug education takes place outside the hours of 9 to 3.30. Get Real’s objectives are therefore to provide schools with the resources to independently empower them to incorporate drug education into their curriculum and more broadly their school community.

On the other hand Life Education disempowers schools by the very fact outside facilitators come in and provide students with an incursion about drugs. Although its curriculum aims to provide students with social skills which in theory aims to empower individuals, teachers are temporarily handing over power to outside individuals whose job it is to come in for a one-off session. And yet ironically, drug education is not a one-off program, it is expected that it will be an on-going program. Teachers may find this a relief in the sense that they are not burdened with more information being crammed into an ever growing curriculum; however, there is the danger that what is being taught is not consistent with school policy and does not take into account individual issues such as culture, gender and ethnicity factors.
DARE’s theoretical base aims to increase children’s social skills by attempting to inoculate them against using drugs in the future. This approach is backed up by the threat that authorities will act should drug use take place. These sessions are public because they are normally delivered by the local police officers who go into classrooms and teach abstinence as the aim of drug education.

All the available literature suggest that D.A.R.E and Life Education programs are ineffective in their attempt to prevent long-term illicit substance abuse. The available literature also suggests these programs are popular due to the fact they are seen to be doing something and the old adage that it is not what is happening, but what is seen to be happening certainly applies in drug education circles. A breakdown of the curriculum is difficult to access, so any evaluations within this thesis are limited to other people’s evaluation on the curriculum, instead of first hand curriculum analysis.

This is surprising considering that 70 per cent of American schools implement D.A.R.E as their drug education program. Although there are political biases surrounding this issue because schools have in the past received funding based on how proactive they are seen to be in implementing drug education programs and D.A.R.E is certainly seen to be proactive by the very fact it uses police officers to teach the program.

Get Real has reached the final stage of its initial implementation and it is far too early to determine whether it has prevented illicit substance abuse amongst those children who have been exposed to it. Although it is far too early to make any type of concrete analysis of the success or otherwise of Get Real and its effect as a drug education prevention program, it is possible to point out a number of discrepancies. These include the fact that despite any type of formal evaluation, the program has been refunded for a further 12 months under the new State Labour Government.

Despite the fact that the program has not been formally evaluated, it continues to be funded and those schools in charge of implementing the program have been left to operate on the basis of good faith. According to some teachers using the program, there has been little follow up and very little if any on-going support other than the main in-service days initially offered to teachers. (Jonothan Connor, 19/12/1999 Personal Communications)
Major criticisms have come about from teachers during these sessions because many feel that those in charge of in-servicing them are not qualified to answer their questions. Specific criticisms have included: Lack of definition of the term drug and lack of on-going practical support that allows teachers to measure their program by. In effect this program will have been funded for four years in Victoria without any type of specific evaluation to the cost of $14 million and despite the fact that money is not the object in question, there does need to be some type of accountability factor when programs are given further funding without any type of formal evaluation.

Get Real's literature is certainly focused in achieving its outcomes which are to foster independence in students by empowering them with the knowledge to make realistic choices about the use of drugs in a social context. In terms of its ability to deliver information it cannot hope to be in control of its goals because this is purely up to the school and the teachers involved. However, who is to say that once teachers have attended their in-services, they will commit to the project and deliver the program as its designers intended it? The program includes a section for schools to design and deliver an individual drug policy based on a proforma supplied in the resource package, however, again, there is no guarantee that even if teachers adhere, this will be implemented.

There is also no guarantee that variables such as gender, ethnicity, cultural issues will be taken into account when individual teachers provide drug information to the students. Until further research in the form of student evaluations comparing Get Real schools with non Get Real schools is conducted, it is not feasible to determine whether Get Real is successful in achieving its outcomes. However, based on the broader question of whether drug education works per say, all the literature thus far points to no.

Frameworks need to be developed that enable realistic goals to be achieved; goals that attempt to provide blanket drug education programs are neither realistic in their aims or successful in their attempts to alter patterns of illicit substance abuse in teenagers. Therefore, programs need to assume that teenagers live and socialise in circles where drugs will be either freely available and choices will involve consequences that only they can be responsible for. Bearing this in mind programs need to ensure teenagers
are aware of the possible and probable side affects of drugs in terms of their health
and body images.

They also need to be aware that for the majority of teenagers who use drugs do so in
social settings and eventually most will grow out of the need to feel pressure to
conform to be accepted. This is not to suggest that drug use should be treated with
indifference, it is however, to suggest that our preoccupation with prevention may be
overcompensatory. The Premier’s Drug Advisory Council certainly advocated this
approach when they stated that prevention programs aimed at mental and health
promotion will “be delivered as an integrated part of the school curriculum.”
(P.D.A.C, 1996:79) and this will be all the most people will need.

An appropriate criterion focuses on providing consistent messages that take into
account changing variables such as gender, ethnicity, religion, cultural and linguistic
diversity, different family dynamics and different types of families from the more
traditional to contemporary single parent families is needed.

Perhaps societies preoccupation with drug education programs that prevent illicit
substance abuse would be more realistic if they took into account the need for
children to experiment as part of their transition from childhood to adulthood.
Although this may seem a radical approach when mentioned in contrast to hard line
pro drug education experts, the fact is these are becoming fewer in number. It seems
that the old adage the more we learn about drug education the less we know.

The division between those professionals who believe drug education successfully
prevents drug use and those use do not is steadfastly closing and a new breed of
experts who recommend nothing seems to be emerging. Although their acceptance
has been fought with vigour, particularly in government circles, where governments
need to be seen to be doing something, the available literature seems to be suggest
there is little difference between the two trains of thought.

The key to providing successful drug education messages is to provide accurate
information delivered in a comfortable and respectful environment with realistic goals
in mind. Midford, McBride and Faringdon’s quasi-experimental research of other
people's studies set out realistic goals and consequently recorded high success rates. Its program accepted that students were going to use alcohol as part of their socialisation process and set about teaching them how to decrease its detrimental effects.

Get Real would benefit from this approach because it does not set out to change students' behaviour, it empowers students by giving them skills to deal with issues in their own circles. It is non-judgemental and therefore non-threatening. This should be supported by Rowling's model of drug education, which aims to empower schools and students and the wider community. She has two underlying points which are: Firstly, to empower students and secondly to incorporate the wider community into providing consistent and reinforced drug policy as part of the wider curriculum.

Get Real would benefit by setting more realistic goals instead of focusing on prevention as its main objectives, it should accept that drug experimentation is something that the majority of students will either partake in or at the very least socialise with other students who experiment. Armed with this knowledge drug education should aim to provide students with social skills and accurate information that makes them feel in control of their behaviour as opposed to providing them with another challenge.

Surely adolescence face enough challenges without setting up more hurdles to jump on the track to adulthood. Get Real needs to be evaluated in the next few years in order to determine its success. In the meantime, it could be modified to include realistic outcomes such as those focused on by Midford, McBride & Farrington and Rowling.

As a result of the literature reviewed and the programs studied, it is recommended that formal evaluations be conducted on the Get Real program by examining the actual numbers of students who experiment with drugs and those who do not. It is recommended that a very specific study be conducted in the next 12 months so that some type of measurements can be made about Get Real's effectiveness as a drug education program. It is crucial that this 12 month time frame be adhered to because this is also the time the program has been further funded for. It is also recommended
that further studies around the possibility that drug education does not prevent illicit substance abuse be conducted. This is a much-needed area of study because there are so many programs competing for funding and there is seemingly little evidence of a change in the patterns of illicit substance abuse among teenagers.
References


Connor, J. (19/12/1999) Personal Communications, Teacher St Brigid’s Primary School, Mordialloc, Victoria.


Appendix

Appendix A:

Dusenbury and Falco’s Drug Education Framework 1995

They stated good drug education programs should be:

1. Research-based/Theory driven.
2. Provide Developmentally Appropriate Information about Drugs.
4. Provide Normative Education.
5. Offer Broader-based Skills Training and Comprehensive Health Education.
6. Use Interactive Teaching Techniques.
7. Offer Teacher Training and Support.
10. Offer Additional Components.
11. Include Evaluations.
Author/s:
Lees-Amon, Karen

Title:
How effective are current drug education programs as a means of preventing illicit substance abuse in teenagers

Date:
1999

Citation:

Publication Status:
Unpublished

Persistent Link:
http://hdl.handle.net/11343/35381

File Description:
How effective are current drug education programs as a means of preventing illicit substance abuse in teenagers

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