



**Drug education**  
**changes** **lives**  
**(even little ones)**

**A Discussion On  
Drug Education Changes Lives**

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# ABOUT THE DRUG EDUCATION NETWORK

Our mission is to Work with communities to minimise the harms associated with drug use through the provision of effective, evidence based information and programs

The Drug Education Network (The DEN) is a non-government organization funded to deliver a range of universal and targeted health promotion, prevention, and early intervention programs to reduce the harms associated with alcohol and other drug use across Tasmania. We have a commitment to delivering a service that is focused on community development and capacity building. Activities include:

- The development and /or provision of new, innovative, and evidence based health resources, projects and programs
- The development or contribution to research to enable a better understanding of alcohol and other drug use, and its impact, at a local, regional, state and national level
- The undertaking and distribution of high quality, contemporary information and research findings regarding alcohol and other drug use

The DEN recognises social, economic, cultural and gender factors influence alcohol and other drug use and that disadvantage is often perpetuated through different system and service responses to different population groups.

The DEN works closely with communities and key stakeholders to identify and develop locally owned responses to concerns regarding alcohol and other

drug use focused across 3 prevention areas:

- Primary
- Secondary
- Early Intervention

The services offered by The DEN to the Tasmanian community cover:

- Public awareness
- Capacity building
- Research

## OUR WORK

Recognising that AOD use and misuse affects individual across the lifespan, DEN works from pre-birth to the senior years.

- Alcohol and Pregnancy
- Sporting organisations
- School Communities
- Safe Partying
- Alcohol and Consent
- Tune In Not Out
- Policy and Advocacy
- Research
- Alcohol and Seniors



# INTRODUCTION

This discussion paper on Drug Education Changes Lives explores how effective drug education has been and how effective it can be in the future. It examines what the role of the educator is, the effectiveness of evaluations and looks at particular approaches to prevention education.

The paper also identifies what barriers there are to overcome for health prevention education today and in the future. The paper retraces the history of drug education in Australia and asks some pertinent questions about how far have we come?

The paper explores what skills and attributes today's drug prevention educator must have to be effective, and what's required in terms of resources and investment to make for successful drug prevention education.

Ultimately the drug prevention educator is trying to increase people's knowledge, affecting change in people's thinking, attitudes and behaviors and creates change in culture. There is no silver bullet; instead a myriad of sound innovative evidence based strategies and collaborative strategies are needed to create change.

Does drug education change lives and how do we know? It sounds like a simple question but the answer to this is much more complex and thought provoking than first appears.

One thing is clear however; that drug prevention education is not that simple and learning's from the past, investment into the future and innovative, critical thinking must be employed for effectiveness to prevail into the future.

It appears drug prevention education is a noble pursuit and one worth doing if change happen for individuals, for communities and across systems of service provision.

By: Tracey Groombridge and Vicki Russell. June 2011

# DRUG EDUCATION CHANGES LIVES

For a drug prevention educator the subject of this paper brings up more questions than answers and yet it remains central to the question of prevention.

What is education and how is this linked with the educator role and the recipients of the education program?

Education is defined as

*“any act or experience that has a formative effect on the mind, character or physical ability of an individual. In its technical sense, education is the process by which society deliberately transmits its accumulated knowledge, skills, and values from one generation to another.”<sup>1</sup>*

It is further defined as<sup>2</sup>:

1. The act or process of imparting or acquiring general knowledge, developing the powers of reasoning and judgment, and generally of preparing oneself or others intellectually for mature life.
2. The act or process of imparting or acquiring particular knowledge or skills, as for a profession.
3. A degree, level, or kind of schooling; a university education

## THE EDUCATORS ROLE

There are principles that inform and guide and professional values and beliefs which influence drug prevention education.

A fundamental principle is to ensure content

is always based on sound evidence (evidence based practice). A second principle is to acknowledge that the evidence base is changing particularly as new information emerges from research; that contemporary and historical knowledge and information is valuable and should be shared in the promotion of public awareness and in building the capacity of service provider agencies. Professional values support the belief that such information must be sound and clear, user friendly and publicly accessible.

In summary, the role of the educator is to impart particular knowledge, to provoke thought and shift or reinforce particular attitudes and behaviours. Ultimately it might be argued that education delivers new information that may not have been available and that this supports the making of informed choice/s and other opportunities.

In a global community, conflicting opinions about drugs and their use is conflicting and confusing. Drugs are classified according to lines of demarcation which

1. Distinguishes licit from illicit drugs and, then;
2. Distinguishes licit drugs in terms of their use

Some licit drugs are highly regulated (tobacco) and others are less so (alcohol). The availability of prescription medications is highly monitored

<sup>1</sup> Wikipedia (downloaded from Wikipedia.com 3/6/2011)  
<sup>2</sup> dictionary.com

# A BRIEF HISTORY OF DRUG EDUCATION IN AUSTRALIA

Drug education is not new and had begun in modern times, at least by the early 1800s.

whilst over the counter medications seems dependent on any reported harms. In addition, the production and distribution of drugs, whether legal or not, is strongly linked with profiteering. Tobacco is one example.

It was not so long ago that the tobacco industry, governments and other stakeholders kept vital information about the harms from tobacco products from consumers including an absence of warnings which limited transparency.

Tobacco companies made vast profits and government revenue from tobacco products funded government programs. These groups in collaboration with other stakeholders were aware of the harms and yet failed to bring this to public attention until litigation shifted the balance.

As educators our belief in presenting the evidence with the aim of minimizing the harms of drug use will often be in conflict with those in positions of power.

Levels of drug related harm can be placed on a continuum and this is often fiercely debated.

Drug prevention education is based on the belief that all drugs have addictive properties when misused and that everyone therefore has a right to access true information, access quality health care and other community

supports to address and ameliorate drugs dependency.

Certain drug use and specifically identified population groups of users are strongly linked with the principle of social justice, a term used to refer to:

*“the overall fairness of a society in its divisions and distributions of rewards and burdens.... Social Justice derives its authority from the codes of morality prevailing in each culture.”<sup>3</sup>*

Drug prevention educators aim to apply a principle of social justice perspective to ensure whatever approach is taken through education program, it must be accessible to all people. Those most disadvantaged in communities must have advocacy and education, it is a process through which lobbying can draw attention to the bias that exists in popular media and in policy documents.

There are unreasonable expectations placed on those most disadvantaged in our communities and this disadvantage can be framed as ‘social determinants of health.’

The social determinants of health are well used but not as often addressed. Education and advocacy on behalf of those in society that are not being heard or who don’t have a voice attempts to

address this imbalance.

Drug prevention education is a noble pursuit and one worth doing if we make change happen for individuals, for communities and across systems of service provision. In 1880, in the United States, the Temperance movement used an abstinence message through public education to persuade young people not to take up the use of alcohol, tobacco and/or opium.

Temperance groups were successful in lobbying for legislative changes which made drug education in US schools compulsory and by the 1920s, alcohol was illegal in many parts of the United States and this translated to other developed nations.

At this same time in Australian history, alcohol was fairly entrenched in our way of life. The Temperance movement in Australia had more limited impact than in the United States but did successfully lobby for the early closure of licensed establishments which was regulated during World War 1.

On a harm minimisation continuum the Temperance movement stood for total abstinence of alcohol or other drugs. The abstinence position led to the discouragement of drug prevention education and informed knowledge. This was considered dangerous in that it might support people to take up the use of alcohol and drugs instead of discouraging them. (Midford and Munroe, p20, 2006).

In post war Australia alcohol and tobacco were not yet considered as drugs and all other drugs were classified as narcotics under the Narcotics Drug Act of 1967. Narcotics were generally regarded as morally and legally wrong. As the first wave of baby boomers emerged as teenagers, the use of

*“recreational drugs such as cannabis and hallucinogens were more common place and drug use soon became associated as a young person’s issue.”<sup>4</sup>*

Illicit drug use became so common that it challenged the idea that no drug education was best.

The President’s Advisory Commission in 1963 in Australia wrote:

*“The Commission feels that the real question is not whether the teenager should be educated, but who should educate him? Should it be the street corner addict, or should it be the schools, churches, and community organisations? “ (Midford and Munroe, P22, 2006)*

In contrast, drug prevention education seemed the better response from the politicians of the time. In 1967 the first push of drug education in NSW schools began and focused on information alone within a paradigm of criminal justice and scare tactics.

Alcohol and tobacco were unscrutinised and not considered harmful. Kinder and colleagues

Drug prevention education is a noble pursuit and one worth doing if we make change happen for individuals, for communities and across systems of service provision.

3 Sociology guide.com

4 Midford and Munroe, p29-34, 2007

There were no specific instructions on how to use these resources so drug education mutated with different approaches in different schools and jurisdictions.

(1980) found this approach did little to change the attitudes or behaviors of young people in relation to drug use and its uptake. Treatment services were beginning in Sydney in response to heroin addiction.

There was recognition that early intervention work was essential however military type words appeared in documents – ‘fighting this problem’ and the ‘war on drugs’. This led to a redirection of drug prevention education, particularly in schools.

Instead of past scare tactics, the focus was on encouraging a healthier lifestyle and drug prevention education was contextualized with topics such as safe sex, better nutrition, and drug education.

No longer could drug prevention education be understood in isolation to other life issues.

Health divisions in education and other government departments and program areas were forming and from this perspective, drug issues were seen as health issues and the response was to discuss and inform rather than frighten<sup>5</sup>.

In the 1980s drug prevention education slowly emerged with its place on the political agenda.

The Prime Minister (Bob Hawke) publically disclosed how his own family had been directly affected by drugs with a daughter addicted to heroin.

In 1985 a National Drug Summit was held in Australia,

seeding the first National Drug Policy which focused on enforcement, treatment and education, a shift away from abstinence to reducing drug related harms.

Funding flow increased to prevention providing opportunity for drug prevention education to expand into schools and communities and a mass media campaign was initiated.

A special Taskforce was set up to evaluate the National Campaign Against Drug Use (NCADA). The campaign of that time had a primary goal of ensuring that drug prevention education was part of a more comprehensive health education curriculum in schools.

However this only partially occurred and the original recommendation, which was to ensure that it became part of the core curriculum in every jurisdiction, was found by the Taskforce of reviewers found most educational systems were not participating to a degree that made any real difference.

Barriers were identified such as discontinued funding for programs which often resulted in drug prevention education programs appearing and disappearing very fast and in an ad hoc manner.

Political and educational agendas were also disruptive to effective drug prevention education. Barriers meant few of the drug education programs were able to show any reduction in the uptake of drugs. Inadequate or lack of evaluation or the limitations of ongoing funding compromised any new initiatives in this area.

By the late 1980s, Australian drug prevention education programs drew heavily from both social learning theory and social inoculation theory which positioned drug prevention education taking place in those inoculation ages before the uptake of drug and alcohol occurred.

Results were mixed and the programs showed no sign of reducing drug uptake including the uptake of alcohol which was now documented as another harmful drug.

In schools, less controversial health topics like improved nutrition were preferred topics for the classroom. Teachers required better information and training to gain the necessary confidence to teach drug prevention education to students.

The Principles of School Drug Education were drafted by Ballard, a document which continues to guide national school drug education today<sup>6</sup>.

In the following decade, attempts were made to engage the education sector in line with the National Drug Strategy which had replaced NCADA and better resources were made available to schools.

There were no specific instructions on how to use these resources so drug education mutated with different approaches in different schools and jurisdictions. A prevention agenda was emerging with an emphasis in government policy which supported collaborative relationships.

Little information is available on drug prevention education in the non-government sector and so policy history rests on what was occurring in the Australian government sector.

In the 1990s a high profile case of a young women who reportedly died of ecstasy attracted mass media attention. Her parent’s published book and a level of public panic meant the issue of illegal drug use came to the spotlight again and the problems of alcohol use dimmed.

The Australian Federal and State Governments reacted to mounting pressure and as a result in 1997 the Federal Government launched its “Tough on Drugs” Campaign

No longer could drug prevention education be understood in isolation to other life issues.

5 Midford and Munroe, p29-34, 2007

6 Midford and Munroe, p29-34, 2007

The 'sexier' illicit drugs continue to attract more funding but public attention to the harms caused by alcohol is having an effect, prompting Australians to recognize it as the most harmful drug.

with a returned focus on abstinence rather than harm reduction.

The publication of the National School Drug Education System **No Illicit Drugs in Schools** reinforced the 'zero tolerance' approach to drug education in Australia accompanied by an assumption that those people using drugs were 'outside the norm' or deviant and as a consequence of their actions should be punished by law. Using alcohol or smoking tobacco did not lead to a classification as a 'drug user'.

Today there are a number of different approaches to drug prevention education which are influenced by particular political parties in government; the level of influence of the medical and health professions; and respective policy positions on criminalization.

These phenomena continue to shape drug prevention education programs. For the non-government sector, one key criterion on which a selected approach is determined can be dependent on funding and funding criteria however there is an increased demand for evidence based and innovative drug prevention education approaches.

The other differentiating factor is that most drug education programs are now evaluated although there remains less rigour in measuring attitude and behavioural change.

Midford and Munroe are not sure we have

progressed far and suggest that the

*"momentum built up in the 1990's is being lost, because very little new research or program development is being undertaken."*

The risk concerns the absence of a strong evidence base and the likelihood that drug prevention education will swing again with political pressure and media sensationalism.

The 'sexier' illicit drugs continue to attract more funding but public attention to the harms caused by alcohol is having an effect, prompting Australians to recognize it as the most harmful drug.

At times the drug prevention education history begs to ask the question about coming full circle<sup>7</sup>.

Midford suggests looking towards Scandinavian Countries like Denmark where low rates of drug use, teenage pregnancy, obesity, childcare and domestic violence may offer solutions and different approaches to future drug prevention education.

Denmark's school drug education is often contracted to more 'specialized services' whilst in Australia there remains an emphasis on 'in house' programs.

Drug prevention education for young Danish people takes place in the community (in youth

<sup>7</sup> Midford and Munroe, 2007, p20-34

Effective drug prevention education must be developed and delivered within a lifespan context - pre-birth to death.

clubs) with support from these 'specialized' agencies. It is more often about peer led approaches to drug education that are less reliant on time limited funding.

The other major difference is the Australian perception of drug use as something to be fixed if only we can find the right solution whereas the Danish approach adopts the premise that social problems like drug use emerge from the way society functions and that it's better to have services and supports in place ready to deal with problems as these emerge.

#### WHAT HAS HISTORY TAUGHT US?

- If responses to drug prevention through education are based on political or media pressure rather than on sound research and evidence, the results are likely to be unsuccessful. A reactive response to a long term social issue is never going to work.
- There is no one silver bullet. It often takes multiple attempts over a period of time to have a real measured effect. The effective drug prevention educator will have a range of options which can be used in combination to better assure key objectives. Information and knowledge won't change attitudes and behaviors.
- Short term funding of programs and pilot projects cannot measure the impact of a program. Effective drug prevention education takes time and must be well

resourced. Successful programs must build on evaluation and embody creative approaches and contribute to research.

- Effective drug prevention education must be developed and delivered within a lifespan context - pre-birth to death.
- When best or better practice in drug prevention education is based on evidence then illegal drugs and use/misuse are not the priority. Legal drugs (alcohol and tobacco) are more concerning and need to receive the bulk of education program funding. The evidence base from research continually confirms alcohol and tobacco as the drugs Australians should be most concerned about. The economic cost of harms exceeded \$36 billion in 2010.
- External evaluation which measures the effectiveness of programs on attitude and behavioural change must be a component part of the drug prevention educator resource kit.
- Drug prevention education need to reflect the social context including linkages to other social issues like homelessness, nutrition, mental health, relationships and domestic violence.
- Drug prevention education must focus on a 'whole of community' approach with a philosophy which accepts drug prevention education will be necessary to account for

drug use being an ongoing issue. Creating and sustaining panic and responding in the short term is not a solution.

- Change takes time and an investment of resources.
- Using technology is one way to look beyond traditional education methods. Midford and Munroe suggest Australia should expand current reference points like the UK and the USA for future alternative models of drug education.
- Evidence based practice remains the best framework to work from and is inclusive of the evidence, consultation with the community and professional judgment. Evidence + Professional Judgment + population values = Evidence based practice (Michigan Centre for Public Health, 2005)
- Prevention is the key to drug education. The treatment end or downstream end is where the majority of the funding is spent. Prevention at the upstream point is not highly valued. Primary prevention aims to prevent a problem before it begins; secondary prevention targets higher risk population groups; and early intervention programs target those for whom a problem has already developed with the aim of reducing the impact.
- Advocacy is critical. Lobbying for rights and for supports and services for people who

have no voice and communities who lack the education or resources to navigate an already complicated service system must be a priority. Socioeconomic inequalities in our communities must be addressed to ameliorate disadvantage and to reduce those determinants of poor health which are known to contribute to risk.

- Challenging the powerful tobacco and alcohol lobby groups will require a preparedness to take a risk where it counts.
- Awareness of the diversity of communities begins with conversation and the information gathered must be reflected in determining outcomes to build capacity<sup>8</sup>.

Challenging the powerful tobacco and alcohol lobby groups will require a preparedness to take a risk where it counts.

## MAKING A DIFFERENCE TOBACCO AND INDUSTRY

Big tobacco and big alcohol companies are a huge force of influence with allegiances to shareholders and the aim of making profit. Both global industries manufacture un-ordinary products and these products directly harm Australians' health.

These industries are extremely well resourced, skilled and experienced marketers and promotional experts always seeking new markets and convincing consumers to buy their products. Big Tobacco knew their product was harmful to people's health and

*“they did know and didn't care, and took whatever measures were necessary to protect their products”<sup>9</sup>.*

When scientists and educators began uncovering some of hidden truths, Big Tobacco spent large amounts of money hiring lawyers, scientists and other experts in an attempt to ward off any counter claims. As Michaels writes,

*“the industry and its scientists manufactured uncertainty by questioning every study, dissecting every method and disputing every conclusion. However what they could not question was the enormous, obvious casualty counts”<sup>10</sup>.*

Recently, the Australian Government announced a proposal to enforce tobacco companies to implement plain packaging as a method to limit the advertising of brands to people (especially young people).

This initiative coupled with health campaigns, education, legislative changes and restricted advertising make a difference in the smoking uptake by young people in particular. The industry has typically responded with strong media campaigns against this action including inserts in cigarette packs which supports and promotes the notion of individual choice. At present the Australian Government is holding out for this change to be introduced.

While drug prevention educators and others from the health sector continue to find new ways to combat the uptake of tobacco and encourage a reduction in the numbers who smoke, Big Tobacco utilizes strategies to discredit work already done.

Big Tobacco has a need to refurbish new generations of smokers so deliberate targeting of prospective young smokers through advertising and promotion is ongoing. Some of the documented successes to date have been:

- Mainstream acceptance of the science and research into smoking being harmful to people's health.

<sup>9</sup> Michaels "Doubt is Their Product", 2007 p3  
<sup>10</sup> op cit, pp 4-5

- Advertising control measures in place for tobacco companies (especially where advertising to young people is concerned)
- Little to no sponsorship of sporting teams or events in Australia.
- Governments are tightening control of the industry with legislation and regulation.
- More funding into anti-tobacco services, campaigns and support agencies such as Quit Australia with a larger emphasis on prevention. Over the counter treatment options are a burgeoning industry.
- Scare campaigns have been re-introduced especially through television campaigns and although known to be ineffective as the single method of education, continue to be featured on prime time mass media<sup>11</sup>. The Associate Press did not run with a story about a strong negative correlation between smoking and lifespan from a study by Johns Hopkins researchers. Instead,
 

“the press was accused of caving in to the tobacco companies, all of whom bought reams of evocative advertising featuring happy smokers<sup>12</sup>”.
- Warning labels are required on all tobacco products and in response, the tobacco companies argue that smokers could no longer say they were being deceived in anyway.
- Continued rises in taxes on cigarettes (some might argue this only hurts those most vulnerable in lower socio-economic communities where smoking prevalence is at its highest).
- Successful litigation by ordinary people suing the big tobacco companies including wins for passive smokers.
- Mainstream acceptance of the science and research into the links between smoking and cancer and heart disease.

11 Social Norms Analysis project (SNAP) –University Department of Rural Health TAS, Hughes 2007

12 Michael's (2007) pp.: 5 Oxford University Press, New York.

## MAKING A DIFFERENCE

### ALCOHOL AND INDUSTRY

According to Babor et al, 2003

“Alcohol is no ordinary commodity.”

Big Alcohol is powerful and wealthy and markets and promotes their vast array of products known to contribute to the Australia burden of disease, more than any other illegal drug.

Babor and colleagues also describe alcohol as having

“an adverse impact on many aspects of social life.”

Unlike the anti-tobacco lobby, drug prevention educators have not made as much progress due to:

1. Alcohol is so entrenched in our culture that many Australians do not consider alcohol as a drug.
2. The Australian Government has not regulated the alcohol industry nor is labeling enforced.
3. The alcohol industry has considerable influence in mass media through the investment of millions of dollars used to influence consumers through advertising, promotion and the sponsorship of major sports competitions.
4. The research on alcohol is current but compromised by counter messages and

industry funded scientific research aimed at creating and sustaining doubt.

5. Policy makers, parliamentarians, general practitioners, researchers, teachers and legislators join other Australians in the conventions of alcohol use and a culture of denial is a preferred position when user numbers are so high and election results matter.
6. Unlike tobacco, alcohol is linked with other social issues like family violence, road accidents and criminal behaviours. These issues reaffirm a mobilized belief that alcohol is problematic for some individuals and certain population groups. It reaffirms the persuasive argument perpetuated by the alcohol industries that problematic drinking occurs through individual character deficit or cultural predisposition and that for the majority, alcohol is a pleasurable activity. This position is reaffirmed in major policy documents.
7. The alcohol industry funds global ‘social aspect’ organizations like the International Center for Alcohol Policies, organizations who position their people on drug advisory and policy reference groups. Alcohol policy in Australia reflects the ICAP Blue Book on alcohol policy.

## MEASURING EFFECTIVENESS

If a departmental funding body is questioning relative program success as part of contractual obligations the terms of reference may well be different for the organisation engaged to deliver the education and those receiving it.

At a more local level, the alcohol industry funds Drinkwise, another social aspect organisation which gives attention to drink driving and alcohol use by young people. These latter foci redirect attention from the real harms caused by alcohol across the population; these issues are easily measured and emotive.

8. There is a lack of sustainable and adequate funding to make a difference in targeted programs for all age groups across the lifespan.
9. There is inadequate training and accreditation for alcohol and other drug sector workers, those working in health promotion and other related fields.
10. Drug prevention education generally falls within the mandate of the non-government sector. Inadequate pay rates to maintain and recruit an experienced and quality workforce mean a fairly high turnover. In a recent survey in Tasmania, 39% of respondents said that inadequate pay levels were their number one concern in their sector.
11. A competitive tendering processes adds another barrier to working collaboratively with other organizations within the alcohol and other drugs sector<sup>13</sup>.

In Australia, pressure for change is emerging in non-conventional areas of alcohol harm. International research on pre-birth alcohol harm and the adverse effect of fetal alcohol exposure is gaining public attention in FASD.

A recent announcement by the Cancer Council Australia advises that recent research findings link alcohol with cancers. Ethanol, the chemical present in alcohol beverages, has now been listed as a Group 1 carcinogen.

For governments and funders, the answer may lie in a quantifiable measurement. For the recipient, the answer may be assurances of quality whilst the educator may cite both quantitative and qualitative measures.

Program planning inclusive of evaluation become critical for drug prevention educators to assess effectiveness. In the past, evaluation may have been about ticking boxes rather than improvement and measurement<sup>14</sup>.

Evaluation can light a success or contribution which can be shared so others can utilize the learning and build on it. Not properly evaluating means the project or program will be poorly conceived, have unrealistic objectives, no effective mechanism for management, no quality control and a high risk of failure which in turn can waste precious time, money, resources and most importantly disappoint or negatively affect the community served.

Without evaluation there is no evidence that the project or program is sustainable or worthy of future support and funding investment. As Hawe states

*" we are now working in a climate in which we will be judged not on our intentions, or our philosophies or our enthusiasm, but on what difference we make in people's lives."*

However it's not just evaluation that's needed but rather quality evaluation. Quality evaluation means:

<sup>14</sup> Hawe, P. et al, Evaluating Health Promotion 2005, p.6 MacLennan and Petty

- Good planning processes with evaluation a factor from the beginning of a program or project
- Clear measurable objectives and outcomes
- A systematic evaluation process that includes quality tools. The tools and methods need to be valid, reliable, appropriate, reasonable to the user, ethical and well administered
- Those conducting the evaluation have a commitment to good quality evaluation
- Where possible the evaluation is undertaken by an external contractor or person that does not have a stake in the project. (It should be noted that often smaller services do not have the funds to engage professionals in conducting external evaluations.)
- The word "value" is in evaluation for a reason the measurement should be of the value of something and this should be applied in a rational and simple way. Some evaluations risk weighing down programs and projects with heavy inappropriate evaluations
- Good documentation and systems for storing information are essential
- Uses a combination of comprehensive evaluation types, process evaluation, outcomes based evaluation and impact evaluation.

"with success or failure, the experience of conducting the evaluation brings benefits to the field."

- Time and resources are allocated to quality evaluations.
- Well trained staff; with an acknowledgment that staff may have had bad experiences evaluating drug education in the past and they may be trying to overcome those barriers.
- An administration or organization that values evaluation.
- Close monitoring of the project or program.
- Involves both measurement and comparison.
- Project management timeframes are in place so that the program is ready for evaluation. Assessing when your program or project is ready is a must.
- Avoids pressure from political environments to produce a result that is favorable to those who have commissioned the evaluation.
- Where appropriate it measures a range of outcomes, knowledge, skills, attitudes and behaviors.
- Involves the community in a fun and interactive way where possible.
- Seeks both qualitative and qualitative feedback.

Does it really matter if we reach one person or 20,000 as long as we know for sure that we are being effective in our aims and we affecting positive change in people's lives?

Avoiding evaluation for fear of failure is not an excuse as all learning is valuable.

Evaluation itself is not a science - it's not right nor wrong. As Hawe advises

"with success or failure, the experience of conducting the evaluation brings benefits to the field.<sup>15</sup>"

and Malcolm Forbes states

"Failure is success if we learn from it".

#### PROFESSIONAL JUDGMENT

One of the key components of evidence based practice is to use our own professional judgment. In order to be effective, the drug prevention educator needs exceptional self-awareness and the ability to know, commit to and practice critical thinking.

Professional educators are expected to exercise all manner of judgments in interpreting and analyzing information, problem solving, finding alternative courses of action, making decisions, altering decisions and monitoring those decisions.

<sup>15</sup> Hawe et al, Evaluating Health Promotion (2005), p 14 MacLennan and Petty

Giving professionals the opportunities to use critical thinking to resolve problems.

Critical thinking is inclusive of commitment, willingness and ability to think critically in aspects of drug education, to be,

"reflective, self-corrective...[and have a]... purposeful thinking process." This requires the professional to take into account content knowledge, context, evidence methods, conceptualization and a variety of criteria and standards of adequacy<sup>16</sup>."

There are a multitude of factors that affects critical thinking and such factors have a direct impact on performance as effective drug prevention educators. Factors that need to be in place are:

- Good recruitment procedures and nurturing induction programs.
- Pre and post training and professional development concentrated on not just technical skills and knowledge increases but educating to think critically.
- The professional must maintain with support from the workplace a consistent internal motivation to engage problems and make decisions by using critical thinking.
- External professional supervision and support needs to be provided on a regular consistent basis.
- Support and commitment from the workplace to continual improvement processes.

<sup>16</sup> Facione et al, 1997 p1

- Peer reflection and supervision sessions
- Values and strategic plans clearly identified by the organization that are in support of critical thinking.
- The professional's ability to self-reflect on practice and to seek and receive feedback. To utilize that feedback in a way that means mistakes are not repeated.

• As sense of confidence in the workplace and in the workers to take calculated risk and think outside the square when making decisions and problem solving.

- Giving professionals the opportunities to use critical thinking to resolve problems.

" Educating people with regard to the subtleties of problem identification, interpretation, differentiation and diagnosis...[often]... distinguishes the more experienced professional from the novice...[and is a]... pattern recognition which comes with reflecting on experience and leads persons to learn what to be alert to...<sup>17</sup>"

- Beneficial workplace systems in place to ensure risk is minimized such as policy and procedures, protocols, performance management processes, problem detection systems, licenses, qualifications, experience, legislation, decision making processes and consultation systems.

<sup>17</sup> Facione ibid



## CONCLUSION

It is clear that drug prevention education is not that simple. It is clear however, that drug prevention education is more than just increasing people's knowledge – it needs to affect change in people's thinking, attitudes and behaviors and create change in culture.

All of these systems must have sound quality control measures and allow time for review and reflection.

- Encouraging and rewarding habits of integrity, open mindedness, mental alertness, diligence, attention to detail, confidence, curiosity, innovation, creativity and sound ethical judgments.
- Understanding the context in which the client or audience operates within and understanding the impact decisions may or may not have on their lives.
- Good operating teams that work collaboratively together.
- Mentoring programs in workplaces.

However professional judgment and critical thinking needs to begin at the beginning in schools and training facilities.

An investment into critical thinkers for the funders and governments is a must if we are to have capable, innovative drug educators for the future. Critical thinking should not be seen as another 'soft skill' useful in the drug educator's bag of tricks but an essential requirement to being effective in drug education.

However it could be argued that it's an uphill battle to obtain this level of professional judgment when we require people to work for peanuts and our training grounds are not equipped with the resources or time necessary or time to develop sound critical thinking abilities.

The simplified message "just say no" or "tough on drugs" methods of the past are insufficient to account for the sheer scope of the problem; mistakes and successes; and contributing to making a difference. There is no silver bullet; instead a myriad of sound innovative evidence based strategies and collaborative strategies are needed to create change.

Drug use will be problematic in the long terms and cannot be remedied with short term solutions.

Investment must be for the long term particularly in prevention and research. To

There is no silver bullet; instead a myriad of sound innovative evidence based strategies and collaborative strategies are needed to create change.

address these complex problems, a collective confidence and courageous communities are an imperative.

As a sector, community, state, nation or profession, success and quality work should be celebrated.

There have been successes in tobacco education and youth health education.

In Tasmania, the National Tune In Not Out Website ([www.tuneinnotout.com](http://www.tuneinnotout.com)) gained an honoree mention from the 2011 worldwide Webby Awards alongside international entities like Leggo and MTV.

Tasmania hosted the first national conference on Fetal Alcohol Spectrum Disorder (FASD) and established the first Australian grassroots FASD prevention Taskforce.

One positive change in a person's life has positive repercussions in the community. This is a success despite what contracts might require. If information is power, then the communities need the best information to enable individuals to make informed choices; to create opportunities; and access the best quality of life possible.

"Further we are now working in a climate in which we will be judged not on our intentions, or our philosophies or our enthusiasm, but on what difference we make in people's lives.

The people who sit in judgment are not only governments, administrators or communities we serve, the judges are also ourselves and the confidence with which we say that we are making a real contribution<sup>18</sup>".

18 Hawe, et al (2005), p.5

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