Addressing Substance Use in Canadian Schools

EFFECTIVE SUBSTANCE USE POLICY

A Knowledge Kit for School Administrators

2009

Joint Consortium for School Health

Governments Working Across the Health and Education Sectors

This knowledge kit is part of a series of resources based on evidence drawn from published research and practical literature as well as from the experience of educators across Canada. It seeks to set out the strategies most effective in addressing substance use in schools. All of the kits are linked by a commitment to a population health perspective that underpins the comprehensive school health approach and a common conceptual frame for understanding substance use and the related risks and harms. Nonetheless, each kit in the series is designed to stand on its own and is written with a different audience in mind. As a result, some duplication of content is inevitable. This kit is designed to assist school administrators in their role in helping to shape school policy and the school environment.

This kit was developed for the Joint Consortium for School Health by the Centre for Addictions Research of BC. While the views expressed herein are those of the authors, the Centre wishes to acknowledge the many people who provided assistance by critiquing early drafts, drawing attention to examples of good practice or sharing their personal knowledge. The authors hope that this kit will encourage dialogue and action and result in improved outcomes for Canadian students.

The *Addressing Substance Use in Canadian Schools* series includes:

Effective Substance Use Policy
A Knowledge Kit for School Administrators

Effective Substance Use Education
A Knowledge Kit for Teachers

Responding to the Needs of Higher Risk Youth
A Knowledge Kit for Counsellors and Health Workers

School-Family-Community Partnerships
A Knowledge Kit for School and Community Leaders

Copies can be obtained from www.jcsh-cces.ca.

Up Front …

Media headlines warn us about some "new" drug, with articles going on to explain how teens are destroying their lives faster and more completely than ever. And editorial sections suggest that schools ought to do something.

We are constantly confronted with messages designed to raise our fears and, at the same time, we gravitate to positions that assign the responsibility to fix the problem to someone else. But what if you are that someone else?

If you are, then it's a good idea to start by knowing the truth. It is true that alcohol, tobacco and a wide range of other psychoactive substances are readily available to young people. But not all young people are destroying themselves; in fact, most young people do not use illegal drugs. That said, many do put themselves at risk by using alcohol or other substances in ways that might result in injury or death.

Education is Good

In order to make healthy choices about substances throughout their lives, all students should be exposed to educational experiences that increase their social and emotional competence and overall health literacy. Among other things, *universal classroom education* should convey accurate information on the risks and benefits of psychoactive substance use and provide training on the practical skills necessary for applying this information in day-to-day life. Participatory education methods, which actively involve students in a skill-based learning process, provide the most effective means of generating the practical knowledge and life skills that make up health literacy.[1]

Education is Not Enough

It is easy to suggest that schools need to teach our children to avoid drugs. But addressing substance use-related issues is just not that simple. Despite big claims for drug prevention education, most scientific evaluations suggest that drug education programs have had little success. The provision of information has been ineffective in changing substance use-related behaviour. Without a doubt, this is partly a result of ineffective approaches that have been used and the propaganda-like messages that increase the likelihood of students seeing drug education as irrelevant. Substance use is a cultural reality; addressing the related risks and harms requires a comprehensive approach that is much more than classroom education.

[1] For more information, see the companion knowledge kit, *Effective Substance Use Education.*

Comprehensive School Health

Schools have been dealing with the complex issues related to adolescent substance use for decades. A body of knowledge has emerged, providing insight into what is most effective at increasing the protective factors that mitigate risk and help create health-promoting schools where students gain the knowledge and skills they need to effectively navigate a substance-using world.

This encompasses the whole school environment, with actions addressing four distinct but inter-related components that provide a strong foundation for comprehensive school health: social and physical environment, teaching and learning, healthy school policy, and partnerships and services.

Building a Culture of Resilience

The precise processes for ensuring young people are equipped to deal with their world are not completely clear. It is clear that the experiences young people have at school are important, not only to their education, but also to their ability to thrive in their world. The factors that promote this are complex and involve a variety of environmental and cultural qualities. These include the skills acquired, an environment that is safe and conducive to open interaction and a strong sense of social connectedness. Nurturing a positive environment, through policies and practices that promote these qualities, will allow young people to develop resilience and bounce back from adversity.

Helping Schools to Chart Their Course

The material in this knowledge kit is arranged around the 5-i model of constructivist education developed by the Centre for Addictions Research of BC.[2] The model moves from *identifying* what we currently know to *investigating* the evidence base and *interpreting* the findings for our context. It also asks us to *imagine* possible outcomes and alternatives and *integrate* what we have learned into our policies and practices. The goal is to provide practical and effective support to school administrators (who are not substance use specialists) in addressing substance use from a population and environmental health perspective. This involves (a) helping Canadian students acquire the knowledge and skills necessary to make healthy choices in a society where alcohol and other substances are available, and (b) helping the school community create a health-promoting environment. The traditional emphasis on preventing and responding to problematic substance use by school-age youth is embedded within this larger focus.

[2] See discussion of constructivist education and the 5-i model at www.iminds.ca.

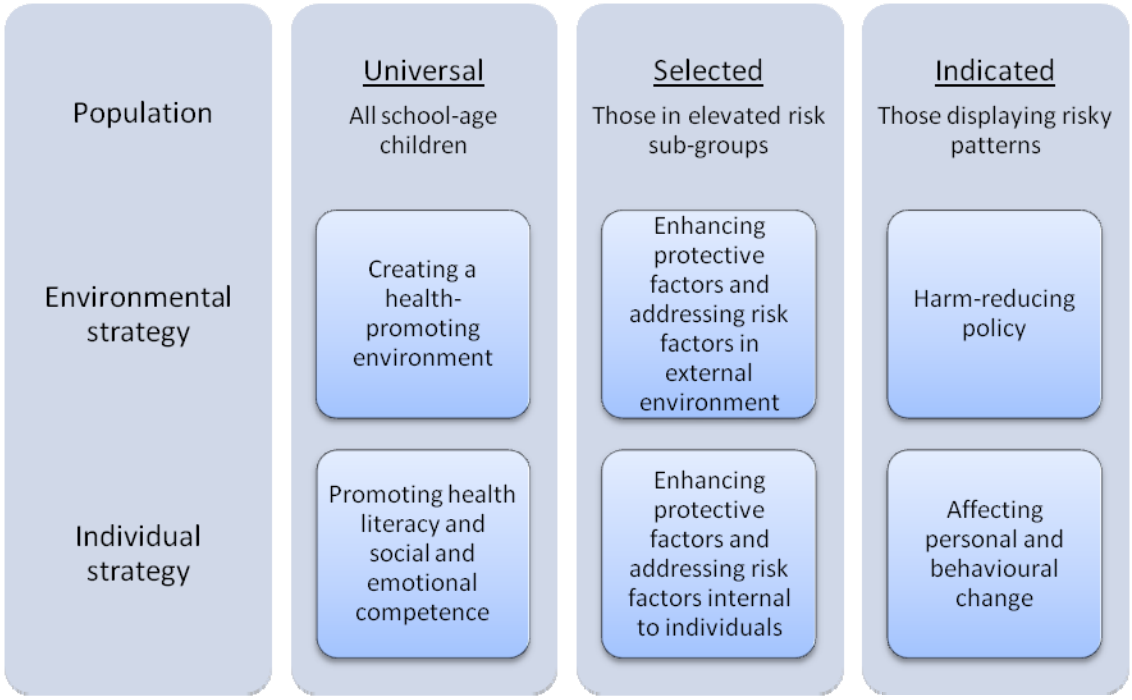
At a Glance

A Comprehensive Approach

Population health involves complex interactions between individual risk factors and broad social conditions. The latter are themselves complex factors involving history, culture, politics and economics. Substance use and substance use-related harm must be addressed within this complexity. Recent research has demonstrated that substance use and substance use-related harm share common determinants with other complex psychosocial problems. Narrow approaches that focus only on individual behaviours or material factors are unlikely to have much impact. This has led to an emphasis on more comprehensive approaches.

Population Health

A comprehensive approach can be seen as involving a matrix of environmentally and individually focused initiatives at three levels of population specificity, as indicated in the model below. The tendency has been to focus on individual strategies and the needs of the indicated population even when delivering services at the universal level. The knowledge kits in this series seek to help school professionals plan and implement a balanced and comprehensive approach involving several components that together address all six areas in the matrix effectively.



Comprehensive School Health

In the school setting, this population health approach is known as comprehensive school health. Comprehensive school health is an internationally recognized framework for supporting improvements in students' educational outcomes while addressing school health in a planned, integrated and holistic way. It has grown out of the vision set out in the World Health Organization's Ottawa Charter for Health Promotion (1986). Comprehensive school health involves attention to the whole school environment, with four inter-related areas for action that need to be addressed. Students need to be exposed to learning opportunities that help them gain the knowledge and skills required to maximize their health and well-being. They need to develop quality relationships with peers, teachers and other school staff in a healthy environment. This requires policies, procedures, management practices and decision-making processes that promote health and healthy environments. Comprehensive school health also requires a continuum of school- and community-based services that support and promote student and staff health and well-being as well as a culture of partnership between schools, families and the community.

Addressing Substance Use in Canadian Schools

The *Addressing Substance Use in Canadian Schools* series includes four knowledge kits that together support a comprehensive school health approach to substance-related issues. Each kit provides a review of the evidence and a discussion of the issues relevant to specific school professionals operating in relevant areas of action.

Universal Education

Universal education has an important place in a comprehensive approach; however, it has to be acknowledged that much of drug education has been ineffective and maybe even have been damaging.[3] Universal education should seek to *educate* students about

[3] Cahill, H. (2006). Devising classroom drug education programs. *Drug Education in Schools: Searching for the Silver Bullet.* Ed. R. Midford and G. Munro. Melbourne, Australia: IP Communications.

substances: their history, role in society, their advertising and the potential harms and benefits related to their use. The overall goal should be to increase the health literacy of students relative to substance use; that is, to provide them with the knowledge and skills needed to maximize their health within their environment. More details about substance use education can be found in the companion knowledge kit, *Effective Substance Use Education: A Knowledge Kit for Teachers*.

Targeted Programs and Services

Higher risk youth often come from socially or economically marginalized groups or have personal factors that contribute to real or perceived disconnection. These students require greater levels of support. Universal education programs lack sufficient focus or intensity to address their needs. Responding effectively to these youth involves helping them develop strong linkages within the school environment. This means helping them develop social and emotional competence and ensuring the school culture is supportive of their engagement. The knowledge kit, *Responding to the Needs of Higher Risk Youth: A Knowledge Kit for Counsellors and Health Workers,* provides a framework, a summary of the evidence and tools to support school professionals in developing a continuum of programs and services targeted to these students.

School-Family-Community

Consistency between school and community is important. This does not mean, however, that the school should simply reflect community norms and common beliefs. The school has a role in influencing the community. At the same time, careful consideration of community values and norms will help in the development of effective and contextually relevant policy and educational strategies. Investments in building school-family-community partnerships can contribute to this multi-directional flow and to the effectiveness of the educational efforts of the school. The knowledge kit, *School-Family-Community Partnerships: A Knowledge Kit for School and Community Leaders,* seeks to raise awareness of the importance of these partnerships within a comprehensive approach and to provide some evidence-informed guidance in nurturing them.

School Policy

Policy initiatives can be designed to create a health-promoting school environment within which other interventions operate. By clearly defining universal expectations within the school environment, they provide some of the most powerful mechanisms for socialization and shaping individual behaviours. Policy effectiveness will be maximized when the policies support environmental protective factors and minimize risk factors. Clear and fair responses to non-compliance are an important part of policy. These need to reflect the evidence on effectiveness and be consistent with messages delivered in other components. Policy issues are discussed in the following sections of this knowledge kit.

IDENTIFY

In this section, we identify what we currently know about:

- substances
  - what they are
  - why people use them
- the factors that contribute to risk and harm related to substance use
  - the context in which they are used
  - the person who uses them
  - and the substance being used
  - as well as the way the substances are used
- substance use among Canadian youth

In pointing to the challenge for schools in addressing substance use, Richard Midford suggests, "Decisions … tend to be driven by political and moral factors …. Often programs are chosen because they are well marketed, or because they accord with conventional community views …."[4]

Perhaps not surprisingly, the conventional views tend to focus almost exclusively on individual responsibility. But substance use education policy is likely to be more effective if it includes attention to the social and structural determinants of harm related to substance use.[5] While there is no "silver bullet", the ways in which schools shape their environment and respond to individual behaviour can have enormous impact on the outcome. Effective policy needs to shift attention from just preventing substance use to educating individuals about substance use and creating health-promoting environments.

WHAT ARE DRUGS?

A drug[6] is a substance that alters the way the body functions, either physically or psychologically. The term "drug" thus applies to a wide range of different substances. Of particular concern are those that act on the central nervous system (CNS) to affect the

[4] Midford, R. (2006). Looking to the future: Providing a basis for effective school drug education. *Drug Education in Schools: Searching for the Silver Bullet.* Ed. R. Midford and G. Munro. Melbourne, Australia: IP Communications.

[5] Wilkinson, R. & Marmot, M. (2003). *Social Determinants of Health: The Solid Facts. Second edition.* Copenhagan: WHO Regional Office of Europe.

[6] Throughout this knowledge kit, the words "drug" or "substance" are used interchangeably and primarily refer to psychoactive substances.

way a person thinks, feels or behaves. These psychoactive substances include alcohol, tobacco and many other legal and illegal drugs.

Drugs are often grouped as legal versus illegal, or soft versus hard. These categories can be confusing and misleading. The legal status of substances changes over time and location, and the concepts of "hard" or "soft" are impossible to define as the effects of any substance differ from situation to situation.

A more useful classification relates to the impact substances have on the central nervous system (CNS):

- **Depressants** decrease activity in the CNS (e.g., decrease heart rate and breathing). Alcohol and heroin are examples of depressants.
- **Stimulants** increase activity in the CNS and arouse the body (e.g., increase heart rate and breathing). Caffeine, tobacco, amphetamines and cocaine are stimulants.
- **Hallucinogens** affect the CNS by causing perceptual distortions. Magic mushrooms and LSD are examples of hallucinogens.

Despite its usefulness, this classification is not perfect. Many substances, such as cannabis, fit in more than one category while others do not fit at all. For more information on psychoactive substances, go to www.carbc.ca/Default.aspx?tabid=202.

Why Do People Use Drugs?

There is no society on Earth that does not in some way celebrate, depend on, profit from, enjoy and also suffer from the use of psychoactive substances. Like most developed countries, Canada has a long tradition with—and of legally sanctioning the use of—older substances such as alcohol and nicotine. Multinational companies manufacture, advertise and sell these products for substantial profit to a large market of eager consumers while their governments and the communities they serve reap a rich harvest from tax revenues. They also reap another kind of harvest in terms of health, legal, economic and social problems which are mostly hidden from view.

The last century saw an upsurge in the cultivation, manufacture and trade of other psychoactive substances, some quite ancient and others new. Some have been developed from pharmaceutical products made initially for treating pain, sleep or mental health problems (e.g., heroin, barbiturates and benzodiazepines). Others have been manufactured for recreational purposes (e.g., ecstasy), while still others, notably cannabis, are made from plants or seeds that have been cultivated and traded to new and much larger markets. As with most countries, Canada has implemented legal sanctions supported by international treaties in its attempts to control the manufacture,

trade and consumption of some of these products, though their use continues in varying degrees.

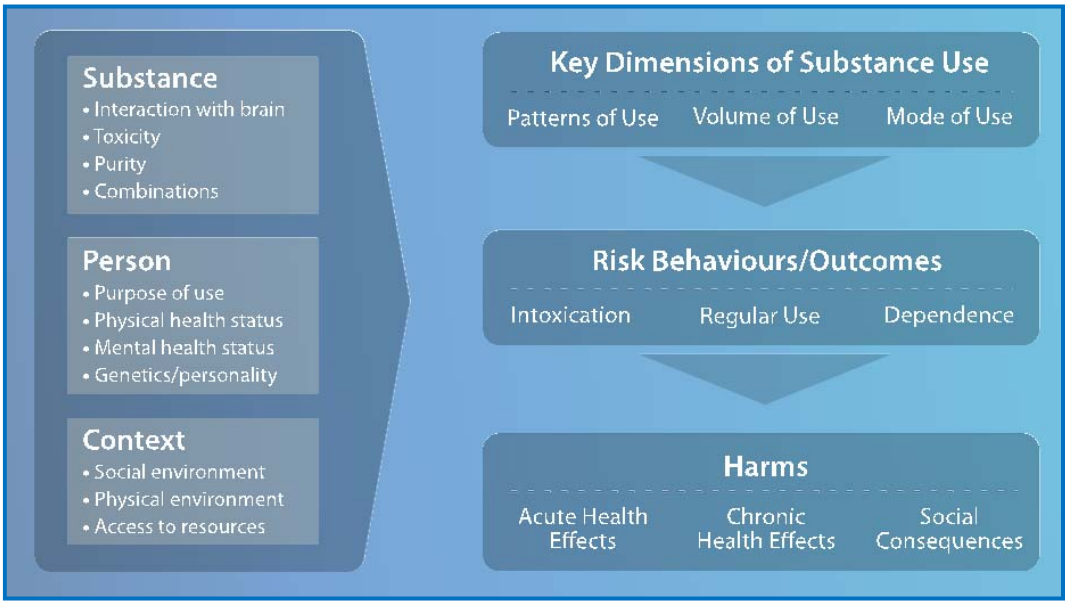
Around each of these substances, with their different effects on human behaviour and emotion, cultures and rituals have grown that shape traditions and patterns of use for particular purposes. For almost every type of human activity, there are substances used to facilitate that activity in some way (e.g., religious ceremonies, sport, battle, eating, sex, study, work, dancing, public performances and socializing).

In the case of adolescents, research suggests reasons for use include: curiosity, fun, self-discovery, to fit in, coping with stress, pain or boredom, staying awake to study, alleviating depression, out of habit, rebelliousness, weight loss and to aid sleep. These different motives for use powerfully influence the pattern of use and the risk of harmful consequences. If the motive for use is fleeting (e.g., curiosity), then only occasional or experimental use may follow. If the motive is a strong and enduring one (e.g., a chronic sleep or mental health problem), then more long lasting and intense substance use, with many problems, may follow. A shorter term but intense motive (e.g., to fit in, to have fun, to alleviate temporary stress) may also result in risky behaviour and harm such as injury or acute illness.

So What Is the Problem?

Unfortunately, the wrong substance, or perhaps just the wrong dose of a substance at the wrong time and administered the wrong way, can not only impair performance but also lead to serious harm. The type of substance used (e.g., a stimulant such as caffeine or a depressant such as alcohol), the dose taken, the way in which it is taken (e.g., smoked, injected or drunk) and the setting in which use occurs can all influence whether the effect enhances or impairs performance or results in actual harm. Harmful consequences, for the user and those around them in the wider community, include social problems as well as injuries, illness and death.

While the use of almost any psychoactive substance by children or adolescents may be a cause for concern, there are a number of factors that determine how probable or serious the resulting harm may be. As shown in the model below, these factors can be categorized into those that are about the substance itself and its direct effects, those that arise out of characteristics of the individual user and those that describe the setting or context of use. These factors interact to influence the patterns and behaviours related to substance use and thereby determine levels of risk that may result in real harms.



THE CONTEXT

Too often, the media and others focus on the drug. Yet the places, times and activities associated with substance use powerfully influence patterns of use and the likelihood of harm occurring. Alcohol use by teenagers in the absence of parental supervision is particularly likely to be high risk. Being in a situation of social conflict or frustration while under the influence of depressants such as alcohol or anti-anxiety drugs (e.g., benzodiazepines) can increase the likelihood of a conflict being resolved by violent means. Using such substances before or while engaging in physically hazardous activities such as driving, boating or hiking on dangerous terrain, also increases the risk of injuries. The overall social and cultural context surrounding substance use will also influence the extent to which a young person has different substances available to them and is encouraged or restrained from using them.[7] The economic availability of different substances is critically important – the cheaper they are, the more likely they are to be used. This applies not only to legal substances like alcohol and tobacco but also to illicit substances. Family and friendship networks and the degree of engagement in, and connection to, the wider community all influence the likelihood of young people

[7] For example, in the 1970s, tobacco was quite widely used both by the adult and adolescent populations while cannabis use was comparatively rare. Today, knowledge about the risks of tobacco use and a range of legal sanctions and restrictions on where people can smoke tobacco have resulted in fewer teenagers smoking tobacco. On the other hand, in almost all Canadian jurisdictions, cannabis has become increasingly available and, according to the Canadian Addiction Survey, past year use of cannabis by 17-19 year olds increased from 25% in 1994 to 44% in 2004. Use by younger teens has remained stable at just below 30%.

engaging in substance use as well as experiencing mental health or behavioural problems. In contexts in which dialogue about substance use is common, use by youth is less common, presumably as a result of the respectful transmission of knowledge about appropriate use. The table on the following page includes some of the risk and protective factors[8] touching on these various contextual themes.

The Person

A variety of personal factors affect the probability that an individual will engage in risky substance use. These include current physical and mental health. For example, someone with anxiety or depression may try to feel better by drinking alcohol. There is some evidence that genetic inheritance and personality or temperament also have an impact. For example, tendencies towards sensation seeking (e.g., high on curiosity and need to find excitement) increase a person's risk of harm from substance use.

Environmental experience, however, shapes many of these and other factors that place individuals, and in particular young people, at increased risk. For example, personal experience of adverse life events, such as physical, sexual or emotional abuse, may impact the individual's physical or mental health. Awareness of this has led to increased emphasis on developmental pathways. The intention is to eliminate or reduce the preconditions for the development of a risk factor (e.g., by reducing children's access to alcohol to avoid early initiation; supporting families to reduce stress and the potential for trauma; or by providing early help in developing literacy skills to avoid academic failure). Not all risk factors can be eliminated, however. Neither can schools (or parents) reverse existing risk factors. In this case, the goal is to help mediate the risk impact by building resilience through increasing protective factors.

[8] Considerable attention is given to risk and protective factors in the literature. As used here, **risk factors** are the social, environmental and individual factors that independently predict involvement in early and heavy drug use as well as a range of mental health and behavioural problems. **Protective factors** moderate and mediate the effect of risk factors by increasing resilience, although they do not, of themselves, directly influence the likelihood of drug use after adjusting for known risk factors. Risk factors act in a cumulative way over time. Some are present from the early years, others emerge in adolescence – but no single risk factor lies at the heart of drug-related problems. The more risk factors that persist over time, the greater the likelihood of significant impact on development. Programs should either enhance protective factors or eliminate risk factors where possible. See Loxley, W., Toumbourou, J., Stockwell, T.R., Haines, B., Scott, K., Godfrey, C., Waters, E., Patton, G., Fordham, R.J., Gray, D., Marshall, J., Ryder, D., Saggers, S., Williams, J. & Sanci, L. (2004). *The Prevention of Substance Use, Risk and Harm in Australia: A Review of the Evidence.* National Drug Research Institute and the Centre for Adolescent Health; Derzon, J.H. (2007). Using correlational evidence to select youth for prevention programming. *Journal of Primary Prevention,* 28, 421-447.

	Risk Factors	Protective Factors
Community	• Economic disadvantage • Social or cultural discrimination or isolation • Availability of substances and high tolerance for use	• Opportunities for meaningful participation in community groups and activities • Involvement with adult mentors and role models
Family	• Low parental expectations • Tolerant parental attitudes towards teen alcohol/substance use • Parental mental illness or substance use problems	• Family nurturance and attachment • High level of participation with adults
Peer	• Peer rejection • Member of deviant peer group	• Member of pro-social peer group
School	• Poor attachment to school • Poor school performance • Difficulty at transition points (e.g., entering school, transition to secondary school)	• Caring relationships within school community • High but achievable expectations
Individual	• Temperament (sensation seeking, poor impulse control) • High levels of aggression • Early regular substance use	• Ability to genuinely experience emotions and assert needs • Sense of agency and optimism • Good literacy and capacity for problem solving

THE SUBSTANCE

All psychoactive substances have the potential to cause harm, but different substances pose different types and severity of risk. The legal classification of substances has little correlation to their potential to cause harm at the individual level[9] or to the actual harm measured at a population level.[10] For example, legal substances—alcohol and tobacco—contribute far more to the burden of disease than illegal substances and cost the healthcare system much more than all illegal substances combined; therefore, they

[9] Nutt, D., King, L.A., Saulsbury, W., Blakemore, C. (2007). Development of a rational scale to assess the harm of drugs of potential misuse. *The Lancet*, 369, 1047-1053.

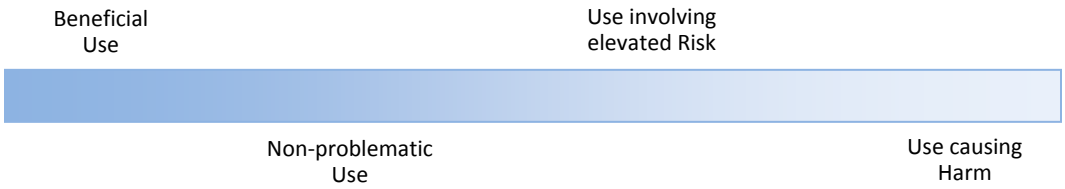
[10] Rehm, J., Baliunas, B., Brochu, S., Fischer, B., Gnam, W., Patra, J., Popova, S., Sarnocinska-Hart, A., Taylor, B. (2006). The costs of substance abuse in Canada 2002: Highlights. Ottawa: Canadian Centre on Substance Abuse.

need to be the primary focus of interventions.[11] Moreover, tobacco kills more of its regular users than any other substance.

On the other hand, some illegal substances—notably heroin, cocaine and methamphetamine—can have devastating consequences for a small number of individuals who use them regularly. The high prevalence of cannabis use and the cultural associations of some substances such as ecstasy may warrant particular attention even though their potential for harm is less severe. The non-medical use of pharmaceuticals appears to be growing in some jurisdictions and also needs special attention.

Use, Risk and Harm

It is important to acknowledge that the careful use of many psychoactive substances can be harm-free and even beneficial. Nonetheless, psychoactive substance use involves risk. Substance use can be regarded as being ranged along a continuum from mainly low-risk and sometimes beneficial use (e.g., opiate use for addressing acute pain), through potentially hazardous use to clearly harmful use (e.g., opiate injection using a non-sterile needle leading to infection).



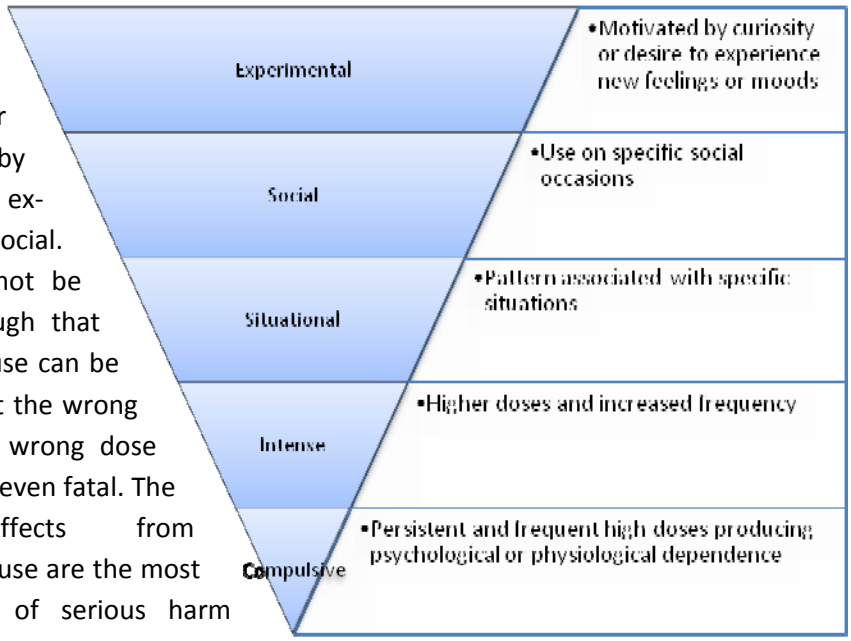
Repeated use of a substance, especially on a daily basis, may pave the way for a strong habit or dependence that can be hard to break. Some of the main signs of dependence are:

- increasing tolerance for a substance, meaning higher doses are required to get the same effect;
- increasing discomfort (psychological and physiological) when attempting or forced to abstain;
- increasing fixation on the substance at the expense of other activities.

Such intense patterns of use tend to require significant funds to support the habit, and compete with other social demands and expectations from family, school and the wider community. There is also evidence that patterns of intense use temporarily blunt the

[11] British Columbia Ministry of Health (2006). *Following the Evidence: Preventing Harms from Substance Use in BC*. Ministry of Health: Victoria, BC.

capability of an individual to experience pleasure in other ways – the reward centres of the brain have become "hijacked" by the need to be repeatedly provided with rewards from the drug of choice, whether it be alcohol, tobacco, cannabis or some other psychoactive substance.



As shown in the diagram on the right, most alcohol or other substance use by young people is experimental or social. However, it cannot be emphasized enough that even occasional use can be hazardous and, at the wrong time and in the wrong dose and wrong place, even fatal. The short-term effects from occasional heavy use are the most frequent causes of serious harm from substance use among young people. Dependence, though serious, is much less common.

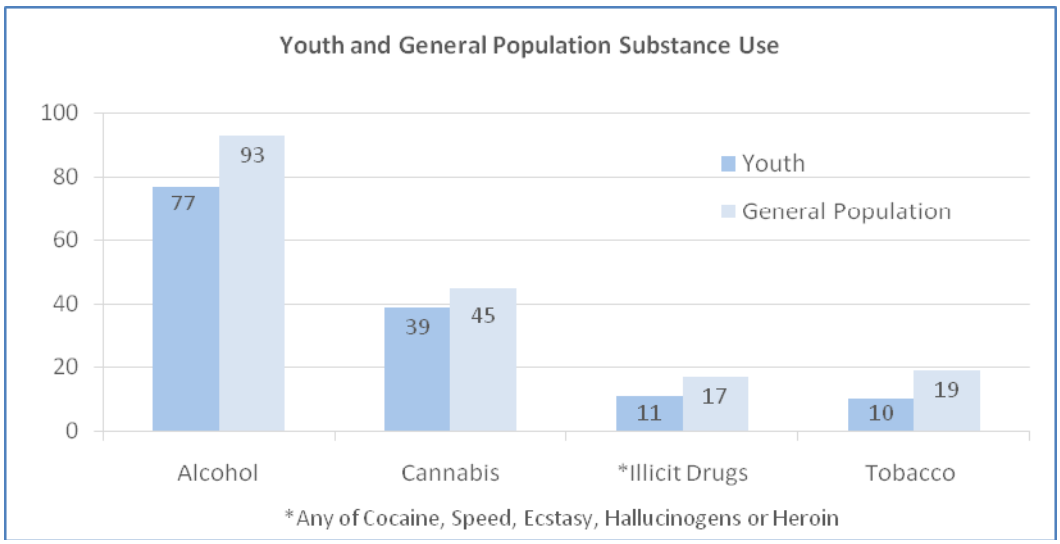
The prevention of substance use-related harm requires the identification and reduction of major patterns of risky substance use and the enhancement of a wide range of protective factors.

Some signs that substance use has become particularly risky or harmful include some or all of the following: early age of onset (especially before age 13 or 14); use to cope with negative mood states; habitual daily use; use before or during school or work; use while driving or during vigorous physical activities; use of more than one substance at the same time; and use becoming a major form of recreation.

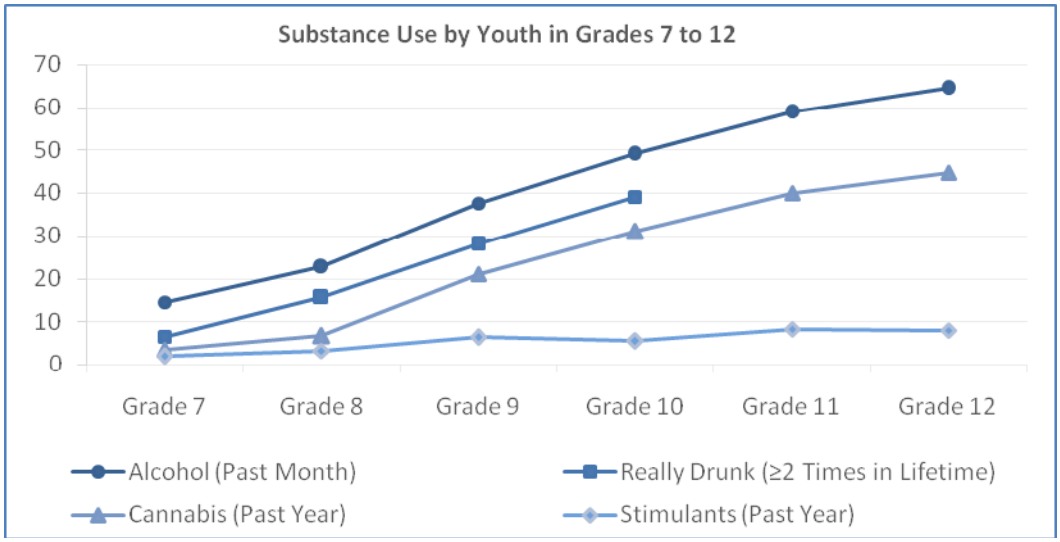
Signs that patterns of use are less likely to be harmful include: taking precautions when using; being careful to use only in small or moderate amounts; less frequent use and only in particular contexts; and being able to stop using at any time.

Substance Use among Canadian Youth

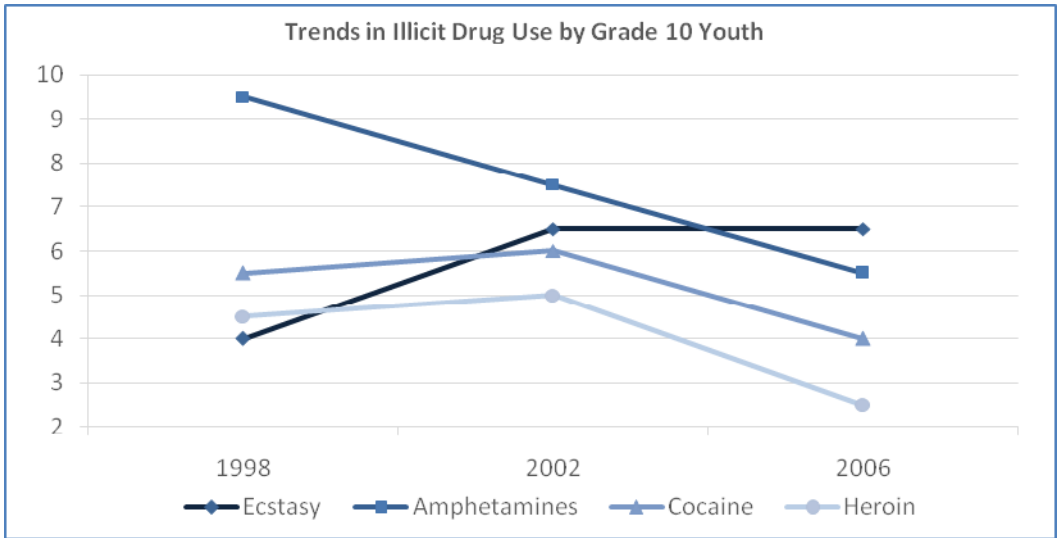
Youth use the same substances as adults though their rates of use are significantly lower. The 2004 Canadian Addiction Survey reports 77 percent of youth aged 15 to 17 years have consumed alcohol at least once in their lifetime. This compares with 93 percent of the general population. Similarly, 39 percent of 15- to 17-year-olds have used cannabis at some point in their life, compared to 45 percent of the general population. Use of other illicit drugs by youth and the general population is much lower. Approximately 11 percent of 15- to 17-year-olds have used other illicit drugs (any one of ecstasy, amphetamines, hallucinogens, cocaine or heroin) at least once in their lifetime (compared to 17 percent of the general population). Tobacco use by Canadian youth is also lower than alcohol consumption or cannabis use and has been in steady decline for several years. The 2007 Canadian Tobacco Use Monitoring Survey reports 10 percent of 15- to 17-year-olds are current smokers, down from 18 percent in 2002. The same survey reports 19 percent of the general population as current smokers.



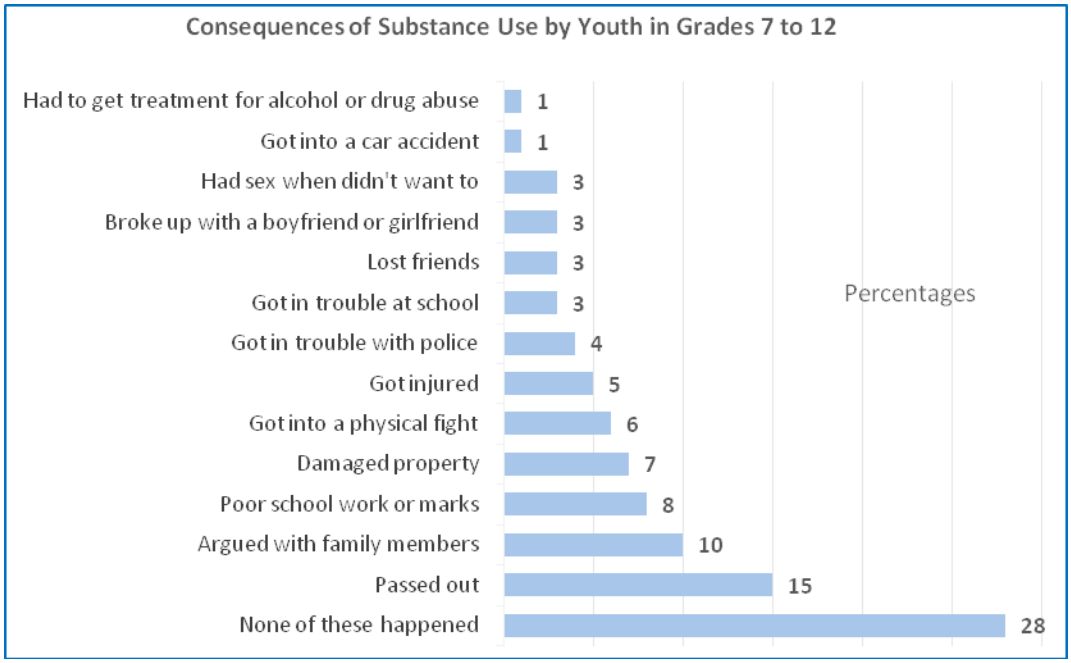
While the rates for substance use are lower for youth than for adults, these rates, particularly for alcohol and cannabis, increase rapidly as young people age. The 2007 Ontario Student Drug Use and Health Survey (OSDUHS) demonstrates this steady rise in the use of alcohol and cannabis by students in grades 7 through 12. Getting drunk also increases as youth get older. The Health Behaviour of School-Aged Children study shows drunkenness rates increase steadily by grade, with approximately 39 percent of grade 10 students reporting being really drunk at least twice in their lifetime. By comparison, use of stimulants increases for students in grades 7 through 11 but declines slightly for those in grade 12.



Overall, national data shows illicit drug use by youth is declining or remaining stable. Results from a recent World Health Organization study, the Health Behaviour of School-Aged Children, demonstrate Canadian youth rates of use of other illicit drugs such as ecstasy, amphetamines, cocaine and heroin are reasonably low and, despite common beliefs, have not increased throughout the past decade. The data also reveals the illicit use of medical drugs, glues and solvents has declined. Nevertheless, even though the national data shows use is declining for these substances, for some jurisdictions there are indications that use is increasing among youth.



When youth are asked about any negative outcomes related to their alcohol or substance use, some types of problems or consequences are reported more frequently than others. For instance, the 2003 Adolescent Health Survey of students in British Columbia found the main consequences reported were passed out (15 percent), arguing with family members (10 percent), and poor school work or marks (8 percent). Only one percent of students reported having to seek treatment for their alcohol or substance abuse or being involved in a car accident. Just over one-quarter of students reported no negative consequences at all.



Regional variations provide another aspect of the overall picture of substance use by Canadian youth. Where available, data tends to show rates and patterns of substance use vary between rural and urban communities and northern and southern jurisdictions. For instance, substance use may be higher in northern and remote communities than in southern urban communities. Communities with the greatest challenges, such as remote or northern areas, are likely to have the least access to services and some other protective factors; a disparity that not surprisingly, is reflected in the rates of substance use .

Insights into local or school-level substance use rates and patterns can be gleaned using student and/or community surveys, administrative data such as suspension rates and/or other data available at the local level.

INVESTIGATE

In this section, we investigate the evidence related to:

- how substance use is related to educational outcomes
- grounding school policy in risk and protective factors
- building policy to promote resilience
- foundational values for effective policy
- replacing some ineffective approaches

The realization that universal classroom-based prevention efforts have only small and short term effects on youth substance use led to calls for broader approaches. The rationale is that, by virtue of including multi-faceted organizational and programmatic changes at the school level, such approaches are better able to tap into the various spheres of influence at play in educational environments.

A key aspect of comprehensive approaches is that they broaden the focus to include school and organizational elements in the suite of options to promote health and reduce harm from behaviours like substance use. This is significant because traditional efforts have tended to focus on students and their "problems" and to miss the fact that modifying school and organizational factors to promote engagement and connectedness at the school level is actually a very powerful lever for enhancing resiliency in youth.

Many schools have substance use policies, but policies are not all created equal. This section summarizes the evidence about elements of effective school policies for reducing the harm related to substance use. An effective policy will recognize the synergistic relationship among a wide range of individual, social and contextual factors that influence human behaviour in general, and substance use in particular; therefore, a substance use policy needs to be embedded within a larger healthy school policy that fosters health and learning.

A POLICY TO MAXIMIZE EDUCATIONAL OUTCOMES

To be effective, schools must focus on their primary responsibilities related to teaching and learning. The complex issues connected to substance use may seem a distraction; however, addressing substance use and the related risks and harms is essential to a school's instructional mandate.

The complex relationship between substance use and educational outcomes requires that schools engage directly in issues related to substance use. First, substance use can interfere with learning because of the neural impact of the substance used or because

of the social context of the use.[12] On the other hand, students who fail to do well in school are at significantly higher risk for developing harmful patterns of substance use. In particular, early school failure in primary school may be a risk factor for the later emergence of drug use problems.[13] Academic achievement has been found to predict involvement in illicit drug use, but is unrelated to alcohol use. The relevant factors are likely not about the substances but about the social dynamics involved. However, students who develop strong connections with school and positive relationships with teachers or other school staff show less involvement with health-risk behaviours and are less likely to develop mental health or substance use problems.[14] Additionally, there is growing evidence that learning social and emotional competence contributes to both better academic performance and positive health behaviours.[15]

RISK AND PROTECTIVE FACTORS

Some of the most fruitful research on how to impact educational, social and health outcomes identifies what are called *risk and protective factors*.[16] Increasingly, attention is drawn to factors external to the individual. Some risk and protective factors are specific to the school environment. The table below[17] sets out scientifically validated risk and protective factors in the school context associated with early or problematic substance use in youth. Although particular factors can appear at any age or stage of development, they are listed here according to when they are most likely to appear in a child's life.

A large number of studies have demonstrated reductions in student behavioural problems as a result of policies, procedures and structures within the school being

[12] Roberts, G., Krank, M., Comeau, N., McLeod, B., Paglia-Boak, A., Patton, D., Lane, J. & Naidoo, K. (awaiting publication). *School-Based and School-Linked Prevention of Substance Use Problems: A Knowledge Summary.* Surrey, BC: Canadian Association for School Health.

[13] Loxley, W., Toumbourou, J., Stockwell, T., et al (2004). *The Prevention of Substance Use, Risk and Harm In Australia: A Review of the Evidence*. Canberra, Australia: The National Drug Research Institute and the Centre for Adolescent Health. Available from http://eprints.lis.curtin.edu.au/archive/mirror/mono_prevention.pdf.

[14] Resnick, M., Bearman, P., Blum, R., et al (1997). Protecting adolescents from harm: Findings from the longitudinal study on adolescent health. *Journal of the American Association, 278*, 823-832.

[15] Greenberg, M.T., Weissberg, R.P., O'Brien, M.U., et al (2003). Enhancing school-based prevention and youth development through coordinated social, emotional, and academic learning. *American Psychologist,* 58, 466-474.

[16] The previous section included a broad discussion of risk and protective factors. Here the discussion will focus on the implications of this literature to school policy.

[17] Adapted from Loxley et al (2004).

modified to address risk and protective factors.[18] Effective policies are aimed at encouraging positive interpersonal interactions, maximizing learning opportunities, promoting a safe and healthy environment and better preparing children for transitions.[19]

Risk Factors	Protective Factors
Age 5-11 • Early school failure **Age 12-17** • Difficulty transitioning from elementary to secondary school • Poor school performance • Lack of connection and commitment to school • Norms that reflect greater tolerance for use • Bullying or being threatened • Unsafe physical environment	**Age 5-11** • Positive school and teacher bonding **Age 12-17:** • Opportunities and rewards for school involvement • Teacher connectedness • Peer bonding

School Connectedness

There is good evidence suggesting that supportive and caring relationships within schools promote academic motivation and performance among students.[20] Students with positive teacher, learning and social connectedness also fare best in terms of later mental health and involvement in health risk behaviours.[21] Conversely, young people who are not engaged in learning and have poor relationships with peers and teachers (e.g., they are bullied, feel like they do not belong or feel stressed) are more likely to experience both academic and mental health problems and be involved in various health risk behaviours. Not completing secondary school is a risk factor for early adult substance use problems.

[18] Toumbourou, J.W., Rowland, B., Jefferies, A., Butler, H. & Bond, L. (2004). *Early Intervention in Schools: Preventing Drug-Related Harm Through School Re-Organisation and Behaviour Management.* Melbourne: Australia Drug Foundation. Available from www.druginfo.adf.org.au/downloads/Prevention_Research_Quarterly/PRQ_04Nov_Early_intervention_in_schools.pdf.

[19] Spooner, C., Hall, W., & Lynskey, M. (2001). *Structural Determinants of Youth Drug Use.* ACT: Australian National Council on Drugs. Available from www.ancd.org.au/publications/pdf/rp2_youth_drug_use.pdf.

[20] West, P. (2006). School effects research provide new and stronger evidence in support of the health-promoting school idea [Editorial]. *Health Education*, 106(6), 421-424.

[21] Resnick et al (1997).

Much of the school connection research is not designed to determine how much of the sense of connection comes from attributes of teachers and schools and how much is due to student traits and motivation, or even parent or neighbourhood attributes. However, some evidence suggests that students who attended elementary schools that had a positive school ethos (i.e., students felt attached to school, engaged in education, and got along with their teachers) were less likely to smoke, drink and use illegal drugs at age 13 and 15 than students attending schools with a poor ethos.[22]

School substance use policies should focus on maximizing the opportunities and rewards for school involvement. These approaches will be more effective than those that concentrate on measures to identify the presence or use of drugs and respond with punitive consequences. The research indicates that punitive programs often leave young people less connected and more vulnerable than they were at the outset. Deterrent intention does not always translate into deterrent effect and, when it does not, it may result in a failure to exercise the duty of care. [23]

The main goal should be to optimize the students' relationship with the school so that it can provide a stable protective force in their lives. Thus, rather than focusing on substance use per se, these initiatives should seek to facilitate meaningful connections between staff, students and parents as a way of achieving broad benefits both academically and in terms of well-being.

Teacher Connectedness

Teachers have a great capacity to contribute to the well-being and academic success of their students. Even students with multiple risk factors who perceive a connectedness with teachers are less likely to become involved in harmful substance use or other problem behaviours than counterparts who do not feel connected.[24] Ongoing teacher connectedness can offset the effects of poorer social connections.[25] School policy should ensure teachers receive appropriate training, understand the conceptual model and feel supported in their efforts to build resilience in their students.

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[22] West, P., Sweeting, H. & Leyland, A. (2004). School effects on pupils' health behaviours: Evidence in support of the health promoting school. *Research Papers in Education*, *19*(3).

[23] Norden, P. (2005). *Keeping Them Connected: A National Study Examining How Catholic Schools Can Best Respond to Incidents of Illicit Drug Use.* Richmond, Victoria: Jesuit Social Services, Ignatius Centre for Social Policy and Research.

[24] Voisin, D.R., Salazar, L.F., Crosby, R., DiClemente, R.J., Yarber, W.L. & Staples-Horne, M. (2005). Teacher connectedness and health-related outcomes among detained adolescents. *Journal of Adolescent Health*, *37*, 337.

[25] Bond, L., Butler, H., Thomas, L., Carlin, J., Glover, S., Bowes, G. & Patton, G. (2007). Social and school connectedness in early secondary school as predictors of late teenage substance use, mental health, and academic outcomes. *Journal of Adolescent Health*, *40*(4), 357.

Social Connectedness or Peer Bonding

Depending on the nature and quality of the relationships students have with their peers, these may have a protective or risk enhancing effect. If social life is characterized by bullying or being threatened, social connections will have a risk-enhancing effect. Similarly, bonding with peers who engage in problematic substance use can also enhance risk. On the other hand, positive social connections can act as a protective factor.[26] An inclusive school culture that provides a framework for positive attitudes and actions among all school participants will help build resilience.[27] School policy should ensure attention to the development of a peer connectedness system.

Physical Environment

Healthy (clean, safe, health-promoting) physical environments help prevent injuries and disease and enable healthier choices. Unsafe or "un-owned" places, where school personnel are not typically present and rules are more difficult to enforce (hallways, dining areas and parking lots), can contribute to problems, including those involving substance use. The manner in which the physical environment interacts with social norms and behaviour (e.g., verbal bullying, victimization) is important in understanding the problem as well as how best to intervene.[28] The goal of interventions should seek to create accessible and sustainable environments that promote physical activity, safety and freedom from bullying or harassment.

Norms

Norms, reflected in the attitudes and behaviours of students, teachers and administrators about the acceptability of different forms of substance use, are another factor affecting the school environment. Research has shown a clear association between school norms and substance use. For example, students in junior and senior high school are more likely to use substances when the norms in school reflect a greater tolerance for substance use.[29]

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[26] Roche, A.M. (2006). The role of 'school' versus education: Social capital, connectedness and resilience. *Drug Education in Schools: Searching for the Silver Bullet.* Ed. R. Midford and G. Munro. Melbourne, Australia: IP Communications.

[27] Deed, C. (2006). School programs for high-risk students. *Drug Education in Schools: Searching for the Silver Bullet.* Ed. R. Midford and G. Munro. Melbourne, Australia: IP Communications.

[28] Reid, R.J., Peterson, N.A., Hughey, J. and Garcia-Reid, P. (2006). School climate and adolescent drug use: Mediating effects of violence victimization in the urban high school context. *The Journal of Primary Prevention*, *27*(3).

[29] Kumar, R., O'Malley, P.M., Johnston, L.D., Schulenberg, J.E. & Bachman, J.G. (2002). Effects of school-level norms on student substance use. *Prevention Science*, *3*(2).

From Risk to Resilience

The precise relationship between risk and health outcomes is complex and not completely clear. Risk factors alone do not accurately predict outcome.[30] Why do some children with significant risk factors succeed despite adversity while others do not? Considerable research has been done exploring the qualities that contribute to resilience, the ability to rise above or bounce back from adversity. Evidence suggests resilience results from the presence of basic human protective systems.[31]

Next to families, schools are the social institution with the greatest potential impact on children. Benard (2000) emphasizes, "The major message from [research] is that it's how we do what we do that counts. In other words, context matters more than content; process more than program."[32] Building resilience through promoting healthy development and competence is as important, if not more important, than preventing or responding to problems. Attention should be given to three interconnected strategic elements.

Asset Focused

Asset-focused approaches seek to build on and support the personal capital of the child. This perspective resists labelling children and adjusting our expectations accordingly. It recognizes that the most significant risk factors are located in the community and environment rather than the individual or family. Providing a safe context characterized by caring relationships, appropriate expectations and opportunities for participation and contribution will allow the innate assets of children to flourish.[33] Schools can provide a range of activities that allow children to explore various ways of expression and achievement. Celebrating individual and group successes will help reinforce self-efficacy and motivation.

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[30] Derzon, J.H. (2007). Using correlational evidence to select youth for prevention programming. *Journal of Primary Prevention,* 28, 421-447.

[31] Masten, A. & Gewirtz, A. (2006). Resilience in development: The importance of early childhood. *Encyclopedia on Early Childhood Development*. Centre of Excellence for Early Childhood Development. Published online at www.child-encyclopedia.com/documents/Masten-GewirtzANGxp.pdf.

[32] Benard, B. (2000). From risk to resiliency: What schools can do. *Increasing Prevention Effectiveness.* Ed. W.B. Hansen, S.M. Giles & M. Fearnow-Kenney. Greensboro, NC: Tanglewood Research. Available from www.tanglewood.net/projects/teachertraining/Book_of_Readings/Benard.pdf.

[33] Benard (2000).

Risk Focused

Reducing the exposure of children to preventable risk is important even in a strengths-based environment. Care must be taken, however, not to personalize risk in the individual or family but to recognize risk as a contextual quality often shaped by social and organizational policy. For schools, risk reduction might involve articulating appropriate expectations, providing orientations to smooth transitions, providing supports to ensure academic success and ensuring a safe environment.

Process Focused

Attention to mobilizing the fundamental protective systems for development is critical. For schools, this might include providing teachers with more training or resources to maximize effectiveness in the classroom, ensuring that every student is matched to a staff member who builds an effective and caring relationship with the child, and providing a rich array of activities that link students with each other in multiple configurations.

Children's engagement or disengagement in institutions such as schools depends largely on whether children's fundamental needs for belonging, autonomy and competence are being fulfilled.[34]

Foundational Values for Effective School Substance Use Policies

Defining a clear set of underlying assumptions and values can provide a useful starting point for schools that are interested in developing policies focused on the achievement of educational outcomes and broad health goals such as reducing the adverse consequences of substance use.

The following assumptions and values were adapted from a United Nations handbook on school-based drug education[35]

- illegal or unsanctioned drug use at school can have significant social, legal, health, safety and educational implications for young people;
- responses to student alcohol, tobacco and other drug use should recognize that use is often occasional and does not imply addiction or risk of addiction;
- consequences of possessing, using or selling substances at school should be public, fair and consistent;

[34] DeWit, D.J., Akst, L., Braun, K., Jelley, J., Lefebvre, L., & McKee, C. (2002). *Sense of School Membership: A Mediating Mechanism Linking Student Perceptions of School Culture with Academic and Behavioural Functioning*. Toronto, Canada: Centre for Addiction and Mental Health.

[35] United Nations Office on Drugs and Crime (2004). *Schools: School-Based Education for Drug Abuse Prevention*. Vienna: United Nations Office on Drugs and Crime.

- students have a right to attend school if they are not a threat to others, and a range of strategies should be utilized to retain students in cases where the health and safety of the school is not threatened; and
- student substance use should be considered in the context of the student's life, family situation, mental and emotional health, intellectual ability and the degree to which they may have been, or are, in control of their actions and decisions.

Replacing Ineffective or Harmful Measures

It is important to recognize that social harms related to youth substance use can be derived from the use of the substance itself or result from the response taken to the substance use. An example of the former would be chronic use of cannabis leading to avoidance patterns and the breakdown of family communication. On the other hand, school suspension that leads a student to further disconnect from meaningful involvement in school culture is an example of the latter.[36] In all interventions, then, it is important to ensure that responses do not introduce new harms but instead facilitate the restoration of social bonds and relationships that are so crucial for building personal resiliency in youth.

Policy frameworks built around a zero-tolerance or tough-on-drugs approach have not demonstrated effectiveness[37] and often undermine the powerful protective factor of school connectedness as well as discourage help-seeking.[38] These approaches favour policies and procedures regarding substance use that utilize a non-discretionary enforcement policy emphasizing punitive consequences and aggressive measures to identify the presence or use of substances. Although strict punitive policies for responding to incidents involving substances at school may seem like reasonable responses to difficult circumstances, the research indicates that they often do more harm than good.

Punitive Consequences

Punitive measures alone, such as suspension, expulsion or involvement of law enforcement are *not* successful in reducing student substance use or substance-related harms or in increasing school safety.[39] Punishment-oriented policies have been linked to

[36] Norden (2005).

[37] Paglia, A., & Room, R. (1999). Preventing substance use problems among youth: A literature review and recommendations. *Journal of Primary Prevention*, *20*(1), 3-50.

[38] D'Emidio-Caston, M. & Brown, J.H. (1998). The other side of the story: Student narratives on the California drug, alcohol, and tobacco educational programs. *Evaluation Review 22*, 95-117.

[39] Beyers, J. M., Evans-Whipp, T., Mathers, M., Catalano, R. F. and Toumbourou, J. W. (2005). An international comparison of the school drug policy environments in Washington State, U.S. and Victoria, Australia. *Journal of School Health,* 75, 134-140.

heightened emotional problems in youth and, in some cases, *increased* substance use. Since such approaches can lead students to further disconnect from meaningful involvement in school and prevent them from seeking assistance, they may result in serious detrimental impacts (academic and social). Moreover, they tend to shift harms from one school to another without ever addressing the underlying issues. These approaches neither improve student behaviour nor increase general school safety.[40]

Drug Searches and Drug Testing

Measures to detect substances in schools or identify students who use them are controversial and require careful attention to the rights of students. The intention of such measures is to deter use (or encourage cessation of use), to provide early detection and provide opportunity for early intervention or to increase safety (or reduce risk) within the school environment. Searches may be appropriate when there are reasonable grounds; however, the evidence suggests that drug detection programs do little to deter the initiation of, or encourage cessation of, drug use in schoolchildren.[41] Drug detection techniques rarely distinguish between experimental use in a safe environment surrounded by family members (or, for that matter, consumption of cough medicine to treat a mild cold) and severe use by student athletes or distressed youth.[42] Rather than leading to improved intervention, drug detection programs have been associated with several negative outcomes including poorer attitudes toward school and greater preference for riskier substance use (e.g., using less detectable substances that may be more harmful).[43]

Drug detection programs have little effect on their intended outcomes, while paradoxically increasing a wide range of risk factors for substance use and other risky adolescent behaviours. Detection often results in exclusion from extra-curricular activities such as sports or cultural programs, temporary suspension or expulsion from school, all of which decrease connectedness. A minority of students feel embarrassed, humiliated or distressed by having to undergo drug testing and may therefore, withdraw from activities such as sports where drug testing may be more likely to occur.[44] Any activities that lessen school connectedness may impact on students' health and

[40] Skiba, R.J. & Peterson, R.L. (2000). School discipline at a crossroads: From zero tolerance to early response. *Exceptional Children, 66*, 335-346.

[41] Roche, A., Pidd, K., Bywood, P. et al (2008). *Drug Testing in Schools: Evidence, Impact and Alternatives.* Canberra, Australia: Australian National Council on Drugs.

[42] Caan, W. (2005). Random drug testing in schools. *British Journal of General Practice*, 55(517), 637.

[43] Goldberg, L., Elliot, D.L., MacKinnon, D.P., Moe, E., Kuehl, K.S., Nohre, L. et al (2003). Drug testing athletes to prevent substance abuse: Background and pilot study results of the SATURN (Student Athlete Testing Using Random Notification) study. *Journal of Adolescent Health*, 32(1), 16-25.

[44] Taras, H.L. (2003). Out-of-school suspension and expulsion. *Pediatrics*, 112(5): 1206-1209.

emotional well-being and increase their likelihood of developing depressive symptoms or alcohol or other drug use.[45] Ironically, those students most in need of being connected to the school are most likely to use drugs and therefore to be excluded from the community based on zero tolerance criteria.[46]

Finding alternatives

Ensuring that responses do not introduce new harms but instead facilitate the restoration of social bonds and relationships that are so crucial for building personal resiliency in youth is critical. Several alternatives to punitive polices have demonstrated greater effectiveness in reducing substance use and in promoting safe and positive contexts in which students can learn and thrive.

Tackling drug-related issues in isolation is unlikely to lead to positive outcomes. Evidence strongly suggests that interventions act in a synergistic way to both improve educational outcomes and reduce risky behaviours such as harmful drug use.[47] A comprehensive approach that addresses substance use through multi-level strategies embedded within the educational and social mandate of the school is therefore desirable.

Strategies designed to enhance levels of connectedness to the school have the strongest evidence of positive impacts across a wide array of behaviours and health areas as well as improved educational outcomes.[48] Substance use education programs in the context of a comprehensive approach that help students develop social and emotional competence rather than focus on drug awareness and resistance skills are effective.[49] Providing early identification and brief intervention for students at risk of developing substance use problems is promising in terms of outcomes for both the students and the school.[50] There is growing evidence for schools to implement programs that

[45] Resnick et al (1997).

[46] Roche et al (2008).

[47] Toumbourou et al (2004); Dusenbury, L. (2000). Implementing a comprehensive drug abuse prevention strategy. *Increasing Prevention Effectiveness.* Ed. W.B. Hansen, S.M. Giles, & M. Fearnow-Kenney. Greensboro, NC: Tanglewood Research., Available from www.tanglewood.net/projects/teachertraining/Book_of_Readings/Dusenbury.pdf.

[48] Roche et al (2008).

[49] Faggiano, F., Vigna-Taglianti, F.D., Versino, E., Zambon, A., Borraccino, A. & Lemma, P. (2005). School-based prevention for illicit drugs' use. *Cochrane Database of Systematic Reviews*, 2005, Issue 2: first published online 20 April 2005. For further discussion of substance use education, see the companion knowledge kit, *Effective Substance Use Education.*

[50] Toumbourou, J.W., Stockwell, T., Neighbors, C., Marlatt, G.A., Sturge, J. & Rehm, J. (2007). Interventions to reduce harm associated with adolescent substance use. *The Lancet*, 369(9570): 1391-1401. For further discussion of early identification and brief intervention, see the companion knowledge kit, *Responding to the Needs of Higher Risk Youth.*

strengthen parent-child communication and relationships.[51] The implementation of restorative practices in lieu of expulsion or suspension is showing real promise in schools.[52] The following table summarizes the efficacy of various strategies for building a comprehensive approach to address substance use.

Strategy		Notes on Efficacy
Enhance school connectedness	☺	Strong evidence base. Strategies designed to enhance levels of connectedness to the school have positive impacts across a wide array of behaviours and health areas
Social and emotional learning	☺	Solid evidence base. Participation in programs teaching social and emotional competence develops attitudes in children that are inconsistent with harmful behaviours, including substance use
Early identification and brief intervention	😐	A growing evidence base for approaches that combine the proven elements of brief motivational interventions with effective screening. The impact is positive for a range of behaviour problem areas
Parent programs	😐	A good evidence base for well designed and delivered programs that build the effective functioning of families. The impact is positive for a range of health areas
Restorative practices	😐	A growing evidence base for restorative approaches. Strategies designed to enhance personal responsibility and self-efficacy
Punitive consequences	☹	Lack of evidence for positive impact and may have unintended negative consequences
Drug searches and drug testing	☹	Lack of evidence for positive impact and may have unintended negative consequences

[51] Allen, D., Coombes, L. & Foxcroft, D. (2006). The role of parents and the community in drug prevention. In R. Midford and G. Munro (eds), *Drug Education in Schools: Searching for the Silver Bullet*. Melbourne: IP Communications. For further discussion of working with parents, see the companion knowledge kit, *School-Family-Community Partnerships.*

[52] Karp, D. and Breslin, B. (2001). Restorative justice in school communities. *Youth and Society, 33*(2), 249-272; Chmelynski, C. (2005). Restorative justice for discipline with respect*. The Education Digest,* 71(1), 17-20; Wachtel, T. (1999). *Restoring Community in a Disconnected World.* Bethlehem, PA: International Institute for Restorative Practices. Available from: http://www.iirp.org/pdf/SSSRestoringCommunity.pdf.

INTERPRET

Emerging from the evidence is a series of good practices:

- Good practice addresses specific health and social issues within the context of the whole child: intellectual, social, physical, psychological and emotional;
- Good practice addresses the needs of every child through policies that take into account unique needs and include special measures for cultural differences, gender differences and various sub-populations of disadvantage;
- Good practice takes a whole school approach and promotes multi-level interventions, both across settings and within settings, that address both individual and environmental factors;
- Good practice involves the whole school community through collaborative engagement of students, teachers, administrators, staff, parents, and other stakeholders at each stage of the policy cycle[53]; and
- Good practice requires leadership at the school and district level to ensure the required time, resources, training and accountability needed for effective implementation are available[54].

Good practice is not so much about finding the right program to implement as it is engaging effective practices based on appropriate values. When the good practices listed above are supported by school policy, they will encourage the development of a school environment that promotes health and learning. These practices apply irrespective of the specific situation of the school or the specific program components utilized. The following focus questions may assist you in interpreting how these good practice guidelines apply in your particular context. The questions are not intended as a formal assessment but as a means of prompting you to reflect on, and engage with, the evidence presented above.

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[53] Hawks, D., Scott, K., McBride, N., Jones, P., & Stockwell, T. (2002). *Prevention of Psychoactive Substance Use: A Selected Review of What Works in the Area of Prevention*. Geneva: World Health Organization. Available from: www.who.int/mental_health/evidence/en/prevention_intro.pdf.

[54] Johnson, K., Hays, C., Center, H., & Daley, C. (2004). Building capacity and sustainable prevention innovations: A sustainability planning model. *Evaluation and Program Planning*, *27*, 135-149.

The Whole Child

- What is the focus of substance use policy in your school?
    - To prevent and respond to problems?
    - To build resilience in students?
- To what degree does your school's approach to substance use reflect a "whole child" perspective?
    - Does it deal with substance use in isolation of other issues?
    - Is substance use addressed within a commitment to the educational and social development of students?
- How does your school's approach to substance use promote the intellectual, social, physical, psychological and emotional development of students?
- How does your school's response to substance use incidents reflect this concern for the student's intellectual, social, physical, psychological and emotional development?

Every Child

- How does your school's substance use policy address diversity?
- In what ways does it reflect and respond to cultural differences among students and families?
- How does it reflect and respond to gender differences related to substance use?
- How does your school's policy allow and ensure consideration of the role of various factors that impact on student substance use?
    - Social and physical environment
    - Access to resources
    - Physical and mental health status
    - Personality
- In what ways does your school respond to the needs of:
    - All students (universal)?
    - Students in elevated risk sub-groups (selected)?
    - Students displaying risky patterns (indicated)?

Whole School

- How does your school's substance use policy provide a coherent and consistent framework for addressing substance use within the school?
    - Classroom education
    - Healthy school environment
    - Support services
    - Incident management
- In what ways does your school's substance use policy promote and support:
    - approaches that influence physical environmental factors
    - approaches that influence social environmental factors
    - approaches that build resilience within individuals
- How does your school link to families and the community to provide a consistent approach to substance use?

Engage Everyone

How does your school engage each of the following stakeholders?

	In developing policy	In implementing policy	In evaluating policy
Administrators			
Teachers			
Students			
Parents			
Other school staff			
Others community stakeholders			

LEADERSHIP

- Who provides leadership in developing and implementing a coherent and consistent framework for addressing substance use within your school/district?
- Does your school provide adequate time, resources, training and accountability to ensure effective implementation?

IMAGINE

In this section, we encourage you to imagine what could be. The following examples provide illustrations of how some good practice related to substance use policy have been applied in Canadian and international contexts. The list is by no means comprehensive, nor is it implied that all of the evidence referenced in this kit is being applied in any given example cited.

RESTORATIVE PRACTICES IN SCHOOLS

Illustrates an approach that:

- *addresses health and social issues within the context of the whole child*
- *addresses the needs of every child*
- *takes a whole school approach*
- *practises collaborative engagement*
- *emphasizes the importance of committed leadership*

The restorative approach is based on the belief that the people best placed to resolve a conflict or a problem are the people directly involved, and that imposed solutions are less effective and less educative than those developed through participatory processes. In order to engage in a restorative approach to conflict and challenging behaviour, people need certain attitudes and skills. These attitudes and skills have a wide variety of applications that meet the needs of the whole school community. The ultimate aim is to build a strong, mutually respectful, safe and inclusive school community in which everyone feels valued and heard.

Schools in Canada, the USA, Australia, the UK and other countries have found that restorative practices have reduced incidents of disruptive behaviour and out-of-school suspensions. In other words, they have had positive impact on both behaviour and system response.

A pilot project by the Kawartha Pine Ridge School District in Central Ontario was so successful that the Board has embraced restorative practices for use in all of its schools. Other districts from British Columbia to Prince Edward Island have been experimenting with the approach. The general experience has been that, when the initiatives are supported by committed and enthusiastic leaders and significant staff development, there are clear positive impacts on relationships in school.

FOR MORE INFORMATION:

WWW.KPRSCHOOLS.CA/PROGRAMS/RESTORATIVE_PRACTICE.PHP;

WWW.IIRP.ORG/PDF/SSSPILOTS.PDF.

Alternative High School, Calgary Board of Education

Illustrates a policy framework that:

- *addresses health and social issues within the context of the whole child*
- *addresses the needs of every child*
- *takes a whole school approach*
- *practises collaborative engagement*

The Alternative High School was started in September 1974 by a group of parents who were looking for another way for their sons and daughters to acquire a high school diploma.

The mission of the school is to create a caring community providing academic and personal support by living within the aspects of the Circle of Courage (adopted from Aboriginal philosophies and consistent with resilience research).

The Circle of Courage takes into consideration the universal growth needs of all children. Policies based on the Circle strive to establish a sense of *belonging* and community where students feel valued, important, comfortable, safe and welcomed, and where they can develop positive connections. Students who feel a sense of belonging are able to develop a strong sense of *generosity* and empathy toward others, learning how to play and work together, and to share knowledge and resources. Policies guided by the element of *mastery* provide opportunities for students to develop a strong sense of competence and, through experiences of success and acknowledgement of achievement, strengthen the desire to seek more skills and knowledge. Finally, policies in this model are designed to lead to *independence* by building respect, teaching inner discipline and encouraging students to make decisions, solve problems and take personal responsibility for themselves and their actions. A lack of strength in any of the four directions of development can result in emotional and behavioural difficulties.

Some of the special features at Alternative High School that promote development in the four directions are:

- a mentorship system in which all students are paired with a staff member;
- weekly democratic meetings in which students and teachers determine non-academic operations of the school; and
- a “STEP” system that encourages students to take responsibility for their actions and at the same time seeks to provide them with as much support as possible within the school setting.

For more information: http://schools.cbe.ab.ca/b863/home.htm.

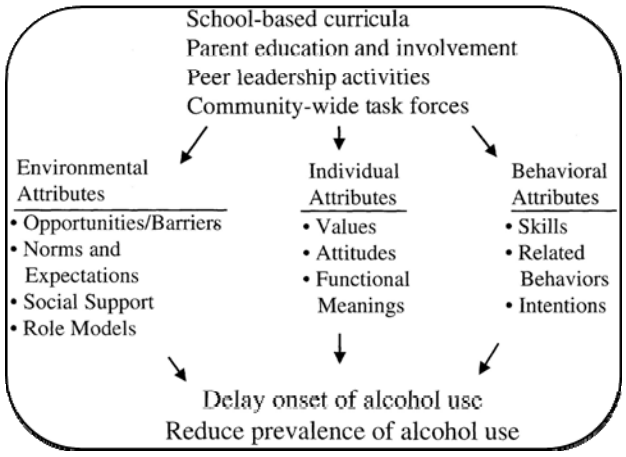
PROJECT NORTHLAND

Illustrates a program that:

- *promotes multi-level interventions across settings*
- *practises collaborative engagement*

Project Northland is a multi-level intervention involving students, peers, parents and the community in programs that have demonstrated ability to delay the age at which adolescents begin drinking and limit the number of alcohol-related problems among young drinkers. Among those students who had not begun using alcohol by the beginning of the program, reports of cigarette use and marijuana use were lower in those who participated in the program. Administered to adolescents in grades 6–8 on a weekly basis, the program has a specific theme within each grade level that is incorporated into the parent, peer and community components.

The conceptual model for Project Northland is illustrated in the chart on the right. Analysis suggests the factors that contribute most to the program's impact include increasing self-efficacy among those students who had not begun to use alcohol, decreasing peer influence to use alcohol or other drugs, and increasing functional meanings supporting non-use and increasing parent-child alcohol-related communication.



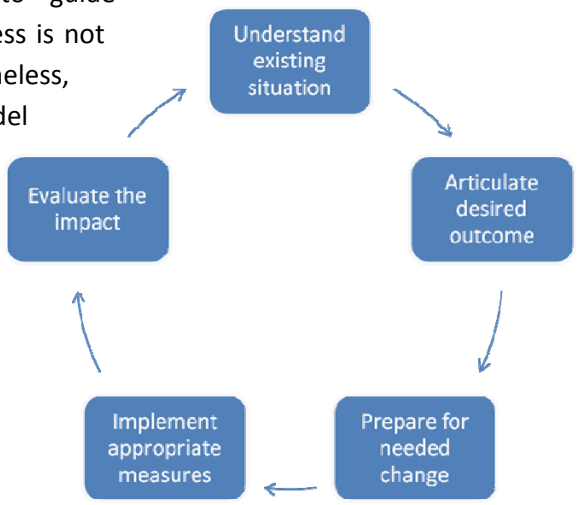
An important point to note is that the program delayed use rather than prevented use. Differences in use between those who were in the program and other students diminished in grade 9 and disappeared by grade 10. Nonetheless, the impact is significant and the lasting benefit of the identified factors may extend beyond rates of use.

For more information: http://her.oxfordjournals.org/cgi/reprint/16/1/59.

INTEGRATE

The earlier sections of this knowledge kit introduced some of the evidence related to an effective school policy for promoting student performance and development and addressing substance use issues. The last two sections encouraged you to think about how this evidence might relate to your context, and have illustrated how others have used it in different situations.

Using evidence-based good practice to guide change and achieve increased effectiveness is not as simple as one might hope. Nonetheless, using a simple change management model like the one on the right can increase our chance of success. Change is incremental; therefore, the model is cyclical. One small change creates a new context from which we can attempt further change.



STEP 1 – UNDERSTAND THE EXISTING SITUATION

One way to assess the existing situation is to prepare a report card on how your school is doing relative to the good practices identified earlier. Ideally this report card should be prepared using feedback from a variety of stakeholders.

Using Worksheet #1, you can prepare such a report card by;

- collecting qualitative information on current strengths and possibilities by having several stakeholders complete the worksheet
- collating the information into one report
- discussing the results with stakeholders

STEPS 2 – ARTICULATE A DESIRED OUTCOME

Based on the report card prepared in Step 1, you can identify priority areas for action. Again these should represent a shared vision among the key stakeholders.

Record recommended actions in the second column of Worksheet #2. It is not necessary to articulate actions for all areas of good practice at once as this worksheet can be continually updated.

Step 3 – Prepare for Needed Change

Many activities fail because of insufficient planning. At this point there are several important questions to ask. Record relevant information in the appropriate columns of Worksheet #2.

- What activities are needed to bring about the recommended action? What training will be needed? How will this be provided? What resources are needed? Are they available? If not, how can you get them? Who might be impacted if the change succeeds? Will they welcome the change? What needs to be done in order to prepare them? What needs to happen to make the change sustainable? How will it get institutionalized? (Column 3)
- Who will be responsible for implementing the change? (Column 4)
- When should the change happen? (Column 5)
- What will be the indicators of progress and success? (Column 6)

Step 4 – Make It Happen

Change actually happens one step at a time as you implement your work plan. Some factors are critical to the success of the process.

- Support from appropriate leaders
- Clarity concerning responsibility and accountability
- Good communication to keep all partners informed of progress
- Clear mechanisms for partners to monitor and modify the work plan as needed

Step 5 – Evaluate the Impact

Evaluation is an important part of learning and is also an important part of the change process. This does not need to be overly complicated. Two ways that you can keep track of progress are:

- constantly revisit and revise your work plan (Worksheet #2)
- periodically reassess the situation by collecting feedback from your partners and stakeholders and produce a report card (Worksheet #1)

WORKSHEET #1 – PARTNERSHIP REPORT CARD

Area of Good Practice	Stage	Current Strengths	Possibilities for Improvement
Our school addresses specific health and social issues within the context of the whole child: intellectual, social, physical, psychological and emotional			
Our school addresses the needs of every child through policies that take into account unique needs and include special measures for cultural and gender differences and various subpopulations of disadvantage			
Our school takes a whole school approach and promotes multi-level interventions, both across settings and within settings that address both individual and environmental factors			
Our school involves the whole school community through collaborative engagement of students, teachers, administrators, staff, parents and other stakeholders at each stage of the policy cycle			
Our school has leadership at the school and district level to ensure the required time, resources, training and accountability needed for effective implementation are available			
Stage of Implementation: I=Implemented P=Partially implemented N=Not implemented			

WORKSHEET #2 – PARTNERSHIP WORK PLAN

Good Practice	**Recommended Actions** what needs to be improved	**How** activities, training, resources, etc.	**Who** person/team	**When** complete by	**Indicators** progress/success
Our school addresses specific health and social issues within the context of the whole child: intellectual, social, physical, psychological and emotional					
Our school addresses the needs of every child through policies that take into account unique needs and include special measures for cultural and gender differences and various subpopulations of disadvantage					
Our school takes a whole school approach and promotes multi-level interventions, both across settings and within settings that address both individual and environmental factors					
Our school involves the whole school community through collaborative engagement of students, teachers, administrators, staff, parents and other stakeholders at each stage of the policy cycle					
Our school has leadership at the school and district level to ensure the required time, resources, training and accountability needed for effective implementation are available					

RECOMMENDED RESOURCES

The following are readily available resources that provide further information or tools of a practical nature. The studies that support the content presented in this knowledge kit are provided in the footnotes throughout the document.

Cahill, H., Murphy, B., & Hughes, A. (2005). *A Toolkit of Interventions to Assist Young People to Negotiate Transitional Pathways*. Canberra, Australia: Department of Health and Ageing. Available from: www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/499247D1160777C0CA2571A20021F1FB/$File/toolkit-interventions.pdf

Health Canada. 2001. Preventing Substance Use Problems Among Youth People: A Compendium of Best Practices. Available from: www.hc-sc.gc.ca/hl-vs/alt_formats/hecs-sesc/pdf/pubs/adp-apd/prevent/young-jeune-eng.pdf.

Joint Consortium for School Health. (2009). *JCSH Healthy School Planner*. Online tool available from: www.jcsh-cces.ca

Meyer, L. & Cahill, H. (2004). *Principles for School Drug Education.* Canberra, Australia: Department of Education, Science and Training. Available at: www.dest.gov.au/NR/rdonlyres/60B9A2F3-BF3C-4A7E-90D7-AF5DD95EC97A/7601/PrincSchoolDrugEd.pdf.

Whitlock, J. (2004). *Places to Be and Places to Belong: Youth Connectedness in School and Community.* Ithaca, NY: Family Life Development Centre, Cornell University. Available from: http://www.actforyouth.net/documents/PLACES_REPORT.pdf.

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