

## **Is Australia 'Fair Dinkum' about Drug Education in Schools?**

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## **Abstract**

School drug education is seen by governments as an ideal prevention strategy because it offers the potential to stop use by the next generation. Australian schools substantially expanded drug education during the 1960s in response to rising use by young people, and in 1970 the first national drug education program was launched. In the mid 1990s the level and quality of drug education increased noticeably.

Unfortunately, subsequent national initiatives have failed to capitalise on the gains made during this period. Some, good quality, independent research, such as the Gatehouse Project and the School Health and Alcohol Harm Reduction Project (SHAHRP), have been conducted in Australia. However, national level momentum is being lost, because there is little commitment to the development of evidence based mass programs. In this climate drug education has become vulnerable to short term decision making that emphasises palatable, policy driven outcomes and focuses on strategies designed to bolster the legitimacy of these goals. So is Australia 'Fair Dinkum' about drug education in schools? There is a history of innovation, and past programs have left behind pockets of expertise, but the challenge is to continuously invest in methods with evidence of success, rather than settle for cyclical programs driven by the political and moral palliatives of the day. To do less is to fail the young people of Australia.

## **The Rationale for Prevention**

Prevention programs for young people are driven by two main factors: the burden imposed on society by drug use, both legal and illegal, and the disproportionate risk experienced by young people. Use generally starts during high school and each class of drug causes a particular set of problems, which can be better ameliorated if addressed early.

The 2002 survey of alcohol use by Australian high school students found that by the age of 17, 89% had tried alcohol and 50% were current drinkers. Binge drinking is a particular problem, with 44% of 17 year old students drinking in manner that risked acute harm at least once in the preceding week [1]. Young people disproportionately suffer the consequences of their drinking. In the period 1992-2001, 15-29 year olds suffered the greatest number of acute alcohol caused deaths of any age group: 3,394 out of 12,463 deaths. In the period 93/94-00/01, 15-29 year olds were hospitalised as a result of acute alcohol harm more than any other age group: 92,278 out 266,460 occurrences [2].

Smoking causes most harm decades after it is taken up, and young people can feel that they are not at great risk, but high school is the period when habits are formed which have their consequences in later life [3]. At 12 years of age 6% of students are current smokers, whereas by the time they reach 17 years 25% are current smokers [4].

Illicit drug use can be very enticing for students for reasons that go beyond the physical effects of the drug. These include risk taking, peer bonding, declaration of independence and maturity, and a challenge to authority [5]. Cannabis is the illicit drug most used by students, with 42% of 17 year old students having tried cannabis. By comparison only 15% of 16-17 year old students have tried an illicit drug other than cannabis [6].

Harm from illicit drugs is more difficult to quantify because of their illegal nature, and apart from cannabis, low prevalence of use. Acute consequences include overdose fatalities, suicide, HIV/AIDS, poisoning and self inflicted injury. On top of this there is related harm such as increased risk of mental illness [5].

## **Why Drug Education?**

Educating young people is seen by governments in most western countries as an ideal prevention strategy. It offers the potential to stop the next generation from experiencing problems with drug use: if you tell them about all the problems, why would they want to use? In addition there is a natural logic to providing this education in schools, as they are places of learning, with students as a captive audience [7]. Finally, it is a way of assuaging public concern that something should be done about drug use by young people [5]. However, as Stothard has pointed out, education is not necessarily prevention, because it focuses on improving understanding and skill, which may or may not lead to a change in behaviour [8]. On top of this there is the question of what drug education should seek to prevent. Should it take an abstinence approach and seek to convince young people not to use drugs at all, or should it acknowledge that most students do use drugs (licit or illicit) and seek to reduce harm?

## **The Early History of Drug Education in Australia**

In post war Australia drug education was not on the agenda. Alcohol and tobacco were not thought of as drugs. All illegal drugs were classified together as 'narcotics' and were regarded as both morally and physically dangerous. Use was generally limited to members of the medical profession and those associated with the small beat culture, such as artists, writers and jazz musicians. In schools temperance groups carried out some education about the dangers of alcohol and tobacco, but this was not part of the mainstream curriculum [9]. This was very similar to the situation that existed in the United States at the time, where the first drug Tsar, Harry Anslinger, discouraged education on the basis that knowledge led to experimentation [10].

In the early 1960s increasing drug use in America challenged the notion that no education was good prevention. This change of national mood was reflected in comments by the 1963 President's Advisory Commission on Narcotic and Drug Abuse [11]:

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 the community organisations? (p. 18).

This presaged a massive increase in drug education in the late 60s and early 70s as part of President Nixon's 'War on Drugs' [12].

In Australia, during this period, use of prescription 'pep pills' by young people, such as methedrine, benzedrine, to lift mood, for weight loss or to help study began increasing and became a concern for parents. Drug use also became associated with the various youth sub cultures that emerged at this time. These were the 'bodgies' and their female partners 'widgies', who identified with American rock and roll culture and the 'surfies', whose identity was linked to the beach and board riding [9].

By the mid 1960s young people were moving on from amphetamine based 'pep pills' to the use of cannabis and LSD. As these drugs were classified as 'narcotics', alongside heroin, they acquired a very dangerous reputation. The media reported this trend in sensational terms and in August 1967 an incident in Sydney crystallised simmering concern about the increase in drug use by young people. The media reported that three teenage girls from a public school had been taking LSD given to them by a teacher in his flat at Kings Cross. The state government of the day saw drug education as the best response to the youth drug problem and assured the public that an expanded health education syllabus, incorporating education about drugs, would provide a solution [9].

Australian drug education methods of the late 1960s were based on simple information provision about the dangers of illicit drug use. Often school drug education was undertaken by police officers, who added the threat of legal consequences and anecdotes about the dire consequences of use [9]. This substantially followed practice in the United States, where information based drug education programs were justified in terms of contemporary behaviour change theory [13]. This approach held that providing factual information on the harmful effects of drug use would establish negative attitudes and a fear of use. Some of these programs emphasised the provision of objective information. However, others used 'scare tactics' in the belief that such an approach would maximise fear arousal. A review of

drug education from this period indicated that the information approach did little to change drug use [14].

In the evolution of Australian drug education during this period, leadership by public health bureaucrats was a critical factor. Drug problems were construed as a health issue and flowing from this was the need to get young people actively involved in choices about their health. Accordingly, there was increasing recognition that drug education needed to facilitate responsible decision making, rather than rely on fear to motivate change [9].

### **Developing a National Approach**

In 1970 the Australian government launched the first National Drug Education Program, with A\$500,000 to be shared amongst the states. It addressed both legal and illegal drug use and had implicit abstinence goals. Drug education, it was believed, should be integrated into the health education curriculum. Interactivity and evaluation were seen to be important, as was normative information, to counter the belief that drug use was usual amongst young people. The overall aim was 'education for living' - teaching young people to live without the need to use drugs [9].

The healthy living approach taken in Australia during this period reflected the development of affective programs in the United States [15]. These sought to reduce alcohol and other drug use by enhancing young people's ability to make positive healthy choices. Programs typically included training in self-esteem, decision-making, values clarification, stress management and goal setting. As was the case with information programs, the evidence indicated that affective programs did not demonstrably succeed in changing drug use [7]. This was not surprising, because these affective programs had use or abuse reduction as their stated goal, but targeted different variables, such as self-esteem.

A major change in Australia's drug policy occurred in the mid 1980s, very much as a result of the then Prime Minister, Bob Hawke's public acknowledgement of his daughter's heroin addiction. There was a national drug summit in 1985, from which emerged a national drug policy and an associated campaign that encompassed

enforcement, treatment and education [16]. An important development was that abstinence was no longer the only goal, rather the policy aimed to:

‘...minimise the harmful effects of drugs on Australian society’...(p. 20).

There was increased funding for drug education, but most of this went into media campaigns, rather than school drug education. There was also limited commitment by state education authorities to implement school-based drug education and as a consequence little changed for students [16,17].

A new generation of American school drug education programs, drawing on social modelling theory, began appearing in the 1980s [13]. The rationale for this social learning approach was that young people begin to smoke, drink and use other drugs because of social pressure from a variety of sources - the mass media, their peers and even aspirational images they have of themselves. In order to resist this pressure, young people need to be inoculated by prior exposure to counter-arguments and have the opportunity to practise responses [18]. Unlike previous approaches, some of these social influence programs were able to demonstrate modest reductions in student drug use.

An Australian drug education intervention of the period, the Illawarra Program, drew on the social learning approach, but unlike American programs measured harm as well as use. Students exposed to the program were significantly less likely to start using tobacco, but were no different from control student groups in their uptake of alcohol [19]. They did, however, demonstrate lower levels and safer patterns of use. These findings demonstrated the potential of well conceived Australian drug education programs, particularly in the neglected area of harm reduction. There was, however, no systematic follow up in the form of derivative mass programs.

In the early 1990s, the next national program, the School Development in Health Education Project (SDHE) deliberately sought a more local level approach, in which clusters of schools collaborated on health education and promotion. The presumption was that provision of drug education would be part of the response. The reality was different, with uncontroversial health topics, such as nutrition, tending to receive most

attention. Training in drug education was provided for school teachers as part of SDHE, but the most influential project undertaken was the development of a short monograph *Principles for Drug Education in Schools* [9,20]. This outlined 15 principles for effective drug education and was a point of reference in the development of school drug education programs in Australia for at least a decade from the time of its publication in 1994.

Commencing in the mid 1990s, the National Initiatives in Drug Education (NIDE) program sought to increase education's contribution to the national drug strategy. To this end teacher training was improved and new classroom resources developed. A great strength of NIDE was that it sought to enhance existing state initiatives, and one of the consistent themes that ran through the program was a commitment to collaborative decision making among the state and federal partners. The other was selection of approaches that had harm reduction goals. This latter emphasis was probably unique in government supported school drug education at the time and further legitimised the approach. Evaluation of the program indicated that it increased the level and quality of drug education activity in Australia and bolstered the case for the education sector to play a greater role in prevention [21].

### **The Current Approach – ‘Tough on Drugs in Schools’**

As the NIDE program was drawing to a close there was a steep rise in heroin deaths, and one particularly high profile death of a young woman, after using ecstasy. Media coverage of the death toll from drugs was intense, and both the federal and state governments were under pressure to prevent further loss of life [9]. Stopping use increasingly featured in government rhetoric on drugs during this period. This was the context in 1997, when drug education received \$27.3 million over four years as part of the Australian government's 'Tough on Drugs' campaign. At the same time responsibility at the federal level for drug education in schools was transferred from the department with responsibility for health to the department with responsibility for education. This shift in responsibility was accompanied by a change in emphasis to the way school drug education was supported. Health culture values research evidence and demonstrable change in outcomes, whereas education culture assigns greater importance to practitioner experience and achieving change in knowledge.

Accordingly, these latter criteria assumed greater importance in drug education funding decisions made by the federal government. Research evidence was seen as less relevant, because it generally derived from externally controlled programs and effectiveness was determined by change in drug use behaviour. The publication of the National School Drug Education Strategy in 1999 further shifted the emphasis of drug education away from equipping students with behavioural skills to reduce risk and harm, in that the key goal of the strategy was ‘no illicit drugs in school’ [22]. While superficially laudable, this is really a slogan substituting for a meaningful program outcome. It makes no mention of the drug that causes most harm to young people, alcohol, and by focusing on possession of illicit drugs at school it diverts attention from to the broader purpose of drug education, namely equipping students with the skills to make more responsible decisions in a range of settings where both licit and illicit drugs are available.

One of the lessons from this initiative is that tough slogans are easy, but delivering the results is not. The evaluation specifications for the National School Drug Education Strategy (NDES) [23] required:

... reliable qualitative and quantitative information on: The extent to which the Strategy and COAG Tough on Drugs in Schools measures have achieved their objectives. This should include an assessment of the process, impact and outcomes...(p. 12).

However, the evaluation report lamented that the basis for finding out what was achieved by NDES was simply not there:

The Performance Indicators (PIs) identified in the Strategy for monitoring and evaluating its objectives suffer from a number of conceptual flaws that limit their usefulness and application. (p. 2).

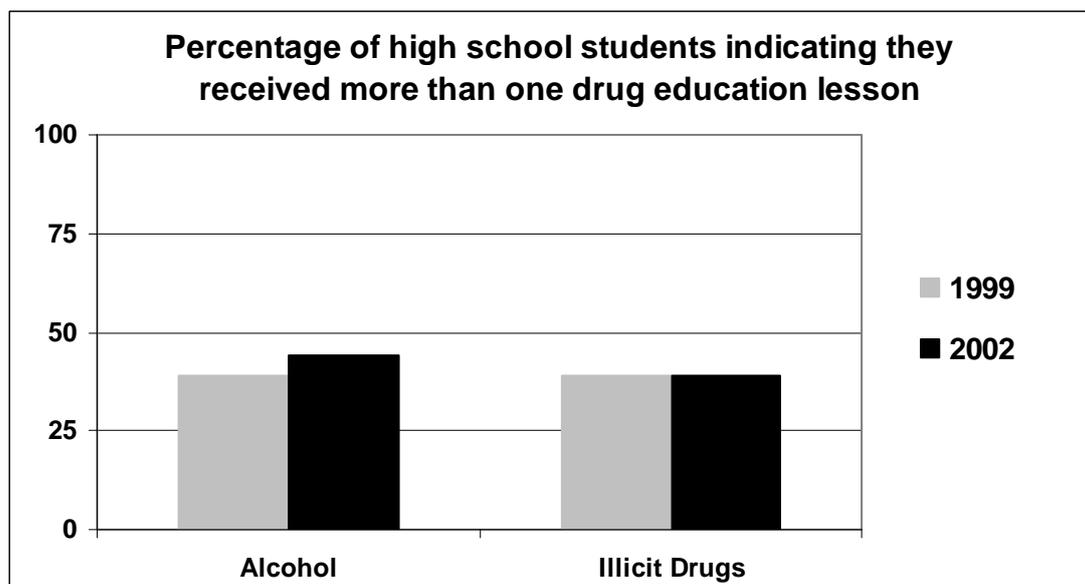
At the end of this program, even with a formal evaluation, there is little information on what was achieved, beyond vague generalities:

Further, no data collections supporting these PIs were established that would enable progress to be monitored or reported in a comprehensive and consistent manner across all States and Territories. Some States and Territories established data collection systems, but no standard definitions or counting rules were defined, and data collection has by no means been universal.

Finally, even had such data collections been defined, no ‘targets’ were established for any of the outcomes or the PIs, either the quantitatively or qualitatively. Consequently, any assessment of progress towards their attainment is largely qualitative with limited quantification. (p. 19).

One independent measure as to the impact of the national drug education strategy is provided by the periodic surveys of Australian secondary students’ use of alcohol and other drugs [1,4,6]. One question asked how much drug education the students remembered receiving in the previous year. Their responses, presented in Figure 1, indicated that most remembered receiving one or less lessons. Additionally, recollection of multiple lessons only increased marginally for alcohol during the course of the ‘Tough on Drugs in Schools’ initiative. By any measure cited in the drug education literature one lesson is an insufficient ‘dose’ to influence behaviour and the great majority of effective programs comprise 10 or more lessons [24].

**Figure 1. Reported Level of School Drug Education**



This is not to say that the picture is completely bleak. A number of good education resources such as *Cannabis and Consequences* [25] and policy guidelines such as the *National Framework for Protocols for Managing the Possession, Use and/or Distribution of Illicit and Other Unsanctioned Drugs in Schools* [26] have been produced at the national level. A national survey of 151 people involved in drug education, published in 2002 as part of a research project revising the principles for effective drug education, found strong support for evidence-based program and harm reduction goals [27]. A number of states have very good service delivery systems, run by experienced and motivated staff. So a reactionary national approach cannot completely turn back the clock: both drug educators and students are too sophisticated in their understanding of drug use issues for this to occur.

### **The Australian Evidence Base for Drug Education**

A counterbalance to particular moral and political agendas as to what drug education should teach is evidence. Some good research has been conducted in Australia, but the following lament in a review of drug education conducted in 1991 [17] is probably still true today:

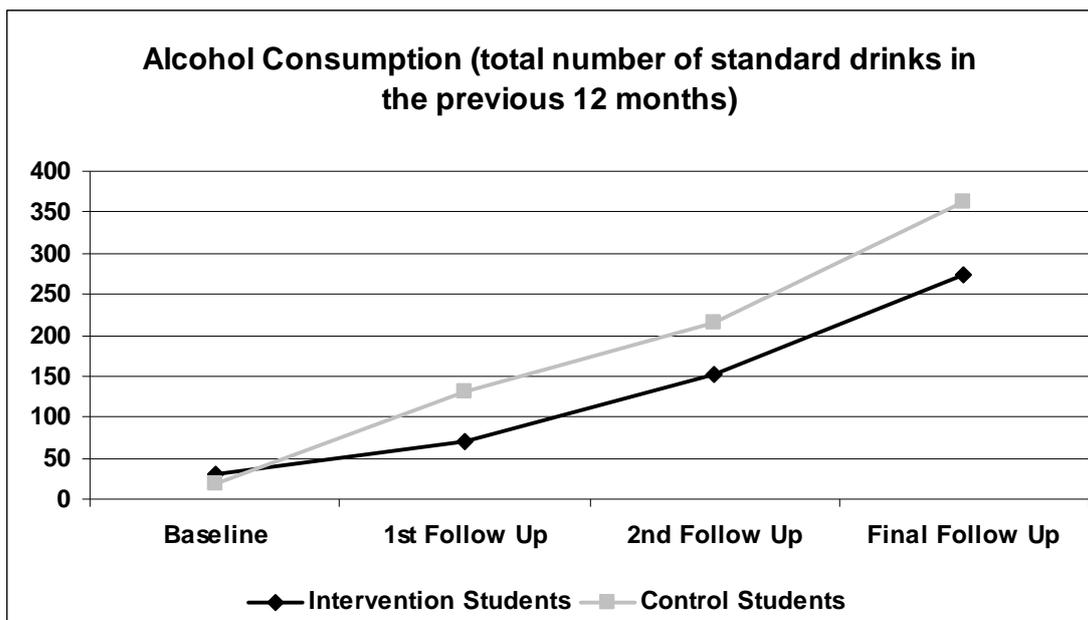
... it appears that most educational systems are not participating to a degree that will make a difference. Programs such as the ones we reviewed, suddenly appear, get evaluated and then disappear in a totally random fashion. They are subject to budget restraints, ad hoc political and educational interests or research funds. (p. 32)

There have been few drug education research projects in recent times with published results and these have been essentially independently funded. The Gatehouse project in Victoria took a whole of school approach to the promotion of emotional and behavioural wellbeing of students as a means for reducing a range of health risk behaviours [28]. Results indicated that the intervention was particularly effective in reducing alcohol and tobacco use, with drinking and smoking by intervention students consistently 3-5 percent less than controls. The largest specific drug education project in recent years was the School Health and Alcohol Harm Reduction Project (SHAHRP), conducted in Western Australia [29]. This classroom based,

demonstration, intervention aimed to reduce alcohol related harm in junior high school students. Over 2300 students from 14 Perth government high schools were involved in the study. The intervention consisted of 17 skill-based activities in year eight (first year of high school in Western Australia) and 12 follow up activities in year nine. Activities included delivery of utility information, skill rehearsal, individual and small group decision making and discussions based on scenarios suggested by students. The activities were deliberately designed to be as interactive as possible.

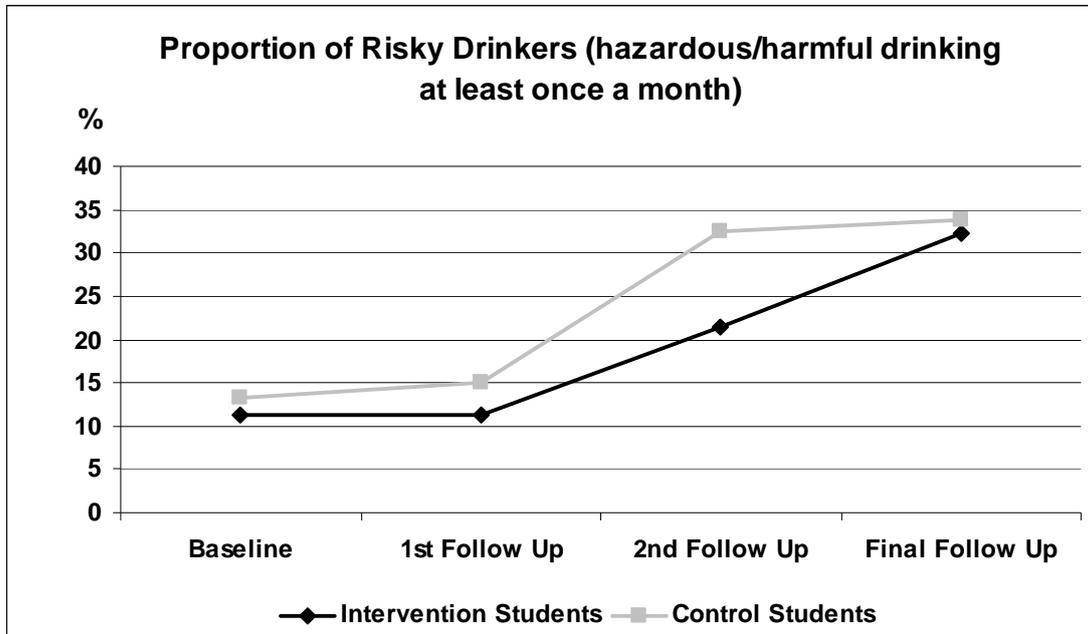
Total alcohol consumption was less in the SHAHRP group than in the control group at the end of the program (see Figure 2).

**Figure 2. SHAHRP Student Group Total Alcohol Consumption**



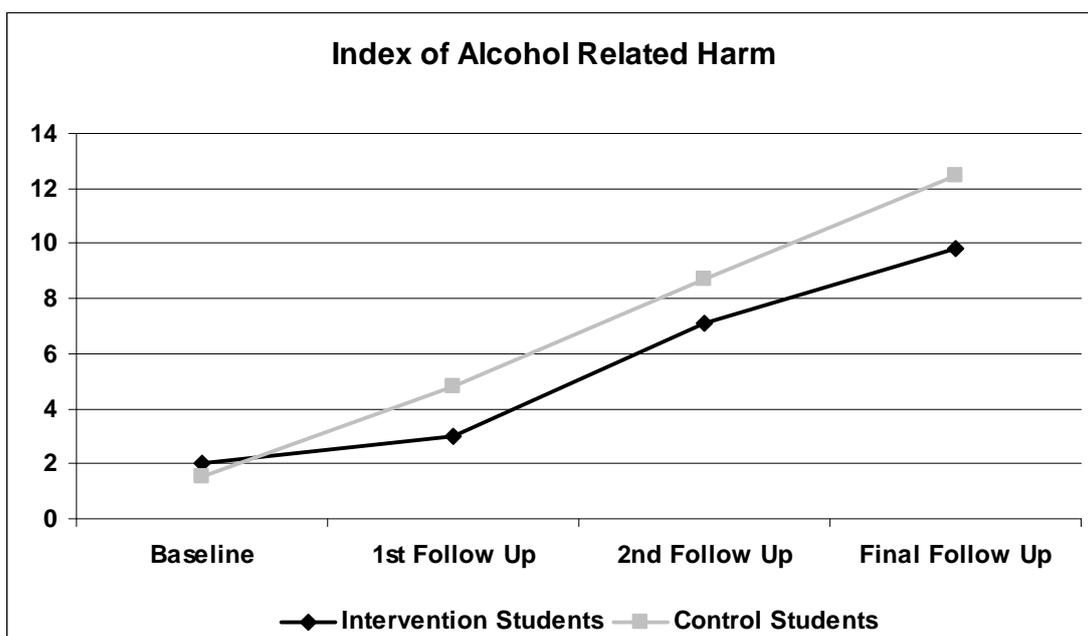
SHAHRP students were less likely to drink in a risky manner by the end of the program, although the difference was small (see Figure 3).

**Figure 3. SHAHRP Student Group Proportion of Risky Drinkers**



Alcohol related harm experienced by SHAHRP students remained substantially lower than that of control students throughout the study (see Figure 4).

**Figure 4. SHAHRP Student Group Index of Alcohol Related harm**



Findings from the SHAHRP and Gatehouse projects are particularly encouraging in that they respectively indicate the benefits that derive from a harm reduction and a whole of school approach to drug use by students. They also provide readymade benchmarks for practice in Australia. However, they have had little impact on national drug education policy.

### **The Future of Drug Education in Australia**

Australia has failed to capitalise on the gains in drug education made during the 1990s and momentum is being lost. The absence of research evidence creates a vacuum in terms of objective criteria on which to base decision making. This is compounded by a national drug education strategy that lacks the conceptual substance and measurable goals to provide direction [30]. Finally, there is a little corporate knowledge of effective drug education approaches at the national level, which reduces leadership capacity.

All of these factors seem to be behind an increasing focus on short term activity with non controversial, tangible outcomes such as drug education resource material, rather than commitment to long term improvement through staff training and the development of demonstrably effective programs. With no clearly articulated long term plan, decision making becomes increasingly vulnerable to political pressure and moral imperatives, resulting in unrealistic goals. The consequence is that money gets spent on programs that fit prevailing political rhetoric, with no evidence that they make any difference to levels of misuse. At its worst, this approach is an abrogation of our society's responsibility to educate and protect young people, in that it becomes more important to give the 'right' message about drug use, than to demonstrably prevent misuse and harm.

### **So, is Australia 'Fair Dinkum' about Drug Education?**

Some world class drug education research has been conducted in Australia and this can provide a point of reference for future programs [19,28,29]. There are good pockets of expertise, comprising experienced, committed staff and well conceptualised independent and state level programs. This provides Australia with a

latent capacity, so that when the conditions are right school drug education can blossom and make considerable strides. What Australia has never done very well is set up an ongoing and demonstrably effective national school drug education programs. However, it is important that drug education, with a sound basis in evidence, be provided to each successive generation as a routine part of the socialisation and skill development process that happens in schools. Transmission of cultural norms and practical harm reduction in terms of drug use has to be continuous; not just in times of crisis, such as when overdose deaths rise.

Drug education will continue to be conducted in Australia because it is a cornerstone of national drug policy [30]. However, it can develop in number of different ways. The challenge, if we are to be 'Fair Dinkum', is to continuously invest in the methods that demonstrate the best evidence of success. This means further developing whole of school and harm reduction approaches, rather than settling for cyclical programs driven by the political and moral palliatives of the day. To do less is to fail the young people of Australia.

### **Critical Issues and Recommended Responses**

- Most high school students remember receiving very little drug education. ----- Provide more evidence based drug education, particularly in the early years of high school, before rates of use increase.
- Drug education is not well supported in schools. ----- Build ongoing support structures for drug education so that high quality programs are a routine part of high school education.
- There is a national focus on short term activity with non controversial, tangible outcomes such as drug education resource material, rather than a commitment to long term capacity building. ----- Provide more integrated professional development for school staff involved in drug education and related prevention programs.

- Drug education is a cornerstone of national drug policy despite little indication as to the effectiveness of current mass programs.----- Support basic, independent, research that builds on successful whole of school and harm reduction initiatives to create a coherent body evidence of what works in the Australian context.

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