

# A critical review and analysis:

# Cannabis education in schools

Cannabis use by young people has been shown to be increasing throughout the western world. National drug surveys conducted in 1996 and 1998 indicate that Australia is mirroring these international trends. The publication, *Educational outcomes and adolescent cannabis use* (NSW Department of Education and Training, 2000) provides further information on the prevalence of cannabis use amongst young people in Australia.

People who use cannabis, particularly long-term heavy users, can experience significant health effects. There are acute harms that may result from cannabis intoxication, such as negative psychological effects; inability to think clearly; poor co-ordination; and increased risk of paranoia and anxiety amongst vulnerable individuals. In addition, there are possible chronic harms associated with daily or near daily use of cannabis over several years. They include cannabis dependence, subtle effects on cognitive functioning and increased risk of respiratory diseases.

The taboos against cannabis use tend to be breaking down and young people are increasingly being faced with choices about its use. Research indicates that young people perceive drug use quite differently from adults. They see it as part of youth culture and consequently view it as a normal part of adolescent behaviour. They tend to overestimate how many of their peers use illicit drugs. This change in social norms needs to be considered when designing cannabis education programs for students.

## A brief history of drug education

Past approaches to school-based preventive drug education in Australia have tended to follow trends from the USA. In the early 1900s drug education in the USA was discouraged as it was thought that any drug education would encourage young people to experiment. Drug education expanded considerably during the 1960s. Factual information on the harmful effects of drug use was provided, on the assumption that this would promote negative attitudes towards drugs. However, information only approaches had little impact on changing attitudes and behaviours. Affective programs which sought to reduce drug use by enhancing interpersonal and intrapersonal skills including self-esteem, communication, decision making and goal setting skills were introduced in the 1970s. Once again this approach did not achieve significant results. The social influence model has dominated the most recent phase of drug education. This approach is based on the belief that young people begin to smoke, drink and use other drugs because of social pressures from a variety of sources such as the mass media, peers and the image they have of themselves. To resist developing undesirable drug use behaviours, young people need to recognise the ways in which social influences may affect their decision to use drugs. They should have the opportunity to learn and practise skills to resist these influences before they are faced with real-life situations.

# A critical review and analysis: *Cannabis* education in schools

This pamphlet is based on *A critical review and analysis: Cannabis education in schools*, a report prepared by the National Drug Research Institute, Curtin University of Technology, Perth, for the NSW Department of Education and Training. A copy of this report is available in NSW government schools and colleges. For further details please refer to the full report.



## Critical elements

## What this means for schools

Drug education is best taught in the context of broader health skills.

The PDHPE syllabus includes drug education from Kindergarten to Year 12. The integrated nature of the syllabus allows aspects of drug education to be introduced within a broad health context.

Drug education messages across the school environment should be consistent and coherent.

Whole school policies and practices should complement the curriculum and reinforce the objectives of drug education.

Drug education needs to be based on current research as to effective curriculum practice and the needs of students.

Effective programs are based on the understanding of what causes young people to use drugs and what may reduce the harms of drug use.

Objectives for drug education should be linked to the overall goal of harm reduction.

Programs need to focus on reducing the harmful effects of drug use. Strategies need to aim towards non-use and for those already using, towards reduction in use or changing patterns of use. For example, in cannabis education, strategies which focus on changing patterns of use such as not using cannabis before school, not coming to school with a cannabis 'hangover' and not combining cannabis use with alcohol use, should be included. Students need to explore and discuss the benefits or otherwise of different patterns of use. These strategies may reduce harm but not necessarily reduce use.

Prevention education is best provided before behavioural patterns are established.

Programs which address drug issues need to be introduced when the prevalence of use of the particular drug is still low and before most young people are exposed to the possibility of use.

Primary prevention is most effective if introduced before patterns of use are established. Cannabis education should begin before young people are likely to be exposed to cannabis use and before they need to make choices about it. Data from the 1996 Australian School Students Alcohol and Drugs Survey showed that 13.5% of 12 year olds, 34.5% of 14 year olds and 55.4% of 17 year olds had used cannabis at least once in their lifetime. This data suggests that cannabis education should begin in Stage 4 (Years 7 and 8) and possibly, for small groups of high risk students, in Stage 3 (Years 5 and 6).

Drug education programs should be relevant, developmentally appropriate and have sequence, progression and continuity.

Programs must be credible and useful to students. They need to be provided regularly at different stages of schooling and address content and issues relevant to each stage. Rather than repeat the same content, programs need to build on what has gone before.

Mechanisms should be developed to involve students, parents and the wider community in school-based drug education.

Consultation and involvement of all stakeholders will provide a greater sense of ownership and programs are more likely to address the needs of all groups.

Any development process for a new drug education program, particularly if it is likely to be controversial, should involve extensive consultation with the whole school community, particularly students.

Drug education should be responsive to developmental, gender, cultural, socio-economic and lifestyle differences.

Programs that are sensitive to the different backgrounds of the students will be more relevant and effective.

## Critical elements (cont)

Teachers should be trained and supported to conduct drug education.

Programs should demonstrate adequate coverage, sufficient follow-up and ability to achieve long-term change.

Social resistance skills need to be developed.

Normative education practices need to be included in drug education programs.

Interactive teaching and learning strategies are essential for effective drug education.

Approaches should address the values, attitudes and behaviours of the community and the individual.

Drug education programs should acknowledge the interrelationship between the individual, the drug and the environment in determining the impact of drug use.

The use of peer leaders should be considered.

Programs and resources should be selected to complement the role of the classroom teacher.

## What this means for schools (cont)

The classroom teacher, with specific knowledge of students and the learning context, is best placed to provide drug education. Research indicates that adequate training of teachers in implementing programs is a vital element in effective drug education. Teachers need up-to-date factual information and training to further develop skills in presenting drug education.

An adequate education program should have follow-up sessions at regular intervals. For example, issues around cannabis use could be addressed in each stage of learning from the initial intervention to combat the ongoing influence to use drugs. Cannabis education programs should be introduced in Stage 4 (Years 7 and 8) with follow-up sessions in Stages 5 and 6 (Years 9 to 12).

Social resistance skills assist in motivating young people against drug use and help them identify and resist pro-drug influences. Such programs help adolescents identify internal and external pressures to use; counteract pro-drug arguments and beliefs that 'everyone uses'; and learn skills for resisting drug use when faced with situations where they may feel influenced to use.

Normative education teaches adolescents that most people do not use drugs or approve of using drugs. This is done by comparing their expectations of how many of their peers are regular users with actual data and by discussing their overestimates of prevalence.

Teaching and learning strategies which promote active involvement of all students, such as small group discussions and activities, have been shown to be more meaningful and effective.

Responsible decisions by students about drugs are more likely where peer and community groups demonstrate responsible attitudes and practices.

A young person's drug experience is influenced by the interaction of these three components and students need to be aware of the importance of this interaction when discussing drug issues. As the interrelationship changes so does the impact on the individual, others and the community.

The research indicates that peer led approaches offer a number of advantages in terms of modelling and sharing positive attitudes and values. Peer leaders should have credibility with high risk adolescents, have well developed communication skills and show responsible attitudes. Peer leaders should be given adequate training and support to fulfill a leadership role. Drug education programs could use peer leaders and teachers in combination, where the peer leaders facilitate small group discussions on drug issues.

The classroom teacher, with specific knowledge of students and the learning content, is best placed to provide drug education. Outside agencies and personnel should be used only where relevant and appropriate, and where they enhance existing ongoing drug education.

**Table 1:** Summary of critical elements in effective school-based drug education

Adapted from Midford, R., Lenton, S. and Hancock, L. (2001) A critical review and analysis: Cannabis education in schools, NSW Department of Education and Training.

## **School-based drug education: what works?**

There is good evidence as to what works best in drug education. Table 1 summarises the research on the critical elements of drug education programs that have been found to delay uptake or reduce the use of drugs. These critical elements are common to cannabis, alcohol and tobacco education. Drug educators need to consider carefully these critical elements of drug education.

## **School-based cannabis education: what is likely to produce the best results?**

There has been recent research on what works and what does not work for drug prevention programs that have measured cannabis use. An evaluation of 37 school-based general substance abuse prevention programs in the USA that measured cannabis use identified the following critical elements that were found in programs that produced a reduction in its use.

### *Interactive programs are more effective*

Interactive programs were significantly better than didactic programs (teacher-centred) in both changing attitudes to cannabis and reducing cannabis use. Such programs had planned activities to present content and develop skills, but they also provided opportunities for exchanging ideas between peers. Interactive delivery allows students to acquire, practise and refine new prevention skills in a supportive environment and equips them to cope better with real world drug-related situations.

### *Effective programs have certain essential content*

Programs that cover knowledge of the short- and long-term effects of drug use, normative information on drug use by young people, (ie. that most young people do not use drugs or approve of using drugs), attitudes to drug use, interpersonal skills that assist in drug refusal and practical intrapersonal skills tend to be effective in cannabis education.

Table 2 summarises the content and delivery features that work and that do not work for drug prevention programs, including cannabis.

This research also showed that effective drug education programs for late primary and early high school students were equally successful in reducing the use of cannabis, alcohol and tobacco. This indicates that initially drug education does not need to be compartmentalised by drug type and a more generic approach that incorporates alcohol and tobacco prevention can be used. However, findings from studies of older adolescents suggest that a more differentiated approach may need to be adopted to address issues specific to cannabis use and harm. This means that in Years 9 to 12 a separate cannabis education program or well-differentiated program components focused on cannabis should be offered. The target age group may vary depending on the specific needs of the students and the school community.

## **Challenges for teachers in cannabis education**

Generally, Australian school-based drug education programs adopt a harm reduction approach. However, this approach presents challenges for teachers when the focus is on illicit drugs such as cannabis. Cannabis use is illegal throughout Australia and teachers are in a difficult position when discussing student use in the same way they would with tobacco and alcohol. Schools tend to focus on an abstinence approach when addressing illicit drugs. They do not wish to be seen as condoning or even encouraging illicit drug use by discussing issues around student use in the same way they would with tobacco and alcohol.

Cannabis education needs to acknowledge what students already know by direct or indirect experiences. One of the reasons Australian alcohol education programs have been so well received by students and teachers is that they openly address all aspects of alcohol use. Cannabis education needs to do the same. Teachers need to provide opportunities for students to discuss cannabis issues; this will make cannabis education more relevant in a world where drug use is a fact of life for many young people.

Schools have an important role to play in equipping young people with the knowledge, skills and attitudes to establish and maintain a healthy lifestyle free of the problems associated with drug use. At a time when cannabis use among young people is increasing, schools need to provide developmentally appropriate cannabis education based on the current research and the needs of students in their community.

	<b>What works</b>	<b>What doesn't work</b>
<b>Knowledge</b>	Short-term effects Long-term health consequences	Omission of short-term consequences
<b>Attitudes about drug use</b>	Feedback from surveys of peer drug use Analysis of media and social influences that promote pro-drug attitudes	Omission of perceptions of peer drug use Omission of media influences Approaches which focus mainly on ethical or moral decision making and values teaching
<b>Interpersonal skills</b>	Drug refusal skills Assertiveness skills Communication skills Safety skills	Omission of interpersonal skills, especially drug refusal skills
<b>Intrapersonal skills</b>	Coping skills Stress reduction techniques Goal setting Decision-making/Problem-solving	Solely intrapersonal focus Solely self-esteem building exercises
<b>Delivery of lessons</b>	Everyone actively involved Participation between peers Student-generated role plays Supportive comments from peers Rehearsal of drug refusal skills Sufficient practice time of refusal skills Peer modelling of appropriate behaviour Developmentally appropriate activities to promote bonding between younger adolescents	Passive participation Lectures Teacher-centred class discussion Unstructured dialogue sessions Effective classroom management techniques without an accompanying drug education program

**Table 2:** What works and doesn't work in drug prevention programs: content and delivery features

Adapted from Midford, R., Lenton, S. and Hancock, L. (2001) A critical review and analysis: Cannabis education in schools, NSW Department of Education and Training.

### About the National Drug Research Institute

The National Drug Research Institute (NDRI), formerly the National Centre for Research into Prevention of Drug Abuse, was established at Curtin University in March 1996 as one of two Australian Centres of Excellence in Drug Research. The mission of the Institute is to contribute to the overall aim of the National Drug Strategy, which is to minimise the harm associated with drug use. For further information, visit the NDRI web site: <http://www.curtin.edu.au/curtin/centre/ndri/>

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