PROTECTIVE FACTORS FOR ILLICIT DRUG USE:
THE ROLE OF SCHOOLS

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Introduction

The national reports on the health of Australia’s children and young people stated that most children enjoy good health. (Moon, Rahman & Bhatia 1998; Moon, Meyer & Grau 1999; Al-Yaman, Bryant & Sargeant 2002). However a number of areas of concern were identified, including the risks to health and wellbeing associated

- with the use of alcohol, tobacco and other substances, including the illicit drugs.
- attendance rates and leaving school early, [Apparent retention rates to Year 12 were 66.4% males and 78.5% females in 1999. These retention rates have been stable since 1996 after reaching a peak in 1992 of 73% for males and 82% for females, then declining (Collins, Kenway & McLeod 2000)
- the level of youth involvement in illegal activities.

Looking specifically at drug use, the harmful impact on Australian Society has been well documented over many years. These harms include illness and disease, disruption of family and other relationships, problems in the workplace, injury, violence and crime. The impact of harmful drug use on the individual and the community has been a powerful rationale for schools to provide a response to reduce drug-related harm. This paper will provide a brief overview of past school-based approaches, current research and theories on the factors that influence young people’s drug use and the implication this has for school-based responses. This will be illustrated with some practical examples.

Early Approaches – “Drug Education”

The early school-based response to drug-related issues was to provide “drug education” to the students. As theories have been tested and changed so have the school-based responses. Many of the earlier school-based drug education programs were based on a primary prevention approach – that is preventing the initiation into drug use (Tobler 1986; Cohen 1993). The following is a brief overview of significant changes that have occurred since the first school-based drug education programmes commenced, in Australia, in the 1970’s.

One of the early approaches to drug education, the Information Model, was based on the concept that if young people were informed of the harmful effects of drugs then they would not use them. Some of the strategies used in this model included shock or scare tactics, talks by ex-users and “experts” with pharmacological and medical knowledge (Pickens 1985). This was followed by the Affective or Personality Deficit Model, which hypothesized that young people used drugs because of low self esteem, poor communication and interpersonal skills. Strategies focussed on issues such as building self esteem and communication skills. These programs also avoided inclusion of any drug information (Wragg 1991; Rowling 1995). It has now been shown that high self esteem does not preclude drug use (Coggans et al 1991). The Psycho-Social Model was based on a blend of a number of theories including social learning theory (Bandura 1977) and problem behaviour and social inoculation theories (Wragg 1991; Howard 1997). The psycho-social approach used a number of strategies including; providing students with relevant and accurate information, media analysis, role modelling, peer resistance and peer refusal skills. The belief that peer pressure was a prominent determinant of adolescent drug use led to a number of programs being developed that had a major focus on refusal skills, the “Just Say No To Drugs” programmes. It has now been suggested that peer pressure is less important than has been commonly believed (Coggans & McKellar 1994; Bauman & Ennett 1996). The Ecological or Interactive Model has built on the psycho-social model (Rowling 1995) and recognises the complex interaction between the individual (e.g. gender, age, health, mood, and expectations), the drug (e.g. chemical properties, strength, and frequency of dose, method of use, and use with other drugs) and the environment (e. g place, time of day, other people and culture – community or group).
The Interactive Model

Drug Use, Beliefs and Behaviour

Many of the early responses to alcohol, tobacco and illicit drug use did not acknowledge that drug use is functional, that it often provides immediate benefits and frequently is experienced as pleasurable, and for some users it has been a rational choice (Coggans et al 1991; Moore & Saunders 1991; Coggans & McKellar 1994). Also in developing these early school-based responses, little consideration was given to the levels of use. Young people were classified simply as users or non-users. There are different levels of use from non-use, experimental, occasional and regular use through to dependent use. Depending on the costs or benefits (real or perceived) that may be obtained from the use of any drug there may be movement in either direction. Use at a lower level does not mean that there will be a progression to a higher level of use.

This was explored more fully when the attitude of young people to drugs and drug usage behaviour was a focus of the research conducted on behalf of the Commonwealth Department of Health and Aged Care by Blue Moon Research and Planning Pty Ltd (2000). The researchers hypothesized that there were six broad groupings, within their sample, which was based on their attitudes to and usage of drugs and their motivations for behaviour in relation to drugs. These groupings were:

- Cocooned Rejectors,
- Considered Rejectors,
- Ambivalent Neutrals,
- Risk Controllers,
- Thrill Seekers, and
- Reality Swappers.

The ‘Cocooned Rejectors’ and the ‘Considered Rejectors’ both felt they had no ‘need’ to use drugs and that drugs were ‘bad’. The ‘Considered Rejectors were happy with their lives and felt in control of things and made ‘informed choices’. Whereas the ‘Cocooned Rejectors were not particularly happy or secure in their lives and did not feel in control. Illicit drug use in these two groups was relatively low. The ‘Risk Controllers’ and the ‘Ambivalent Neutrals’ showed a moderate level of use or potential use of illegal drugs. The researchers saw these two groups as ‘typical’ young people. Both groups were relatively happy and secure in their lives and felt in control. There were some differences in that the Ambivalent Neutrals’ lived for today with little concern for the future whereas the ‘Risk Controllers’ were concerned about the future and also were concerned about how others saw them. The ‘Thrill Seekers’ were heavy users of drugs. They were found to be a happy, secure, self-motivated group who were looking for additional excitement in their lives. They had the highest incidence of trial of all drugs other than heroin. The ‘Reality Swappers’ were the heaviest drug users. In contrast with the ‘Thrill Seekers’ they felt unhappy and insecure; they had a less positive attitude towards drugs and did not feel in control of their lives. This group had the highest level of trial of heroin.
The researchers identified three of the six groupings as being of greatest risk of moving towards heavy use or already using heavily. These were the ‘Thrill Seekers’, ‘Reality Swappers’ and the ‘Cocooned Rejectors’. The ‘Cocooned Rejectors’ were considered to be at risk because their rejection of drugs was based on external factors rather than it being a considered and self confident choice. They also shared many of the attitudes of the ‘Reality Swappers’ in that they were unhappy with their lives and therefore could use drugs for solace. This study reflects findings of other research that many young people use drugs to socialise and to have fun while others use them to deal with problems and they choose those drugs that will meet that need (Reilly and Homel 1987; Khantzian 1987; Spooner, Flaherty & Homel 1992; Szalay et al 1993; Wood et al 1995). Each of these groups will require different approaches and interventions which takes into consideration their attitudes towards drugs, their reasons for using drugs and their current or potential drug use behaviour.

Risk and Protective Factors

It is important to acknowledge that drug use is not solely influenced by individual factors but also by a range of other factors including: family factors, local and macro environmental factors (Hawkins, Catalano & Miller 1992; Ministerial Council on Drug Strategy 1998; Spooner, Hall & Lynskey 2001).

Some examples of these individual, family and environmental factors are:

- health factors such as chronic physical pain, stress, anxiety and depression;
- early initiation into substance use (including use of tobacco and alcohol), association with drug using peers, low self esteem;
- social and cultural factors such as parental and sibling drug use, cultural norms within a particular group or setting;
- market factors such as the promotion, cost and availability of alcoholic beverages and medications and the illicit drugs; and
- economic and physical environmental factors such as income and levels of employment, access to health and recreational facilities.

It has been identified that there are a number of common risks factors for young people associated with hazardous substance use, poor school attendance, leaving school early or becoming involved in illegal activities (Plant & Plant 1992; Gutierres, Molof, & Ungerleider1994; Resnick et al. 1997; Withers & Russell 1998; National Crime Prevention 1998; Spooner 1999; Pollard, Hawkins & Arthur 1999; Bond et al 2000, Spooner, Hall and Lynskey 2001). These include: inter and intra-relationship problems; poor family management practices; family conflict or break up; parental or sibling problem drug use; poor bonding to family; detachment from school; poor academic performance; unsupportive or rigid school culture; traumatic life events; emotional, physical or sexual abuse; mental and physical health problems; behavioural problems. It has also been shown that increased levels of risk factors in the young person’s life are associated with increased levels of substance use and anti-social behaviour (Newcomb et al 1987; Bond et al 2000; Newcomb & Felix-Ortiz 1992).

Pollard, Hawkins and Arthur (1999) grouped the protective factors into three basic categories: individual characteristics (e.g. a positive social orientation, high intelligence, and a resilient temperament), social bonding (e.g. warm, affective relationships), and healthy beliefs and standards of behaviour. Social bonding can occur within a number of settings including family and schools. Resnick et al (1997) found that parent-family connectedness and perceived school connectedness were protective factors against all health risks behaviours they measured (tobacco, alcohol, and marijuana use; violence; emotional distress; suicide; and age of sexual debut) except for a history of pregnancy. Enhancement of the school as a protective factor includes having a safe and caring environment, some opportunities for success at school and recognition of achievement.
Whilst some authors have argued that the focus should be building the protective factors associated with resilience others have argued that to focus only on this one strategy ignores the social and contextual risk factors (Pollard, Hawkins & Arthur 1999). In their study, Pollard, Hawkins and Arthur (1999) found the results indicated that prevention policies and programmes should focus on both the reduction of risk factors and the promotion of positive influences if the reduction in substance use, crime, and violence among adolescents or the improvement of academic performance are intended outcomes.

Health Promoting Schools

While the school can put in place a range of strategies to reduce the risks and enhance the protective factors there is a limit to what they can achieve on their own. The health promoting school concept provides an ideal framework for schools to develop a potentially more effective response to drug and other social and health-related issues.

While definitions of a health promoting school may vary the World Health Organisation (1998) suggests a Health Promoting School can be characterized as a school that is constantly strengthening its capacity as a healthy setting for living, learning and working. The health promoting school aims to create an environment that promotes and enhances the health and wellbeing of students, teachers and other school staff. It is an approach that develops and strengthens collaboration between members of the school community and the broader community.

Within this framework, to achieve the best education and health outcomes the approach needs to be:

- **comprehensive in concept** (e.g. having policies which impact on the physical and psychosocial environment of the school, developing links with the wider community, including parents and health-related services),

- **comprehensive in content** (not focus just on health problems but also include elements of personal and social development, life skills relevant to the students needs and the positive aspect of health as a resource for life), and

- **based on partnerships** (e.g. between teachers, students and parents, and the school community with health practitioners and relevant agencies) (National Health and Medical Research Council 1996; Allensworth 1944).

Broadly there are three elements to the health promoting school:

**Three Interlocking Elements of a Health Promoting School**

![Diagram: Three Interlocking Elements of a Health Promoting School](image)

(National Health and Medical Research Council 1996)
**Curriculum, Teaching and Learning**

Drug-related and other health and social issues should be part of a planned, sequential health programme and, where relevant, integrated into other subjects. The programme also needs to include those drugs that are most commonly used by young people and that are associated with the most harm (Ballard, Gillespie & Irwin 1994; National Health and Medical Research Council 1996). The planning and implementation needs to take into consideration:

- local issues and needs,
- student needs and learning styles,
- student-centred teaching,
- experiential learning, and
- building opportunities for success.

It is important that the teachers are supported with quality resources and professional development.

**School Organisation, Ethos and Environment**

Many factors contribute to providing a caring and supportive environment for students and teachers. Examples of these include having policies and guidelines for the management of issues such as:

- licit (including medications) and the illicit drug-related issues
- a smoke-free environment, and
- harassment and bullying.

It also includes:

- providing a range of alternative activities for students (e.g. sport, drama, music and community service activities),
- recognising and celebrating their achievement, and
- providing support services for students and staff (e.g. peer support programs, breakfast clubs, school-based counsellors, nurses and chaplains).

**Partnerships and services**

Collaborative partnerships are an integral component of a health promoting school in developing a range of multi-modal strategies. The partnerships can be between parents, students and teachers or the school community with human services providers and others from the broader community. These partnerships can support not only teaching and learning but can also contribute to a supportive and caring environment. Examples of this are:

- Encouraging school, parent and student interaction through newsletters, “take-home” activity worksheets, presentations of student learning and involvement in curricula and policy decisions.
- Health agencies and other services providing expert advice in the development of curricula, resources, policies, and school-based services and providing supportive services for students and staff.
- Linking school activities to community, state and national health promotion activities e.g. Quit campaigns, National Alcohol Campaign.
Examples: From Macro to Micro

The strategies individual schools can develop may range from universal (for the whole school population) or are targeted for specific groups or individuals. The South Australian Curriculum Standards and Accountability (SACSA) Framework provides schools with the flexibility to develop a curriculum that meets the needs of the school community.

South Australian Curriculum Standards and Accountability (SACSA) Framework

The South Australian Curriculum Standards and Accountability Framework describes the curriculum Key ideas from birth to Year 12 for all government schools and children’s services. It provides the elements that form the basis for educators to design the detailed learning which suits the needs of children and students in their settings and which emphasises local priorities.

Built into all the learning areas are the Essential Learnings which describe the values, dispositions, skills and understandings that are considered crucial in the education and development of all learners.

The Essential Learnings are as follows:

- **Futures**: Learners develop the flexibility to respond to change, recognise connections with the past and conceive solutions for preferred futures.
- **Identity**: Learners develop a positive sense of self and group, accept individual and group responsibilities and respect individual and group differences.
- **Interdependence**: Learners develop the ability to work in harmony with others and for common purposes, within and across cultures.
- **Thinking**: Learners become independent and critical thinkers, with the ability to appraise information, make decisions, be innovative and devise creative solutions.
- **Communication**: Learners develop their abilities to communicate powerfully using literacy, numeracy and information and communication technologies.

Whilst this is a curriculum focus, the building of these values, dispositions, skills and understandings across all areas of learning has the potential to have a positive impact not just on the students as learners but also on their overall wellbeing. It is supported by other strategies that relate to the other two elements of the health promoting school. Further information on SACSA can be found at [www.sacsa.sa.edu.au](http://www.sacsa.sa.edu.au)

**SA School Drug Education Strategy Project and SA Health Promoting Schools (HPS) Partnership Project**

Whilst these are separately funded projects, team members of each project maintain a close working relationship to ensure that the work of each supports and complements the work of the other. The School Drug Education Strategy takes a “Whole of School” approach that reflects the three elements of the Health Promoting Schools Framework – Curriculum, Environment and Partnerships. A core team with representation from school staff and students, parents and the local community is formed to “drive” and support each school’s individual strategy. Training and ongoing support is provided by the Project Team. Curriculum and other resources are also provided to the project schools. Further information can be found on the Drug Strategy Website for Schools at [www.drugstrategy.central.sa.edu.au](http://www.drugstrategy.central.sa.edu.au)
The HPS Partnership Project has membership representing the Children’s Health Development Foundation (focus nutrition and physical activity), SHine (previously Family Planning), the Division of Mental Health (Northern CAMHS) of the Women’s and Children’s Hospital, Quit SA and the Drug and Alcohol Services Council. Working in partnership they have provided workshops for school staff, students, parents and local agency personnel to support the schools in developing their own Health Promoting School initiatives. During the workshops, links are made between the following health issues: sexual health, mental health, tobacco, alcohol and other drug use, physical activity and nutrition. The resource ‘Health Promoting Schools: supportive environments for learning and health’ forms part of the package offered to schools. Small funding grants have been made available to some schools to assist them in developing and implementing their HPS initiatives. Further information and examples of case studies can be found on the CHDF website at www.chdf.org.au

One school’s approach to enhancing the protective factors and reducing the risk factors
Parafield Gardens High School’s focus is “Youth and Community Development”. The school has developed strong community links in forming partnerships with the local council, businesses, health, welfare agencies, police, service clubs and universities in the development of a range of projects.

One of these was the Crime Prevention and Community Safety Project which included four discreet but inter-related projects. These were the production of a “Crime Prevention and Community Safety Curriculum”, the “No Room for Racism” Project, “Making Choices About Drug Use” Project and the “Youth Multi-media” Project. A brief description of two of these projects follows.

“Making Choices About Drug Use” Project
This project was designed to address cannabis use and increase student involvement though an expressive and creative activity – Dance. The issues addressed in the dance performance and included in the package of support material were based on a survey conducted by Year 8 students and workshops conducted with the support of health agency staff and a local police officer. The supportive material included: a “Question and Answer” video on marijuana which was researched and developed by a group of Year 8 students; a video of the dance performance (videoed by an ex-student of the school); an information booklet on marijuana; worksheets (performance analysis) and pre/post questionnaires. The package could be used independently thus extending the life of the project beyond the live performances.

Youth Multi-media Project
The aim of this project was to work with a small group of young people who were considered to be ‘at risk’ and to reconnect them with the education system through the medium of creative technology. This involved the young people in the creation of individual web pages. After a series of preliminary workshops, the issues identified and selected by the young people for their web pages were sexual assault, graffiti, marijuana and heroin. Information on their chosen topics was provided through presentations, printed information and personal contact with relevant agencies. Translating the information from the pamphlets into language suitable for young people provided a challenge for all involved in the project. An IT company and graphic artist were contracted to assist the students in the development of their web pages. All the student-related activities associated with this project were held outside the school environment, food was provided and for the practical computing sessions transport was organised to get the students to the IT company’s premises.

The students involved with these projects received formal accreditation for their work, each of the projects was publicly launched by the State Attorney General and the students received public acknowledgement of their work through the media (TV, print and radio). More detailed information can be found in Grove & Nolan 2001.
Conclusion

These last two projects illustrate how schools can put theory into practice. Programmes can be specifically designed to reduce the key risks factors and enhance the protective factors. The protective factor, addressed in these projects, was perceived school connectedness, which has been shown to be an important factor in reducing the risk of young people leaving school early, becoming involved in offending behaviour including the use of illicit substances. This was achieved by the students being actively involved in the development and management of the projects and gaining a range of skills and knowledge that could be used within and beyond the school environment. Also the students’ achievements were recognised publicly and they received formal school accreditation for their work. School staff and other personnel involved in the projects provided a caring and supportive environment for the students to undertake the project activities. This included developing a trusting relationship with the young people, listening to them, providing opportunities for them to make decisions and set their own tasks and by building confidence in their ability to achieve. The feedback from the students indicated that they had increased their knowledge and gained new skills and the learning was enjoyable.

The projects fitted within the Health Promoting Schools framework as the strategies involved a cross curriculum approach and was supported by the school’s wholistic approach to the health and well-being of its students. The partnership between the school and local community was an important element of this project as it used the expertise of each partner to achieve the shared goals which possibly would not have been achieved by each working alone.
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