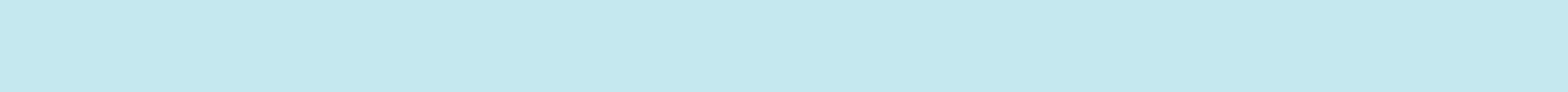




Public Health
Agency

Guiding effective drug prevention

Revised edition



Rationale

For the purpose of this paper, a drug is defined as a substance that changes the body in some way. This includes alcohol, tobacco, over-the-counter and prescribed medication, volatile substances and controlled drugs.¹

Why a paper on effective prevention?

- To contribute to the debate within the field around approaches to drug prevention.
- To define prevention and its components, and to present key principles – drawn from preventative research and applied within a local context – that are central to best practice.

Who is it for?

- Those who work across tiers one and two within the voluntary, statutory and community sectors.
- Those working primarily with young people; however, many of the principles also apply within an adult context.

What does it hope to achieve?

- Highlight and promote best practice/approaches in drug prevention.
- Create a common language that will strengthen interagency and intersectoral collaboration.
- Contribute to the priorities set out in the *New strategic direction for alcohol and drugs 2006-2011* (NSDAD) including:²
 - promoting good practice in alcohol and drug-related education and prevention;
 - targeting those at risk and more vulnerable young people;
 - addressing underage drinking;
 - tackling alcohol and drug-related antisocial behaviour;
 - workforce development.
- Contribute to the future planning and commissioning of services.

This paper originates from one initially produced by EDACT in 2005 by: Peter Dornan, Education and Personal Development Officer, BELB; Michael McKay, SHAHRP Project, Lisburn YMCA; and Ed Sipler, Health Development Department, South Eastern Trust.³ It was updated and amended in 2009 by: Kim Scott, South Eastern Education and Library Board; and Michael McKay and Ed Sipler

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Foreword

Around 35% of 16–24 year olds in Northern Ireland report having ever used an illegal drug. Whilst encouragingly, overall prevalence has declined since 2001, there has been a significant increase in the use of cannabis, particularly in some of the most vulnerable populations of young people. Early intervention and effective prevention are key in preventing young substance users, or those susceptible to use, developing problems later in their life.

Prevention is difficult. Recent high profile reports by the Advisory Council for the Misuse of Drugs and UK Drug Policy Commission argued that as prevention interventions have not had significant impacts on levels of drug use, they should be reassessed, particularly in schools and community settings.^{4,5} However, reliance on prevalence rates as indicators of success misses some important opportunities.

Substance use should not be seen in isolation from other issues and behaviours. The Northern Ireland drugs strategy NSDAD, published in 2006, combined both drugs and alcohol in one strategic framework and responded well to the challenges of prevention.² Among its many aims is the “promotion of opportunities for those under the age of 18 years to develop appropriate skills, attitudes and behaviours to enable them to resist societal pressures to drink alcohol and/or use illicit drugs, with particular emphasis on those identified as potentially vulnerable”.

By seeing interventions in their wider context – beyond drug use to the whole of a young person’s biography – drug services can provide an integrated package of support that can potentially reduce a repertoire of risk and problematic behaviours. Drug prevention is not just about drugs (discussed in more detail in the body of the report).

What should local agencies do, then, to tackle substance use and other challenges in young people? There is no easy answer but there are some things to always bear in mind. Firstly, professionals should always respond to, and predict, the acute and chronic needs of the client, in which substance use may only be a secondary concern. Young people themselves should subsequently have a voice in decisions made over the support they receive.

It is also well established that evidence-based and evidence-informed interventions are much more likely to achieve the desired outcomes. The National Institute for Health and Clinical Excellence (NICE), for example, issued guidance on prevention of substance misuse in vulnerable young people.⁶ Whilst this describes approaches that research suggests are effective, many organisations will not have the skills or resources to implement these sometimes technical interventions.

This is where this report is essential. By developing services in accordance with strong, evidence-based principles, agencies can be confident that they have templates for success. Indeed, the Northern Ireland drugs strategy highlighted the prevention principles contained in this document as an example of good practice. The challenge comes in ensuring that these principles are translated into credible interventions that are sensitive to the needs of, and engage and retain, the target population. This is where the unique skills of professionals working with young people are critical.

Finally, it is important for agencies to document and evaluate their activities. This allows development and sharing of unique approaches that may be of great relevance to other professionals. Good evaluation ensures that the work, and the outcomes of that work, is recorded in a standard way that has the potential to contribute to the wider evidence base.

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Introduction

Prevention, they say, is better than cure. It is certainly cheaper. In terms of drugs and alcohol there are many initiatives and projects that can be categorised as "prevention".

These projects are typically aimed at individuals or groups of people before drug and alcohol-related problems become a reality, and are usually delivered before use begins or during the experimenting (recreational/occasional use) stage.

This document seeks to explore the nature of prevention work in the world of drugs and alcohol. Furthermore, it seeks to offer practical advice and support to those engaged in prevention work, and to give direction to those embarking on new prevention initiatives.

It is a guide to what effective prevention means – not an exhaustive literature review, which has been done elsewhere (see Bibliography).

The document is primarily for those working with young people; however, many of the principles also apply within an adult context. Young people are defined in this document as being 17 and under; however, as stated in the NSDAD, in some preventative settings the age range would be 25 years and under.²

For those already delivering drug prevention initiatives, the document should provide a benchmark against which to review your current provision and for planning future drug prevention work.

As stated earlier, it is primarily aimed at workers across tiers one and two. The four-tier model of services is presented in Appendix 1 with a description of the tiers, key tasks, and who can carry out this work.

The document does not seek to equip those who read it with all the skills necessary to work in every area of drug prevention. It may be that workers on the ground offering general prevention services should employ a system of "alert and referral" so that they would refer on to services with more expertise should some problematic drug and alcohol issues arise.

Therefore, it is hoped that this document will be of use to:

- those working in the field of prevention such as teachers, community or voluntary sector organisations, youth and community workers, etc – the document will give you a deeper understanding of the background to drug/alcohol prevention work, and will enable you to contextualise the work in which you are engaged;
- those wishing to set up a prevention project – the document will help you understand some background ideas and concepts to drug/alcohol prevention;
- those simply wishing to know more about prevention.

The focal point of the document is a centre page pullout highlighting 12 principles of best practice for effective drug prevention work. The remainder of the document provides background information and context for these principles.

It is our hope that this document will go some way to making prevention initiatives more effective and engaging throughout the region.

Setting the scene: the current situation

According to the findings of the first joint drug prevalence survey of households in Ireland and Northern Ireland, one in five (20%) of respondents in Northern Ireland admitted lifetime use of an illegal drug.⁷ Cannabis was the most commonly used illegal drug, and young people reported higher rates of illegal drug use than older people.

A secondary analysis of the 2007/2003 *Young persons behaviour and attitudes survey* found that of the pupils surveyed (aged 11–16), lifetime use of any drugs or solvents had decreased from 23% in 2003 to 18.9% in 2007; with last month use also decreasing from 11.5% in 2003 to 7.5% in 2007.^{8,9} For alcohol, between 2003 and 2007, the proportion of pupils ever having an alcoholic drink decreased from 59.9% to 55.1%. Among pupils who had ever drunk alcohol, there was no significant change between 2003 and 2007 in the proportions who reported ever being drunk (55.2% in 2003 compared to 54.5% in 2007).

Belfast Youth Development Study (BYDS)

The youth development study is an ongoing longitudinal research project on adolescent development by the Institute of Child Care Research, Queen's University Belfast.¹⁰ Over 3,500 schoolchildren, across 43 post primary schools, have participated in the study since 2000. The young people were all Year 8 pupils (First Form) in 2000, and were interviewed annually until 2005 (Year 12, Fifth Form). The data collection was repeated in 2007 when the young people were aged around 18, and again in 2009 when they were aged around 20.

The researchers have collected information on adolescent life including smoking, alcohol and drug use, their friendship networks, relationships with their parents and friends, personality, leisure activities, behaviour problems, attitudes to education, and behaviour in school and the neighbourhood in which they live. In addition to the main cohort study, interviews were conducted with the family members (parents and older siblings) of a sub-sample of cohort members.

To date, the research team has identified a number of important issues, including as follows:

- While drug use is very limited among young people in their first year of secondary school (age 11–12), by the time they are aged 15 almost half have used an illicit drug and over 1 in 10 have made the transition to more regular drug use (once per week or more).
- Regular drug users, by age 15, are more likely to be in contact with the criminal justice system, experience drug related problems, and problems at school.
- Increased disposable income among teenagers is associated with increased levels of drug use, even after controlling for family socioeconomic conditions.
- Early onset cannabis use is linked to sustained cannabis use across the school years.
- While boys tend to use drugs first, by age 15 there is little difference in the prevalence of drug use among boys and girls. The one exception is smoking, where the number of girl smokers exceeds the number of boys.
- Higher levels of drug use were found among particular sub-populations of young people such as those excluded from school, those in care, those living in single parent households, and those attending emotional and behavioural units.
- While most parents were aware that their child had drunk alcohol (65%), few were aware that their child had been involved in any delinquent activities (between 0.5% and 6% depending on the offence). Around 6% believed that their child had tried illicit drugs.
- While parents tended to have negative attitudes towards drug use, over 10% of them had used cannabis and 3% amphetamines.

Strategic context

Many of the strategic documents that help guide the work in the development of young people in Northern Ireland present a consistent message.

All of the current strategy and policy documents – whether produced by the DHSSPS (*Investing for Health*, NSDAD etc) or the other government departments (OFMDFM's *Our children and young people: our pledge*, DENI's *Review of the Northern Ireland curriculum*, etc) have the ultimate aim of working towards changing and shaping services so that young people can achieve their full potential.^{11,2,12,13}

All of these documents view drug and alcohol misuse as detrimental to adults and young people reaching their full potential.

The NSDAD in conjunction with the action plans from the local drug and alcohol coordination teams will be guiding prevention efforts until 2011. The NSDAD emphasises the need to focus more on vulnerable and at risk groups, the role of assessment and referral, and the importance of evaluation.²

What do we mean by prevention?

By definition, to “prevent” something means to stop something from happening. “Drug prevention” traditionally has referred to a range of activities, from regulation to education, with the aim of controlling the supply of drugs and reducing of the demand for them.¹⁴

Drug and alcohol prevention projects and initiatives therefore aim to:

- prevent initial use;
- delay onset of use;
- promote cessation of use;
- reduce harms resulting from use.

Is prevention effective?

Measuring success of any prevention efforts by prevalence rates alone is misleading. Prevalence rates as a performance indicator reveal nothing about substance abuse behaviour and harm related to substance misuse.

Many young people experiment with alcohol and drugs and do not develop long-term problems. Drug prevention cannot inoculate against drug use.

Contemporary drug prevention views substance use as one part of a young person’s story – in which there may be many more problematic or acute needs. Many prevention initiatives for young people are dedicated to providing wider support and reducing the repertoire of risk and problematic behaviours.

Effective drug prevention may not even explicitly mention substances.

It may be judged successful if it reduces risk factors for use or for problematic use.

Risk and protective factors

It has been suggested that a promising route to effective prevention for problematic alcohol and other drug problems is through a risk-focused approach.¹⁵ This approach identifies key risk factors that increase the likelihood of young people developing problems across a range of risky behaviour.

Their research also points to the existence of protective factors, also referred to as assets or strengths, which reduce the likelihood of the development and maintenance of problematic behaviour including substance misuse. The resiliency research also identifies these protective factors as being significant in helping young people thrive in quite difficult circumstances.¹⁶

This approach requires identification of methods by which risk factors are effectively addressed and protective factors enhanced, and the application of these methods to both high risk and general populations. Why is this important?

When risk factors are reduced in individuals, and also across families, schools and communities, and protective factors enhanced, young people are less likely to develop more acute problems, such as physical, mental, social and/or relationship problems.¹⁵ Even with well thought-out prevention initiatives, success is not guaranteed.

Risk and protective factors interact in a complex way, not in a simple cause/effect mechanism. Both risk and protective factors can have an additive or multiplying effect.^{17,15}

Understanding and identifying risk factors may help individual projects, organisations and key community figures to develop the most effective and appropriate intervention for substance misuse/abuse/dependence.

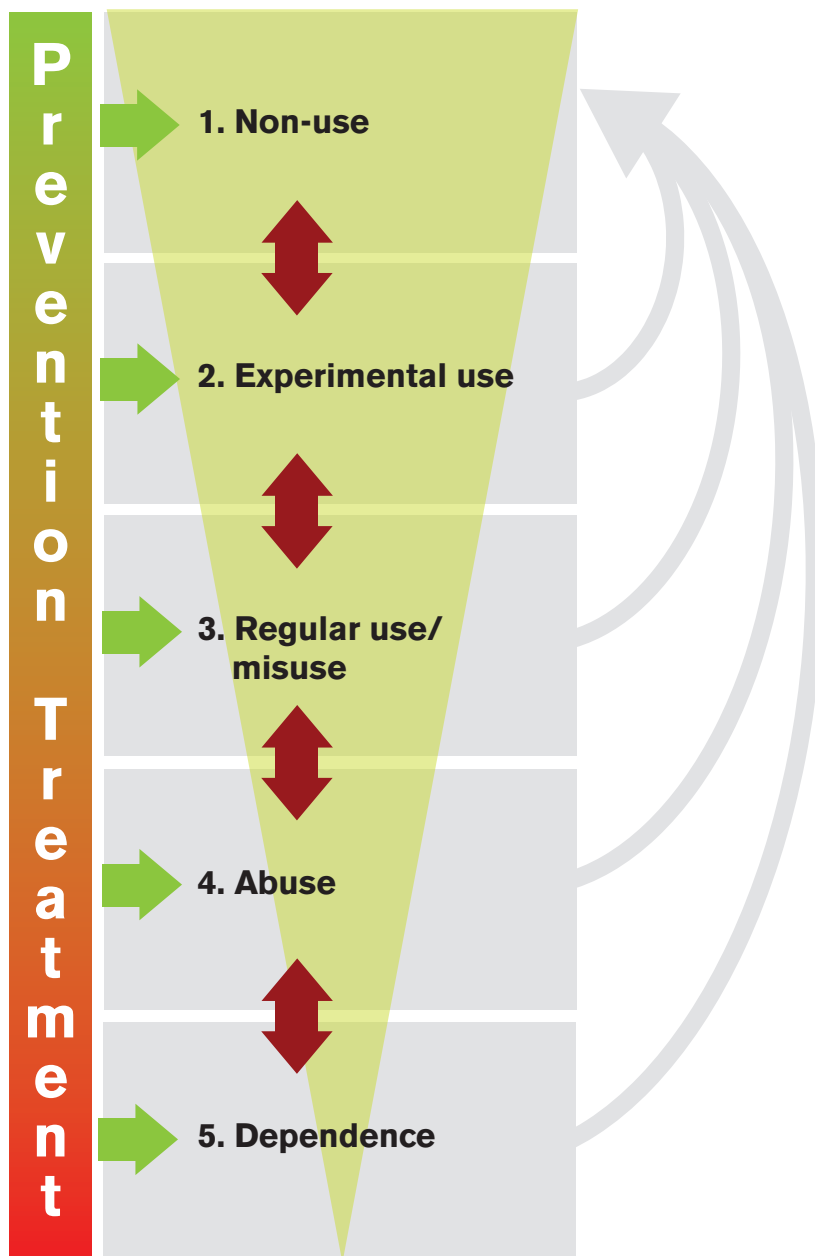
As stated several times in this paper, effective prevention may not be specifically addressing drugs, but building protective processes and reducing risk factors. This is particularly important for at-risk and vulnerable young people.

For a more complete discussion of risk and protective factors resources tools or other information outlined in this paper, visit the Local Resources section of www.edact.org or see Hawkins et al.¹⁵

The drug and alcohol continuum

Various developmental stages exist for individuals in terms of their use of drugs and alcohol, ranging from non-use through to dependence (addiction). The “drug/alcohol use continuum” can be depicted as follows:

Drug/alcohol continuum



Perhaps the most important thing to note from this diagram is the demarcation between prevention and treatment.

Prevention initiatives can still be effective with regular drug and alcohol misusers. If the person slips into abuse/dependency, treatment services are needed rather than prevention.

Employing this notion of a drug/alcohol use continuum, we know from experience that:

- Not everyone will necessarily progress downwards, therefore dependence is not inevitable.
- Many people can move forward a stage or back a stage by choice, but for some there is an imperceptible drift.
- Effective prevention strategies need to clearly and properly determine what stage the person (or people) is/are at and act accordingly. What is effective at one stage may be ineffective at another. Movement from one stage to another may not always be immediately obvious.
- Experimentation with controlled drugs, while illegal, does not always lead to problems in a person's life.

Assessment tools

A role in tier one and two is the identification of problematic substance misuse. Services should have policies and procedures that guide their workers' responses.

An initial substance misuse assessment tool for use with those aged 17 was piloted for use in Northern Ireland. The Regional Initial Assessment Tool (RIAT) is intended to be of use to mainstream children's services and will be piloted within education, youth justice, social services and youth community/voluntary settings across the region prior to being rolled out.

It allows workers to undertake a brief assessment of a young person's substance misuse to help determine where the person is on the drug/alcohol continuum, and therefore what level of support (if any) the young person may benefit from. The tool is accompanied by a guidance document that details what services are available locally for young people spanning drug education, prevention, early intervention and treatment. It also gives instructions as to when and how to refer young people onto services.

For more information on the RIAT, please contact your local Drugs and Alcohol Coordination Team (contact details on the back cover).

Key message

Workers on the ground offering general or drug-specific prevention initiatives, and who find their client's drug use is becoming progressively worse, should employ a system of "alert and referral". They should refer-on to services with more expertise.

People should not undertake assessment and offer services or interventions in which they are not experienced and/or trained.

Levels of prevention

In a 1994 report on prevention research, the Institute of Medicine (IOM) proposed a new framework for classifying prevention based on Gordon's *Operational classification of diseases*.^{18,19}

The IOM model divides the continuum of care into three parts:

- prevention;
- treatment;
- maintenance.

The prevention category is further subdivided into three classifications:

- universal;
- selective;
- indicated.

Viewed simply, these three classifications refer to the target audience of a specific programme.

In practice, the following is understood:

Universal prevention

Universal prevention interventions are targeted at the general population or sub-sections of the general population such as individual communities or schools, regardless of the perceived risk of initiating drug use. Children and young people are usually the focus of such universal interventions, with the emphasis on the prevention of precursors of drug use or the initiation of use. Universal prevention activities may include schools-based prevention programmes or mass media campaigns, or they may target whole communities, or parents and families. Examples of this kind of intervention include:

- a curriculum-based drug prevention programme in schools;
- a binge drinking media campaign.

Selective prevention

Selective prevention interventions target groups or subsets of the population who may have already started to use drugs, or are at an increased risk of developing substance use problems compared to the general population, or both.²⁰ Children excluded from school and the children of drug users are examples of groups who may be particularly vulnerable to drug use and misuse. Selective prevention interventions are generally longer and more intense than universal programmes and may directly target identified risk factors. Examples of this kind of intervention would include:

- Youth Justice Agency initiatives;
- an early intervention group work initiated with young people at risk.

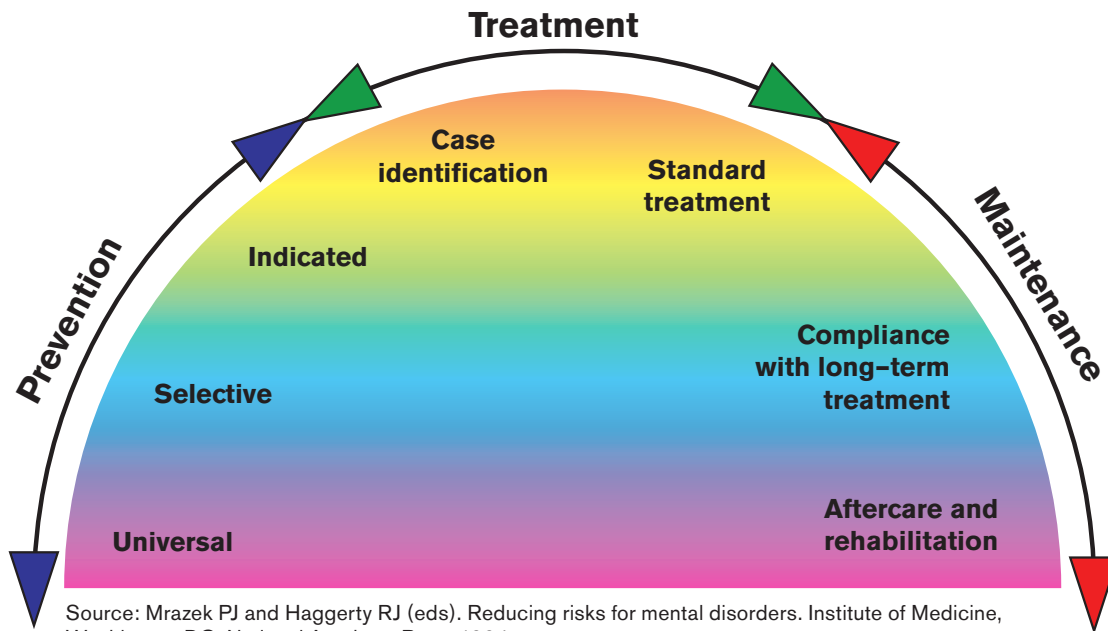
Indicated prevention

Indicated prevention interventions target individuals who may already have started to use drugs or exhibit behaviours that make problematic drug use more likely, but who do not yet meet assessment criteria for substance dependence. Indicated prevention activities are aimed at preventing or reducing continued use, and preventing problematic and harmful use. Interventions delivered may include:

- a mentoring programme;
- group work with known substance misusers;
- individual work.

For more information on indicated prevention, see Appendix 2.

Intervention spectrum for behavioural disorders



Using the IOM framework (above), a group of pupils has been identified with poor school work and identified needs (selective) during a whole school approach to personal development and drug education (universal).

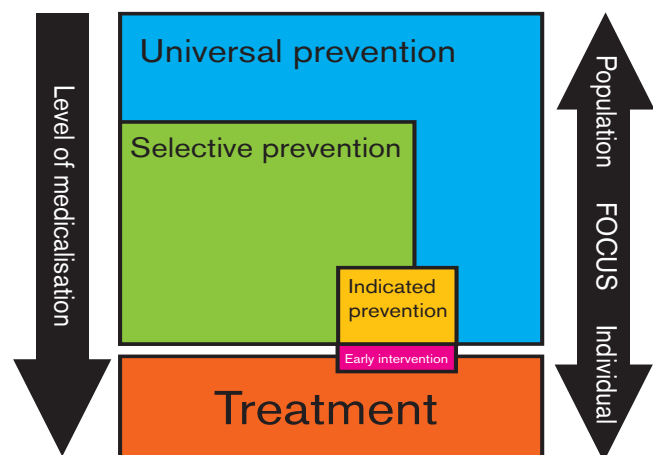
Targeted activities with this group have shown some of these young people to be using drugs regularly (indicated). A local service funded to provide group work is commissioned to provide a group work experience for these young people.

It must be understood that while it is possible to create three general areas of prevention, treatment and maintenance, the boundaries between prevention and treatment and between treatment and maintenance are not always clear and definitive. One has only to think of early intervention (counselling and/or brief interventions) where prevention and treatment begin to weave together (see figure below).

Preliminary research suggests brief interventions are effective, particularly for early stage drug/alcohol users. Using the word “brief” does not necessarily mean easy. Brief interventions are a skilful way of working, usually coupled with the use of motivational interviewing. Good assessment is crucial to identify who will benefit most from brief intervention. Training and the development of skills are essential for the effectiveness of brief interventions.

The recommendations by NICE for young people having been identified to be at high risk of developing drug/alcohol abuse or dependence are included in Appendix 3 to help bridge prevention and treatment needs.

In 2009, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) presented a pictorial view of how the levels of prevention – universal, selective and indicated – interface with treatment.²¹



Effective prevention principles

What helps prevention work?

Below is a list of principles based on Nation et al that should be used to guide effective prevention work.ⁱ This is not necessarily an exhaustive list; however, ongoing research and evidence continue to highlight these as important elements of effective prevention work. While every drug prevention programme or intervention will not incorporate all of these elements, it is recommended that organisations or projects review existing programmes in light of these principles and ensure that all future programmes are designed with these principles in mind.

Understanding risk and protective factors is central to understanding effective drug and alcohol prevention. Prevention initiatives should attempt to reduce known risk factors and/or enhance protective factors for drug and alcohol abuse.

PRINCIPLES RELATED TO PROGRAMME ELEMENTS, CONTENT AND DELIVERY

1. Prevention initiatives should be comprehensive, employing multiple approaches in multiple settings.

Multiple approaches

Programmes that use knowledge, affective (eg self-esteem) and skills elements have been shown to be more effective than knowledge or awareness only.

Multiple settings

There is some evidence to support the idea that combined parent, peer and school interventions support successful positive outcomes (see box below). So, for example, if young people are the target audience then programmes should seek to address peer influence, school, family and community issues.

Programmes, therefore, should be well planned and aware of:

- the target population (who the programme is aimed at, ensuring it meets local need);
- the setting (where it is going to take place);
- the approach (what is going to be done and how);
- how it is going to be evaluated.

Velleman et al highlighted the importance of the involvement of parents, especially in relation to younger children and early adolescents.ⁱⁱ Recruitment and sustained involvement is more successful if the issues covered are wider than drugs, there is small group interaction, and there are close links with school and community. When targeting local geographical communities, the evidence would suggest that key community representatives need to be involved in the planning and implementation of the programme.

2. Prevention initiatives should be active and skills based.

Active learning approaches have been found to be more beneficial than passive learning.

Examples of specific skills include improved communication, assertiveness skills, and skills for resisting peer pressure.

3. Prevention initiatives should be of sufficient quantity and quality.

The greater the needs of the participants, the greater the intensity of the prevention initiative. The effects of interventions tend to gradually decay over time; therefore, effective interventions could include a follow-up or booster session(s) to sustain the impact. Lack of robust research, however, means that the long-term impact of such work is unknown.

4. Prevention initiatives should be theory driven.

Prevention initiatives should take into account what has been proven to work. There are many programmes and/or approaches that have been shown to make a difference, and these should influence your work.

There is no point in doing something “for the sake of it”, nor is there any point in “reinventing the wheel”. However, when using interventions that have been evaluated elsewhere, any social or cultural differences should be taken into account.

5. Prevention initiatives should encourage the development of positive relationships.

Where children and young people are enabled to develop strong positive relationships especially with peers, parents, teachers and/or significant adults, this is associated with positive outcomes.

6. Prevention initiatives should encourage people to look at both the long and short-term consequences associated with drug and alcohol misuse.

Focusing on the longer-term negative effects of substance use only may not impact on younger users. Many people, especially young people, are influenced more by the “here and now”, rather than by long-term consequences. A positive attitude toward use has consistently been shown to be a risk factor for problematic alcohol and drug use.

7. Prevention initiatives should consider the value of normative education.

Correction of misconceptions about the perceived high prevalence, availability and acceptability of drug use can be beneficial. This is especially true if the young person’s key friends are not active drug users.

If young people believe that the majority of their peer age group is doing something, they will be more likely to copy that behaviour. Surveys show that drug use, more so than alcohol use, remains relatively low among young people in Northern Ireland, and this should be reinforced in prevention settings.

8. Prevention initiatives should avoid poorly constructed and delivered “one-off talks” or group information sessions.

More intensive programmes have been shown to be more effective, although the fact that there are many sessions alone does not guarantee effectiveness. Ultimately, it may be better to have one hour of good evidence-based material and delivery rather than several mediocre sessions involving poor material.

PRINCIPLES RELATED TO MATCHING THE PROGRAMME WITH THE POPULATION OR PARTICIPANTS: TARGETING THE RIGHT PEOPLE

9. Prevention initiatives should take account of age, maturity, experience and ability of participants as well as considering drug prevalence, availability, legality etc. Effective practitioners will additionally be aware of the fact that young people have different learning styles and will plan appropriately.

The IoM warned that “if the preventive intervention occurs too early, its positive effects may be washed out before onset; if it occurs too late, the disorder may have already had its onset”.ⁱⁱⁱ It is suggested that individual programmes ought to try to have resources, language and approaches which are tailored to the specific subset of the population to whom it is being delivered. This can mean interviewing early in terms of age, early in their substance-use careers, or at points transition such as the move from primary school to post primary. Projects must be clear on whom they are targeting, and seek to address risk and build on protective factors.

10. Prevention initiatives should be socio-culturally relevant, taking account of cultural beliefs and practices as well as religious diversity.

They should also consider local community norms. This relevance should go beyond the surface structure of the programme (eg language) to look at the relevance of the deeper programme structures. When programmes are not relevant, they may have difficulty in retaining the more at-risk participants. This is particularly important as Northern Ireland becomes more culturally diverse. Service user involvement with the planning and delivery of programmes can help to address this.

PRINCIPLES RELATED TO IMPLEMENTATION AND EVALUATION OF PROGRAMMES

11. Programmes should evaluate both delivery and impact.

Evaluating delivery measures whether participants felt that the programme was clear, effectively delivered and had good resources. A short questionnaire may be used. Evaluating impact measures whether the programme makes a difference to participants' knowledge, attitudes or behaviour. This involves gathering the same information before and after the programme to measure if it made a difference.

Evaluation should be ongoing so that changes can be made to interventions as they develop. Changes need to take account of the views of participants, and consider if the intervention is really making a difference.

12. Staff delivering the programme should be well-trained.

The implementation of prevention programmes is enhanced when staff members are sensitive, competent and have received sufficient training, support and supervision. Even where effective training has taken place, the effectiveness of staff can be undermined or limited by high rates of staff turnover, low morale or a lack of “buy-in”. Staff delivering interventions should be aware of other locally accessible interventions and/or materials, should they need to refer people on.

Anyone planning a prevention initiative or planning to deliver an existing initiative should be aware of these issues and should aim, in so far as is possible, to include their use in that prevention initiative.

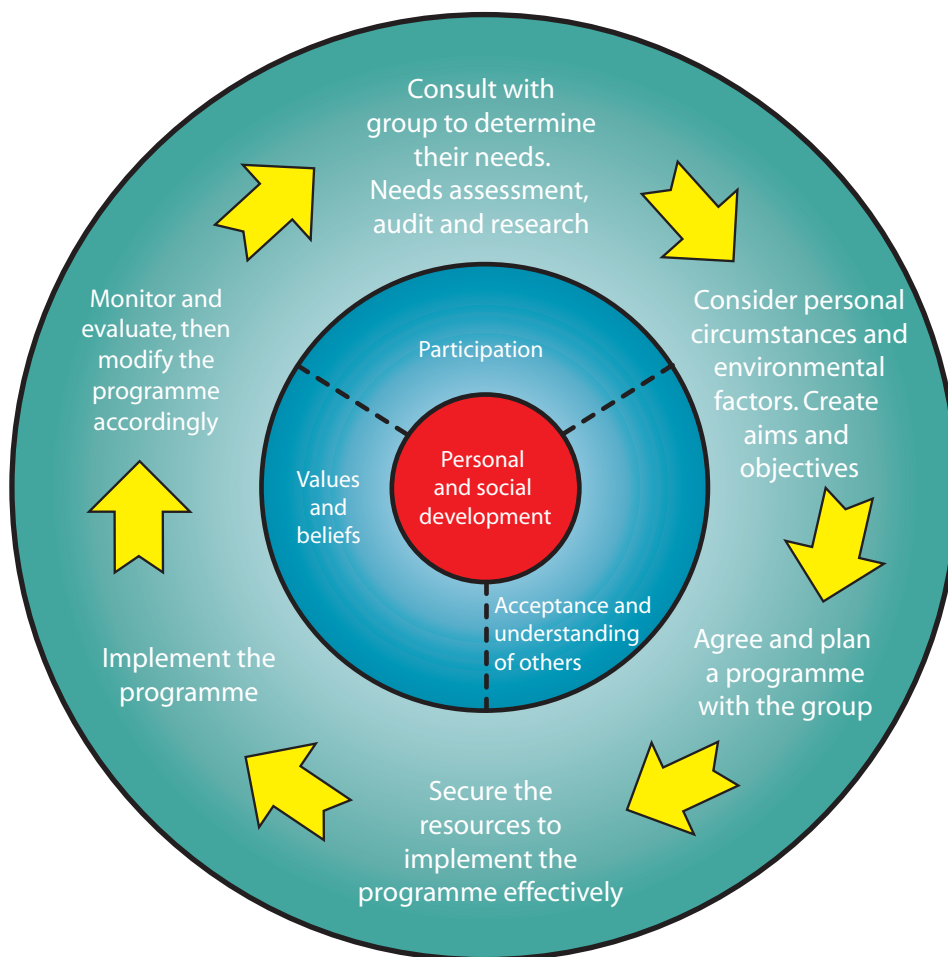
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Planning and initiating a prevention programme

In practice, the three important elements of a drug prevention intervention are the target population, the setting and the approach.

The diagram below illustrates the processes by which a prevention initiative may come into existence.



1. The population

As discussed earlier, the IOM framework for classifying prevention divided the continuum of care into three parts: 1) Prevention; 2) Treatment; 3) Maintenance. The prevention category was further subdivided into three classifications: a) Universal; b) Selective; c) Indicated.¹⁸

Universal refers to the general population (eg a whole school project). Selective refers to a subgroup of the whole population (eg all the boys and girls identified as being at risk in the school). Indicated refers to specific individuals who have exhibited specific problems (eg boys in a given school who have been caught with drugs).

So... how is the group going to be targeted? Is this a universal programme for everyone? Is it for a group living in a certain postcode or community with indicated needs? Is it a selective group with a specific drug problem or is it an individual with selective needs?

2. The setting

Broadly speaking, this is divided into six categories (which can be further sub-divided as necessary). The six main settings are:

- i. **The individual** – what is the individual like in terms of age, gender, maturity, experience, literacy, academic ability, participation, trust level, expectations or other relevant factors?
- ii. **The family** – how does the family function in terms of bonding, connection, involvement, communication, negotiation, problem solving, history of drug use or misuse/abuse/dependency, parenting skills?
- iii. **The school or workplace** – what are the levels of connection, academic failure, reward or recognition, types of leadership/teaching, the school/work climate and culture, levels of support at which power is shared?
- iv. **Peers** – what are the connections within the group, how great an influence is the group (or particular individuals/leaders) on each other, how much negotiation or debate is possible within the group, etc?
- v. **The community** – what are the community norms when it comes to drugs and alcohol, local laws and bye-laws versus local practices, levels of community involvement and empowerment, existence of paramilitaries, levels of deprivation and/or lack of facilities?
- vi. **The wider environment** – what are the issues that happen at the macro or government level such as taxes on alcohol and tobacco, laws around controlled drugs, police enforcement policies, age limits, public policies, prescribing practice, or dealing with drug dealers in a locality?

Consideration may be given to how a combination of various settings can be utilised.

3. The approach

Throughout the past few decades, a number of different approaches underpinning prevention work have been developed. These include:

- i. **Health information** – while on its own it will have limited impact, health information can increase awareness and, with hard-hitting messages, create an emotional arousal.
- ii. **Personal development approach** – specific resistance and coping skills are taught. Programmes such as these attempt to empower the individual by helping them develop social skills and enhancing their self-esteem. Other names for this approach include assertiveness training, affective education, resistance and refusal skills, decision-making skills, building self-esteem.
- iii. **Providing alternatives to drug use** – this involves organising alternative activities as a means of reducing the likelihood of drug use, for example involving young people in outdoor pursuits and showing them how they can achieve a “natural high”. It can include active involvement in sports, hobbies and community service.
- iv. **Harm reduction** – this approach takes a pragmatic view that not all drug users want to stop their drug taking, so minimising the health-related harm is a benefit to the individual, to their families and to society. A “harm-minimisation” approach creates a hierarchy of health goals which includes abstinence, but also a range of short-term and, arguably, more achievable goals.
- v. **Peer education** – this rests on the view that young people learn a lot from one another as part of their everyday lives and choices. Peer groups play an important part in defining an individual’s identity. Within this approach, peer educators (ie someone of equal status) are thought to have credibility and thus serve as role models. Caution is needed in respect of peer education as it is often the peer educators who benefit most. It remains unclear whether the training the peers receive has a beneficial impact on them. Some evidence suggests that grouping low risk and high risk peers together can be detrimental to the low risk group (see Sanchez et al and Argys and Rees on contagion effects within mixed peer groups ^{24,25}).
- vi. **Community development** – this is about developing the power, skills, knowledge and experience of people at a local level, enabling them to undertake initiatives within their community to combat social, economic, political and environmental problems. It is a bottom-up rather than a top-down approach.
- vii. **Legislative approach** – this relies on developing legislation that limits, moderates or prevents drug use in society. Its effectiveness depends on the clarity and enforceability of the specific laws. Examples include age limits on purchasing alcohol or tobacco, smoking bans in public places, drink or drug-driving charges.

- viii. **Family approach** – while the family can be the setting for prevention, focusing on family dynamics and building protective processes within the family is also an approach. This can be accomplished individually, with whole families, or parents in a group setting. The approach examines issues within the family such as bonding, communication, clear rules regarding substance use and supervision that influence the level or degree of misuse by members of the family.
- ix. **Mentoring** – “mentoring is to support and encourage people to manage their own learning in order that they may maximise their potential, develop their skills, improve their performance and become the person they want to be” (Oxford School of Coaching and Mentoring, www.theocm.co.uk). Mentors act as role models who can encourage people to make positive changes in their lives, such as regular school attendance, taking part in further or higher education, and staying out of trouble with the law.
- x. **Media campaigns** – these campaigns reach large audiences and are effective in the long term at influencing cultural change. These influences can be more effective if supported by other actions.
- xi. **Supply reduction** – restricting the access to, and the availability of, drugs.

Putting the three building blocks – population, setting, approach – together allows for the planning and execution of an effective drug prevention initiative.

There is no specific order in which the three elements have to be decided on. It may be that a population (eg group of young people) presents itself as high risk, or you discover a good programme which has worked well elsewhere and you wish to replicate it/pilot it locally (approach), or a mapping exercise finds a particular setting (eg schools) to be under-served in terms of provision.

Below are some examples of how an initiative may come about. These are only two examples as there are many creative ways that can be effective in prevention efforts.

Example 1 – We are going to run a programme for teenage drinkers (population) with a group no larger than 12, who have been identified as regular binge drinkers in a certain community. It will involve a six session programme in a local youth centre (setting) culminating in an outward-bound weekend away in the Mourne. A life-skills approach will be taken, also incorporating alternative or diversionary activities, and the programme will be delivered by trained peer educators.

In advance of the programme, the young people are consulted and some thought given to the risk factors: living in a certain neighbourhood, mixing with a certain peer group, having a positive view of and/or positive expectancies of alcohol use.

Example 2 – Parents (population) in a local community have identified preventing alcohol and drug use as an important issue for them. A programme is being organised using the school as a source of recruitment. The programme will be open to parents from the entire school community (setting). The programme seeks to build the parents' confidence to talk openly about drugs and alcohol to their children. It will help build the parents' understanding of risk and protective factors and focus on key protective processes including setting clear rules, clarifying expectations, monitoring behaviour, communicating regularly, examining their own attitudes and modelling positive behaviours (family approach).

Conclusion

As page 30 of the NSDAD states under 6:14 Workforce Development:

“A broad range of workers have a key role to play in addressing substance misuse, and reducing substance misuse should be regarded as a core business to many services. It is clear that the successful implementation of the NSD will require colleagues in related sectors to recognise the significant contribution they can make to addressing drug and alcohol issues. Although numbers in the workforce are important, it is the competence of those staff which has the most crucial relationship to achievement of the NSD aims.”²

It is essential that all those working in prevention embrace the principles contained in this document. Furthermore, it is hoped that these principles will influence and contribute to the training of those who work in the field of substance misuse prevention.

To reiterate: prevention is better than cure. It is hoped that the efforts put into prevention have the desired impact – to be effective.

Where do local prevention efforts, interventions and research go from here? Current work is examining the building blocks to resilience, the role of expectations in young peoples' drinking, what an intervention with parents achieves, and training staff in brief intervention and motivational interviewing skills among other areas of development.

It will be through evaluation of current efforts and examination of emerging research that we will have a better understanding of what is effective in prevention of alcohol and drug misuse in Northern Ireland.

Key message

Prevention is a broad area, and prevention work of one kind or another is necessary at every stage of a person's relationship with drugs and/or alcohol. In order to be able to best address the area of prevention, the use of the principles contained in this document is recommended.

They are to be understood as pointers to aid more effective and purposeful prevention working rather than an exhaustive list of compulsory elements.

It would be hoped that existing services would attempt to incorporate them into existing practice and that new services or work would be planned with them in mind.

Appendix 1

Four tier model of services²⁶

Tiers summary - Adapted by National Collaborating Centre for Drug Prevention from Health Advisory Service 2001

TITLE	TIER 1	TIER 2	TIER 3	TIER 4
SUMMARY	Universal and generic. Frontline of service delivery with direct access for young people and their families	Frontline of specialist services. Youth oriented services delivered by practitioners with specialist youth knowledge and some knowledge of drugs and alcohol	Services provided by specialist teams	Very specialised services
AIMS & PURPOSE	To ensure universal access to all generic services for young people and to identify those vulnerable to substance misuse issues	To reduce risks and vulnerabilities, reintegrate and maintain young people in mainstream services	To respond to the complex and often multiple needs of the young person, not just in relation to substance use problems. To reintegrate the young person into their family, community, school, training or work	To provide specialist intervention[s] and setting for a particular period of time and for a specific function, as an adjunct to and backstop for the services provided in other tiers
TARGET POPULATION	All young people	All young people, but in particular those with more problematic drug use or additional vulnerabilities	Young people with tobacco, alcohol and drug problems that significantly interfere with other aspects of the individual's life. Multiple underlying problems often also exist	Young people with complicated substance problems requiring specific interventions and/or care and protection
PRACTITIONERS	Include teachers, voluntary agencies, social services, police, school medical staff, GPs, nurses in primary care, potentially young people as confidantes and peer educators	Include CAMHS, voluntary youth services, paediatric & psychology staff, Connexions personal advisors, YOT drugs workers, and others with a specialist remit within universal services. Practitioners with addiction skills must be incorporated into services and not work in isolation	Multi disciplinary teams tailored to meet the specific needs of the young person and capable of responding to problems of high complexity. Teams could include mental health, paediatric and addiction specialists working in close collaboration with education, social services and YOTs	Include child/adolescent addiction and forensic psychiatry, social services, paediatrics and voluntary sector
KEY TASKS	Assessment of all young people for tobacco, alcohol, drug use and misuse & identification of those that are more vulnerable or at risk. Appropriate referral as necessary	Holistic assessment of the young person, to clarify degree of substance use problem in the context of other vulnerabilities. Clear referral pathways and links with tier 1 & 3 services. Case worker role, including maintaining contact with the young person during involvement with tier 3/4 services	Comprehensive assessment and formulation of an overall care plan. Delivery of a spectrum of interventions. All substance interventions set within the context of integrated and comprehensive packages of care	Particular interventions or focused work over short or temporary periods. Continuity of care to be maintained through the continued involvement of tiers 2 and 3 before, during and after admission. Responding to child protection and other dangerous situations. Adding further depth of understanding to comprehensive assessments carried out at tiers 2 & 3
INTERVENTIONS	Information and advice, health promotion, drug prevention programmes, support for young people and their families	Proactive outreach (including use of non-professional staff, young people and communities to conduct outreach work), information and advice, practical advice on associated issues [eg housing], crisis support, delivery of targeted prevention programmes, appropriate therapies [e.g. family therapy], generic counselling	Provision of multi-component, multi-faceted and multi-agency interventions for complex problems facing young people and their families. Pharmacotherapy provision and ongoing monitoring, harm minimisation and uncomplicated detoxification	Inpatient adolescent units or forensic units supported by specialist young people's addiction teams, adolescent paediatric beds, intensive day centres, crisis management, specialised housing or fostering, multi component or highly intensive therapies that have a residential component, complicated detoxification and pharmacological interventions

Appendix 2 Indicated prevention

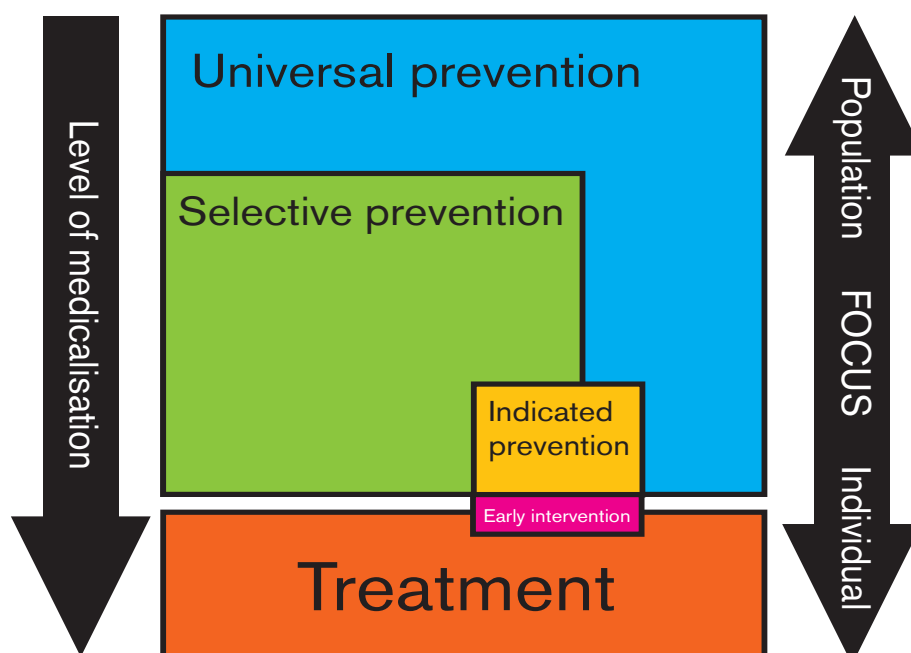
According to EMCDDA, indicated prevention strategies are designed to prevent the onset of substance abuse in individuals who are showing earlier danger signs, such as falling grades and consumption of alcohol and other gateway drugs.

The effort is aimed at individuals, with “substance-abuse-like behaviour at a sub clinical level”, with the goal to identify these individuals and target them with special programmes.

Developmental psychopathology and child psychiatric research are also relevant to prevention strategies because individuals with a high risk of failing to meet developmental tasks (such as school, peer contacts) are often predisposed to an elevated risk of developing substance abuse and many have child psychiatric disorders show a strong correlation with the development of a dependence.

Indicated prevention describes a preventive, individualised approach targeted at those at risk of developing substance abuse or dependence later in life. That there is a need for indicated prevention is shown by existence of strong indicators for the development of a later substance use disorder.

As indicated, prevention can be seen to lie somewhere between treatment and selective prevention; it is necessary to identify the points at which these definitions overlap. Clear definitions of the target groups for the different interventions, based on their level of risk, will also be an important factor in determining efficacy.



However, the borders between the different intervention strategies are not clear-cut (see above). In defining indicated prevention, the overlap between it and treatment is of special interest, as here the worlds of prevention and treatment collide. This can create problems in a line of dwindling financial resources, as each side may argue that the other side might take care of this population.

The task of differentiating between treatment and indicated prevention is made more difficult by the fact that treatment itself is seldom clearly defined. In *Guidance for the measurement of drug treatment demand*, “drug treatment is considered to be structured intervention aimed specifically at addressing a person’s drug use”.²⁷

However, the definition remains vague in its practical applicability. For example, insurance companies will pay for the treatment of classified and defined disorders (ICD-10 or DSM-IV*), but not for the treatment of conditions. It should be stressed, though, that whenever a defined disorder (here, a substance use disorder) is present, treatment is necessary.

Within the group that can be identified as requiring prevention, there is a section for which “early intervention” is appropriate. This sub-group includes people who show strong indicators of developing substance abuse later in life and who consume drugs, but not to an extent that permits ICD-10 or DSM-IV diagnosis of substance abuse disorder or dependence. Compared to other prevention approaches, early intervention is closer to treatment and, therefore, often requires services from the medical system.

Early intervention describes the approach situated between the overlapping fields of indicated prevention and treatment. The target group is individuals who already use drugs, but who do not fulfil ICD-10 or DSM-IV criteria for substance abuse or dependence.

Early intervention can be classified as prevention, though treatment is often required at this stage of substance use.

Indicated prevention can be summarised as:

- Preventative interventions that are targeted at the individual.
- The individual presents voluntarily or is referred to an expert by, for example, parents, teachers, social workers, paediatricians.
- The individual is identified on an individual level based on a professional’s evaluation.
- The individual might exhibit substance use, but does not fulfil criteria for dependence (according to ICD-10 or DSM-IV) and/or shows indicators that are highly correlated with an individual risk of developing substance abuse later in life (such as psychiatric disorder, school failure, antisocial behaviour). Substance use is not a necessary condition for inclusion in preventive interventions.
- Distinguished from selective prevention by the stronger correlation and individualised nature of indicators for the development of a substance abuse or dependence.
- Distinguished from treatment by the requirement of individuals to fulfil ICD-10 or DSM-IV criteria for substance abuse to receive treatment.
- The aim of indicated prevention is not necessarily to prevent the initiation of use or the use of substances, but to prevent the development of dependence, to diminish the frequency and to prevent ‘dangerous’ substance use (eg moderate instead of binge-drinking). In addition, some indicated prevention measures are classified as early interventions, which can be defined as interventions targeted at individuals with identified strong indicators and substance use (but who do not warrant ICD-10 or DSM-IV diagnosis).
- The field of “early intervention” is within the overlapping borders of indicated prevention and treatment.

* *International classification of diseases (ICD)* by the World Health Organization and the *Diagnostic and statistical manual of mental disorders (DSM-IV)* by the American Psychiatric Association are used for the diagnosis of a variety of conditions and disorders, including drug and alcohol abuse/dependence and co-morbid conditions including depression, anxiety or schizophrenia.^{28,29}

Appendix 3

NICE guidance

In the event of young people having been identified as at high risk of developing drug/alcohol abuse or dependence, NICE guidelines recommend the following actions:⁶

Target population

- Vulnerable and disadvantaged children and young people aged 11–16 years and assessed to be at high risk of substance misuse.
- Parents or carers of these children and young people.

Who should take action?

Practitioners working with these people in the NHS, local authorities and the education, voluntary, community, social care, youth and criminal justice sectors. In schools this includes teachers, support staff, school nurses and governors.

What action should they take?

- Offer a family-based programme of structured support over two or more years, drawn up with the parents/carers and led by competent staff. The programme should:
 - include at least three brief motivational interviews each year aimed at the parents or carers;
 - assess family interaction;
 - offer parental training skills;
 - encourage parents to monitor their children's behaviour and academic performance;
 - include feedback;
 - continue even if the child or young person moves schools.
- Offer more intensive support (eg family therapy) to families who need it.

Target population

- Children aged 10–12 who are persistently aggressive or disruptive and assessed to be at high risk of substance misuse.
- Parents or carers of these children.

Who should take action?

Practitioners trained in group-based behavioural therapy.

What action should they take?

- Offer group-based behavioural therapy over one to two years, before and during the transition to post-primary school. Sessions should take place once or twice a month and last about an hour. Each session should:
 - focus on coping mechanisms such as distraction and relaxation techniques;
 - help develop the child's organisational, study and problem-solving skills;
 - involve goal setting.
- Offer the parents or carers group-based training in parental skills. This should take place on a monthly basis, over the same period (as described above for the children). The sessions should:
 - focus on stress management, communication skills and how to develop the child's social-cognitive and problem-solving skills;
 - advise on how to set targets for behaviour and establish age-related rules and expectations for their children.

Target population

Vulnerable and disadvantaged children and young people aged under 25 years who are problematic substance misusers (including those attending post-primary schools or further education colleges).

Who should take action?

Practitioners trained in motivational interviewing.

What action should they take?

- Offer one or more motivational interviews, according to the young person's needs. Each session should last about an hour and the interviewer should encourage them to:
 - discuss their use of both legal and illegal substances;
 - reflect on any physical, psychological, social, education and legal issues related to their substance misuse;
 - set goals to reduce or stop misusing substances.

For NICE guidance concerning prevention in vulnerable young people, see <http://guidance.nice.org.uk/PH4>

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