



A Guide for Policymakers and Funders
To
School-Based Drug Prevention

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1. Introduction

This publication has been written for decision-makers, planners and evaluators without a health promotion or drug prevention background whose main interest lies in policymaking or funding for school-based drug prevention. This publication aims to provide a general introduction and overview, especially for those who are relatively new in this field.

Drug abuse is an issue of public concern in most European countries. As a result, most governments aim to reduce drug abuse in their population, especially in regard to young people. School-based drug prevention is one of the most popular types of drug prevention in Europe. The extensive nature of the school system enables authorities to reach a wide range of young people with health promotion and drug prevention messages. Therefore, most large-scale drug prevention programmes are run through schools.

Despite the widely shared aim of reducing drug abuse in society, there are considerable differences between and within European countries regarding policies and guidelines for schools. Some countries have adopted the concept of health promotion in their national educational curriculum, requiring schools to devote attention to promoting a healthy lifestyle for young people. Other countries have formulated specific guidelines for school-based drug prevention programmes and school policies, but their number is limited. Many European countries have adopted policy aims for drug prevention in schools in their national drug strategies, but in many cases these aims have not been implemented in practice.

Only a limited number of European countries have developed a systematic approach towards school-based drug prevention, including monitoring and evaluation systems that can help determine what the outcomes of these prevention efforts are and how the policies should then be adjusted. As the European Monitoring Centre for Drugs and Drug Addiction concludes in its policy briefing on school-based drug prevention, “*Few Member States can guarantee that their prevention measures are selected, implemented and quality-controlled thoroughly and extensively.*” (EMCDDA 2002).

When politicians formulate policy goals that aim to reduce the abuse of legal and illegal drugs, policymakers are charged with translating those aims into effective policies at the lowest possible cost. Since policymakers are usually not experts in drug addiction and drug prevention they have to co-operate with and rely on a wide range of experts and stakeholders, each of them with their own demands, interests and working methods.

In order to be effective, policymakers and sponsors need some basic understanding of the nature of drugs and drug related dangers as well as the impact drug prevention may have on the people’s behaviour regarding health. A thorough understanding of what is possible and what is not regarding school-based drug prevention is important in order to prevent misconceptions and disappointment.

The next few chapters contain practical information, elaborating on the question of what policymakers and sponsors need to know and do or not do when developing a policy in this specific area of health promotion.

In *chapter 2* some basic information is given about drugs, drug use and drug addiction. *Chapter 3* contains information about drug prevention with an emphasis on effective prevention in a school setting. In *Chapter 4* some basic conditions for a

successful policy are introduced, while in Chapter 5 an example of a policy-development process is presented. Chapter 6 focuses on the important issue of funding of school-based drug prevention. In the appendix, references to relevant literature and interesting websites are given.

Finally, readers interested in school-based drug prevention should read the manual 'Making Schools a Healthier Place – manual on effective school-based drug prevention' (Gallà et al, 2002) and/or other publications developed in the framework of the project 'The European Healthy School & Drugs'.

2. Drugs, drug use and drug addiction

One important problem in relation to policymaking in the field of drugs concerns the lack of knowledge among political representatives, policymakers, the media and the general public. There are many misconceptions about drugs and drug use, which make it difficult to take a realistic approach towards drug prevention. Politicians sometimes overreact to drug incidents and make promises that cannot be put into practice. Generalisations about the effects of illegal drugs can be read in the media every day. The public is shocked when a young person dies after having misused the drug ‘ecstasy’. The fact that many more young people die in alcohol-related traffic accidents every year causes much less public consternation.

Policymakers need to understand the different health risks connected to the abuse of both legal and illegal drugs. They must also be able to distinguish between real and perceived problems regarding drugs. They need to separate fact from opinion and develop effective policies.

2.1 What are drugs?

In this publication, when we refer to drugs, we refer to all legal, illegal and medically prescribed substances. The question of what is considered a drug, is not always easily answered. Sometimes the effect of a certain substance is taken as the point of reference, whereas at other times, it is legislation governing the specific substance that carries more weight.

As far as the effects of a certain drug are concerned, a substance is commonly defined as a ‘drug’ when it has an effect on the human central nervous system that results in an alteration of the mental and/or physical state. The effect can be stimulating or the opposite, stupefying. A third possible effect is best described as a change in a person’s consciousness and perception of reality. Some drugs have a mixed effect.

By this definition, if we look only at the effects, then substances such as tea, coffee, tobacco, energy drinks and over-the-counter drugs (e.g. cough syrups containing codeine or DXM) are also all drugs. In most countries, a distinction is made between legal and illegal drugs. Alcohol and tobacco are usually considered legal drugs. Cannabis, ecstasy, cocaine and opiates such as heroin, are generally considered illegal drugs. Most prescription medicines, which are by our definition drugs, are not regarded as illegal drugs, since they are distributed in a controlled manner through physicians’ prescriptions. In some countries, a distinction is also made between soft drugs (e.g. cannabis) and hard drugs (e.g. cocaine, heroin).

The list of substances that are considered ‘drugs’ — be it legal or illegal — changes all the time, due to new substances frequently appearing on the market. Energy drinks, Magic Mushrooms and new synthetic designer drugs (e.g. 2-CT-2) are examples of this. The use of medical drugs for recreational as opposed to medical purposes is considered illegal. Examples of this are GHB, Diazepam and Viagra. The attitude of society to drugs changes over time. Opium and cocaine, for example, are now considered to be illegal drugs. Historically however, they were both used for medical purposes.

There is a great deal of controversy regarding the effects and health damage of different types of drugs. Although the long-term effects of most drugs (e.g. heroin, cocaine, cannabis, amphetamines) are known, there is quite a difference in the way countries and prevention programmes present these effects to the general public. From a policy perspective, not only the toxicity and effect of a substance is relevant.

The legality of a drug also plays an important role, as does the social acceptance of a specific type of drug. In many individual countries, as well as at a pan-European level (EMCDDA, 1999), 'risk assessment' protocols have been developed in which health hazards (both individual and public) and other dangers (e.g. risk for public order and safety and risk of involvement of (organised) crime) are assessed by experts both quantitatively and qualitatively. The EMCDDA publishes regular risk assessment studies on new (synthetic) drugs appearing on the market, e.g. risk assessment on PMMA (EMCDDA, 2003).

Because perceptions about drugs and their positive and/or negative effects differ so widely, this 'bias' is often reflected not only in drug policies, but also in scientific studies. There is an increasing need for evidence-based information about drugs. The Trimbos Institute together with a number of European partners hope to set up the *Evidence-based Electronic Library on Drug Addiction* during 2004, containing evidence-based information about a number of substances derived from a systematic screening of scientific literature. This database (www.eelda.org) will present information about the toxicology and pharmacology of substances, as well as information about effective prevention and treatment of addiction. It will also include an overview of the scientific debate where no consensus has been reached regarding the long-term effects and risks of certain types of substances.

2.2 Types of drug use

In many drug prevention programmes the effects of drug abuse on the individual are simplified and exaggerated, especially in the case of illegal drugs. At the same time, the use of legal drugs (e.g. alcohol, tobacco) is often underestimated. The fact is that the large majority of young people will never become problematic drug users, even if they experiment with drugs or use them in a recreational setting. It is important for policymakers to differentiate between experimental, recreational and problematic drug use (substance abuse or dependency).

There are a number of international standards for diagnosing substance use disorders. In tables 2.1 and 2.2 criteria are presented for substance abuse (Diagnostic and Statistical Manual (of Mental Disorders) -IV, table 3) and substance dependence (DSM-IV, table 4) respectively. Another classification is provided by the WHO in its International Statistical Classification of Diseases and Related Health Problem (ICD). The latest classification of mental and behavioural disorders due to psychoactive substance use can be found in the tenth revision (ICD-10) (WHO, 1992). Policymakers do not necessarily need to know the details of these standards, but it is useful to know what type of information is included in these standardised (diagnostic) tables.

It is possible to divide drug use into different types of categories. In this publication, we distinguish roughly three types of drug use:

2.2.1. Experimental drug use

Experimental drug use concerns the one-time only or limited use of a legal or illegal drug for experimental reasons. Experimental drug users might 'try-out' a drug, but usually they do not develop a drug habit. Most people who experiment stop after a relatively short period of time. In statistical comparisons, this type of drug use is often presented in the 'life-time prevalence' (LTP) data, which shows whether a person has used a specific type of drug once in his life and/or a relatively long time ago (usually >1 year).

2.2.2. Recreational drug use

Recreational drug use concerns a more frequent use of drugs. Recreational drug use takes place during leisure time and/or in a relaxing atmosphere and is often incorporated in a specific lifestyle or (sub-) culture. Examples of this are young people taking party drugs such as ecstasy during house parties, adults drinking wine during dinner and cannabis users who smoke marijuana on the weekend. Recreational drug users usually do not use drugs in a risky manner (see table 2.1 for DSM-IV criteria on substance abuse). They use drugs occasionally in a non-problematic way and do not become dependent. In statistical comparisons, this type of drug use is often presented by the 'last-year prevalence' (LYP) or 'last-months-prevalence' (LMP) data, which shows whether a person has used a specific type of drugs in the past year or month.

Table 2.1 DSM-IV criteria for Substance Abuse

DSM-IV Table 3: Criteria for Substance Abuse	
A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:	
	1) recurrent substance use resulting in a failure to fulfil major role obligations at work, school or home (e.g. repeated absences or poor work performance related to substance use, substance-related absences, suspensions or expulsions from school; neglect of children or household)
	2) recurrent substance use in situations in which it is physically hazardous (e.g. driving an automobile or operating machinery when impaired by substance use)
	3) recurrent substance-related legal problems (e.g. arrests for substance-related disorderly conduct)
	4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g. arguments with spouse about consequences of intoxication, physical fights)
B. The symptoms have never met the criteria for Substance Dependence for this class of substance.	
<i>Source: American Psychiatric Association (1994). 'Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Washington, D.C. [U.S.A.], adapted from: Spooner et. al. [2001].</i>	

2.2.3. Problematic drug use

Problematic use of drugs entails the drug user finding it increasingly difficult to have a normal life without drugs. His functioning in social and/or professional surroundings is negatively influenced by the drug abuse. He might (begin to) suffer from physical or mental health damage, caused by the drug abuse. Problematic drug users are either on their way to or already have a dependency (see table 2.2 for criteria on substance dependence). They use drugs in a risky manner and are likely to develop (mental) illnesses after a certain period of time. Problematic drug users usually use opiates, cocaine, amphetamines, or alcohol or a mix of these substances. Ecstasy and cannabis are usually not included in this category since these drugs have a low risk for development of a dependency or because the long-term effects of high-frequent use are still unknown (ecstasy). In statistical comparisons, problematic drug use is often indicated by 'last weeks prevalence' or 'daily use'.

Table 2.2 DSM-IV criteria for Substance Dependence

DSM-IV Table 4: Criteria for Substance Dependence	
A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time within a 12-month period:	
	1) Tolerance, as defined by either of the following: a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect; b) markedly diminished effect with continued use of the same amount of the substance
	2) withdrawal, as manifested by either of the following: a) the withdrawal characteristic for the substance (refers to Criteria A and B of the criteria sets for Withdrawal from the specific substances (*)) b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms;
	3) the substance is often taken in larger amounts or over a longer period than was intended
	4) there is a persistent desire or unsuccessful effort to cut down or control substance use
	5) a great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use of the substance (e.g. chain-smoking), or recovering from its effects;
	6) important social, occupational or recreational activities are given up or reduced because of substance use
	7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)
<i>Source: American Psychiatric Association (1994). 'Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Washington, D.C. [U.S.A.], adapted from: Spooner et. al. [2001].</i>	

(*) not included in this publication)

Experimental and recreational drug users are usually not mentally ill nor do they need treatment. Prevention aimed at experimental drug users therefore should focus on the reduction of drug-related harm, including attention to immediate health risks, social exclusion, etc. Prevention aimed at recreational drug users should take into account the specific (recreational) setting, subculture, and lifestyle of the user. When looking at the whole spectrum of drugs used for non-medical purposes, it must be noted that the magnitude of health damage in the overall population due to tobacco use and alcohol abuse is greater than the harm from any other (legal or illegal) drug.

2.3 Determinants of drug abuse

It is not possible to predict whether a person who takes drugs will end up as a drug addict, although research shows that there may be factors that increase the risk of problematic drug use. However, the large majority of people who take drugs do not become addicted and when they use drugs, it usually fits in their lifestyle without problem. Drug addiction on the other hand, is a mental disorder, a mental illness. Most addicts do not become dependent just because of the substance use itself. While most people have a sense of self-preservation, this 'natural threshold' that protects people from self-destruction is often distorted or even absent in problematic drug users. This is why drug addiction should be seen as a health issue in the first place. Law enforcement and legislation on drugs often aims to reduce public nuisance caused by drug use and drug users and as such fight the symptoms of (addictive) behaviour. A policy that advocates abstinence (zero-drug use) does not necessarily focus on health damage or public nuisance caused by

drug use, but instead aims to uphold an ideological policy choice. In cases of the latter, drug-related harm might have nothing to do with health damage caused by substance use, but rather with legal or social consequences for the individual.

Despite the availability of a tremendous amount of reliable information about drugs, drug use and drug addiction, there is still a lot of confusion around about drugs, their effects and the damage they can do. Despite the fact that the abuse of not only alcohol and tobacco, but also the massive (and sometimes wrongful) use of prescription drugs causes a lot of health damage to relatively large proportions of the population in many Western countries, much more emphasis is often placed upon the prevention of illegal drug use. And often information about these illegal drugs is incomplete, biased or even wrong.

Apart from plain misconceptions, there are also strong beliefs that persist even when they cannot be substantiated by evidence. For example, in parts not only of the political and scientific community, but also among the general public, a strong belief is maintained that if a young person starts to use one type of illegal drug – e.g. cannabis - he will soon move on to another, more harmful drug and will end up as an addict or a criminal.

This claim, which is also known as ‘the stepping-stone theory’ or the ‘gateway-drug-theory’ has never been empirically proven. One of the main arguments which supporters of this theory use, concerns the fact that most drug addicts have also used a ‘lighter’ or less addictive drug before they got dependent on hard drugs. Most drug addicts support that claim. But the argument is incorrect, because it reverses cause and effect. All drug addicts have drunk water in their life. If the theory were correct, a much larger percentage of people using cannabis would also use other, more harmful illegal drugs. The prevalence figures (see below) show that this is not the case.

In addition, if the stepping-stone theory were correct, why would there be a difference between the use of legal and illegal drugs? After all, the difference between these types of drugs is the result of legislation. In terms of the nature of the drug, its effect and health damage, spirits (distilled alcohol) could be considered a hard drug as well. A large proportion of European citizens frequently drink strong alcohol, but the majority of them do not become dependent on it nor on other drugs.

Drug addiction is the result of varied factors. This raises the question of which factors increase or diminish the chance of a person developing a habit of problematic drug use.

2.3.1 Risk factors for adolescent drug use

Researchers have tried to determine what specific characteristics in a young person’s character or surroundings might increase the chance of problematic drug use or abuse. If such risk factors or ‘determinants of drug use’ can be identified, prevention can be targeted at specific groups. A risk factor for a certain type of behaviour (e.g. drug use) is any factor that is associated with an increased likelihood of that behaviour.

Spooner et al. [(2001) identify a number of risk factors for adolescent drug use, categorised on four different levels:

Individual level:

- Genetic predisposition
- Personality factors (e.g. lack of social bonding, resistance to authority)
- Inadequate knowledge about drugs
- Lack of coping skills (towards difficulties in life, etc.)
- Inadequate commitment to education
- Academic problems
- Early age of first use

Family level:

- Ineffective parental management techniques
- Negative communication patterns between parents and children
- Poor family relationships
- Inadequate parental role-modelling

Local environment level:

- Traumatic experiences (e.g. child abuse, war, refugee camp)
- Deprived socio-economic status
- Lack of support (e.g. peers, community)
- Negative peer influences
- Labelling of students (into social classes, etc.)

Macro environment level:

- Inadequate legislation
- Inadequate law enforcement
- Availability (of drugs)
- Social messages about drug use (e.g. via the media).

It must be noted that a one-to-one relationship between drug abuse and any of these risk factors does not exist. People react differently, even when they face very similar circumstances. The question of whether an adolescent would become a problematic drug user also depends on the intensity and combination of these risk factors in a young person's life and on the level in which protective factors offer a counter influence on his behaviour.

2.3.2 Protective factors

Spooner et al. (2001) also defined a number of protective factors that enable a person to deal with problematic, adverse environments. These are factors that (a) reduce the impact of a behaviour, (b) help individuals not to engage in the behaviour, (c) reduce the chances that individuals will engage in the behaviour, and/or (d) promote an alternative pathway (Spooner et al. 2001). These factors are:

Competences of the individual:

- Physical competence (good health, easy-going personality, etc.)
- Social and relational competence (e.g. secure attachment to other people, ability to seek help from others, etc.)
- Cognitive competences (e.g. I.Q. and Emotional Quotient, self-efficacy, ability to communicate, etc.)
- Emotional competence (e.g. sense of humour, high self-esteem, etc.)
- Moral competence (ability and opportunity to contribute to others)
- Spiritual competence (e.g. having faith that one's life matters).

Protective processes in families:

- Supportive parent-child relationships
- Positive discipline methods

- Monitoring and supervision
- Family advocacy for the children
- Families seek information and support for the benefit of their children

Protective factors in schools:

- Increasing pro-social bonding
- Setting clear & consistent boundaries
- Teaching life skills, providing care and support
- Setting and communicating high expectations for all
- Providing opportunities for meaningful participation

Protective processes in communities

- Neighbourhoods with healthy institutions (such as schools, churches and youth organisations which provide positive role models for children)
- A proper infrastructure for youth programmes
- Strong social networks in which adults are connected with each other.

Protective factors are characteristics or conditions believed to decrease the probability of — in this case — substance abuse. They therefore are the opposite of risk factors. They may alter, or even reverse, predictors of negative developments and enable individuals to cope with negative life events.

2.4 Prevalence of drug use among school-students

For policymakers it is important to have information about actual drug use and drug related problems in the general population as well as in specific target-groups such as school students. In Europe and the U.S.A., periodic nationwide surveys are organised that try to map out the prevalence of drug use among school students aged 15 to 16. One example of these studies is the European School Survey on Alcohol and other Drugs (ESPAD) (Hibell et al., 2000). In the tables below, some of the outcomes of the latest ESPAD survey (including comparable data from the U.S.A.) are presented. The survey was conducted in almost 40 European countries. It is important to note, though, that this survey mainly targets young people in general secondary education. Groups of young people that are difficult to capture (school drop-outs, students in specific types of vocational education and training) are not or not always included.

Country	Drink alcohol 40 times or more in life	Drink alcohol 10 times or more in last month	Was drunk 20 times or more in life	Was drunk 3 times or more in last month
Denmark	59%	18%	41%	30%
United Kingdom	47%	16%	29%	24%
Ireland	40%	16%	25%	24%
Finland	20%	1%	28%	18%
Norway	16%	3%	16%	14%
Sweden	19%	2%	19%	14%
The Netherlands	37%	20%	8%	11%
France	20%	8%	4%	6%
Portugal	15%	6%	4%	4%
United States	16%	5%	11%	4%
Greece	42%	13%	4%	3%
Italy	17%	7%	2%	3%

Source: ESPAD 1999

Table 2.3 shows the level of alcohol use in the student population. The last column gives some indication of the phenomenon ‘binge drinking’, which means that people drink a lot of alcohol in a short period of time with the aim of getting drunk. The Scandinavian countries rank higher in this listing than countries with a more traditional ‘drinking culture’ (France, Italy).

Country	Recent smokers (last month)	6 or more cigarettes per day in last month
France	44%	18%
Finland	43%	18%
Norway	40%	13%
Italy	40%	13%
Denmark	38%	17%
Ireland	37%	16%
The Netherlands	36%	17%
Greece	35%	17%
United Kingdom	34%	16%
Portugal	31%	7%
Sweden	30%	7%
United States	17%	4%

Source: ESPAD 1999

Tobacco – after alcohol - is the second most prevalent drug among school students (table 2.4). Governments are paying increasing attention to the prevention of tobacco use among under-aged students. The health damage caused by frequent use of tobacco is eminent, although in society this damage is not always recognised by the general public. Many more parents worry about the use of cannabis by their children than their children’s alcohol and tobacco use.

Country	Ever use (LTP)	Recent Use	Six times or more in the last month
United States	41%	19%	9%
United Kingdom	35%	16%	6%
France	35%	22%	9%
Ireland	32%	15%	5%
The Netherlands	28%	14%	5%
Italy	25%	14%	4%
Denmark	24%	8%	1%
Norway	12%	4%	1%
Finland	10%	2%	1%
Greece	9%	4%	2%
Portugal	8%	5%	2%
Sweden	8%	2%	0%

Source: ESPAD 1999

Table 2.5 shows that frequent use of cannabis is lower than the frequent use of alcohol and tobacco. The health damage caused by cannabis is lower than most legal and illegal drugs, although there are concerns about the increasing strength of the effective substances in cannabis, as well as the high frequency of use among certain groups of users.

Country	Ever use (LTP)
United States	8%
United Kingdom	3%

The Netherlands	3%
France	2%
Ireland	2%
Italy	2%
Denmark	1%
Finland	1%
Greece	1%
Norway	1%
Portugal	1%
Sweden	1%

Source: ESPAD 1999

The lifetime use of cocaine (table 2.6) by school students is relatively low in Europe when compared to the United States. Cocaine is often used in dense urban areas or within certain subcultures (e.g. club-scenes). The frequent use of cocaine is even lower. In some countries there seems to be a trend that users shift from synthetic drugs such as ecstasy and amphetamines to cocaine.

Country	Ever use of ecstasy (LTP)	Ever use of amphetamines (LTP)
United States	6%	16%
Ireland	5%	3%
The Netherlands	4%	2%
United Kingdom	3%	8%
France	3%	2%
Denmark	3%	4%
Norway	3%	3%
Italy	2%	2%
Greece	2%	1%
Portugal	2%	3%
Finland	1%	1%
Sweden	1%	1%

Source: ESPAD 1999

The use of designer drugs such as ecstasy and amphetamines (table 2.7) among the school student population is modest compared to that of alcohol and tobacco. The United States shows a rather high prevalence of these two types of drugs compared to most Western European countries.

Overall, one can say that in the nineties there was an increase in drug use among students aged 15-16 in most countries in Europe and the United States. By the end of the nineties, a gradual stabilisation took place in most countries. Illegal drug use in the countries of Central and Eastern Europe – which had a traditionally low level - has been on the rise since the early nineties and seems to be following a Western-European pattern.

3. Drug use and abuse prevention

In chapter 2 different types of drug use were presented, as well as some of the risk and protective factors that influence the likelihood a young person would develop a habit of problematic drug use. In this chapter we will elaborate on the different types of drug prevention, present criteria to increase the effectiveness of school-based drug prevention programmes, and give an example of the steps through which such a programme can be designed.

It is not always clear what is meant by the term 'drug prevention' nor what the policy behind it is. In some countries, such a policy is aimed at preventing all (illegal) *drug use* in the population. In other countries, drug prevention is seen as harm or risk reduction, in order to prevent drug abuse. The term 'harm reduction' is politically sensitive in some countries. In those cases, policymakers prefer to speak of health promotion, which sounds different, but actually is the same in practice. In reality, no government or policy has ever been able to achieve complete abstinence from (illegal) drug use in its population. Therefore, most drug prevention policies aim to reduce the level of drug use in the population (drug demand reduction), usually in combination with a reduction of the risks of drug use or the promotion of health.

3.1 Types of drug use and abuse prevention

As indicated in chapter 2, drug addiction is a mental health disorder. Within the prevention community, mental health prevention interventions were traditionally divided into three categories (Cuijpers, 2003). The first category was *Primary prevention*, which was aimed at the prevention of drug use all together, or at preventing drug abuse and dependence disorders according to the diagnostic criteria (see tables 2.1 and 2.2). *Secondary prevention* was identified as treatment of identified cases, in order to reduce the damage caused by drug use. The term *Tertiary prevention* included many of the interventions that are now generally considered to be treatment-interventions and not prevention.

Mrazek & Haggerty (1994) developed a more detailed schematic intervention spectrum for mental health disorders (figure 3.1). The spectrum provides an overview of intervention categories with their own types of interventions that correlate with the severity of the drug-related mental disorders. The model consists of three categories of mental health interventions, each with its own subdivisions, namely:

- **Prevention:** universal, selective and indicated interventions
- **Treatment:** case identification & standard treatment interventions
- **Maintenance:** long-term treatment & after care interventions

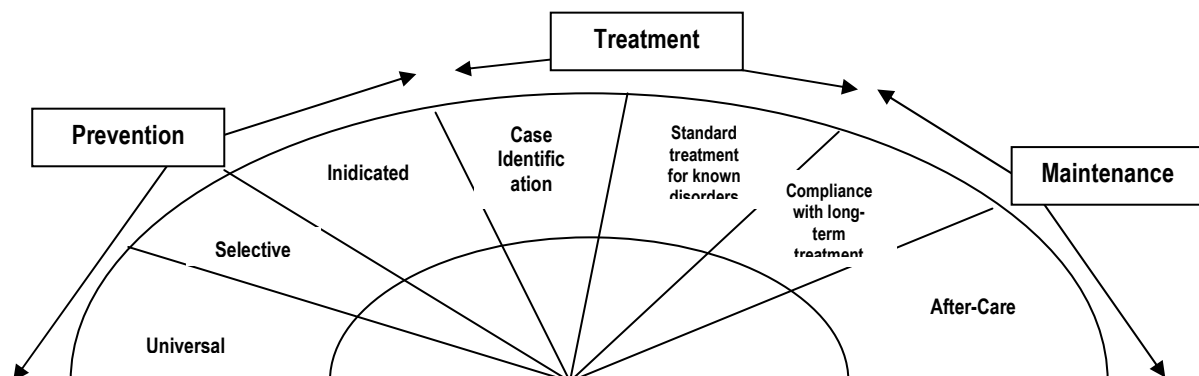


Figure 3.1 Intervention spectrum for mental health disorders (Mrazek & Haggerty, 1994).

When we speak about drug prevention in this publication, we focus on the first category of the intervention spectrum: prevention. This category consists of the following three types of interventions:

- ▶ **Universal prevention** aimed at the general population or a part of it (e.g. student population) that is not identified on the basis of individual risk factors (e.g. mass media campaigns and school-based programmes aimed at all students). The target audience has an average risk of problematic drug use.
- ▶ **Selective prevention** targeting specific groups of individuals (e.g. school students) who have an increased risk of drug use problems (e.g. programmes aimed at children of alcoholics or at high-risk inner city youth, etc.).
- ▶ **Indicated prevention** aimed at individuals (e.g. school students) who do not have addiction problems according to the diagnostic criteria for substance use disorders (see table 2.1), but who have some early characteristics of problematic use (e.g. interventions aimed at young people who frequently use drugs in a recreational setting). The target audience has a high risk of problematic drug use.

Types of prevention programmes

In the past decades, many prevention programmes have been developed (Cuijpers, 2003). Most of them are conducted in schools. The other main categories of interventions are mass media, family, and community interventions. Most prevention programmes have different aims, but usually include the following:

- Increase knowledge about drugs in adolescents
- Reduce the use of drugs
- Delay the onset of first use of drugs
- Reduce the abuse of drugs
- Minimise the harm caused by the use of drugs

School-based drug prevention interventions have been evaluated most rigorously. Research has shown that this type of programme can be effective in reducing drug use among adolescents. For the project 'The European Healthy School & Drugs', research was done to determine which factors increase the chance that a school-based drug prevention programme was actually effective in reaching its aims (see § 3.2).

Family-based interventions are a relatively new type of intervention that has not been evaluated much so far. Family-based interventions may include training programmes for parents with the aim of strengthening protective factors in families as mentioned in chapter 2. The results are encouraging, but still inconclusive.

Mass media interventions are generally not considered effective in reducing drug use among the target groups. However, they have a good chance of increasing knowledge and strengthening the effects of local or community interventions.

Community interventions often aim at adolescents in a specific local community, but also at parents, policymakers, professionals and other relevant groups. Community interventions are also relatively new and their effectiveness is still being researched. However, several well-designed studies have shown that this type of intervention

has been effective (e.g. alcohol abuse related accidents). Some studies have shown that the combination of school-based drug prevention programmes and community interventions increase the effectiveness of the former.

Despite experience throughout Europe with drug use and abuse prevention programmes, there is still no definite answer as to whether drug prevention programmes reduce major drug problems. Nor do we know which dissemination (and/or implementation) method is best equipped to achieve the aim of drug abuse prevention. In that regard, much still has to be done in terms of systematic research into drug prevention interventions.

3.2 School-based drug prevention

As indicated in the previous paragraph, there is limited scientific evidence available as to which elements make a prevention programme effective. Most scientific research has been done in the United States. It is possible to derive criteria for an effective school-based drug prevention programme from the scientific literature, but it is still unclear which specific activities in such programmes increase effectiveness, how intensive a programme should be and what elements in a prevention programme are essential for success. There is also a lot of 'best-practice' information available. Disregarding the different sources of this 'evidence from practice' in different countries, it seems that a lot of the criteria for effective practice are very similar.

One important question that needs to be answered at the start is what an effective school-based drug prevention programme really is. In this publication we have chosen to define an effective school-based drug prevention programme as a programme that:

- a) Prevents or delays the onset (first use) or reduces the frequency of drug use among students, and/or;*
- b) Reduces the social and health risks and possible harm of drug use among students, including their functioning in school, and/or;*
- c) Increases the ability of students to make informed and responsible decisions about their personal drug use, and/or;*
- d) Has a lasting effect.*

Practically all school-based drug prevention programmes increase knowledge about drugs and drug addiction among young people. But, evidence shows that this knowledge in and of itself is not enough to change behaviour. Programmes that just increase knowledge (which most programmes do) are therefore not necessarily 'effective'. In fact, most school-based drug prevention programmes are not effective at all or cannot prove that they are (Cuijpers, 2002). This is often due to a lack of structure within the programme, flaws in the design and approach and – very often – a lack of proper implementation within the school setting.

One example of lack of effectiveness is the Drug Abuse Resistance Education programme (DARE) that has been running not only in large parts of the United States, but also in Europe. This programme has been proven not to be effective in reducing drug use and abuse in students. The programme might have other, positive results (e.g. an improved relationship between students and law-enforcement officers who deliver the programmes), but that does not make it an effective school-based drug prevention programme.

3.2.1 Effective school-based drug prevention

In table 3.1 we present some of the evidence-based criteria found through a systematic review of the scientific literature. These evidence-based criteria have subsequently been supplemented with criteria derived from practice. Together, they form an interesting checklist, which not only schools and professionals, but also policymakers can use to assess the design of both existing and newly developed school-based drug prevention programmes. These criteria have also been adopted in the manual 'Making Schools a Healthier Place' (Gallà et al., 2002).

1. Evidence-based criteria

For the project 'The Healthy School and Drugs', the Trimbos Institute conducted a systematic review of the scientific literature in order to establish which characteristics determine the effectiveness of drug prevention programmes (Cuijpers 2002). This review differed from most other evaluation studies, as it combined three different study categories, some of which involved the same types of programmes, but with an evaluation from a different perspective or the use of a different methodology.

2 Criteria based upon 'best-practice'

Drug prevention is one of the few areas where science has followed practice for a long period of time. Innovations in this field have seldom been initiated by scientific research. Most of the time they were the result of prevention practice. In table 3.1 criteria are presented from best practice. These criteria focus primarily on the scope of prevention programmes and their structure, planning and implementation. There is some similarity to the evidence-based criteria.

3. Criteria for school effectiveness

Although drug prevention in schools has its own specific aims and approaches, the link with what is going on in the school is very strong. The implementation of a programme in each school is crucial to its effectiveness. Each school is different with its own structure, culture and value-system. Policymakers and professionals in drug prevention must realise that embedding a drug prevention programme requires knowledge of the way the school system works. Furthermore, it is only logical that those elements which improve the quality of regular, academic teaching are also relevant to the effectiveness of drug prevention programmes in schools. Therefore, we should expect that the implementation of a drug prevention programme in a school with effective teaching is likely to get better results than implementing the same programme in a less effective school (one with poor academic performance).

MacBeath et al. (2001) have formulated eleven indicators important for the effectiveness of a school, or in other words, whether the school achieves its aim of providing a good learning environment for its students (and staff). We have elaborated upon these criteria and related them to the implementation of a school-based drug prevention programme.

If a school is not effective in its teaching, the running of an effective prevention programme will become very difficult. The lack of clear objectives for the educational process, transparency, or involvement by all concerned in the school in its daily running will complicate the implementation of an effective prevention programme.

Table 3.1 Criteria for effective school-based drug prevention

1. Evidence-based criteria	2. Practice-based criteria for effective school-based drug prevention	3. Criteria for school effectiveness
<p>Proven effects The effects of a programme to be put in practice should be demonstrated by well-designed scientific research. This is an important criterion, as most drug prevention programmes have been shown not to have any effect on drug use or abuse. Only a small sample of drug prevention programmes is effective. This criterion is different than the other criteria printed below, as it does not indicate a characteristic of the programme itself, but rather requires that the effects be proved. However, it is an important criterion and therefore is retained in this list in first place.</p>	<p>Content of prevention</p> <ul style="list-style-type: none"> • All types of substances should be targeted, including tobacco, cannabis, benzodiazepines (e.g. tranquillisers and sleeping pills), and solvents (e.g. glue). • Depending on the social environment and the local (or national) prevalence of drug abuse, targeting should also include locally produced drugs. • Include attention to experimental drug use. Abstinence-oriented prevention can also be included, if based upon a 'safety first' and/ or risk reduction approach. • Provide objective and reliable information about both the relaxing aspects as well as the risks and dangers of drugs and drug use. • Emphasize protective factors (e.g. what precautions to take when using certain types of drugs) and risk reducing factors (e.g. drinking and driving). • Do not moralise, but rather encourage young people to think for themselves. • Focus on needs and priorities of the target group and the programme's surroundings. • Repeat the prevention message in an age-specific manner in future classes, incorporating shifts in consumption from one drug to another (and therefore adjusting the message). 	<p>Professional leadership (1)</p> <ul style="list-style-type: none"> • Schools are well-run and management pays attention to the needs and problems of all • The school policy contains clear rules on drugs. • Rules are implemented by the school administration. • The school expresses self-confidence. • The school has a drug-incidence action plan. • The drug prevention programme has realistic aims. • School administration facilitates the educational process and provides adequate resources for drug abuse prevention (time, staff, involvement).
<p>Interactive delivery methods Universal school-based drug prevention programmes should use interactive delivery methods instead of non-interactive delivery methods. Interactive programmes provide contact and communication opportunities for the exchange of ideas among participants and encourage learning drug refusal skills. In interactive programmes, students receive feedback and constructive criticism in a non-threatening atmosphere, enabling students to practice newly acquired refusal skills. Non-interactive programmes focus mainly on knowledge provision and some discussion. The superiority of interactive programmes compared to non-interactive programmes has been clearly demonstrated in scientific analysis.</p>	<p>Dealing with drug incidents</p> <ul style="list-style-type: none"> • Teach teachers and non-teaching staff about the complexity of detecting drug abuse in students, which includes training to identify the physical and mental characteristics of drug use in order to recognise 'real' drug-related problems and avoid making false accusations. • Provide anonymous and safe counselling opportunities in schools, or information on referral to professional drug services. • Counselling and access to information about drugs and drug use should also be available for others involved with the schools (teachers, non-teaching staff, and parents). • Be honest and direct with students, and let them know if and when you cannot guarantee them confidentiality, were they to inform you of their drug use. • Programmes should be consistent in terms of aims, objectives, activities and expected outcomes; different activities should reinforce each other and not be contradictory. 	<p>Shared visions and goals (2)</p> <ul style="list-style-type: none"> • There is support by the whole school community for the prevention objectives. • There should be no ambiguity in prevention messages; any contradictory information or examples (e.g. health education teachers smoking in school).
<p>Based on the 'social influence model' Prevention programmes based on the 'social influence model' are the most effective programs available and prevention programs should adopt this model. The social influence approach to drug prevention is based on the idea that 'inoculation' in the classroom against active or indirect social pressure to use drugs will help prevent substance use.</p>	<p>School rules and regulations on drugs</p> <ul style="list-style-type: none"> • Rules and regulations must be realistic: schools should not attempt to set rules that they cannot enforce, or assume responsibilities that belong to parents. • 'Moving' the problem does not solve it. Schools often will expel students who have been caught using drugs. Removing a student from his or her daily social environment is probably the most ill advised course of action and may place the student at even greater (social) risk. Professional counselling and guidance is a much better option. • Rules apply to everyone in school, including teachers and non-teaching staff; sanctions should be in proportion to the offence. 	<p>A learning environment (3)</p> <ul style="list-style-type: none"> • A safe social atmosphere • The school should work with modern and interactive teaching methods.

<p>Focus on norms, commitment not to use and intentions not to use</p> <p>As part of the social influence approach, prevention programmes should focus especially on existing norms (knowledge of the prevalence of drug usage among peers; social acceptability knowledge; normative expectations; friends' reactions to drug use); commitment of students to not use substances; and intentions not to use. Research on mediating variables has shown norms, commitment, and intentions to be vital mediating variables.</p>	<p>Parents</p> <ul style="list-style-type: none"> • Parents are important role models for children, both in positive and negative terms. • A drug prevention programme in schools should provide parents with information about drugs and drug use. • Schools are advised to communicate with parents about the drug prevention programme to be implemented in the school. • Promoting communication between parents and their children about drugs is important. 	<p>Concentration on learning and teaching (4)</p> <ul style="list-style-type: none"> • The educational process is at the heart of the school activities. • The gap between what students learn and what teachers teach is reduced to a minimum, as teachers take note of their students' perceptions towards drug use and drug prevention.
<p>Adding community interventions to school-based interventions</p> <p>Strengthens the effects of school-based interventions. Community interventions include family interventions, mass media campaigns, and community mobilising committees. The strengthening effect of community interventions has been demonstrated both in the meta-analysis and in comparative research.</p>	<p>Target groups</p> <ul style="list-style-type: none"> • A school-based drug prevention programme requires a distinction be made between various types of drugs and approaches at different class levels, as each age group requires an age-specific strategy. • Differentiate between prevention for the average student and at-risk student populations. 	<p>High expectations (5)</p> <ul style="list-style-type: none"> • Teachers are committed to achieving success with every student without exception; 'second rate' students do not exist.
<p>Use of peer leaders</p> <p>The use of peer leaders may strengthen the short-term effects of prevention programmes, therefore programmes should use peer leaders instead of — or in combination with — adult leaders, if possible.</p>	<p>Participation</p> <ul style="list-style-type: none"> • Search for ways (if not available already) to have students participate actively in the plan, design, implementation and evaluation of the programme. • Parents and teachers themselves can be a target group for specific activities, but can also function as intermediaries. 	<p>Positive reinforcement (6)</p> <ul style="list-style-type: none"> • A positive approach to students and their characteristics: solution- oriented instead of problem-oriented • The school atmosphere should be characterized by positive relationships and mutual respect.
<p>Adding life skills training to social influence programmes</p> <p>Life skills elements may strengthen the effects of prevention programmes. However, there is insufficient research-based evidence on mediating variables proving that social skills training, enhancement of self-esteem, or focusing on psychological well-being increase the effects of prevention programmes.</p>	<p>Facilities and training</p> <ul style="list-style-type: none"> • Make the training of different groups an essential element of the programme, not only regarding knowledge, but also in terms of techniques and attitudes (empowerment, personal coaching). • Provide sufficient (staff) time for activities and interventions. • Time-effective programmes have more support than very time-consuming programmes. • Teachers and others involved in school-based drug prevention (e.g. students) need information and training about substances and substance use. 	<p>Monitoring progress (7)</p> <ul style="list-style-type: none"> • Monitor the impact of prevention efforts. • Measurable aims have been defined within the school-based drug prevention programme.
	<p>Programme delivery</p> <ul style="list-style-type: none"> • Ensure that sufficient time is reserved in the school's curriculum so that all relevant aspects of a school-based drug prevention programme can be adequately addressed. • Repeat the prevention programme after some time has passed and try to adjust it to new groups of students. 	<p>Student rights and responsibilities (8)</p> <ul style="list-style-type: none"> • Participation • Peer involvement • Being taken seriously and taking others seriously • Encourage responsible behaviour in students and then trust students to act responsibly.
		<p>Purposeful teaching (9)</p> <ul style="list-style-type: none"> • Teachers are motivated, well-trained and

		<p>professional</p> <ul style="list-style-type: none"> Teachers teach with clear objectives of what they want students to achieve
		<p>A learning organisation (10)</p> <ul style="list-style-type: none"> The school learns from mistakes and events that occur in connection with drug use; it adapts to new trends and developments, including shifting views and opinions in society on drugs and drug use.
		<p>Home-school partnership (11)</p> <ul style="list-style-type: none"> Parental involvement is important for a comprehensive prevention approach

3.2.2 Design of a school-based drug prevention programme

In addition to the criteria presented above, the design and implementation of a school-based drug prevention programme is of great importance for its effectiveness. In the manual 'Making Schools a Healthier Place', we presented a model and design for an effective school-based drug prevention programme at the school level.

Roughly, the programme development and implementation cycle follows the steps given below (Gallà et al., 2002: chapter 3). The criteria presented in the previous paragraph need to be incorporated in the choices made.

Needs assessment

This step concerns the needs assessment at the school level (but also, for example, the direct surroundings of the school). The question of why the school wants to introduce a drug prevention programme should be posed with the input of all stakeholders in the school regarding drug use collected. Based on these opinions of why a programme is needed and how it could be done, a preliminary framework can be drafted.

Formulation of aims and objectives

The needs assessment will indicate what the stakeholders in the school perceive to be the relevant issues that need to be addressed by a school-based drug prevention programme. Subsequently, these must be formulated into clear aims for the envisaged drug prevention programme. Schools need to make certain that they formulate SMART¹ aims within the school context, so that progress (or failure) can be made apparent once the programme is running. The SMART aims can be accomplished by sets of clear measurable outcome indicators (for success). This stage also includes the process of defining the approach and message the school wishes to convey regarding drug use.

Programme assessment and selection

This step involves selecting a programme after having evaluated it in terms of the school's needs. There are many prevention programmes available. Sometimes it is better to 'buy' programmes off the shelf and adjust them to the schools needs rather than try to create a totally new programme. The assessment and selection phase is important because the choices made here influence the entire programme. Which programme suits the needs, expectations, and aims of the school best is the question that needs to be addressed.

Preparation

This pre-start phase (Gallà et al., 2002: chapter 5) includes the preparation of communication strategies and project activities and the raising of support for the programme among stakeholders within the school. If at all possible, an assessment of possible outcomes of the programme, both expected and unexpected, should be carried out.

Implementation

This phase concerns the actual introduction and running of the programme inside the school (Gallà et al., 2002: chapter 5). The implementation phase of a school-based drug prevention programme is crucial for its success. The prevention programme needs to be 'tailor-made' to the school's needs and adjust to the school's specific situation and population.

¹ SMART: Specific, Measurable, Acceptable, Realistic and Time bound (Gallà et. al., 2002: Tool 3.1).

Monitoring

The monitoring phase is – strictly speaking – not a phase of the project, but rather a part of the implementation process. By monitoring changes in knowledge and attitude, and – if possible – behaviour regarding drug use, the impact of the programme can be measured. Changes in attitude or behaviour at the school level cannot be measured easily without rigorous scientific research (e.g. a randomized controlled trial), especially when one would like to draw conclusions regarding the impact of a prevention programme. Furthermore, changes do not occur overnight, but only after a certain period of time has elapsed. In the manual 'Making Schools a Healthier Place' (Gallà et al., 2002: chapter 6) a monitoring tool for the school level is presented, which is available on the Internet (www.school-and-drugs.org). This tool is exactly that: a tool for schools wanting to monitor changes in attitudes and knowledge. The monitoring tool does not provide scientifically reliable information on the effectiveness of a drug prevention programme, but the results do help schools set priorities.

Evaluation

Every school-based drug prevention programme should be evaluated. For scientific comparisons, a scientific evaluation is required. At the school level it is important that the (interim) evaluation show whether the SMART aims and objectives have been reached. This can be done, among other ways, by looking at the indicators chosen during the aim-setting phase. Evaluation takes place once a programme has been implemented and the programme-activity cycle has been completed. In the manual (Gallà et al., 2002: chapter 7) suggestions on how to evaluate a programme are presented.

4. Towards a policy on school-based drug prevention

4.1 Introduction

This publication's main aim is to offer basic information about specific questions, problems, concerns and characteristics which might arise while developing or examining a policy on school-based drug prevention to policymakers and those who fund school-based drug prevention.

The need for drug use and abuse prevention policy is widely supported in most European countries. Most people agree that (the prevention of) drug abuse is a public concern. They realise that if young people experiment with drugs while unaware of the potential dangers of the different types of substances, they might put themselves at risk and damage their own health or the health of their friends and peers. People who become problematic drug users face an increased risk of becoming socially excluded from society as well as becoming involved in drug-related crime.

Prevalence studies show that most (young) people begin to experiment with (legal or illegal) drugs during their adolescence. In most European countries, young people start smoking cigarettes at the age of 12-13, drink their first alcoholic drink at the age of 13-14 and use cannabis for the first time at the age of 15-16. Given this pattern of (emerging) drug use in the age group of 12 to 18, there is a strong argument to aim drug abuse prevention at young people in that age group.

However, drug prevention in general, and prevention at schools in particular, is no magic solution for many of the causes that may lead to problematic drug use. Drug prevention can improve knowledge and awareness among young people regarding drugs. Drug prevention, including life skill programmes, can enhance their abilities to make responsible choices about their own (non-) drug use. But, as the risk and protective factors as presented in chapter 2 point out, factors such as family structure, individual well-being, socio-economic status and the health situation of young people have an influence on the likelihood that they develop a habit of drug use or abuse. These factors develop through time, given the specific background and situation of each individual. The development of problematic drug use in a young person is often a symptom or a result of these other factors rather than a direct result of experimenting with drugs. Taking that into account, it is justified to conclude that a drug prevention policy alone will not solve the problem of problematic drug use among young people. A comprehensive youth policy, including drug prevention strategies, towards youth might - on the other hand - help to reinforce protective factors and limit risk factors.

Countries or regions with groups of young people-at-risk therefore should not only invest in drug prevention programmes, but also, and perhaps foremost, in other areas of youth policy: education, employment, social welfare, general healthcare, proper housing, etc. Unfortunately, in many countries a coherent youth policy covering all those areas does not exist, often due to a lack of co-ordination, a lack of resources and/or absence or fragmentation of effective youth services. One might even say that in many countries youth policies predominantly target young people as a problem, not as a source of positive change and self-empowerment (De Winter 1997). Most youth policies (and prevention programmes) aim to influence, correct or change unwanted behaviour or undesirable 'life-choices'. Youth policies are usually reactive instead of pro-active and focus on young people facing and causing problems rather than empowering young people to avoid or tackle problems.

Fortunately, there are also approaches and drug prevention policies that try to reinforce young people's skills in dealing with difficult situations in life. In the past few years, an increasing number of European countries have paid attention to drug abuse prevention programmes that aim to develop life skills in young people. Networks such as the 'European Network of Health Promoting Schools' try to focus on the general development of health in school children. By doing so, young people develop the necessary personal skills themselves to make responsible decisions about their own health, including their position towards drugs. Life skills programmes exist in many forms. There are drug prevention programmes with life skill elements and life skills programmes with drug prevention elements. These approaches offer young people the possibility of developing skills that allow them to achieve a healthy lifestyle rather than just trying to forbid a certain type of behaviour.

4.2 Basic conditions for a school-based drug prevention policy

Secondary schools offer access to large groups of young people in this age group. That is the reason why school-based drug prevention is one of the most popular types of drug prevention, even though not all young people participate in secondary education (e.g. drop-outs, working youth) and despite the fact that school-life is only one of the important 'domains' in a young person's life (others being e.g. family and leisure time). In most European countries, schools run some type of drug prevention programme. Unfortunately, as mentioned in chapter 3, we have already concluded that most school-based drug prevention programmes are not effective at all and that there is a great lack of evaluation of existing programmes. Some drug prevention programmes in schools turn out to have unexpected, or even counterproductive effects on drug use.

These considerations clearly show why there is a need for school-based drug prevention policy. Finding out what works in prevention and translating that information into quality criteria, allocating limited resources to effective programmes, providing guidelines to schools about what approach is desirable regarding drug use as well as defining their role in drug prevention are some of the steps that - together - contribute to a systematic approach towards effective school-based drug prevention.

A *scientific theory* tries to describe and explain certain problems or phenomena in society (Van Mierlo, 2002). Scientists try to identify the causal relationships (cause-effect) in such phenomena. *Policy theory* tries to reduce the negative consequences of these problems and phenomena or promote positive alternatives. Whereas scientists explain a problem and/or try to predict its future development, policymakers try to solve problems by influencing their causes through the development of a policy. In order to reach that aim, the policymaker chooses a relevant mix of means and instruments.

In the case of school-based drug prevention, policies usually aim to delay, reduce or abolish (legal and illegal) drug use in school-going youth. This policy aim is not easy to achieve. Many drug prevention programmes and policies in school education do not have the desired outcome. This is not always because ineffective prevention methods are being used, but often because of structural flaws in the policy itself. Van Mierlo (2002) describes a number of factors that are crucial for successful policies, such as basing policies on sound (scientific) evidence, formulating clear aims with measurable results, and having realistic expectations in regards to the outcome of the policy. But, he also stresses the importance of defining policies while having a good match between policy theory and practical feasibility. Finally, he

stresses that sometimes policies fail because policymakers chose policy options that were not the best solution, but that were ideologically preferable.

Below, a number of important conditions and factors for success are presented. The list is not exhaustive. In chapter 5 a step-by-step presentation of a policy-development process will be introduced.

4.2.1 Scientific evidence as a basis for policy

For a proper analysis of a problem, policymakers need relevant scientific information that provides insight into the problem's causes and consequences. Scientific evidence is also important for the development of an efficient and effective response to the problem. However, too many policies in school-based drug prevention still lack such a scientific basis, resulting in a lack of information and understanding of the perceived problem, as well as a response that does not target the right causes.

There is no good reason for this lack of scientific knowledge as a lot of scientific research available on drug use, drug addiction and drug prevention is available. Although there is no instant solution or policy that can make young people change their behaviour overnight, there is a lot of evidence available that – when used in policymaking – can increase the effectiveness of school-based drug prevention policy. In chapters 2 and 3 we have presented prevention guidelines and quality criteria for school-based drug prevention programmes, including elements that deal with approach, types of prevention and the organisation and embedment of drug prevention at school level. Many of the guidelines and criteria that we found were already available in international scientific literature and/or at the level of professionals. It is important though to find out what works within the context of each specific country and education system, with its specific characteristics, cultures and structures.

Policy-relevant scientific information includes:

- Monitoring the development of prevalence of drug use among school students
- Monitoring the (mental) health condition of school students
- Gathering reliable information about existing and emerging trends in drug use
- Gathering reliable information about structural determinants (risk and protective factors) for drug abuse among adolescents, taking into account the circumstances in a given country or region
- Identifying the short and long-term effects of the use of specific types of drugs (e.g. ecstasy)
- Making an inventory of the school-based drug prevention programmes that exist in a given country or region
- Identifying which of them have been evaluated and proven effective
- Identifying what quality criteria in school-based drug prevention can improve effectiveness, so that existing programmes can be analysed accordingly

Without a proper understanding of the problem or phenomenon a policymaker wishes to address, it is unlikely that a policy based upon that uncertainty could be successful.

Prevalence surveys

Monitoring the prevalence of drug use in school students is done in many countries in Europe. Over 30 countries participate in the *European Survey on the Prevalence of Alcohol- and Drug Use (ESPAD)*, which is organised among school students aged 15-16 in secondary schools. The information gathered with the national surveys

can be used not only to identify priorities in (school-based) drug prevention, but also to recognise patterns in drug use both within the country and between countries and regions. The benefit of surveys like ESPAD is that the same methodology and approach in monitoring is used in all participating countries, so that comparable results can be obtained.

In a number of countries, including the Netherlands, municipalities have set up *local health monitors* for their population, usually focusing on a variety of subjects, including drugs. This type of monitor provides valuable systematic information about the health situation among the local population, revealing geographic and socio-economic particularities within the local community. The information can be used to set priorities and develop tailor-made interventions that support school-based drug prevention. Policymakers need to be aware of possible differences in methodology and approach when local health monitors are concerned. Unless standardised, data from local health monitors cannot be compared easily.

While national monitors provide insight about drug use in the whole (student) population and local monitors allow differentiation in policy at local level, there is also a need for *surveys at the school level*. In Flanders, the drug prevention institute VAD has conducted a standardised survey in a large number of schools. Participating schools received a school-prevalence report, including a narrative report with explanations and recommendations. Such tailor-made reports can help set priorities in drug prevention at school level and are valued as a feedback instrument. In the framework of the project 'The European Healthy School and Drugs', an internet-based monitoring tool has been developed with which schools can monitor themselves. However, school surveys are a sensitive issue, even for policymakers. Schools with high prevalence figures might suffer from the results. If student privacy and a safe environment cannot be guaranteed, the reliability of the survey is endangered. Furthermore, results from different schools can often not be compared because these surveys are not part of a co-ordinated scientific exercise.

4.2.2 Setting clear aims and objectives

A second important condition concerns the need to formulate clear policy aims and measurable output indicators. Again, a policymaker needs to have a clear understanding of the problem he wishes to address in order to develop policy measures that can influence the causes of the problem. Without clear aims, it is difficult to know what the policy is actually trying to achieve and almost impossible to measure what the achievements are. In such a situation, it is difficult to make informed decisions about the allocation of time and resources.

The results of policies that aim at a change in behaviour in drug consumption among school students are difficult to measure, especially because these policies are not run in a controlled laboratory or experiment. However, by defining SMART aims (see appendix 2) linked to specific activities and instruments, the effects of a policy can be made more explicit. In chapter 5 we provide an example of a policy-development process, based on the *Logical Framework Analysis* model, in which some specific policy aims and means have been worked out in detail.

4.2.3 Finding the right match between science and policy theory

A third important condition for a successful policy concerns the correct translation of scientific knowledge and the perception of problems into policy theory. Even when policymakers have relevant up-to-date scientific knowledge available and even if they set clear policy-aims, it does not mean that every policy is possible, acceptable or sustainable in practice. Policymaking does not take place in a

vacuum. Policymakers need to take into account existing limitations such as limited resources, as well as restrictions due to existing cultures, traditions, legislation, value-systems and the influence of opponents, representatives and stakeholders. Many policies are the result of compromise and debate.

Even if science can point out specific causes for the problem that needs to be tackled, it is not always possible to implement the most suitable evidence-based policy. A solution to a policy problem based on scientific research and best evidence only is not necessarily the most useful approach. Sometimes a greater effect is obtained by choosing a second best, but cheaper policy option rather than choosing an evidence-based, but costly solution with a smaller scale of success.

This necessity for compromise also exists in the field of school-based drug prevention. Effective school-based drug prevention programmes can reduce drug use among school students. However, the education community may be unwilling to run drug prevention programmes because it thinks that is the task of parents. Policymakers at local level might not accept the guidelines laid down by national government. A policy that aims to eliminate drug use by students by imposing mandatory, unexpected drug testing in schools may conflict with privacy laws or the social identity of schools.

In short, it takes a lot of support, effort and investment to develop and implement a systematic approach towards school-based drug prevention. Transparency, involvement of stakeholders and a clear understanding of what is acceptable in society are therefore crucial for the selection of acceptable and feasible alternative policy-solutions.

4.2.4 Having realistic perceptions of policy impact

A fifth condition for policy effectiveness concerns the expectations policymakers have towards the impact of their policies. Even if a policy is based on sound scientific research with clear and measurable policy aims established in co-operation with relevant stakeholders, it might still not be successful in reaching its aims at all. The impact of the policy may be limited because there are other influences that are counterproductive, e.g. new trends in lifestyle or the emergence of new drugs. If policymakers are not aware of the limitations of their policies and do not anticipate possible unexpected or undesirable effects, the policy chosen might even complicate the perceived problem and create new ones.

Regarding school-based drug prevention and its influence on the drug consumption among school students, policymakers should be modest in their expectations as well. Behavioural change is not done overnight and the effects of prevention cannot always be measured (in the short run). The frail balance between effective drug prevention and unwanted policy effects is a concern in many policies. Each year, many school students are criminalized (given a police-record), medicalized (sent to treatment centres after e.g. experimenting with alcohol or cannabis), or socially excluded (expelled from school, often resulting in alienation from their social structures). One should question whether some of these measures are really effective in preventing young people from getting into trouble. It seems rather that some of these measures are more harmful than the problem they aim to solve.

4.2.5 Being aware of policymakers' bias

Even if scientific knowledge and the input of stakeholders clearly identify options and directions for an effective policy, it does not mean that policymakers always choose the best solution. Some policy-alternatives do not fit the perceived solutions

and options policymakers and their political decision makers envisage and consider appropriate.

Still, it is quite common for policymakers to choose a policy-alternative that clearly does not contribute to the solution of the target problem. Some policymakers are very persistent in upholding certain paradigms, traditions or ideological points of view. This might be the result of professional blindness to new approaches or evidence that shows that a policy is not effective. But, sometimes the reason is that the policymaker decides that upholding a certain image, pursuing a political ideology, ignoring a problem, or avoiding unpopular choices is preferable to a policy with an effective solution. Such window-dressing can be beneficial for political decision-makers in terms of popular support or political profiling. However, stakeholders asked to implement the policy and reach the unrealistic (due to bias) aim are, in fact, being asked to solve a problem with the wrong instruments.

The field of drugs is one area where policymakers' bias is frequently found. Drug abuse is a controversial subject. There are school-based drug prevention policies that recommend that health risks related to (experimental) drug use be exaggerated in order to scare students away from using drugs. Scientific evidence and best practice has shown that such messages lose credibility when young people find out that they are incorrect and biased. The result may be that young people will also not believe prevention messages that present real health risks anymore, resulting in more drug-related accidents. From a drug prevention point of view, the policy does not contribute to fewer incidents of risky drug use and would therefore be considered as failing to reach its objectives. However, an increase in drug-related accidents may strengthen the public's perception that drugs are dangerous and that young people should be warned against using them. Although the policy does not reduce drug use, it might be effective in raising popular opposition to (illegal) drug use, which might be an overall objective of the policymaker who thinks drugs should be banned.

4.2.6 Policy co-ordination

It is difficult to develop coherent health promotion policies if there is not a clear division of tasks and responsibilities between governmental structures. In some countries in the European Union where the responsibility for school education and drug prevention is not combined in one department, policymakers are often not aware of each other's activities, policies and projects. The result is that each department, and sometimes even different units within the same department, develop policies that aim at the same target-group. This is not only the case in the field of drug prevention, but also in other fields in society since schools are often chosen as the information-gateway to the majority of young people. Examples other than drug prevention are anti-bullying programmes, traffic safety, environmental projects, etc.

Most of these policies have similar aims (raising awareness, influencing behaviour). However, the approaches within the policies often differ and combined they require a lot of time and resources. This is one of the reasons why in some countries policymakers try to develop one general school-health policy in which several themes can be introduced through similar working methods and existing structures. It is advisable that one policy co-ordinating body for school-based drug prevention be appointed that oversees all (related) activities and policies in this field. The co-ordinator needs to have an overview of the stream of prevention policies and plans that focus on the same target group in schools, not only in the field of drug prevention, but also regarding health promotion in general and other

areas of youth policy. The co-ordinator does not need to know all these policies in detail, but should be able to recognise overlap and/or contradictions in aims and activities.

Such co-ordination of prevention policies and programmes aimed at school education can prevent schools from being overwhelmed with contradictory and counterproductive initiatives, plans and programmes. However, co-ordination should not only take place within the governmental departments that focus on youth as their main target group in policy. Co-ordination with and between other organisations and structures (e.g. prevention and research institutions, regional health and addiction services, etc.) is needed to prevent these structures from 're-inventing the wheel'.

4.2.7 Policy coherence

Apart from the need for co-ordination of the different policies from both governmental and non-governmental organisations, targeting school-going youth with a variety of messages and interventions, the coherence of all those activities is another point of concern.

Policies need to be coherent, both in regards to their internal design as well as to their external interaction with other policies. *Internal coherence* entails the different aims and objectives within one policy being complementary, consistent and leading to an added value in achieving the primary policy goals when combined with each other. Internal coherence is an important condition in the policy development process.

External policy coherence entails policies focusing on the same target group or policy problem being in balance with each other, if possible complementing and reinforcing each other, but at least having no contradictory impact. This important condition is not always easy to achieve since different policymaking structures have different policy aims, approaches and political surroundings. Ensuring an effective and coherent school-based drug prevention policy requires that there be policy coherence between policymaking structures dealing with – among others - education, health promotion and law enforcement.

In paragraph 4.1 the case has already been made that school-based drug prevention needs to be part of and integrated within a broader framework of health promotion and youth policy. There are many conflicting policies, even in an area such as school-based drug prevention, often due to imperfections in policy co-ordination or due to conflicting 'rationales' in the political principles and views that constitute them.

Policymakers need to be aware and think in advance about how their policies interrelate with other policies. This requires not only transparency within the policymaking process and good communication with other departments and services in the health, education, youth and/or drug control field, but also with professional organisations and stakeholders involved in these policies in daily practice.

Example: response to drug incidents

One area in school-based drug prevention where policies may have contradictory aims and impact concerns the response to drug incidents at school. From the perspective of an undisturbed educational process in school, a student who is causing upheaval because he is caught using drugs might best be suspended or

expelled. However, from the perspective of harm reduction and/or health promotion such a measure would be counterproductive and a bad alternative to counselling, since it increases the risk of social exclusion and further health damage. Alternatively, from the perspective of law enforcement on the one hand, it might be desirable to report such a student to the police, while on the other hand, from the perspective of improving the school’s social climate, that would be undesirable.

Policy coherence cannot be achieved without policy co-ordination. And policy co-ordination makes no sense without policy coherence.

4.2.8 Pursuing a prevention mix

In chapter 3, it was pointed out that although most evaluations in drug prevention concern school-based drug prevention programmes, many of these programmes fail to achieve their aims. Other prevention activities, such as family-based interventions, community-interventions and mass media campaigns look promising, but there is a lack of consistent evidence that makes one type of prevention preferable to another. In this publication we have focused on school-based drug prevention programmes in detail. Most of these programmes are universal programmes, targeting a wide audience of young people with generic messages.

In order to provide tailor-made prevention for the different types of drug users in this target-group (experimental users, recreational users, problematic users) most universal programmes are too general. Therefore, a drug prevention policy should not merely focus on what is taking place inside schools, but also on what is happening around schools, in family-life and during the leisure time of young people.

As indicated in paragraph 3.2, there are different types of prevention programmes available, at school-level as well as programmes aimed at the general public (mass media campaigns), at families and programmes involving the community. Developing a policy that includes a prevention mix supports the effectiveness of school-based drug prevention programmes best. For example: combining school-based drug prevention programmes with specific interventions aimed at high-risk families and specific prevention activities at leisure time events (e.g. house-parties) in local communities. In addition, mass media campaigns aimed at improving communication about drugs between parents and students in a local community parallel to drug prevention activities within schools in that community would be beneficial.

Table 4.1 Example of a prevention mix policy supporting school-based drug prevention

	Universal prevention	Selective prevention	Indicative prevention
School-level intervention	Life skills programme with drug-prevention module	Counselling for students with a high truancy rate and bad school results; preventing drop-out	Counselling for students who have participated in binge-drinking activities during extra-curricular activities
Family interventions	General information about drugs and drug use for parents & carers of students	Counselling and programmes for students who have parents with an alcohol or drug problem	Interventions aimed at families within e.g. a cultural or social setting where alcohol or other drug use is highly prevalent
Community	Promoting co-	Establishment of low-	Targeted prevention

intervention	operation between schools, health promotion services the police and e.g. pub- and club owners.	threshold community services (social welfare, help lines, etc.)	activities, e.g. during rave parties
Mass media	Television, radio and poster campaigns promoting responsible behaviour, parent-student communication, etc.	E.g. low threshold, interactive websites, self-tests, etc.	Using mass media to target specific subcultures (e.g. on the internet, etc.)

From a policy perspective, it is advisable that schools be encouraged to develop a good relationship with health authorities and addiction services within their local community. Furthermore, a good relationship should also be established with the local police and with local entrepreneurs (e.g. club-owners, bars, tobacco shops, etc.). By appointing mutual contact persons between schools and the relevant services and by defining a protocol on what to do in case of (possible) drug abuse incidents, support to students with an (emerging) drug problem can be improved. This is particularly important for schools based in areas near drug scenes or that have a history of drug incidents.

By doing so, schools and services are better prepared for unforeseen circumstances before they emerge, while possible stigmas and problems can be alleviated. Local policymakers should support such communication and co-operation.

4.2.9 Learning from evaluation

The final condition for improving the success of a school-based drug prevention policy concerns the importance of learning from earlier experiences and mistakes. The EMCDDA has examined the evaluation practice regarding drug prevention within the European Union and came up with a number of recommendations (EMCDDA, 2000), many of which are relevant for national policies on school-based drug prevention as well. Below, some of these recommendations have been listed. Many of these recommendations sum-up some of the basic conditions mentioned above.

Improving prevention through evaluation: evaluation processes, while meaning extra costs, should ensure that drug-prevention programmes and projects are better focused and more efficient.

Providing means for evaluation: appropriate means (including financial resources) should be available for developing and implementing adequate evaluation protocols for all drug prevention programmes and projects

Importance of needs assessment: needs assessment and evaluation are essential for effective drug prevention and are an integral part of programmes and activities at all levels, whether international, national, regional or local. Proper need assessment must be included at the initial stage of any evaluation and should serve as an instrument for feedback during the evaluation process.

Establishment of quality criteria: it is important that policymakers develop and adhere to mutually agreed evaluation criteria for drug prevention policies and programmes. Criteria such as clear and coherent objectives, goals, purposes and

available resources are important in comparing policies and programmes and their outcomes. An example of such criteria for programmes in school-based drug prevention can be found in the manual on effective school-based drug prevention (Gallà et al. 2002: chapter 2). The EMCDDA (1998) has also developed guidelines for the evaluation of drug prevention in general.

Co-operative development: close co-operation should be established between the authorities (political and others) and professional bodies dealing with drug prevention in any evaluation procedure.

Involve actors and stakeholders in evaluation: the evaluation procedure should be devised in close co-operation with the programme designers and implementers as well as with the main players who will use the evaluation results. Key programme personnel should be involved in planning the evaluation and all stakeholders should receive continuous feedback during the process.

Make effective use of evaluation results: evaluation results should be used for developing new and refining existing drug-prevention programmes and, where appropriate, for selecting which projects should be implemented in practice.

Interpret evaluation results adequately: mechanisms should be used to facilitate the dialogue between practitioners and policy-makers on what evaluation findings mean for the further development of drug-prevention programmes.

Role of internal evaluation: internal evaluation of projects and programmes is essential and should be undertaken throughout the planning and implementation phases.

Role of external evaluation: the stakeholders and actors involved in a drug prevention programme should establish whether additional, external evaluation is required before the project or programme is initiated. The external evaluator's involvement should last at least for the duration of the project or programme.

Use of ethnographic research for evaluation: taking into account the ethnographic factors in the target groups' social context (norms, values, lifestyles) is more likely to enhance their acceptance of an intervention, and target groups should be considered the key source of information in the needs assessment process.

5. Developing a policy on school-based drug prevention

After having addressed the relevance, benefits and background knowledge about effective school-based drug prevention, the question of how an effective policy can be developed and implemented arises. There is more than one way to develop a policy on school-based drug prevention. The approach followed in the next few pages is neither exhaustive nor perfect. However, it does provide an example of some of the crucial steps within a policy process. For use as an example we have worked out one specific case for all the different steps.

STEP 1: Problem identification

Most policies are developed to address a specific problem or concern or to provide an answer to a certain phenomenon that requires a response. In the problem identification stage, the phenomenon, problem or public concern that emerged on the policy agenda is being identified. The questions that can be asked here are:

- What is the exact nature of problem or phenomenon that was brought to the policy agenda?
- Why is it a problem?
- Who thinks it is a problem?
- How was the problem put on the policy agenda?
- Who put the problem on the agenda?

A problem usually does not just appear out of the blue. Often it is put on the policy agenda because a number of coincidental happenings and events occurred that made that the problem or phenomenon became 'apparent' or 'surface'. Such a set of coincidental happenings is often referred to as a 'policy window'. Furthermore, even if there are no objective signs that a specific problem or phenomenon has actually emerged, it might still be that the general public and/or relevant stakeholders are convinced that a problem exists, forcing policymakers to act.

Policy example school-based drug prevention

In a given country the following developments took place:

- Drug treatment centres reported an increase in the number of young people aged 12-18 showing symptoms of problematic drug use (e.g. alcohol, heroin);
- Reports about drug-related incidents emerged in the media, in which young people aged 12-18 suffered serious health damage due to risky use of illegal drugs;
- The police in the capital city reported an increase of street-violence and/or traffic accidents caused by young people aged 12-18 who were under the influence of alcohol;
- Parents' associations expressed their concern over a lack of information about drugs and drug use in school education;
- Health statistics and general medical practitioners indicated increases in chronic fatigue, poor concentration and other psychological problems due to drug use, occurring at younger and younger ages each year. However, data is not available on the prevalence of drug use among the population.

Based on an analysis of the developments listed above, the problem identified concerned *the increase in problematic drug use among young people aged 12 to 18*.

STEP 2: Problem assessment

In this stage the phenomenon, problem or public concern is broken down and analysed. The following questions can be raised:

- What specific elements constitute the problem that was identified? (E.g. a breakdown of the problem into smaller 'partial' problems);
- What specific consequences of the problem require a solution?
- What causes for the problem can be identified and which of them can be targeted by specific policy measures?

The answers to these three main questions provide an indication of the seriousness of the problem, its origins and possible solutions – or directions for solutions – that can be employed. In order to answer these questions, a policymaker needs to gather policy-relevant information. There are a number of sources available, among which are:

- Assessment of scientific evidence, facts and figures about the problem in question, its consequences and causes;
- Needs assessment: gathering perceptions, opinions, value-systems, political realities, public concerns gathered from and with the help of stakeholders and other relevant actors;
- Existing policies (and the analyses supporting those policies), laws, rules and regulations and other legal resources;
- The perception and judgement of the policymaker and his team.

Policy example school-based drug prevention

Assessment of scientific evidence, facts and figures

- Information can be gathered about the specific behaviour and circumstances that caused problems to emerge. E.g. what substances are primarily abused by the target-group, where and in what setting does the abuse take place?
- With the relevant substances identified, information about the toxicology (potential health risk) and pharmacology (mental and physical effects and addictive characteristics) of these substances can be gathered. This information forms the basis for a *risk assessment*. For most of the substances these risk assessments have been done. Most of this information can be found at the EMCDDA.
- The information about toxicology and pharmacology can be completed with information about the social and legal consequences of the drug abuse, taking into account the set (situation, location) and setting (circumstances, emotional state).
- Information about the availability of drugs among the target-group or – in other words – where do students get their drugs?
- As a result of this exercise, it is possible that gaps in the available scientific knowledge are revealed which need to be bridged. E.g. no prevalence information exists because there are no reliable drug prevalence monitors in place.

Needs assessment

Apart from the facts and figures, which might provide objective and – hopefully - unbiased information about the nature of the problem, it is also important to examine the perceptions, opinions and recommendations in regard to the problem among stakeholders and other relevant actors. Without this information, policies would only target the technical causes of a problem, but ignore the political and cultural realities that might influence possible solutions. In our example, (increasing drug abuse by students aged 12-18), information can be gathered from scientific experts, health professionals, education professionals, young people in the

target group who use drugs, parents/care-takers, law enforcement officials, local experts, etc.

These groups can be asked about their perception of the problem and their ideas about possible solutions. By doing so, information is also gathered about the values and norms that exist in society regarding the problem and possible support for one direction of solutions or another. This part of the problem assessment phase is often referred to as the *needs assessment*.

Policymakers sometimes hesitate to conduct a needs assessment at the early stage of development of a prevention policy. They hesitate not only because of the expected costs of a thorough scientific evaluation, but also because assessments are thought to take a lot of time. In recent years, practical assessment methods have been developed that are valuable in those situations in which a policymaker needs a rapid assessment of a new problem and where a fast identification of the problem is more important than scientifically precise knowledge about the exact effects and/or magnitude.

Such methods are also useful when the target group of a needs assessment is difficult to monitor or in those situations where a phenomenon (e.g. an emerging trend in drug use) is too small to be measured in a broad, national prevalence survey, but important enough to follow, for instance at the local level. Among others, Braam, Verbraeck and Trautmann (2002) have developed a Rapid Assessment and Response (RAR) tool, which offers policymakers and professionals the possibility of assessing a drug-related problem rapidly, including the opinions and problem perceptions of the most important stakeholders involved. This, in turn, can be used in developing (new) more effective policy-responses to the perceived problem.

Assessment of existing policies, regulations and legislation

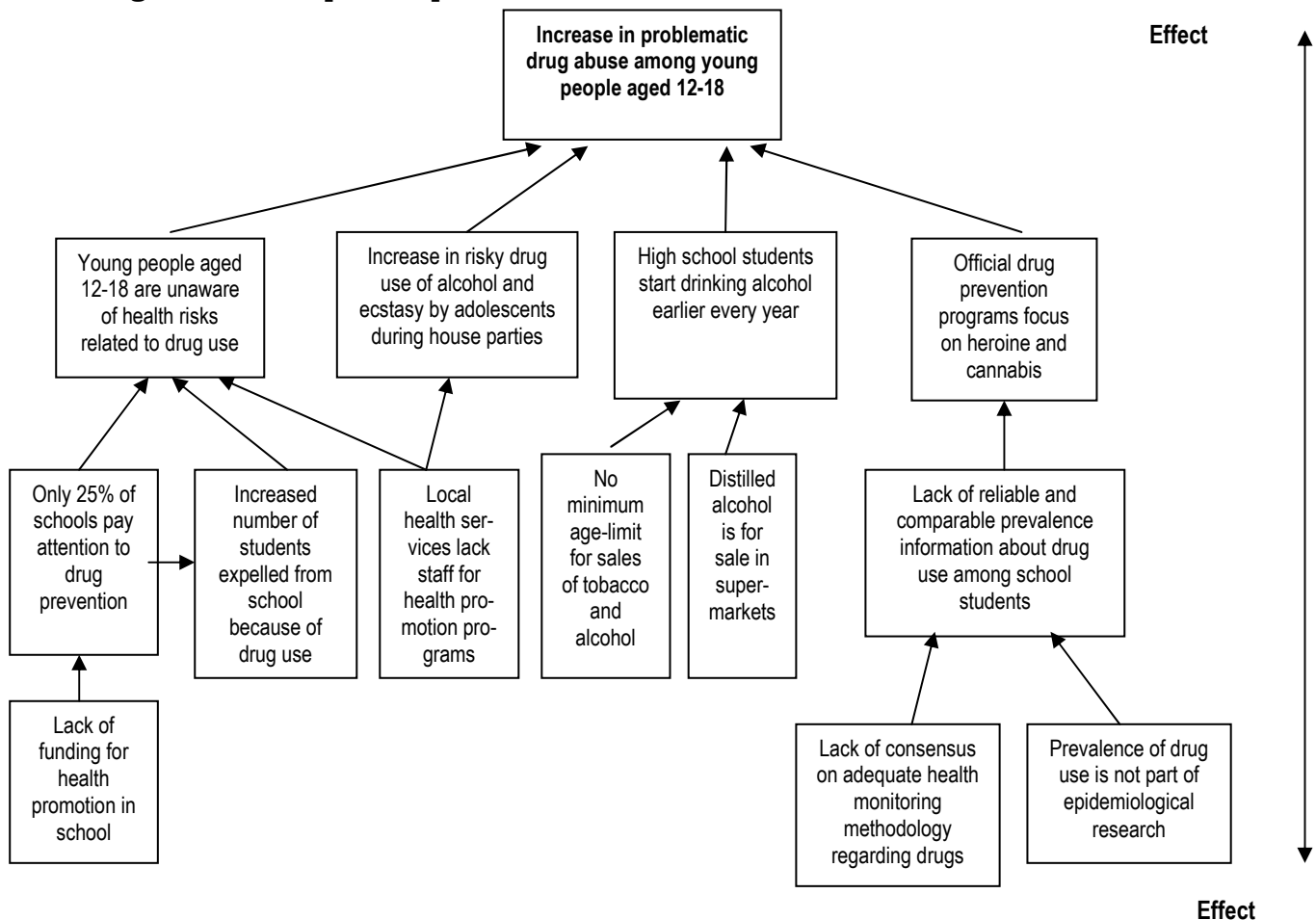
For policymakers, another important issue in this assessment phase deals with what laws, regulations and policies already exist in relation to the perceived problem and to what extent they are successful or not. For example: What laws and regulations already exist that are relevant to the perceived problem? This does not only concern possible regulations in regard to the target-group of the problem, but also secondary rules and regulations that may influence the problem. Do minimum-age limits for the purchase of alcohol and tobacco exist and if so, how are these enforced? What are the laws and regulations concerning the possession and use of illegal drugs for personal consumption? What regulations do schools need to follow when they catch a student using drugs (E.g. report to police, mandatory referral to treatment centre)?

Judgment of policymaker and/or his team

When gathering different sources of information about a specific problem, this information needs to be synthesised at some point. The broad spectrum of information gathered so far is likely to provide a good basis for further decisions. However, some of the information may be contradictory (e.g. scientific facts versus the perceptions of stakeholders). The judgement and experience of the policymaker is an important asset in such situations, provided he takes into account the basic conditions as laid out in Chapter 4. Judging and weighing the information gathered does not mean that the personal opinions or bias of the policymaker should be decisive.

Based on the problem assessment, the initial problem can be broken down into different parts. This can be presented schematically in a 'problem-tree' (Van Mierlo, 2002). In a problem tree, the perceived problem is broken down into cause-effect relationships. In figure 5.1 an example of a problem tree is given, based on the problem we identified in Step 1.

Figure 5.1 Example of a problem tree



STEP 3: Determining policy need and policy alternatives

Utilizing the information gathered during the first two stages, the next step aims to determine whether a (new) policy is needed to address the problem already identified and if so, what policy alternatives might be available.

Determining the policy need

In order to reduce excessive regulations and the policy-burden to society, the need for every new policy should be clarified and justified. Policies should not be developed just for the sake of policymaking, but in order to address real problems. Accordingly, the following questions can be raised:

- Does the information gathered so far indicate whether there is a need to develop a policy to tackle the problem?
- Does the information gathered so far indicate a direction in which the policy should be developed? E.g. a direction indicated by the needs assessment and/or risk assessment.
- Are these alternatives feasible for tackling the problem given the political, ideological, and cultural views influencing possible choices?
- Does the problem seem to have a temporary nature and as such can be expected to resolve itself?

The reason for the emergence of a problem on the policy agenda usually provides an indication of a need for a policy response to it. Furthermore, the policy assessment stage provides enough background information for the policymaker to decide whether a policy is required, often indicating a possible direction in which a solution can be found.

Most prevention policies make use of one or more of the following three policy instruments:

- *Convincing a target group to change their behaviour* (e.g. by means of awareness raising, running prevention campaigns aimed at decision-making skills, etc.)
- *Stimulating (healthy) behaviour* (e.g. by promotion healthy alternatives to drug use, as well as by pricing policies including taxation of unhealthy behaviour or products)
- *Enforcing behaviour* (e.g. by penalisation of drug use, by imposing policies that limit one's free choice to use drugs, by making certain types of drugs illegal, etc.)

The choice of instruments differs from country to country. Some countries choose a pragmatic approach to drug use and drug addiction and develop policies that try to mitigate the negative effects of (problematic) drug use for individuals and society and/or try to promote a positive and healthy lifestyle. This approach usually stems from the idea that while drug abuse can not be abolished from society completely, its negative consequences for society can and should be reduced as much as possible (harm reduction).

In countries in which a normative, ideological approach is chosen towards (illegal) drug use, policies are often designed with the idea that the public and drug users in particular need to be protected. Most normative drug prevention policies are run from the perspective that a drug-free society can and should be achieved and spell out what behaviour towards drugs and drug use is desired. The difference between this and the pragmatic approach is that in this approach the relationship between problem, cause and consequence is less relevant. Illegal drug use is not accepted, independent of its positive or negative effects or possible health risks. In school-based drug prevention, programmes that advocate this approach usually focus on abstinence from drug use, e.g. the 'Just Say No' approach.

What instrument is chosen should, ideally, depend on the nature of the problem, the possibilities of influencing people's behaviour, available knowledge about effective prevention measures and questions such as whether there are adequate resources available to enforce the law. Often ideology and public perception of a problem have a great influence on the choice of instruments. Most countries choose a mix of instruments.

Ideally, the choice of instruments is preceded by a SWOT analysis, in which the strengths, weaknesses, opportunities and drawbacks of each instrument are examined. Based on this analysis, greater insight can be obtained into what policy instrument might be most promising. For example, if regulation of a certain type of unwanted behaviour is not feasible because the SWOT analysis indicates a lack of capability and low priority in law enforcement agencies, it would be better not to use this instrument.

Policy example school-based drug prevention

If we examine the problem tree in figure 5.1 in which our perceived problem was deconstructed into separate cause-effect relationships, the main problem of

increasing problematic drug use among young people aged 12-18 seems to be multifold. It is the result of a lack of drug prevention programmes in schools, a lack of co-operation between schools and health services, and the absence of a minimum-age for the sale of tobacco and alcohol, combined with alcohol being easily available in a wide range of outlets. Finally, policy relevant information regarding the prevalence of drug use among school youth is missing due to lack of agreement on standards. This, in turn, results in a drug prevention policy that does not target the current most prevalent and problematic combination of drug use (alcohol, ecstasy). We have chosen to tackle this problem by means of a policy mix of awareness raising actions (drug prevention in schools), regulations (minimum age-limits) and health promotion.

STEP 4 Development of policy aims and activities

After having established the specific characteristics, causes and consequences of a problem as well as the general direction in which a solution can be found, the next step involves the development of clear policy aims and actions. This is one of the most important stages in the policy development process.

By developing a *logical framework* for the policy theory, we can formulate policy aims and objectives, anticipated results and some of the means that can contribute to reaching the aims in a structured manner.

In a logical framework four levels of development can be distinguished, including an internal and external dimension. The *internal logic* is the basis of a logical framework and presents the causal and hierarchic relations between the four levels of development: policy actions (A), policy results (B), the policy goal (C) and the overall policy objectives. In figure 5.1 we have worked out a schematic example of an internal logical framework, presented in a 'policy tree'. The policy tree provides an overview of the hierarchic and causal relationships between the different levels of development.

In Table 5.2 the logical framework has been completed with the *external logic*, which consists of external factors that may influence the policy result, preconditions for the policy that need to be met and the basic assumptions about the external environment and future developments that can be made at the time of the policy development. In the external logic, the policymaker also tries to anticipate possible unexpected developments during the implementation phase that may influence the outcome.

The policy goal (C) is the situation that should exist once the policy is implemented according to plan. In our example, the policy goal '*Reduced drug abuse among school students aged 12-18*' has been formulated as a solution identified in Step 1. The overall policy objectives (D) concern the long-term desirable effects to which the policy goal contributes. In our example, these objectives are: '*Improved (mental) health in the population*', '*Avoiding social exclusion of young people due to drug abuse*' and '*Reducing drug related juvenile delinquency*'. The policy goal in itself is quite general. Just as the defined problem in our example was broken down in partial causes in step 2, the perceived solution – the policy goal – can be broken down into smaller objectives or policy results as well. In our example we have – among others – defined the results as '*Doubling the number of students taught relevant life skills in dealing with drug use*' and '*Access and availability of drugs for young people is reduced*', etc. The fourth level in the internal logical framework concerns the level of policy actions. Actions are, for example, '*widespread introduction of drug prevention in secondary schools*'.

By breaking down the perceived solution to the problem, a systematic overview of actions, results, policy goals and long-term objectives is developed. Each of the policy aims (the goal, the results) should be defined according to the SMART methodology (see appendix 2). Furthermore, in order to measure the degree of progress toward the policy goal and the policy results, verifiable indicators should be defined, which reflect the SMART characteristic of these aims. E.g. attaching a percentage to the number of schools that should be teaching life skills in regard to drug use after a set period of time.

In short, the development of a logical framework includes the following stages:

- Define the policy goal that needs to be achieved, as well as the overall objectives that are being reinforced by the policy goal.
- Define SMART policy results that contribute to the realisation of the policy goal, including objectively verifiable indicators and benchmarks.
- Define actions and measures that contribute to the realisation of the policy results.
- Test the internal logic (relationship between results, actions and measures).
- Make the preconditions for success explicit.
- Define the assumptions incorporated in the policy that are of importance for the realisation of the policy goal.

STEP 5 Policy implementation

Once the policy framework has been formulated, the implementation of the policy can be undertaken. This phase requires a great deal of attention by policymakers, although such is not always the case. At this stage of the policy process a lot of attention has to be paid to co-ordination between relevant structures. Some important recommendations for the implementation phase are:

- Set up an advisory structure that can monitor progress throughout the implementation phase, consisting of fellow-policymakers, researchers, prevention professionals and other relevant stakeholders.
- Make use of existing structures and/or existing knowledge in similar or related policy fields in order not to 're-invent the wheel'.
- Make certain the policy is context specific; i.e. that it is suitable for the structures and (cultural) groups targeted and that it leaves enough room for adjustments at the operational level.
- Ensure coherence between the implemented policy and policies in related areas.
- Conduct pilot tests or pre-tests where possible.
- Allocate adequate means, time and resources.
- Think ahead and anticipate possible difficulties and unwanted effects.
- Ensure the involvement of the target-group in all stages of the policy process, especially during the implementation stage.

Figure 5.2 Example of an internal logical framework

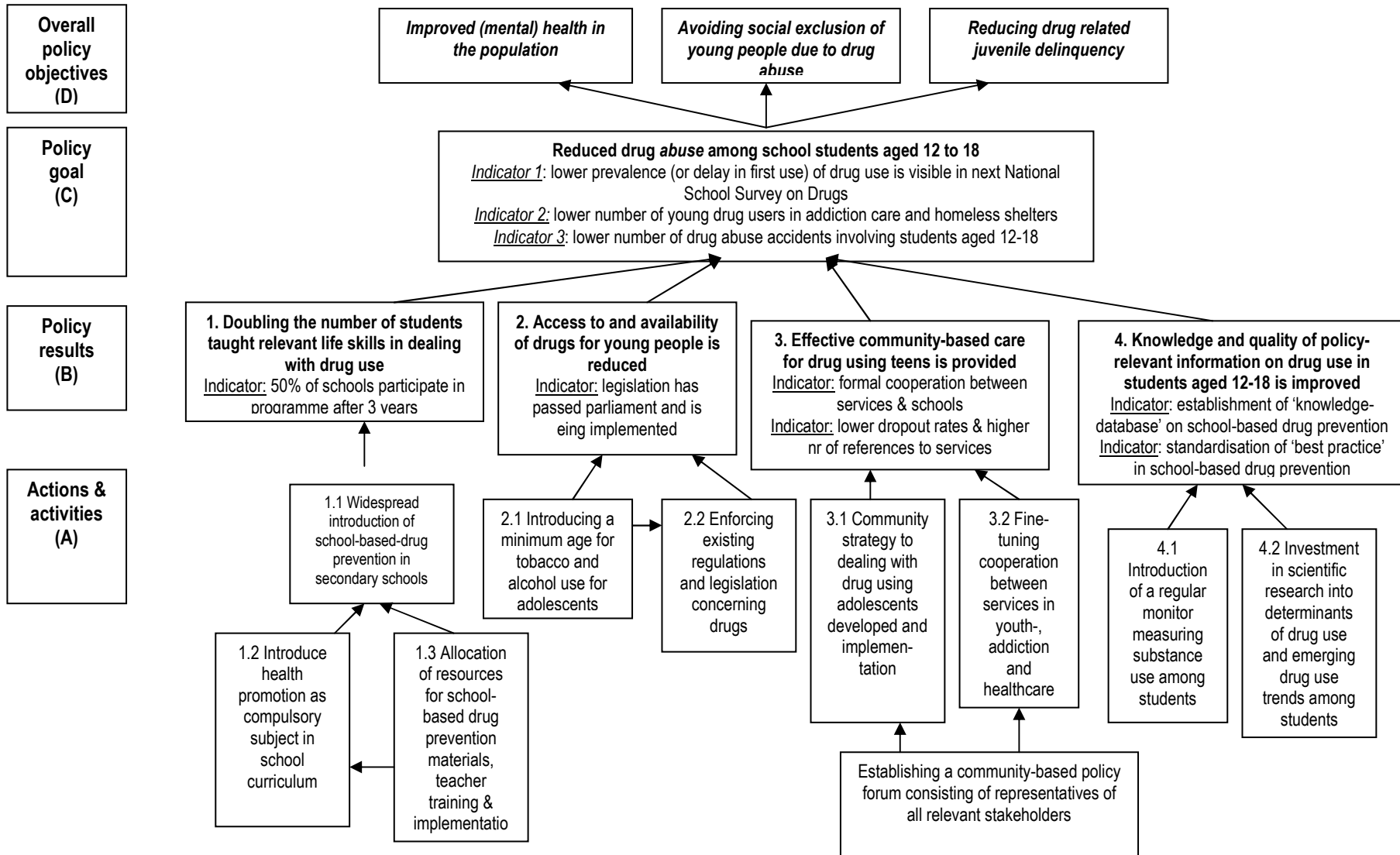


Table 5.1 Logical Framework of a School-based Drug Prevention Policy

Internal logic				External Logic
Narrative description		Verifiable indicator	Means of verification	Assumptions
OVERALL OBJECTIVES				
Overall objective 1	Improved (mental) health in the adolescent population	(Mental) health monitor in the population reports lower number of people with double diagnosis of drugs and psychological problems	(Mental) health monitoring	1. Monitor is sensitive to relations between drug use and (mental) health
Overall objective 2	Avoiding social exclusion of young people	Monitor shows reduction in number of new young people in homeless shelters. Inspections show no rise in number of new young people in the streets	Monitoring homeless youth in shelters Visual inspections of 'known' youth homeless scenes in the streets	1. Shelters exist and register homeless youth 2. Outreach work exists, targeting young drug addicts
Overall objective 3	Reducing drug related juvenile delinquency	Number of drug abusing young people in prison for drug related crime is reduced	Monitoring the registration of drug related juvenile delinquency by young drug users	1. Reliable registration exists that distinguishes between young drug user related crime and other (drug related) crime
Narrative description		Verifiable indicator	Means of verification	Assumptions
POLICY GOAL	Reduced drug abuse among school students aged 12 to 18	1. Lower prevalence (or delay in first use) of drug use is visible in next National School Survey on Drugs 2. Lower number of young drug users in addiction care and homeless shelters 3. Lower number of drug abuse accidents involving students aged 12-18	Systematic survey conducted in representative number of secondary schools Registration of young drug users in addiction care and homeless shelters	1. The monitoring system is representative for the whole (youth) population
POLICY RESULT				
No	Narrative description	Verifiable indicator	Means of verification	Assumptions
1	Doubling the number of students have been taught relevant life skills in dealing with risky substances	50% of schools participate in programme after 3 years	Inspection of drug prevention programmes by school inspectorate	1. An effective life skills programme exists for school education
2	Access and availability of drugs for young people is reduced	Legislation has been passed by parliament and is being implemented	Survey into dissemination of new rules and level of priority among law enforcement at local level	1. Laws are enforceable; i.e. young people obtain age verification document 2. Alcohol and tobacco industry is informed about new regulations

3	Effective community-based care for drug using adolescents is provided	Formal cooperation agreements between 50% of services & schools Lower drop-out rates & higher number of references to services	Inventory of agreements by health inspectors Registration of drop-out reasons (drug related) and referral registration between schools and services	<ol style="list-style-type: none"> 1. Health and addiction services have time and staff available for drug prevention activities geared towards schools 2. Agreement includes active communication policy between schools and services
4	Knowledge and quality of policy-relevant information on drug use in students aged 12-18 is improved	Establishment of 'knowledge-database' on school-based drug prevention Standardisation of 'best practice' in school-based drug prevention	Annual synthesis report of newly acquired information and knowledge Annual synthesis report on best practice in (school—based) drug prevention	<ol style="list-style-type: none"> 1. Research expertise into drug prevention is available 2. Practitioners are willing to share practice information
Policy Actions	Narrative description	Verifiable indicator	Means of verification	Assumptions
Action 1.1	Widespread introduction of school-based-drug prevention in secondary schools	Examining the teaching curricula at a randomised selection of secondary schools.	Inventory by the school inspectorate of schools running drug prevention programmes	<ol style="list-style-type: none"> 1. Resources and facilities are available to introduce the programmes, including teacher-training schemes and materials.
1.2	Introduce health promotion as compulsory subject in school-education curriculum	Ministry of education has included health promotion	Publication in official newspaper of the Ministry	<ol style="list-style-type: none"> 1. Decisions about the contents of the school curriculum are the jurisdiction of the government, i.e. the Ministry of education 2. The contents for the new subject in the curriculum are available
1.3

The implementation of drug prevention policy is not the task of policymakers in most European countries. Often, it is delegated to prevention organisations in the education or drug prevention field. It is important to establish a clear agreement about the division of tasks, roles and responsibilities. Prevention organisations will implement policies and programmes based on the criteria set by the policy and by their own professional standards.

In some countries, like the Netherlands, many organisations have developed guidelines for best practice. In the Netherlands, for example, the prevention community has developed a Health **Promotion Effect Management Instrument** (Peters, et al., 2003), a diagnostic quality tool that offers starting points for increased effectiveness of health promotion projects.

STEP 6 Monitoring

Monitoring is an essential instrument for a school-based drug prevention policy, regardless of what level it is being conducted at. A monitoring instrument can help gather relevant information and data on changes in the outcome indicators that provide information about the level of success and/or failure of the policy.

The monitoring stage in a policy process deals primarily with the progress made within the policy. Prevalence monitors are presented in paragraph 4.2.1. At this stage of the policy process it is relevant to question whether the policy has reached its benchmarks, measured by the verifiably indicators as defined within the logical frame.

STEP 7 Evaluation and assessment of policy impact

Despite evaluation having been adopted in most countries as an important means to measure the effectiveness, efficiency and impact of governmental policies, regarding school-based drug prevention this instrument is often not used in daily practice. This lack of evaluation is due to several reasons, among which are:

- *Unspecified aims:* drug prevention policy aims are often not specific. Policy plans lack clear performance-indicators, which makes the evaluation of the outcomes difficult.
- *Lack of knowledge and know-how:* knowledge on how to conduct a thorough and relevant evaluation is not always available at the operational level. The outline for an evaluation should have already been developed before a policy is implemented.
- *Lack of funding:* evaluation requires investment. Although the information derived from evaluations can show flaws in policies and/or help to make them more effective, policymakers often hesitate to pay for an evaluation study. An evaluation study of a national school-based drug prevention programme (running in many schools) can run up to 25-30% of the total programme cost.

In the policy process, the main aim of an output evaluation is to assess whether the policy results and the policy aim have been realised. This can be done by measuring the progress made on the verifiable indicators defined previously as part of the logical framework. Apart from the output evaluation, it is also important to evaluate the policy-development and implementation process. In our example, it is not only important to find out if drug abuse among school students has been effectively reduced, but also if the approaches chosen and the policy instruments deployed were effective.

Comprehensive political evaluation of public policy

There are different methods to determine whether a policy is effective, efficient and reaching its aims. However, public policy is not value-free and is influenced by political, cultural and public pressures. Furthermore, the policy environment changes all the time. A policy that is relevant and suitable in tackling a specific problem today might be irrelevant and useless tomorrow. Focusing solely on whether a policy has reached its aims often ignores the question whether a policy is actually justified under the given circumstances or whether there are better, alternative policies available. This question brings us back to steps 2 and 3: was the problem assessment conducted correctly and was the policy choice (or choice of instruments) the most suitable given the information available at that time?

Fischer (1995) identified a systematic model for policy evaluation, which includes two levels of judgement. The first level (1a-1b) focuses on the verification of results and the justification of the policy chosen. In our example, this means that evaluation focuses on whether the policy results are what we aimed for and whether the policy aims are still valid given the current circumstances. At this level the question whether a policy is justified, acceptable and the best solution possible is not being raised. The policy approach and overall objectives are not being questioned here.

1a. Technical verification

If the policy was implemented as planned, did we get the results under the given circumstances? This part of the evaluation often focuses on the development, implementation and monitoring/ evaluation phases of a policy process.

Example: if the aim of the policy was a reduction of drug abuse among school students aged 12 to 18, did drug use go down after having attained all policy results?

1b. Situational justification

If the policy was implemented as planned, did we actually set relevant aims under the given circumstances? Like 1a this part of the evaluation focuses on the policy development, implementation and monitoring/ evaluation phases of a policy process.

Example: Is it realistic to aim for a reduction in drug use among school students at the same time that there is a growth in drug use among the population as a whole at the national or international level? Should not the policy be reformulated in such a way that the new aim is to stabilise and/or delay drug use in school students?

The second level of policy evaluation Fischer distinguishes (2a-2b), focuses on the overall justification for a specific policy choice. The question is not whether a policy reaches its aims, but rather why that policy has been chosen and whether there are other alternative policy choices available.

2a. System vindication

At this level of policy evaluation the question should be raised as to whether the proposed policy is the most suitable for solving the problem aimed at, given the current political culture and way of life. This part of the evaluation often focuses on policy identification: agenda setting and policy development phases in a policy process.

Example: Why is reduction of drug use in school students something to aim for? Why not just provide adequate drug prevention that reduces harmful drug use? The answer to these questions is a description of the political culture and value-system in society, in which drug use is seen as an unnecessary health risk and – for certain substances – illegal.

2b. Rational choice

At this highest level of evaluation the principles behind a policy are examined, independent of the existing value-system in society. This allows for a thorough review of the fundamental principles and way-of-life in society. What kind of society do we have, what kind of society would we like to be and what is needed to reach that aim? This part of the evaluation often focuses on the policy identification phase in a policy process.

Example: narrowing this almost philosophical question down to our example, the question arises whether drug use should be tackled differently in society. An example of this might be by legalising soft drugs, focusing prevention on the reduction of risky drug use and by regulating the distribution and sales of hard drugs through a system of licenses and prescriptions. Alternatively, options might include extreme choices such as the ending of prevention and treatment schemes and tackling drug abuse by means of the criminal justice system only.

STEP 8 Maintaining, adjusting or terminating policy

This final stage of the policy process is often one of the most problematic. The reason is that it is too often forgotten. Once a policy (or programme) has been implemented and evaluated, an evaluation report is written. Policymakers are not always aware of the importance of this next step. Policies often just end (e.g. because funding is no longer available) or continue without focus.

In principle, there are three possible outcomes of a policy process:

- **Maintaining policy:** if the evaluation of the policy shows that it has been successful, it seems logical that it be continued for as long as the perceived problem exists *and/or* as long as the policy as such continues to be accepted by the different stakeholders.
- **Adjusting policy:** if the evaluation indicates that the policy has not been as successful as hoped or when there are changes in the causes of the problem- the policy should be adjusted to fit the needs better. But, adjustment might also be required if the external logic, the external environment of the policy, changes. For example, when a new harmful drug is emerging while the policy still prioritises two highly prevalent, but less harmful drugs.
- **Terminating policy:** this option is often a matter of having spent all the available money in a given budget. However, in those cases where long-term funding provisions have been made, it is important to realise that termination of policy is a genuine option when the policy has not achieved the anticipated results or when it has strong undesirable effects that are worse than the original problem. Policy termination is not always easy, especially at the end of a long-term funding relation with organisations representing the (other) policymakers, implementing agencies, target groups and stakeholders. They often have vested interests in and influence on the continuation of a policy (for reasons of continuity, ideology, etc.) Sometimes, especially after long term financing of a specific prevention policy, the costs of terminating the policy may be excessive. Furthermore, the termination of an ineffective policy may lead to a demand for a new, more effective policy that might be even more expensive.

6. Funding of school-based drug prevention

6.1 Introduction

In most European countries, the funding of drug prevention in general and school-based drug prevention in particular is an issue of ongoing concern. National drug strategies prominently point out the importance of drug abuse prevention policies aimed at young people. However, many governments lack a systematic approach towards school-based drug prevention. Funding is not always adequate or available and not spent according to a clear prevention strategy. In only a few countries are well-structured and widely implemented school-based drug prevention programmes run. Drug prevention in schools often differs from one region to another, sometimes even from school to school. Most countries have not developed quality criteria for their prevention efforts. In some countries (e.g. Germany) there are big differences between federal states in approach, design and funding level of school-based drug prevention.

Effective drug prevention in and around schools requires facilities and means. Politicians and policymakers are not always willing to fund drug prevention activities, because, at first glance, the results are neither visible nor clear. After all, one can measure how many drug users have sought treatment or how many people have been arrested for possession of illegal drugs, but it is much more difficult to measure how many people have *not* become problematic drug users and whether that was the result of a school-based drug prevention programme. Nevertheless, several studies have shown (Cuijpers, 2002) that school-based drug prevention programmes can have an effect on the level and frequency of drug use.

6.1.1 Social costs and benefits of drug addiction

Researchers have been trying to determine for some time already what the costs to society are of drug use and drug addiction. These ‘social costs’ of drug use are difficult to measure because they involve many unknown variables. The type of social costs that are relevant here are for example, *medical costs* (general health care, hospitalisation, drug treatment, etc.), *prevention and research costs*, *law enforcement costs* (including customs, police, courts, etc.), and costs related to *loss of income from taxes*, *loss of earnings* for families, *loss of productivity* for employers, etc. In addition, there are also costs that can’t be earned back by society, such as investments in the education of a drug user, etc. Where there are costs, there are usually also benefits, although they are not always realised or recognised when drugs are concerned. Benefits are, for example, money from taxes on alcohol and tobacco that most governments raise. In addition, there are individual benefits for people when they use certain types of (illegal) drugs, whether to relax and lessen stress or, as in the case of cancer-patients, using cannabis to reduce nausea induced by chemotherapy and/or as an appetite stimulant. Moreover, while health care and law enforcement expenses are a burden to society, the jobs they create could be considered beneficial to society, too.

6.1.2 Costs and benefits of school-based drug prevention

Confronted with limited resources, policymakers and those who fund school-based drug prevention need to know whether their money is spent well and effectively. Research has shown that drug abuse prevention pays off: every Euro spent on prevention saves 4 to 5 Euros (Pentz, 1998) compared to a situation in which no prevention exists. Studies focusing on school-based drug prevention programmes indicate that prevention programmes that deal with both legal and illegal drugs are cost-effective as well. Caulkin et al. (2002) found that the greatest benefits of school-based drug prevention targeting the whole range of drugs are generated by a

reduction in tobacco and alcohol use. Reductions in use of these two substances account for 70% of the benefits. A reduction in cocaine, opiate, and amphetamine use and other illegal drugs account for the remaining 30% of the benefits. The size of the effects, in terms of reduced drug use, realised by these programmes is usually small, but significant and the benefits outweigh the costs of prevention. In a large population, even small reductions in drug use lead to substantial benefits.

This research supports the conclusion that the benefits for society in terms of public health, economics and welfare can be found primarily in the reduction of the use of legal substances because more people use and abuse them. For alcohol and tobacco, the negative effects on a person's health have been proven without doubt and become more serious when the abuse lasts longer (e.g. heavy drinking and heavy smoking). The prevention of alcohol and tobacco use, however, is often considered to be less of a priority than the prevention of illegal drug use.

6.1.3 School-based drug prevention: a long-term process

The question of funding school-based drug prevention policies and programmes is always an issue between policymakers on the one hand, and the prevention community, schools and researchers on the other. The prevention and education communities usually try to persuade policymakers that more money is required for innovation and research. Policymakers' interest in school-based drug prevention however, often lasts not longer than the next elections, and the reliability of their promises for funding is dependent on the agenda of their political bosses.

Policymakers and those who supply the funds must understand that a comprehensive and effective policy on school-based drug prevention requires a long-term investment, just like education itself. Every school year new students need to be targeted. And, because trends in society and youth (including drug use) change all the time, prevention policies need to change along with them. One-time efforts and interventions have no result.

Despite these facts, there are only a few European countries that invest in long-term comprehensive school-based drug prevention programmes². Other countries invest on an ad-hoc basis or sometimes even decide overnight that there is a need to do something with drug prevention in schools, possibly as a result of public concerns after drug related accidents involving youth. In those cases, money is made available for short-term actions, but continuation of funding is uncertain.

Lack of (financial) resources is not always the problem. Some countries 're-invent the (prevention) wheel' again and again. They fund pilot projects and other drug prevention programmes for a limited period of time, with unclear aims and/or without enough funding to run a proper evaluation of the results. Many of these pilot projects – including those that show promising results – are terminated once the budget is spent. They are not implemented. After some time has elapsed, sometimes within months, a new pilot project is started and receives funding to begin all over again.

Despite proven results and the large number of young people reached by prevention programmes in schools, the amount of money spent on drug prevention in general and on school-based drug prevention in particular is often only a fragment of the

² Examples are among others: the Dutch 'Healthy School & Drugs' project of the Trimbos Institute (since 1990), the project 'A Drug Policy at School' of the Flemish VAD and Social, Personal and Health Education (SPHE) in Ireland.

funding made available for law enforcement dealing with illegal drugs and drug trafficking.

6.2 Investing in school-based drug prevention

The amount of funding required to develop and implement a school-based drug prevention policy depends on the scope and aims of the policy, the size of the population and many other factors. In many countries in Europe, it is difficult to determine exactly how much money is actually spent annually on school-based drug prevention. Budgets are often scattered over a wide range of departments, institutions and services and the criteria for spending the money is not always clear. In table 6.1 some of the different types of expenses involving school-based drug prevention are listed.

A systematic policy on school-based drug prevention requires investment in the development of prevention approaches, research & development, curriculum and programme development costs, training costs (for professionals, teachers, etc.), implementation costs (school-time, facilities), monitoring costs (prevalence surveys) and evaluation costs. Where possible, school-based drug prevention should be integrated and/or embedded in existing structures, training programmes and educational activities in order to reduce expenditure and to prevent the doubling of infrastructure. For example, a prevalence monitor among students could also be combined with a general health-assessment monitor among young people in the same age group.

Table 6.1 Types of expenses on school-based drug prevention

Categories of costs	School level	Municipal/ Regional level	National level
Development	<ul style="list-style-type: none"> - Staff time, i.e. meetings, training costs, programme development, etc. - Material development - External advisor 	<ul style="list-style-type: none"> - Policymakers time, i.e. meetings, problem assessment, etc. - External advisor 	<ul style="list-style-type: none"> - Development of drug prevention approach & strategy - Establishment of school-based drug prevention infrastructure - Campaign development
Preparation	<ul style="list-style-type: none"> - Staff time, i.e. meetings, training costs, programme preparation - Needs assessment (among students & other stakeholders) - External advisor - School survey (pre & post programme implementation) - Parent information evenings 	<ul style="list-style-type: none"> - Information costs (communication to schools, drug prevention & health promotion services), etc. - Networking costs (bringing together schools, professionals, local businesses, police, stakeholders, etc.) - Training costs for local professionals, incl. police & health services staff - External advisor 	<ul style="list-style-type: none"> - Coordination costs (often delegated to semi-governmental organisations) - Networking costs (bringing together experts, prevention professionals, other departments, stakeholders, etc.) - Costs for development of training curriculum for prevention professionals and teachers - Development of materials & prevention tools - Communication & information costs

Implementation	<ul style="list-style-type: none"> - Teaching time, guidance and counselling time - Drug prevention project costs (extra-curricular activities, student participation & involvement costs) - External advisor 	<ul style="list-style-type: none"> - Information & communication costs - Investment in additional services for schools by local drug prevention & health promotion services - Local activity costs - External advisor 	<ul style="list-style-type: none"> - Running costs (time spent by schools on drug prevention, costs of maintaining infrastructure)
Monitoring	<ul style="list-style-type: none"> - School survey (staff time, resources, etc.) 	<ul style="list-style-type: none"> - Municipal health monitor costs (survey & analysis costs) 	<ul style="list-style-type: none"> - Nationwide prevalence survey costs (e.g. ESPAD) - Research costs
Evaluation	<ul style="list-style-type: none"> - School survey (measuring change ex-post programme implementation) - Qualitative assessment of results (interviews, focus groups, etc.) - External advisor 	<ul style="list-style-type: none"> - External advisor 	<ul style="list-style-type: none"> - Programme evaluation costs, i.e. Randomised Controlled Trials - Research costs - Quality assurance costs (innovation)

6.3 Recommendations to funders

As indicated earlier in this publication, many school-based drug prevention programmes are not effective at all. A policy for drug prevention in schools should aim to get the best value for the money. In chapter 3 we provided a number of quality criteria for effective school-based drug prevention. For policymakers and those who fund school-based drug prevention it makes sense to fund policies and programmes that make use of proven results.

Other practical recommendations are:

- Fund policies and programmes that have clear aims, that focus on a clear target group with well-designed interventions.
- It is better to fund one or a limited number of well-designed and evidence-based projects with a larger budget for a longer period of time than to fund many different projects for a short period of time.
- Agree in advance with all stakeholders involved what the results of the policy should be and what output indicators are needed to determine whether the policy was a success.
- Be realistic in expectations and realise that school-based drug prevention requires a long-term investment. Ask for results, but don't expect miracles.
- Fund pilot-projects that look promising, but set clear aims and decide in advance how the results will be used and how the pilot will be continued if it is successful.
- Know that innovation and adjustment of policies, programmes and strategies in school-based drug prevention will always be necessary because of new trends, drugs, research (into effects), perceptions about drug use, and a constantly changing target group.
- Develop – if possible – a national (or regional/ federal) framework for a prevention programme, to utilize the profits of economies of scale and include a proper monitoring and evaluation system.
- Financial backers should make clear from the beginning whether they are willing to enter into a long-term funding relationship or whether they are primarily interested in short-term innovative pilot projects. If the latter is the case, it should be realised that short-term projects will only show short-term results.

- Set up and invest in specific training facilities and programmes for health education specialists and teachers and – life skills type training – in the regular curriculum of teachers.
- Introduce control mechanisms to ensure that funds earmarked for drug prevention are actually used for that purpose and not for ‘prevention activities’ which are actually treatment.

One of the remaining problems in school-based drug prevention is that often evaluation of the effects of policies is not conducted systematically. Many policies and programmes are implemented without any evidence that they are effective. This lack of evidence is often due to a lack of continuity in prevention programmes in the long run. Many programmes are terminated when a funding cycle has ended. Furthermore, a true effect-evaluation is expensive and requires a thorough scientific approach. Some governments foresee that lack of available evidence and do run prevention programmes with a thorough accompanying evaluation scheme.

Policymakers must be aware that focusing on evidence-based prevention does not automatically mean that prevention policies and programmes become cheaper. However, they are likely to become more effective, better structured and better implemented. In short, the money is spent better.

Finally, it is advisable to aim for school-based drug prevention being structurally embedded in a community setting, This should be done not only with the help of and through regional health and addiction services, but also in combination with local youth policy.

7. Concluding remarks

After reading this publication, it must be clear that health promotion and drug abuse prevention are complex processes that require coherent and effective policies. There are many variables that influence the behaviour of individual people and their drug use. Policymaking in drug prevention therefore, concerns a process of 'managing' the issue of drug abuse with limited resources, imperfect instruments and a rather narrow span of control. Furthermore, for many people using drugs (including alcohol and tobacco) is a part of their lifestyle with pleasurable effects.

For policymakers, it is important to determine whether drugs and drug addiction is primarily a public health concern or a concern for the criminal justice system. As we have indicated in this publication, there is often a contradiction between these two policy approaches. Policymakers need to find a balance between health promotion and restrictive policies. The partners in the project 'The European Healthy School & Drugs' strongly believe that the principle of harm reduction outweighs the importance of a restrictive policy, in particular when the health and well being of young people is concerned. An approach of 'Safety First', which contributes to averting individual health risks, has been shown to be more effective than policies that aim at complete abstinence from drug use and that provide young people with wrong and biased information.

Policymakers who support drug demand and supply reduction need to work together, coordinating and adjusting policies in such a way that they effectively complement and support each other, rather than working in opposite directions which may give rise to undesirable and unexpected results. During the next few years, school-based drug prevention will become more effective and efficient and is likely to be embedded in wider health promotion strategies and policies at all level of society, including school education. An increasing number of European countries already invest in research, best practice and evaluation. Drug abuse will probably continue to exist, but young people will have better knowledge about drugs and have better skills to make responsible choices. Drug prevention is a long-term process. Expecting fast results is usually not realistic. Drug prevention policy requires an open mind and a transparent approach that allows for new insights to be developed, new trends in drug use to be spotted and new problems to be recognised in time.

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Interesting websites

Council of Europe - Pompidou Group

www.coe.int/T/E/Social_cohesion/Pompidou_Group

Council of Europe - Youth Directorate

www.coe.int/T/E/Cultural_Co-operation/Youth

Department for Education and Skills

www.dfes.gov.uk

Erowid

www.erowid.org

European Healthy School & Drugs – project website

www.school-and-drugs.org

European Monitoring Centre for Drugs and Drug Addiction

www.emcdda.org

National Institute on Drug Abuse

www.nida.nih.gov

National Drug and Alcohol Research Centre – University New South Wales
ndarc.med.unsw.edu.au

Rand Organization

www.rand.org

Trimbos Institute

www.trimbos.nl

Virtual Clearinghouse on Alcohol, Tobacco and other Drugs

www.atod.org

Appendix 2: SMART model for policymaking

S	Specific
M	Measurable
A	Acceptable
R	Realistic
T	Time-bound

Specific

Be specific in your policy objectives and activities. Very general objectives lead to uncertain outcomes. Think ahead to determine what the concrete results you would like to have reached are by the time the programme is evaluated.

Specific goals include:

- Enhancing the knowledge of students about substances by reaching all students of a given age group or class with relevant information
- Delaying the first use of tobacco among 12-14 year old students
- Reducing the prevalence of illegal drug use among students aged 12-16

Specific instruments or means are:

- Introducing specific evidence-based guidelines for school-based drug prevention within the national curriculum
- Increasing the minimum age for the sales of alcohol and tobacco to young people
- Prohibiting the location of pubs and bars in the immediate vicinity of schools

Measurable

Ensure that the objectives are measurable as concrete outcomes of your policy and that the policy instruments that are part of the policy are measurable (focus on measurable 'entities'). Formulate indicators or 'benchmarks' for each policy objective, so that progress can be measured.

For example, one can measure the number of schools that have introduced a school-based drug prevention programme. A reduction of tobacco-use in the age group 12-14 can be measured through national prevalence surveys for that age group or through a randomised controlled trial survey among a number of schools that have introduced drug prevention and schools that have not.

Acceptable

The objectives of a school-based drug prevention policy are not always appreciated, understood, or accepted by all stakeholders involved. For example:

- If the objective of the policy is to reduce risky drug use among students by means of drug prevention programmes that teach them how to use drugs in a responsible and safe way, supporters of a 'Just Say No' approach may object.
- Policies that aim to introduce mandatory drug testing for school students may not be accepted by schools and teachers (because they do not want to become 'policemen') or be in conflict with privacy regulations.

The defining of acceptable school-based drug prevention policies requires transparency, communication and involvement of all stakeholders and sensitivity for the specific cultural and current conditions in education today. Many drug prevention policymakers are not in touch with school-education of today, which is

changing rapidly and very different than 15-20 years ago.

Realistic

Nothing is more harmful for positive support and participation in a school-based drug prevention policy than setting unrealistic and unachievable goals. If the activities in a school-based drug prevention policy lead to no significant results, then support for running the programme will fade, not only among those people and professionals that have to execute the policy, but also among financial backers and political decision-makers. Therefore:

- Set policy objectives that can realistically be achieved.
- Be moderate in your expectations about achieving changes in drug-related behaviour among students.
- Be critical when goals are set by political decision-makers, and be aware that you cannot change phenomena not influenced by your policy (e.g. availability of drugs).
- Be certain that you have adequate support from all the key stakeholders before running the policy, including political decision-makers, professionals and researchers in drug prevention and education and local policy-makers and representatives of the target-group.
- Be aware of unexpected new trends and developments that cannot be influenced by the current policy. E.g., drug consumption among school students increased considerably during the nineties in most of the Western world, while it has been stabilising in recent years. These fluctuations are not the result of policies, but seem to be autonomous.

Time bound

Some of the policy objectives should be realisable within a certain, well-defined time frame. For school-based drug prevention, fast changes in behaviour of students are difficult to achieve. Furthermore, the prevention programmes will have to be repeated again and again, while making use of new insights, experiences and scientific research. Therefore, it is more useful to set deadlines for specific elements and sub-goals of the policy.