

drug use. Therefore, the basis on which such prevention programmes are conceptualised and executed should be questioned.

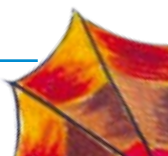
Studies conclude that there is little evidence that health education makes people refrain from using alcohol and illicit drugs or reduces the levels of their use. According to Tobler and Stratton (1997), scare tactics, providing only factual information on drugs and their effects, self-esteem building, responsible decision-making and didactic presentation of material have not proved to be particularly effective in the prevention of alcohol, tobacco and other drug use. Some of these programmes are built on the premise that awareness of the harms of drug use will prevent drug use (Botvin and Botvin, 1992).

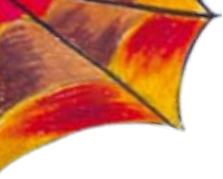
The long-term impact of the programmes is another issue that should be considered (Wiehe, 2005). Skara and Sussman (2003), show that meta-analyses indicate that programmes that have been shown to be not effective in the longer-term are also not effective in the short-term. Programmes that have shown some effects in the short-term have had longer-term beneficial impact. Therefore, it is argued that the continuance of the impact depends on the initial results, which in turn depends on the robustness of the design and content of the programmes.

## ●● What are the general features of effective prevention programmes?

The single most important characteristic of an effective drug prevention initiative is its ability to change behaviour. Therefore factors that initiate and maintain drug use should be addressed effectively if programmes are to be successful. Behaviour change is a continuous process. Factors related to a certain type of behaviour

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(e.g. drug use) should be dealt with in a sustained manner for changes in behaviour to occur and persist.

In broad terms, drug education should be evidence-based, developmentally appropriate, sequential, and contextual. Ideally, programmes should be initiated before drug use commences. Teaching should be interactive and use peer leaders. The role of the classroom teacher is central (Midford, 2002). Prevention programmes should also be long-term with repeated interventions (i.e., booster programmes) to reinforce the original prevention goals (Scheier, 1999).

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It has been shown that prevention programmes should address all forms of drug use, including the use of legal drugs such as tobacco and alcohol, the use of illegal drugs such as marijuana or heroin and the inappropriate use of legally obtained substances such as inhalants, prescription medications, or over-the-counter drugs (Johnston, 2002). Researchers such as Tobler disagree with this, as tobacco and alcohol-specific programmes have shown more significant impacts than multi-drug-use-prevention programmes (Tobler, 1992). In our experience, successful drug-use-prevention programmes should cover all drugs, but should identify and address behavioural and other issues related to specific drugs.

Perceptions of proximity and the intensity of harm by the recipients do matter. For example, for a middle-aged person, the possibility of a tobacco-related heart attack is proximal and will nudge him towards changing behaviour. But the same is not true for a school-going youngster. The most proximal or important health harm for this group can be the possibility of impotence or impaired beauty. Changes that occur in the skin and teeth, is more relevant to this group.

Many experts agree that the social influences approach has been more effective (Cuijpers, 2002). The social influence model aims to develop the social skills useful in resisting social influences which encourage drug use. It seeks to strengthen students' awareness of and resistance to the external pressures exerted by friends, family, and the media, and internal pressures such as low self-esteem, which can lead youth to drug use (Norem-Hebeisen, 1983; Pentz, 1990; Benard, 1990). Prevention curriculum based on SIM consists of objective information about drug use, examines drug use attitudes and behaviours, and gives social resistance skill training (Ellickson, 1990; Mohai, 1991).

## ●● What is the best timing for interventions?

It has been shown that there are three important time periods of relevance to drug use, in a student's development. Based on an extensive literature review, McBride (2003) suggests the following timings when interventions are crucial.

First, programmes can be delivered immediately prior to initial experimentation. This inoculation phase is where the initial knowledge and skills related to drug use have the potential to modify behaviour patterns and responses to drug-using situations.

Second, initiatives should be implemented when students are experiencing initial exposure – the early relevancy period. Here, students gain exposure to programmes when information and skills most likely have meaning and practical application.

The third or the late relevant phase is when the prevalence of use increases and the context of use changes, such as in drinking and

**Interventions are best made at three important junctures: prior to initial experimentation, at the time of initial exposure (early relevancy period) and when the prevalence of use increases (late relevancy period).**

