HEALTH EDUCATION IN SECONDARY SCHOOLS:
A FOCUS ON ALCOHOL

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EXECUTIVE SUMMARY

In 1992-1993, the Youth Research Centre commenced a ‘mapping’ investigation into current practices in ‘alcohol education’ in Australian secondary schools. This report firstly summarises the main positions currently held in the broad field of Health and alcohol education, based on a comprehensive survey of the available literature on alcohol education in Australia.

The report also describes the nature of the ‘alcohol curriculum’ in schools throughout Australia with specific reference to content and coverage across schools, similarities and differences between state policies, and general comprehensiveness of alcohol education in Australian schools. It addresses some of the pertinent issues which influence the effectiveness of alcohol education in schools, in particular: teacher professional development; availability of resources; the confusion surrounding the notion of harm minimisation; and the marginalisation of alcohol and drug education.

The major findings of the project are:

- Health education has an extensive literature, consisting of many articles and studies which contribute to the debate in terms of preferred goals, aims, and strategies, including whom and what should be targeted by alcohol education. The task of sifting through the positions has been complicated by the fact that there are several ‘literatures’. There is, first, a large and current literature specifically on alcohol education, both originating in Australia and overseas (principally Britain and the United States). However, issues associated with alcohol education are also addressed within an equally extensive and more broadly focused literature on drug education. Drug education in turn is also addressed within the large literature and debate associated with the scope of Health Education within schools and in the community.

- On a state by state comparison, the practice of alcohol education in secondary schools is similar. Figure 1 (pages 20-23) provides a schematic comparison of alcohol education across all states. However, the recommendations for action take a state rather than a national perspective because of the complexity of state administrative arrangements, existing infrastructural support, history of course development in schools and professional networks which form the basis of alcohol education.

- Although alcohol education is touched on in a number of subjects across the curriculum, the most systematic coverage occurs within Health Education.

- Health education is not ranked amongst the subjects of the secondary school curriculum which are the highest priority. Figures 4.1 to 4.5 (pages 27-29) show that Health Education takes at most 10% of the curriculum. The proportion of specific alcohol education studies within this 10% varies from school to school, but constitutes a very small proportion.
• Because alcohol education is integrated into the Health Education curriculum (including decision-making, negotiation skills, conflict resolution and communication) it is difficult to draw a clear line separating alcohol education as such from Health Education.

• Although harm minimisation is widely accepted amongst Health educators as the most appropriate strategic goal for alcohol education in secondary schools, the concept is not well understood by teachers, and in practice other objectives, including abstinence, are still present in the curriculum (see figure 2, page 24).

• The content of alcohol education tends to concentrate on drink driving and peer pressure. The place of alcohol as a part of Australian culture is seldom addressed. These findings (figure 5, page 31) indicate that there is further scope for the development of resources which relate to the experience of young people.

• It is difficult to find systematic documentation of practices of alcohol education in schools (possibly due to the limited time available for this aspect of the curriculum in comparison with other areas).

• Many resources for teaching alcohol education are available, but

  a) teachers now have no systematic means for obtaining information about resources;

  b) many currently used resources do not adequately deal with a harm minimisation approach; and

  c) there is a need for more ‘targeted’ resources which aim to reach particular populations (such as isolated, aboriginal or rural young people).

• Professional development of teachers of alcohol education is almost non-existent. Professional development and pre-service training is a serious weakness facing the effective provision of alcohol education across all states.

• Policy documents and guidelines developed by state departments of education provide frameworks for teaching alcohol education within the context of Health Education. A national curriculum for Health Education is being developed.

• Alcohol education in Australia is characterised by its fragmented nature, both in terms of educational programs offered within schools and the many outside agencies which have an interest in the area. There is a need for the development of closer intersectoral cooperation.
Introduction

Alcohol Education in Context

Recent policy documents suggest that there needs to be more careful attention to the links between secondary education and post-compulsory options for young people (Finn, 1991 and Deveson, 1991). These policies provide a perspective from which to assess how well the secondary education curriculum prepares young people for the circumstances and issues which face them as they move towards establishing themselves as independent adults. The Youth Research Centre has identified three significant dimensions to this transition. These are:

- the structured pathways through post-compulsory education, training and employment;
- personal issues; and
- public participation (Youth Research Centre, 1989).

Although the contemporary rhetoric of 'Pathways' (Finn, 1991) has tended to concentrate on the education, training and employment options, the dimensions of personal issues and public participation are of equal significance to young people as they seek to establish an independent adult identity for themselves (Dwyer and Wyn, 1992). The transition to independence is not simply a vocational issue.

Young people's health is a fundamental aspect of 'personal issues', including their access to information and health services and their ability to make informed decisions regarding sexuality, relationships, diet and their use of drugs, including alcohol (Wyn, 1993). Furthermore, as increasing numbers of young people are now continuing their secondary education to Year 12, schools are confronted with the need to relate their curricula and programs to the full diversity of outcomes for young people, and to prepare young people to negotiate positively and successfully their particular pathways to adult life.

Health education in secondary schools has a significant role preparing young people to deal with the complexities they face with regard to all aspects of 'personal issues'. It is designed to 'affect the way students think, feel and act in regard to their own well being and that of others' (Victorian Ministry of Education, 1989a: 7). Yet, with regard to alcohol education, the curriculum has been developed in a context of considerable debate. Widely divergent theoretical and strategic positions are held in relation to fundamental aspects of young people's lives, such as sexuality and drug use.

Alcohol is widely used by young people in Australian society. There have been a substantial number of reports which indicate that a significant proportion of young people use alcohol inappropriately, regularly drinking to excess (binge drinking). This abuse of alcohol is of community concern because of its negative effects on the health and social relationships of
young people and because of the close link between alcohol abuse and death or serious injury by motor accident and through violence.

Awareness of this has coincided with a rise in community awareness of alcohol and drug problems amongst young people. This awareness has been reflected in the implementation of a number of government initiatives targeting young people's drinking behaviour and with the provision of alcohol education programs in schools.

The National Campaign Against Drug Abuse (NCADA) spent 25% of its funds on supporting school-based alcohol and other drug education in both public and private schools. Over half of this allocation was provided directly to education departments (Ministerial Council on Drug Strategy 1992). An evaluation of NCADA reported that one of its major initiatives in schools, the School Development in Health Education (SDHE) was seen as providing a

structured and supported means of introducing alcohol and other drug education into schools which is integrated into the curriculum, yet allows it to draw on community-based programs to enhance its effectiveness. This leads to a diversity of programs which ideally are responsive to the needs of the school and community environment (Ministerial Council on Drug Strategy, 1992: 34).

There is evidence that these initiatives may be having an impact. A 1989 survey by the Health Department of Victoria (1990) on alcohol use amongst Victorian secondary school students reported that, by comparison with 1985, they recorded a significant decline in the overall prevalence of drinking over that four year period.

Despite this, a high proportion of young people continue to drink to excessive levels. A recent study by the Centre for Adolescent Health (Victoria) found that 18.4% of year 11 boys and 19.8% of year 11 girls surveyed in Victoria drank five alcoholic drinks in a row on a weekly basis. Only slightly fewer year 11 students (15.5% of boys and 16% of girls) reported episodes of extreme bingeing (Centre for Adolescent Health, 1993). An ACT survey of drug use amongst students (May 1991) found that 'of students who drank alcohol in the four weeks prior to the survey, 40% of boys and 30% of girls reported binge drinking at least once during the month.' (Alcohol and Drug Service, 1991).

**Project Outline**

In this context, the Youth Research Centre has undertaken a research project which maps the nature and extent of alcohol education in Australian schools. The aims and objectives of the project are presented in Appendix 1. The project has been conducted in two stages. The first documented current research on alcohol education in secondary schools. The findings, presented in the first part of this report, provided the basis for the development and implementation of the second stage of the project: the mapping of alcohol education programs in secondary schools on a national scale.

In the second stage of the project, interviews were undertaken with seventy-five personnel in all states and territories, including representatives in health and education sectors, curriculum and health consultants, teachers in schools, and agencies involved in alcohol education in school settings. Visits to schools and other agencies allowed the researchers to examine teaching frameworks and resources used in alcohol education.
The area of Health Education has, since 1988, been one of the eight learning areas to be addressed within the national collaborative curriculum projects. These projects are under the control of the Education Ministers of the States, Territories and Commonwealth through the Australian Education Council (AEC). Following a consultative process, a national health statement is in the process of being formulated which will provide, for the first time, a framework for cooperation between schools, States and Territories and the Commonwealth, setting out broad goals and defining the scope and sequence of learning for all students.

The draft document states that:

Learning in the Health area focuses on the study of how human beings function at individual, interpersonal and community levels. For this purpose, the Health area is understood in holistic terms, taking account of the social, emotional, spiritual, physical, mental, and intellectual dimensions of human nature (Australian Education Council, November 1992: 4).

Alcohol education, which is already treated within the Health and Human Relationships frameworks, will be addressed throughout the proposed three 'strands' of the Health curriculum:

1. Human functioning, including: patterns of growth and development; movement and participation; people and food; states of health; identity; interaction, relationships and groups; and challenge, risk and safety;

2. Community environments and health, including: consumer and community; environmental interaction; community practices; and health of populations; and

3. Communication, investigation and application, including: communication; accessing and analysing information; planning and action; and reflection and evaluation. (AEC, November 1992: 12-22)

This initiative provides a coherent and systematic framework within which young people may have the opportunity to explore the issues associated with alcohol and its use in our society. These would include basic issues associated with the physical effect of alcohol on the body, as well as the political issues about the advertising and marketing of various types of alcohol. The treatment of identity would provide an important focus for exploring the extent to which alcohol consumption is identified with styles of masculinity and femininity and the implications of this for young people's relationships.

The national collaboration also provides a more systematic basis for the development of a clear picture of the extent and nature of alcohol education in Australian schools. The new Health Education initiative moves towards the acceptance of a holistic approach, consistent with a particular set of goals and strategies identified above. The acceptance of this initiative will depend on the extent to which the community and teachers associated with schools are able to come to terms with the agenda implicit in this approach.

Although there have been some studies of Health Education in Australian schools, we do not yet have a clear picture of how alcohol education is presented in particular schools. We also
need to know more about the ways in which school-based alcohol education relates to programs conducted in the community.

**Alcohol Education in School-Based Health Education Programs**

The reports of school-based alcohol education programs range from those on specific intervention projects to outlines of larger on-going and systemic programs of Health Education. Most of the evaluation reports have concentrated on the former. This is perhaps not surprising - they are coherent, short-term, and have specific objectives which are therefore more easily evaluated than is alcohol education which takes place within a holistic Health Education program.

However, much of the literature stresses that alcohol (and drug) education must be seen as part of an on-going and comprehensive Health curriculum approach. (For example, see: NCADA, 1988; Ballard et al, 1991; James and Carruthers, 1991)

Several Australian Health Education programs have been based on such principles. Four of these are:

**The School Development in Health Education Project (SDHE)**

A joint project of the Curriculum Development Centre (Canberra) and NCADA, the SDHE Project was established in October 1988 to develop a national strategy for drug education in consultation with all Australian education systems. Three states initially participated in the project: Victoria, South Australia and Queensland; it was then extended to other states and territories. In each state, the project worked with a cluster of four schools. (Garrard and Knight, 1989; Irwin et al, 1990; Irwin et al, 1991)

The SDHE Project draws upon curriculum and development principles similar to those of the Victorian Health Education Pilot Project. Its evaluation will support the development of effective curriculum policy and practice in drug education across Australia.

**The Victorian Health Education Pilot Program (HEPP)**

This program, established in 1988 to assist schools and local communities to plan and implement Health Education and drug education programs, was a joint initiative of the Victorian Ministry of Education and the Health Promotion Unit of the Health Department Victoria. It worked in 13 schools in the Western Metropolitan Region, to assist schools in planning and implementing programs which are suitable in their own school-community contexts. (Garrard and Knight, 1989)

The program draws upon theoretical frameworks of:

- community development in health - which stress community action, development of personal skills, creation of supportive environments, reorientation of health services and development of public policy; and

- school-based curriculum development and innovation - that ‘development of comprehensive Health Education will come largely from within each school community, stimulated and sustained by motivated and informed teachers who are adequately resourced and supported in their efforts.’ (Garrard and Knight, 1989: 136)

**The Youth Alcohol and Community Project**

The Youth Alcohol and Community Project was established at the (then) Victorian Alcohol and Drug Foundation in 1990 in response to initiatives from post-primary schools. The schools component aims to ‘assist school communities to respond to alcohol issues using innovative strategies and building on existing ones (and) ... to develop models of action which all post-primary schools can use to address alcohol related issues.’ (Munro et al, 1992)
The project recognises the range of factors influencing young people’s use of alcohol: person (eg confidence, assertiveness); social (eg role modelling, peer pressure); environmental (eg availability and promotion of alcohol); and structural (eg family breakdown, unemployment). A variety of school community responses are supported in nine areas throughout Victoria. The three year project is supported by funding from the Victorian Health Promotion Foundation and the National Campaign Against Drug Abuse (NCADA).

The Health in Primary Schools Project (HIPS)

The Health in Primary Schools Project operated in 45 Victorian primary schools from 1989 to 1992. It encouraged primary school communities to identify innovative ways to improve the Health Education available to students, particularly by considering:

• classroom Health Education programs;
• whole school policies and environments;
• redirecting and accessing local health resources and facilities.

The Project acknowledged the differing needs of individual communities, yet produced some materials and newsletters which shared the common findings with many other school communities. The Project outcomes included local Health curriculum materials, joint community/school environment projects, safer playgrounds, self esteem and personal development programs, healthier canteens and better teaching in schools. (Detailed case studies are outlined in Went, 1991.)

Towards a Descriptive Framework for Alcohol Education Programs

The literature reports substantial differences in the aims, scope and strategies used in alcohol education across and within States and Territories and according to school year level. Some research studies have identified Health Education curriculum approaches which take a systematic, holistic approach, similar to the one outlined above in the national collaboration project. However, in other instances, Health Education is reported to be treated as an ‘extra’ to the regular curriculum, and schools are serviced for a limited time by travelling Health Education experts.

There are also substantial differences in curriculum approaches. Some programs have concentrated on developing centrally prescribed curriculum courses and materials while others stress support for a process of locally developed curriculum responses (Rowling, 1987). In the future, the national collaborative curriculum projects are likely to have an impact on this picture.

There is little information available currently on the nature and extent of different programs dealing specifically with alcohol education. This overview has found that the information is patchy, and that most of the literature has concentrated on intervention programs rather than on mainstream Health Education curriculum.

Based on the findings of the available research, we would suggest the development of a descriptive framework for alcohol education programs in schools throughout Australia, on three broad levels:

a) clarification of the goals of programs:
   • what outcomes are programs trying to achieve?
   • what assumptions underlie these goals?

b) clarification of the strategies of programs:
   • what specific strategies are adopted?
• what are the educational assumptions being made?
• how well do the strategies match the goals?

c) prior evidence about the effectiveness of such programs
• what do we know from the literature about the likely outcomes of programs with these goals and strategies?
• what do we know from the literature about the validity of these assumptions?
The Research Evidence

The Goals of Alcohol Education

The goals of alcohol education generally are to decrease the harmful effects of alcohol consumption on individuals and within the community. However, in relation to Health Education programs, there is little agreement over the specific goals, including the question of what behaviour should be changed, why it should be changed and how such changes can be achieved. These dilemmas, in turn, make it difficult to provide a consistent assessment of whether programs are ‘working’, and in whose terms.

The main goals of Health Education programs in relation to alcohol are:

a) **abstinence.**

Should young people be ‘saying no’ to drinking (assuming they have not begun to drink alcohol) or quitting or decreasing consumption (assuming that they do drink alcohol)? Abstinence was most frequently discussed in the literature produced in the 1950s, although it emerges in assumptions underlying some programs today.

There are complexities here associated with distinctions made by some between the ‘use’ and ‘abuse’ of alcohol, though the issues may be clearer for younger children, where any regular use of alcohol can be considered to be an abuse (Newcombe and Bentler, 1989: 243; Hamilton et al., 1991: 38). On the other hand, concerns about ‘teenage drinking’ centre on the harmful behavioural outcomes of heavy, regular drinking which is associated with general health, deviant behaviour and educational problems (Smith, 1988: 3; Hamilton et al., 1991: 39).

The literature discussing abstinence reveals a debate between programs advocating the prevention of young people initiating drinking and those aiming at encouraging young people to give up or cut down on existing drinking. The literature concludes that ‘campaigns aimed at preventing or delaying the initiation of drug taking are generally preferable to those promoting cessation.’ (Oldenburg and Lemon, 1992: 60; also see: Polich et al., 1984; Reid, 1985)

b) **responsible or appropriate drinking**

Many alcohol (and general drug) education programs espouse an aim of encouraging ‘responsible’ or ‘appropriate’ use (eg Wragg, 1987), while few attempt to define what is meant by these terms (Garrard and Northfield, 1987). Other programs talk of making ‘wise’ or ‘considered’ or ‘knowledgeable’ decisions about drinking. This involves knowing how much to drink, limiting drinking behaviour and similar issues. Often also referred to as ‘prevention of alcohol abuse’ (though there has been a recent movement away from the ‘emotional’ term abuse, to a more value-free statement of misuse), it assumed that misuse was associated with individual deficiencies, either of a clinical, or psycho-social nature. So this goal was often associated with affective approaches to behavioural changes around issues such as self-esteem, value clarification, and power.

c) **harm minimisation**

More recently, programs have adopted a less judgmental approach to drinking and have accepted that some young people will drink for a variety of reasons. These programs seek to minimise environmental factors that lead to harm - factors such as
what they drink, where they drink, and consequences of drinking. ‘The consequences of adolescent drinking and drunkenness include injury, violence, difficulties at home, school and with the law.’ (Hamilton et al, 1991: 39) Similarly, the Commonwealth Department of Health (1985) argued that ‘as part of Health Education, drug education should assist young people to develop healthy and discerning beliefs, attitudes and intent towards their use of drugs with the aim of reducing and avoiding the harmful consequences of drug use generally.’

d) social decision making and action

Most recently, approaches to drug education in general (and alcohol education in particular) have adopted goals that go beyond those of individual decision making about substance use (‘resisting social and environmental influences’) towards those which aim at ‘empowering individuals and groups to change their environment’ (Garrard and Northfield, 1987: 11). Such programs aim to support young people in individual and social decision making about and action on the conditions that hinder their personal and social well being and that influence alcohol misuse. For example, the guidelines of the Victorian Ministry of Education’s Personal Development Approach to Drug Education recommend that programs should ‘give students the capacity to take effective action in their lives’ (1989a: 11).

Current Health Education course descriptions build upon the research evidence of programs based on each of these goals. Such courses incorporate positive aspects of all the above goals in a ‘holistic’ approach. For example, a holistic personal development approach has been described as aiming to:

provide students with the opportunity to gain the following:

- Relevant information
- An awareness of the significance of values and attitudes
- Opportunities to develop skills in communication, assertiveness, stress management, gathering and evaluating information, considering alternatives and their consequences, and taking social action.

(Victorian Ministry of Education, 1989a: 11)

Assumptions about young people

The Deficit Approach

The first two of the goals outlined above are based on psychological or social deficit models that assume that there is something **wrong** with the young person or with their family if they use or abuse alcohol. Therefore, these approaches say, we have to tell them to ‘cut it out’ or ‘cut it down’, or teach them to be ‘responsible/informed’, or patch up other conditions in their lives. The assumptions underlying this approach are summed up by Wragg:

In general the psychological theories of drug abuse assert that drug abusing individuals possess a number of personality deficits. These deficits exist prior to drug use and they create a vulnerable individual who is either predisposed towards drug use, and deviance, or who uses drugs in order to cope with psychological problems.... (However) for the vast majority of adolescent drug-users and experimenters, a personality-deficit hypothesis or a symptom-relief explanation is untenable. (Wragg, 1992: 22)
A further criticism has been levelled at such approaches because they stress individualistic rather than structural or socio-economic factors. They are seen to overlook the extent to which health is a social product, and to assume that people have ‘free choice’. The individualistic approach has also been criticised because it is ineffective (Naidoo, 1986: 19). Others have pointed out the tendency to ‘blame the victim’ that is implicit in the individualistic approach (Bagnall, 1991: 16).

**The Decision-making Approach**

The latter two (and most recent positions) pose an alternative. They argue that young people can and are making choices that they consider valid - an informed or an uninformed choice, a wise or a foolish choice, but a choice all the same. These choices are constructed in interaction with their environment. We should start from acknowledging those choices (though we may disagree with them) and work collaboratively with the young person on ways to take action and exercise control over the environmental factors, in order to avoid harmful individual and social consequences of those choices.

Bagnall notes that this is a difference between **Health Education** which is ‘intended to help individuals to change (or to adopt) healthy behaviours in relation to alcohol use’ and **health promotion** which ‘would have to go beyond this to include ... interventions in the economic and political spheres...’ (Bagnall, 1991: 17).

**Influences: Young People, Alcohol and Environment**

The literature identifies three major and interconnecting factors or spheres of influence on alcohol (and other drug) use (Bagnall, 1991; De Haes, 1987; and Hamilton et al, 1991):

**a) context or environmental factors:** factors in society that promote or reduce alcohol consumption, ranging across epidemiology, social, individual and legislative factors.

Programs from this perspective would concentrate on issues like parental drinking; regulation of alcohol through family, school and work; peer relations; interaction with legislative controls such as a minimum drinking age; influence and nature of advertising and promotion. They aim to make the environment (in this broader sense) ‘less hostile to drinkers’ (Heather, 1985: 191-2)

**b) substance or agent factors:** factors associated with and specific to alcohol itself including legislative controls (see NCADA, 1992).

Preventative measures here focus on the availability of alcohol through legislation. Research evidence is mixed but appears to throw doubts on the efficacy of such measures.

**c) individual or host factors** - factors about the young person using alcohol, including psychological factors.

Programs seek to change an individual’s behaviour and quite often start from a moralistic stance which exhibits concern for the person’s ‘weakness of character’. (Hamilton et al, 1991: 40)

The research suggests that no single factor amongst these can be singled out as more significant than the others. Bagnall concludes that

educational programs based on individual factors in isolation are unlikely to be effective because they do not take account of either the specific drug or of
the context of its use. The same prediction of ineffectiveness would hold for a program which is merely drug based. (Bagnall, 1991: 13-14)

Strategies of Alcohol Education

The development of specific strategies adopted in alcohol education programs have reflected the same assumptions as the goals outlined above.

Shifting Emphases

The shifting emphasis over recent decades in drug education in general has been characterised by the Victorian Ministry of Education (1989a: 11) as:

“Late 1960s:” The emphasis at this time was on knowledge, the rationale being that if students were given the relevant information, the undesirable consequences of drug taking would be reduced. ‘There is a wealth of evidence that knowledge of the facts does not often affect behaviour directly.’ (National Drug Abuse Information Centre, 1987)

“Early 1970s:” At this time, there was a movement towards an affective approach rather than the previous cognitive approach. The rationale was that by helping the individual clarify his or her values and attitudes, it was less likely that this person would misuse drugs. ‘No evidence (has been) found that (these) programs had any success when subjected to scientific evaluation.’ (ibid)

“Late 1970s:” By this time the shift was towards the situational nature of drug taking, highlighting the social skills, such as teaching students effective and socially acceptable ways of saying ‘no’. Successful new programs using this approach have been described. (ibid)

“Mid 1980s:” There was now evidence that a combination of approaches was superior to a single approach, and that programs combining peer influence with specific skills, including peer refusal and communication-skills training, was favoured. (Tobler, 1986)

“Late 1980s:” Most drug education programs have concentrated on the influences on the individual that could lead to the possible misuse of drugs. More recently, suggestions have been made that Health Education programs should include the notion of social action. ‘In turn the individual, singly or in groups, influence the society around them and can take action ... to overcome conditions that hinder personal and social well being.’ (Victorian Ministry of Education, 1989b)

Models for Programs

We can see these broad movements reflected in specific models of alcohol education programs (based on Polich et al, 1984; French and Adams, 1986; Garrard and Northfield, 1987):

Model 1: The information model
This model was, for many years, the dominant approach. It assumed that students lacked information and were ignorant of the harmful effects of alcohol. ‘Programs were information-based, substance-focused and didactic. They frequently lapsed into propaganda, scare tactics and moralistic exhortations not to use drugs.’ (Garrard and Northfield, 1987: 10) Such substance-focused approaches were also allied with legislative measures that attempted to make alcohol harder to obtain.

In more recent variations and in order to achieve similar goals, programs have concentrated on the provision of information on the physiological and social consequences of heavy drinking. In such programs, young people were given information on what drinking does to the body.

For example, Life Education Centres use ‘body information’ or ‘body awareness’ approaches: ‘awareness of themselves by getting to know of what the human body is comprised, how it functions, of how and why it is affected by substances that upset its delicate equilibrium’ (letter from Sheila Hammond, PR Coordinator, 5/3/92); and ‘designed to help the children develop a healthy respect for their bodies, and for themselves ... As children become more aware of the risks, they become less likely to experiment with potentially dangerous substances.’ (letter from Sheila Hammond, 2/5/91)

There is widespread evidence that information provision per se does not work. At best, there may be some knowledge changes, but little or no evidence of attitude or behaviour change (Kinder et al, 1980). In fact, some research indicates a connection between information-provision programs and increased ‘experimentation with alcohol’ (Stuart, 1974; Bagnall, 1991: 24).

**Model 2: The individual deficiency model**

From the early 1970s into the 1980s, some programs based on psycho-social theories particularly emphasised the development of increased self-esteem, and decision-making and communication skills by young people. Palin has noted the assumption in many such programs that ‘people who engage in ... behaviours (relating to drugs) must be in some way personally deficient’ (Palin, 1990: 222) and strongly attacked the evidence for these. He claims that there is little or no evidence that these assumptions are correct or that desirable outcomes occurred. Others have indicated that such ‘affective education’ approaches have shown inconclusive results (Polich et al, 1984; Reid, 1985).

**Model 3: The social pressures model**

More recently, programs have recognised the influence of social and environmental factors on young people’s alcohol use. Strategies have sought to develop young people’s ability to seek ‘alternatives’ to alcohol misuse and have therefore concentrated on areas such as assertiveness and resistance-to-persuasion (Garrard and Northfield, 1987).

The strategies of these programs have been classified as being directed towards:

- increasing knowledge and changing attitudes;
- teaching values and decision-making skills;
- developing peer refusal and social competency skills.


Programs have either stressed personal resistance to pressure or collective action on health issues. Recent US-based programs, in particular, tend to aim to improve health
through developing people’s ability to understand and control their own health status, while programs in England have included both health and social action with the aim of changing environmental, social and economic factors (Garrard and Northfield, 1987; Tones, 1986).

Positive results are reported from such drug education programs (Polich et al, 1984; Reid, 1985; Botvin, 1986; Flay, 1985), though few results are specifically available around alcohol education.

**Model 4: The social action model**

Recent Australian developments in Health Education have been aimed at ‘empowering individuals and groups to change their environment rather than simply learning how to resist it.’ (Garrard and Northfield, 1987: 11) Such approaches are seen throughout the Victorian Ministry of Education’s Personal Development Curriculum Framework approach (Victorian Ministry of Education, 1989b). Skills in making decisions and taking action are developed through phases of ‘choosing’, ‘acting’ and ‘reflecting’.

More recently, strategies within the ‘harm minimisation’ goal have refused to adopt a moralistic approach to drinking (see Berridge, 1992), and have recognised that young people will drink for a variety of reasons developed within the triangle of factors referred to above. Approaches have concentrated on collaborative efforts, peer education (Dayton, 1987) and meeting the expressed concerns of young people around potential harm associated with alcohol abuse.

In current practice, no single model is solely represented in a program. Distinctions are blurred and contemporary holistic Health Education approaches:

- draw on many aspects of the earlier single-focused programs, thereby incorporating features such as: information on short- and long-term health hazards; surveys of drug use and comparisons with students’ perceptions of drug use; values clarification and exercises for building self-esteem; discussion of pressures to use drugs from peers, advertising etc; practising resistance to these pressures; using same- or cross-age peer leaders to lead discussion; understanding social influences and control; and practising individual and group action for social change. (Garrard and Northfield, 1987: 13)

**Inappropriate Strategies**

The Victorian Ministry of Education, referring to Webb (1987), has suggested that certain strategies are inappropriate as they ‘appear ineffective, and possibly counter productive, in that student curiosity could be aroused to the point where the risks of drug taking may become attractive, especially in a drug-oriented society.’ They suggest that the following approaches be avoided:

- Information only approaches, that concentrate on the substance and its effects rather than on the individual.

- The use of emotional scare tactics designed to frighten people into a commitment to abstinence.
• The practice of organising a single session, or inviting a guest speaker for an information evening.

• The use of ex-addict testimonials.

• Over-detailed descriptions of the use and effects of different drugs, and information about methods of use, especially with regard to exotic and illegal substances.

Outcomes

While the most pessimistic commentators suggest that there is no research evidence for any programs working, and that this is not surprising, given the constraints placed upon programs and the strength of influences of the industry lobby groups, including the impact of advertising (see Saunders, 1989; Hawks, 1991), others claim hopeful signs for various approaches (James and Carruthers, 1991; Wragg, 1991).

It is understood that educational campaigns alone are ineffective in bringing about changes in attitudes and/or behaviour, as are public/media education campaigns. However, the evidence suggests that media campaigns ... can increase awareness, change attitudes and provide a context in which other strategies for behavioural change can succeed. (US Dept of Health, 1990: 231; Moskowitz, 1989: 74)

Furthermore, it has been found that strategies that involve only attention to individuals, or only attention to alcohol, without consideration of the environment or social context, are unlikely to show significant results. Indications are that knowledge-only and affective-only programs are ineffective. (Hamilton et al, 1991: 42, quoting other studies)

Attention has also been given to the more general educational lessons around program development. It has been pointed out that the questions of implementation, and in particular of teachers’ attitudes and expertise, are crucial to the effectiveness of programs. Garrard and Northfield note that:

In the rush to produce effective drug education ‘programs’, it is sometimes easier to focus on the more obvious, visible components - the various texts, programs, kits, packages, videos and other tangible resources that aid drug education efforts - and neglect the crucial human resources which can so effectively decide the fate of such programs. (1987: 15)

Other researchers have concluded that education programs must start with the teachers themselves. ‘The only effective way to proceed is to attempt to create the enabling conditions that give them the initiative to bring about change.’ (Walker, 1987: 20)

The Need for an Accurate Map

As secondary schools face the challenge of catering to the diversity of students who now complete their secondary education, the Health Education curriculum has acquired a new significance. The developing national collaborative curriculum project indicates that, in the future, Health Education at all levels of secondary schooling will be cross-disciplinary and systematic. Alcohol education clearly has an important place within this curriculum.

The research evidence reveals that alcohol education is located within an on-going debate about its goals, aims and strategies. More than three decades of research in this area have contributed to an emerging consensus amongst the protagonists about the nature of strategies which are deemed effective. The evidence, however, is drawn largely from short-term, specific alcohol education programs.

What is actually happening in schools? What is the nature of the alcohol education curriculum? Where is it taught and by whom?

The second stage of the project has aimed to fill gaps in our knowledge by mapping alcohol education in Australian secondary schools.
Project Findings

Overview: A National Perspective

The project has found many similarities in the practice of alcohol education in Australia between schools and across states and territories. This is despite differences between the state education systems which influence policy, guidelines, staffing levels and the extent of involvement of 'outside agencies' such as community police or Life Education Centres.

In every state and territory, there is a broad continuum of practice in alcohol education. At one end of this continuum, there are schools with no recognisable health or drug education program; at the mid-point in the continuum there are schools providing a few lessons of drug education and a visit from an outside agency to talk about drugs; at the other end of the continuum there are schools with comprehensive, sequential Health Education programs which give specific attention to alcohol as a topic.

The practice of Health Education in schools across Australia consists of similar content and approaches to teaching. Content regularly includes sexuality, relationships, nutrition, community health, consumer health, growth and development, caring about our bodies, drug use and abuse and safe practices. The most popular teaching resources for these approaches indicate a common and shared use of suitable and preferred teaching materials. The most common approach is one of personal and skill development. This emphasises the processes used in the learning environment and acknowledges that communication, relationships and other interpersonal skills are the same skills upon which drug education programs focus. The need for reasoned decisions, group action, coping with stress and the building of self esteem are all identified as integral parts of drug education.

Figure 1 provides a summary comparison of alcohol education on a state by state basis, illustrating the similarities and differences. The following discussion takes up the most significant issues which arise from this comparison. Consequent recommendations for action necessarily must take a state perspective, because of the complexity of state administrative arrangements, personalities, existing infrastructural support, history of course development, and networks which surround alcohol education at a state and territory level.

It should be noted that arrangements in this chart were reported in interviews in May 1993; specific provisions (particularly of central and regional consultancy support) may have subsequently changed.
**Figure 1: INTER-STATE COMPARISON SUMMARY:**

**DOCUMENTS:**

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Central Policy Document</th>
<th>Health Course Document</th>
<th>Alcohol &amp; Drug Ed Support Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Victoria</strong></td>
<td>School Curriculum and Organisation Frameworks Schools of the Future</td>
<td>Personal Development Framework 1986</td>
<td>Drug Education: A Personal Development Approach - Primary/Secondary</td>
</tr>
<tr>
<td><strong>ACT</strong></td>
<td>ACT Frameworks</td>
<td>Framework for Health Education</td>
<td>None produced locally</td>
</tr>
<tr>
<td><strong>NSW</strong></td>
<td>NSW Board of Studies</td>
<td>Personal Development, Health and Physical Education Syllabus</td>
<td>Key Learning Area Personal Development, Health and Physical Education support document</td>
</tr>
<tr>
<td><strong>Queensland</strong></td>
<td>Corporate Plan: Queensland Education Department 1993-1997</td>
<td>Health Framework P-10</td>
<td>Interpersonal Skills in Drug Education other specific resources (eg PASS, Live to Ride, Dear Diary)</td>
</tr>
<tr>
<td><strong>Northern Territory</strong></td>
<td>Northern Territory Board of Studies Document</td>
<td>Health Education - Draft WA Health Course</td>
<td>‘Interpersonal Skills in Drug Education (NT)’ - based on Queensland material</td>
</tr>
<tr>
<td><strong>WA</strong></td>
<td>WA Health Education Syllabus (K-10) (1984; February supplement 1991)</td>
<td></td>
<td>Specific and detailed Health units for each year level A Program Approach to Drug Education</td>
</tr>
</tbody>
</table>
## COURSE STATUS:

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Course Status - Primary</th>
<th>Course Status - Junior Secondary</th>
<th>Course Status - Senior Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria</td>
<td>Guidelines</td>
<td>Guidelines</td>
<td>Optional VCE subject: Unit 1/2/3/4 'Health' subject</td>
</tr>
<tr>
<td>ACT</td>
<td>Guidelines</td>
<td>Guidelines</td>
<td>Options</td>
</tr>
<tr>
<td>NSW</td>
<td>Mandatory</td>
<td>200 hours Health Education mandatory: school based</td>
<td>Compulsory 25 hour Year 11/12 unit</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Guidelines</td>
<td>Some form of Health Education compulsory in Years 9-12</td>
<td>School-based Health Education courses</td>
</tr>
<tr>
<td>Queensland</td>
<td>Guidelines</td>
<td>Guidelines</td>
<td>Options</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Recommend WA course</td>
<td>Recommend WA course</td>
<td>Use SSABSA courses or other</td>
</tr>
<tr>
<td>WA</td>
<td>Guidelines</td>
<td>Guidelines (average 3.3 units taught: equivalent to 45 hours)</td>
<td>Optional 'Health' unit</td>
</tr>
<tr>
<td>SA</td>
<td>Guidelines</td>
<td>Guidelines</td>
<td>Optional SACE course: 'Health' - half year subject</td>
</tr>
</tbody>
</table>
**SUPPORT: Education**

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Central Education Support</th>
<th>Regional Consultancy Support</th>
<th>NCADA Funding for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria</td>
<td>Drug Education Support for Schools (DESS): 3 persons centrally</td>
<td>8 Regional Drug Education Consultants</td>
<td>(SDHE) DESS</td>
</tr>
<tr>
<td>ACT</td>
<td>Principal Curriculum Officer; 0.5 Schools/SDHE Consultant</td>
<td>All one region</td>
<td>SDHE</td>
</tr>
<tr>
<td>NSW</td>
<td>Health Education Unit Cross-Curriculum Support Unit</td>
<td>Regional Drug Education Consultants</td>
<td>(SDHE) Drug Education Consultants LEC Health Education Unit (Sydney University)</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Principal Policy Officer plus one part-time consultant</td>
<td>Lions DEN - 3 Regional consultants Team-based consultancy model: one Health Education Consultant in North-West</td>
<td>(SDHE) Lions DEN Skills for Adolescents LEC Alcohol and Drug Services</td>
</tr>
<tr>
<td>Queensland</td>
<td>Policy Officer; Alcohol and Drugs Program Unit</td>
<td>Generalist consultancy model: few specific Health Education consultants - Regional priorities</td>
<td>SDHE Alcohol and Drugs Program Unit (in Education) LEC School of Social and Preventive Medicine</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Senior Policy Officer</td>
<td>Health and Personal Development Consultants</td>
<td>SDHE Consultants DARE LEC</td>
</tr>
<tr>
<td>WA</td>
<td>Senior Policy Officer</td>
<td>Health Education Officers (Health Dept) - with schools brief</td>
<td>SDHE (now linked to WASHP)</td>
</tr>
<tr>
<td>SA</td>
<td>Health and Personal Curriculum Officer Health and Personal Development National Curriculum Officer</td>
<td>None</td>
<td>(SDHE) LEC</td>
</tr>
</tbody>
</table>
## SUPPORT: Other

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Other Departmental Support</th>
<th>Special Health Education Projects</th>
<th>Other Agencies in Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria</td>
<td></td>
<td>Youth Alcohol and Community Project funded by ADF and Vic Health</td>
<td>LEC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Drug Education Support for Schools (DESS)</td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>ACT Health - Drugs and Kids Drug Education sessions for parents, Triple T Peer Education Manual</td>
<td></td>
<td>LEC</td>
</tr>
<tr>
<td>NSW</td>
<td>Regional Road Safety Education Consultants</td>
<td>NSW Drug Education Strategy</td>
<td>Lions Drug Education Network (DEN)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>LEC - Primary</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Police in Schools</td>
</tr>
<tr>
<td>Tasmania</td>
<td></td>
<td></td>
<td>LEC - Primary</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Police in Schools</td>
</tr>
<tr>
<td>Queensland</td>
<td></td>
<td></td>
<td>Police in Schools</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>School Nurses - with teaching brief in Health Education</td>
<td>Alcohol Policy Branch (Youth Officer)</td>
<td>DARE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Living With Alcohol (Aboriginal workers)</td>
<td>LEC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Police in Schools Project</td>
</tr>
<tr>
<td>WA</td>
<td>School Health Programs via Health Promotion Services (Health Department)</td>
<td>Western Australian Schools Health Project (WASHP) funded by WA Health Promotion Foundation; Aboriginal School Health Project Ministry Education</td>
<td>LEC</td>
</tr>
<tr>
<td>SA</td>
<td>Health Education Inter-Agency Advisory Committee - Health in Schools Reference Group; Drug and Alcohol Services Council - one Education Officer</td>
<td></td>
<td>DARE (trial)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Police in Schools Project</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>LEC</td>
</tr>
</tbody>
</table>
Approaches to Alcohol Education

Goals of Alcohol Education

Harm minimisation has been identified in the National Campaign Against Drug Abuse (NCADA) guidelines as the overall goal of alcohol education. A harm minimisation approach is one which aims to reduce the adverse health, social and economic consequences of alcohol... by minimising or limiting the harm and hazards for both the community and the individual without necessarily eliminating use.

*National Health Policy on Alcohol in Australia*

*NCADA*

Translated into health and alcohol education in schools, such an approach encourages ‘responsible drinking’ or teaches students ‘how to drink’. It is a move away from telling them that it’s wrong because it’s against the law, or that ‘it would be better if you didn’t’. It acknowledges the statistics about under-age binge drinking, young male deaths in cars and the role that alcohol plays within Australian society, and sets out to educate students within this context. Such an approach would provide strategies which empower students to make responsible choices and respects students’ choice to drink alcohol.

While many senior policy officers and drug education consultants interviewed in this study identified harm minimisation as the most appropriate approach for school-based alcohol education, this was not the case with most teachers. Harm minimisation is not a concept which teachers of health understand accurately, nor one (consequently) with which they feel comfortable. A number of the policy officers and consultants have recognised this, and acknowledge the need to focus future professional development and resources towards a better working knowledge of harm minimisation.
While many of the current resources report harm minimisation as their major aim, the appropriateness of some materials is now being questioned. The objective of learning to ‘say no’ or, in the case of one Northern Territory program, ‘DARE to say no’ is very familiar in primary schools. While secondary schools place some emphasis on responsible behaviour, lessons which focus on getting natural highs rather than chemical highs, and resisting peer pressure are still common. See Appendix 2 for examples of the contradictory messages in some course materials.

By contrast, the following approach emphasises goals of harm minimisation:

It is unrealistic, indeed undesirable, to expect people not to use drugs at all. Rather it is preferable to look at why they take drugs, and suggest ways in which the misuse of drugs can be avoided.

*Drug Education - A Personal Development Approach: Post Primary*
Victorian Ministry of Education, 1989a

Other favoured approaches which alcohol education has in common with other subjects include social skill development, decision making, personal development and comprehensive or holistic approaches. These may include content from a range of different topics and deal with knowledge, skills and attitudes in relation to drug use or sexual behaviour or family relationships. A unit may take a focus on decision making, being assertive or protective behaviours, all of which have enormous scope for the inclusion of health and drug related education. The following chart presents one example.
Figure 3: Drug Education Concept Map
From: Personal Development, Health and Physical Education Course Outline
New South Wales Directorate of School Education, 1992
The Location of Alcohol Education Within the School Curriculum

Alcohol education in every state and territory is seen as a part of drug education which, in turn, is located within the broader area of Health Education. Health Education is recognised by all states and territories as having a body of content of its own. However it is sometimes linked with, or taught as part of, other subjects especially physical education.

A few schools were identified where some of the Health Education content was taught in Pastoral Care or Home Groups (Tasmania and Victoria). In addition, there was frequent discussion of alcohol education occurring ‘across the curriculum’. People working in the area acknowledged that some aspects of alcohol education were covered in a range of subjects, including science, social education, English, home economics and history. The other area where alcohol education is often covered is in road safety education, pre-driver training or driver training courses. As pre-driver training is not mandated, it is usually offered as an option for some students. When Health is taught in a cross curricula fashion it is less likely to be systematically documented than when it occurs within a specified and separate subject framework.

The processes of teaching and learning in the Health area are recognised as an important part of the Health Education curriculum. These include decision making, negotiating, resolving conflict, problem solving and communication, all of which constitute a significant component of alcohol education. In this sense it is difficult, and inadvisable, to separate alcohol education from other Health Education topics.

The Status of Health Education Within the Whole School Curriculum

While most alcohol education in schools occurs within the area of Health Education, at most 10% of the overall curriculum time is allocated to this area. In practice this means that the alcohol education component is very small.

Over the last five years, drug education has been identified as a priority area by a number of school systems, including those of Tasmania, Queensland, New South Wales, Victoria and Western Australia. This support for drug education has involved the appointment of consultants to support schools, the development of state drug education resource documents for teachers, national projects such as the School Development in Health Education Project (SDHE) funded by the National Campaign Against Drug Abuse (NCADA), as well as locally based teacher professional developments. These initiatives coincide with the availability of NCADA funding (although some funding is also provided or matched by state education systems).

In each state and territory, policy and guidelines provide a framework for the Health Education curriculum. However, as schools have moved towards greater curriculum autonomy within their State Education Departments, a diversity has emerged amongst schools in the interpretation of what constitutes a comprehensive Health Education program.

This study found that, particularly in Tasmania and Queensland, as schools respond to changes in the structure and content of the curriculum (for example, in relation to the policy implications of the Finn, Mayer, and Carmichael Reports) and to state education ‘priority’ statements, alcohol and drug education had receded further into the background. Within Health Education, for example, AIDS education has particularly influenced the time allocation given to Health Education, and the comparative emphasis on issues within those courses.

This occurs relatively easily as, within the hierarchy of subjects in schools, Health Education does not rate highly. While guidelines suggest a comprehensive coverage of topics, a number of schools reported only two compulsory semesters over three years (Years 8-10) in which to cover all the Health curriculum content. A number of schools taught some Year 7 Health; however, as Year 7 is part of primary education in some states and secondary education in others, Health Education is taught at this level under a diverse range of conditions. Figures
4.1-4.5 illustrate the relative time allocation for Health and Personal Development in Victoria and the Northern Territory.

**Figure 4.1: Subject allocation in one Victorian Primary School**

**Figure 4.2: Subject allocation in one school's Year 7 curriculum, Victoria**
SECONDARY: Years 9-10 (VICTORIA)

Figure 4.3  Subject allocation in one school’s Year 9-10 curriculum, Victoria

From School Curriculum Organisation Framework
Victorian Ministry of Education, 1986

PRIMARY: YEARS 4-7 (NT)

Figure 4.4  Subject allocation suggested for years 4-7 in Northern Territory Schools
The interviews with Health Education teachers revealed a level of concern about the relatively low profile and minimal allocation of time to Health Education in many schools. The low priority given to Health Education was reflected in the reported strategy whereby ‘Health is taken by anyone on staff who doesn't have a full allotment’.

Our limited survey of schools has indicated that only 28% of respondents reported that Health Education classes in their secondary schools were conducted by specialist Health Education teachers, while 72% were taken by other subject teachers (not always by choice) or by homergroup teachers. In primary schools, Health Education is taught by the classroom teacher, usually as part of an integrated curriculum.

A survey of Health Education in Western Australia, conducted in 1991, reported that the average secondary school taught 3.3 units of Health across Years 8-10, each unit being about 30 hours (Australian Council of Health, Physical Education and Recreation and National Heart Foundation, 1991). Our findings would indicate that this extent of Health Education would only be matched by New South Wales’ mandated curriculum requirements where schools must include 200 hours of Personal Development and Health over the four junior secondary years (7-10) - an average of 50 hours a year. This, in addition to the compulsory 25 hour unit of Health Education in the senior years (11-12), puts New South Wales in a substantially different position to that of other states.

At the senior years, a range of Health units may be offered as electives within school subject selections. The guidelines for these units are developed within HSC/VCE/SACE or the
equivalent body. The percentage of students undertaking such studies varies substantially from state to state. For example, approximately 8% of Victorian VCE students are enrolled in Health units.

**School-Based Programs**

Details of practices in alcohol and drug education in school-based programs are not always easily accessible due to a lack of clear and concise documentation. Traditionally, Health Education has not been well documented in Years 7-10, often because there has been no designated subject coordinator. While many teachers in this study outlined lesson plans and referred to different resources and texts they had used, a number of schools were unable to produce documented unit outlines. A few had rough outlines or an organised list of topics, which constituted their course (see Appendix 3 for one example). Possibly documentation does exist but was unavailable. Possibly some schools and teachers are unwilling to give away copies of their documented programs. This poses a question as to the sustainability of such units, particularly if they are filed in someone’s head, or associated with an individual rather than a subject area.

The schools visited in Western Australia were working from the K-10 document and had outlined the sections of the larger document that they were to use (see Appendix 4). One Tasmanian school had an extensive teaching resource file categorised under topic and year level headings and this was available to all staff. This sets the basis for their courses, however the absence of a specific unit outline had led to some replication. This is a particular issue when the time allocation for Health Education is so small in comparison to the large content area. There appears to be a need for better and more systematic documentation of school based programs.

A number of schools identified prepared school based packages and kits as appropriate school alcohol and drug programs. The Triple T Manual (Teenagers Teaching Teenagers) is one such package which provides schools with a peer drug education approach. The Triple T project was funded and implemented in schools which requested it in the ACT. The implementation and group facilitation was supported by the Alcohol and Drug Service, at no charge to schools. This type of program with such resourcing from outside was the exception.

**Teaching Strategies Used in Classrooms**

The teaching strategies being employed in alcohol education classes appear to be interactive and practical in nature. This reflects a shift in practice away from information-giving towards active learning. While some ‘chalk and talk’ approaches are still reported, the focus of most classes and all teacher in-service training identified in this study is on a variety of teaching strategies which engage students in active roles. Strategies which were reported include role plays, values clarification exercises, small group discussions, debates, independent research, critical analysis, site visits, visual discussion starters, brainstorming, communication games and videos.

One teaching strategy which appears to be favoured and sometimes solely used in drug education in schools and community youth programs is the peer support approach. Peer support programs aim to share the responsibility of drug education with young people by training them to teach each other and use material and content which is relevant to their experience.

**Specific Content of Alcohol Education**

Alcohol and drug education is recognised as an important part of school Health Education in the existing state policy and program documents. The specific content of alcohol education in primary schools may include ‘safe practices, looking after my body, celebrations or different cultures’. It seems that Year 8 and Year 10 are the most common years for a unit on drug education with reference to alcohol to be included within a secondary school Health course.
The research has identified a number of schools which teach units of perhaps 6 to 8 lessons of which four specifically focus on alcohol. The content of alcohol education sessions varies depending on the resources used, teacher skill and experience and access to outside support. However some topics were reported to be given much higher weighting than others. The graph below clearly indicates that drink driving, reasons why young people drink, effects of alcohol on the body and peer pressure are all well covered. In contrast, alcohol as part of the Australian culture, and the alcoholic content of specific drinks were only covered by one quarter of those interviewed. The actual content and topics covered as well as the approach used will inevitably alter the effectiveness of any such programs. Drink driving and its consequences is covered often both in road safety or pre-driver education and in Health Education.

The following chart illustrates the reported coverage of different components of alcohol education (figures are percentages of all responses to a particular option):

<table>
<thead>
<tr>
<th>Component</th>
<th>Comprehensive</th>
<th>Detailed</th>
<th>Brief</th>
<th>Passing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drink Driving</td>
<td>69</td>
<td>19</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Drink Content</td>
<td>24</td>
<td>24</td>
<td>28</td>
<td>24</td>
</tr>
<tr>
<td>Social Consequences</td>
<td>61</td>
<td>18</td>
<td>18</td>
<td>3</td>
</tr>
<tr>
<td>Effects on the Body</td>
<td>48</td>
<td>31</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>Australian Culture</td>
<td>17</td>
<td>41</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Reasons for Use</td>
<td>61</td>
<td>25</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Peer Pressure</td>
<td>61</td>
<td>25</td>
<td>14</td>
<td>0</td>
</tr>
</tbody>
</table>

![Figure 5: Content of alcohol education reported by teachers surveyed](image)

**Evaluation**

Evaluations of the effectiveness of school-based alcohol education programs are scarce. Part of the reason for this may be the complexities involved. ‘No Quick Fix’, the evaluation report of the NCADA-funded SDHE project (Ministerial Council on Drug Strategy, 1992), indicates that
there are a range of approaches used, and that no one approach can be identified as the most effective. Other evaluations have been conducted around aspects of alcohol education programs such as peer education and drink driving. One of the complexities for evaluation is that the aims of alcohol education programs remain diverse. An alcohol education program aimed at increasing decision-making skills may improve general skills, but not have a clear effect on behaviour with regards to alcohol. There is an increasing view that improving knowledge alone will be unlikely to effect behaviour. It is becoming clear, however, that ‘one-off’ education programs have very little impact. Schools also have little information available on which to base effective evaluations.

**Resources and Teaching Materials Used and Favoured by Teachers**

While this research did not attempt to evaluate the range of drug education resources being used, it did identify some resources which were widely used or which were favourites of teachers. The access by teachers to resources varied enormously from a courier service in the ACT which delivered videos from the central library directly to schools at no charge, to Victoria where School Support Centres and Statewide Resource Centres have been shut down and there is no or absolutely minimal access to drug education resource materials without having to hire or buy them commercially.

Several teachers referred to and used their Teacher Resource Centres (where available) as well as Health Promotion Unit services, State Health Department Drug Information pamphlets and the Centre for Education and Information on Drugs and Alcohol (CEIDA) materials. The use of information material from these sources in Health Education classes was seen as very important, and most teachers thought that there was an adequate supply of resources available to them.

In some states/territories, including Queensland, Northern Territory and Tasmania, a number of drug education resources (usually in the form of kits) had been purchased in bulk by the Education Department and provided free to schools.

**Policy and Guideline Documents Provided for Schools**

Policy and guideline documents do not differ significantly across Australia and it is clear that some states and territories have based their policies on those developed by others.

Drug education is most usually framed within Health Education. For example, in New South Wales, the policy guidelines state that

Preventative drug education *programs* should occur within the broad framework of Student Welfare, Personal Development and Health Education. In relation to this context, students will:

- increase their awareness of the complex issues involved in drug use;
- participate in learning activities which will assist them in making informed, responsible decisions.

*Drug Related Issues in Schools: Policy Guidelines*,  
NSW Department of School Education, 1991

In Tasmania, alcohol education is located within a personal and social development approach;

Research and experience confirm that the best way to encourage students to live in a drug taking society is to use a personal and social development approach. The problems are not the drugs themselves, but are in the users, so empowering the potential users with appropriate knowledge, clear values and attitudes and developed skills will lead to behaviours that will allow them to live responsibly with drugs.
The Tasmanian Education Department characterises the approach to be used in the following chart:

values effective
knowledge + attitudes + skills + behaviour =
responsible practice rehearsal
exploration behaviour

The New South Wales Personal Development, Health and Physical Education (1992) document is more comprehensive than those in other states, but consistent with the content and processes suggested elsewhere. It identifies significant support materials for different year levels, as well as topics which have been developed to support the curriculum.

The very comprehensive (if somewhat prescriptive) Western Australian course is used by the Northern Territory as their program in years K-10. It provides teacher background information, class activities and other resources. Many of the specific states’ drug education support documents reflect the Queensland Interpersonal Skills for Drug Education (1988) materials and identical activities are to be found in the various state support documents. A sharing or borrowing of materials is evident, as is some repetition.

Most documents identify approaches to drug education which are ‘more effective’ or ‘less effective’, or specify drug education ‘dos and don’ts’ (see Figure 6). It is important that these guidelines are also followed by outside agencies, and other groups supporting school-based drug education in various ways. Education authorities generally maintain an ‘authorisation’ process to ensure that groups using inappropriate approaches are excluded from schools, or that approaches are modified to integrate with and meet the guidelines. The strictness of adherence to these guidelines varies from state to state.

<table>
<thead>
<tr>
<th>LESS EFFECTIVE APPROACHES</th>
<th>MORE EFFECTIVE APPROACHES</th>
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<tbody>
<tr>
<td>Prohibition</td>
<td>Responsible use</td>
</tr>
<tr>
<td>Scare Tactics</td>
<td>Target gateway drugs: alcohol, nicotine, pharmaceuticals</td>
</tr>
<tr>
<td>Use of experts</td>
<td>Trained teachers</td>
</tr>
<tr>
<td>Irregular isolated sessions</td>
<td>Continuing K-12 program</td>
</tr>
<tr>
<td>Information only</td>
<td>Relevant information</td>
</tr>
<tr>
<td>Ex-addicts context</td>
<td>Develop personal skills in a drug</td>
</tr>
<tr>
<td>Media campaigns only</td>
<td>Up-to-date resources</td>
</tr>
<tr>
<td></td>
<td>Develop curricula for each school</td>
</tr>
</tbody>
</table>
Recently, there seems to have been a push for schools to develop a Drug Education Policy. The idea is that crisis intervention for drug-related incidents should be linked to school welfare and discipline policies. These guidelines, being circulated in many states, encourage a whole school approach - including classroom programs - to dealing with the issue of drug and alcohol abuse.

Drug Education, including the dissemination of information, is an important curriculum matter and should be part of a continuing Health Education program. Drug educators need to be trained, and well resourced.

*Drugs in School - Crisis Intervention for Post Primary Teachers*
Alcohol and Drug Foundation, 1992

It is clear that there is little difference between the aims, concepts and guidelines for implementation expressed in the different state documents, yet at least four states have recently developed their own. Explicit interstate cooperation in the development of resources, or national document development, would appear to be more resource effective. The National Curriculum may force and encourage the development of some of these networks and materials which are common and relevant to all states.

**The National Curriculum - Health and Physical Education**

The development of a National Curriculum for school-based education, which has been under way for two years, is establishing a framework for comparability of educational outcomes in the various states and territories in Australia. Health and Physical Education has been identified as one of the eight key areas for which guidelines, and more specific directions known as ‘profiles’ are being developed. While the developmental process has been collaborative, visits to states and territories revealed a mixture of expectancy and reticence about how the national curriculum would affect Health Education at the state level. Two states have put the development of their Health curriculum documents ‘on hold’ until the national curriculum is complete. It seems likely that the Health curriculum document, to be released in 1994, will affect future programs, resources, and approaches to alcohol and drug education.

People in a number of states spoke of the need to have a document linking the national curriculum with current state documents, and linking specific topics like drug education with the national curriculum. There will be a great deal of interest in any such developments either at a state or national level.

The Curriculum Corporation, established by the Australian Education Council to develop and disseminate curriculum materials nationally on a ‘commercial’ basis, has been identified as the appropriate body to resource the national Health Education curriculum, and there are current negotiations towards funding and supporting this role. Further national resourcing should acknowledge the role of the Corporation and seek to coordinate with and enhance its work.

**Pre-Service and Professional Development for Teachers**

**Pre-Service Professional Development**
There is currently very little or (at some institutions) no drug education provided in pre-service training for teachers. At the primary school level, trainee teachers may receive one unit of Health Education, which requires coverage of all the suggested Health Education content for primary schools; in these courses, only one or two sessions will deal specifically with drug education.

While Health Education teachers in secondary schools will have generally received specific Health Education courses in pre-service training, there is wide variability reported in the content and esteem of these courses, with some teachers referring to a comprehensive preparation, and others mentioning only a cursory reference in their courses to alcohol and drug education. In addition, and as noted previously, over half the teachers taking alcohol and Health Education in secondary schools are not specifically trained in the area. Therefore there is a need for these teachers to have access to professional development training which will equip them for and support them in this role.

**General Professional Development**

The need for professional development education in the specific area of drug education or in the general area of Health Education was identified as the major unmet need by both teachers and consultants interviewed for this study.

The amount and type of professional development currently provided varies enormously between the states and territories, although the general response was that there was an inadequate provision of such professional development activities. Reasons cited for inadequate provision of professional development activities included the lack of skilled consultants, lack of access to support centres, restrictions on funding for replacement teachers and the lack of available courses.

State resourcing for professional development varies widely. While teachers in one state reported that there had been no specific Health Education professional development activities offered in the preceding two years, another state reported that in one region $20,000 targeted for drug education would not be spent because drug education was not the Region’s priority. It had been suggested that the money be used for some other in-service activity.

Consultants were very enthusiastic about on-going professional development, using a whole school community approach. This requires a commitment of several people from different levels within a school community. While this approach has shown itself to be successful in terms of program, policy development, and school change, the current viability of this approach for all schools is under question with decreasing resources. Isolated or one-off professional development activities are definitely not favoured by consultants or some teachers; however, many teachers mentioned the need for an up-grading of their drug and Health Education skills and knowledge, even as a ‘one-off’ activity.

It appears that Education Departments, except where there were specific drug education consultants, have ceased to offer open and free professional development in drug and Health Education. In some cases, such professional development is now being offered by subject associations and other health professionals working in specific areas.

A major problem is the cost to the system for teacher professional development during school hours. A replacement teacher at present costs approximately $170 per day. Outside agencies providing professional development usually charge a fee: for one teacher to attend a two day professional development could cost the school over $500. Many schools find it impossible to meet these costs, and attendance is subsequently low at drug education professional development activities which are currently offered. On the other hand, some teachers reported attending professional development in their own time.
A significant amount of the professional development activities which have been provided for teachers has been focused around use of resources and teaching materials. It is widely acknowledged that resources - kits, videos, texts - which are sent to schools or even purchased by schools, without some type of associated teacher professional development training in their use, will have little uptake in classroom practice. This has implications for any product development in the alcohol and drug area - a training and professional development component must be incorporated in order to support implementation.

Several teachers in this study were most enthusiastic about models for professional development activities that involved them working cooperatively with consultants over a period of time to develop resources and teaching strategies that could be published and disseminated in their area.

The directions taken in terms of professional development education should acknowledge the differing needs of teachers in different settings and the constraints on them in working in sometimes non-supportive environments. These teachers are still expected to cover vital Health Education material, and must be recognised as a group who may benefit enormously from professional development opportunities. A multi-phased approach may be beneficial.
Programs and Projects

The Role of Special Projects Using a Community Development Model

The past ten years has seen the implementation of numerous special school health projects. Recently the larger and more high-profile projects have used a school community development model which, to some extent, is being hailed as a successful model for improving Health Education and promoting school community health.

This approach is one which identifies the needs of different groups and specifically acknowledges the context of the individual community. It demands a significant amount of effort from a cross section of school community members and usually has a multi-faceted approach to dealing with drug issues. The approach can include classroom curriculum, teacher professional development, policy development in the areas of welfare and drug use, parent education sessions, community health promotion events, and co-operation with local traders. The evaluations from a number of these projects have identified exemplary or good practice in schools, as well as increased teacher skill levels.

One such project, a national initiative of NCADA, was the School Development in Health Education Project (SDHE) which operated in some form in every state. It aimed to promote drug (including alcohol) education through strengthening school-based Health Education, classroom programs, teaching skills, community action and encouraging healthy school environments. Another such project, the Youth Alcohol and Community Project (YACP) has identified a community development approach as most successful for creating whole school change. The project has encouraged schools to see youth alcohol behaviour as a community problem and one for which the home must share some responsibility. Further support to school communities who have begun to address alcohol and drug issues should be considered, to enable a consolidation of project outcomes and to establish if changes are, in fact, sustainable.

Intersectoral Cooperation

The notion of intersectoral co-operation is one which has been embraced by a number of different states in an effort to improve the effectiveness of Health Education in schools. One example of this is the Health Education Interagency Advice Committee (HEIAC) established in South Australia.

The HEIAC is predicated on the understanding that intersectoral coordination and collaboration is critical to the effective management of health in schools. HEIAC member organisations are committed to collaborate to support health in schools

Memorandum Of Understanding
Health Education Interagency Advice Committee, 1993

A number of other states reported both formal and informal intersectoral groups and committees which were trying to co-ordinate service provision, inform policy making and look toward projects and programs in health which could no longer be seen as belonging to any one sector. These would possibly be jointly funded and/or administered by Departments of Health, Community Services, Transport and Education. The Drug Education Support for Schools (DESS) Project in Victoria and the Drug Strategy in New South Wales are both examples of this. In Western Australia, an intersectoral group is exploring formalising the intersectoral links through a special project. This group would represent Health, Education (both schools and tertiary sectors) and business. While the need for intersectoral co-operation has been mooted for a number of years, its potential still seems underexplored and largely untested as to its ability to make a difference to school-based Health Education.
National Campaign Against Drug Abuse (NCADA)

The politics about where NCADA funding goes and who gets access is an issue in every state. While there is access to some Federal funding, most comes via state-level allocations and the application process is not consistent between states. Many projects find themselves having to re-apply annually for funding. This creates instability for staff, program directions and planning. As NCADA funding is available for educational programs of all types, some competition is set up between different groups and agencies, professing similar aims, and working to support schools.

Education Department initiatives and programs which are mainstreamed find themselves competing with agencies that may be regarded as on the ‘fringe’. However many of the major initiatives in drug education which have resulted in better practice and improved professional development for schools have been funded largely by NCADA. These include SDHE, the Alcohol and Drug Programs Unit in Queensland, School Drug Education in New South Wales, Drug Education Support for Schools (DESS) in Victoria, and others.

As NCADA provides seeding money there have been a number of cases where projects have lost their funding without follow up support at the state level. This has particularly affected the number of consultants available to help support schools in different states. In Western Australia and Queensland, the Health Departments have decided to administer their own School Health and Drug Education Programs, often working through regional Health Department offices. It appears clear that demand and support for drug and alcohol education in schools has been driven by a national agenda, by the provision of NCADA funds and by the existence of the campaign.

Other Agency Involvement in Schools

As identified in our chart (figure 1), there are numerous ‘outside agencies’ and groups who offer support to schools in drug education. The quality, approach and type of support provided to schools varies enormously from one agency to another. In addition, some organisations have significant community support. The major groups identified in this survey include

- Life Education Centres (LEC)
- Community Police
- Drug and Alcohol Resistance Education (DARE)
- Roads and Traffic Authority (RTA)
- Anti Cancer Council (ACC)
- local Lions Clubs, including the Lions Drug Education Network (DEN)
- Peer Support Foundation
- Community Health Centres
- Alcohol and Drug Foundation - now Australian Drug Foundation (ADF)
- Alcohol and Drug Services (ADS) and
- specific local groups.

A number of specifically targeted school-based programs were also identified as being offered or provided to schools. These include:

- Skills For Adolescents
- Drugs and Kids
- Thrills Without Spills
- Teenagers Teaching Teenagers (Triple T)
This support is often useful for schools, and most programs aim to support on-going school-based Health Education and not replace it. However, in practice, it was reported that the community and some teachers feel satisfied as long as ‘something is being done’; the reality is that, in some circumstances, these external programs do replace more holistic and sequential Health Education courses which incorporate alcohol and drug programs.

A degree of tension is evident: some of these groups, including LEC and DARE, are actually competing with health and education programs for limited Education and NCADA funding. In a number of states we encountered some animosity toward groups because the funding of them was seen to limit or affect the funds that were then available for other education programs, particularly those which worked with or through the system. Some of these support agencies also charge fees for their service and several consultants expressed concern because of the limited resources available for schools and families.

While most groups interviewed reported their role as supporting schools, there were a few which displayed a poorer understanding of state education guidelines and saw drugs as a single and isolated issue. As noted previously, education authorities have developed varying degrees of ‘authorisation procedures’ which seek to endorse some approaches by external agencies and refuse access to schools by those considered inappropriate. The DARE project, operating in the Northern Territory, has not been supported nor has it had a favourable response in some other states.

The support for contentious programs seems inevitably political and creates frustrations when funding is provided contrary to advice of the education sector or funding guidelines. The release of the evaluation of Life Education Centres in late 1993 will hopefully provide an analysis of a program which has received much financial support and created an ongoing debate in the Health Education field for a number of years.
The project has identified a number of areas where alcohol education in Australian schools could be significantly improved. However, 'no quick fix', the title of the NCADA evaluation, (Ministerial Council on Drug Strategy, 1992) is also appropriate here. The improvement of alcohol education in schools requires the recognition that there are several levels at which initiatives need to be implemented. These encompass the level of teacher practice in the classroom, as well as the relationship between stakeholders at state and national levels. The findings of the project, summarised here, address each level.

- Alcohol education in Australian schools across each of the states and territories is remarkably similar, despite the differences in administrative arrangements amongst the states. In some states the crowding of the curriculum and imposition of budgetary constraints have weakened alcohol education. The project has found that teachers are not as well informed about this aspect of the Health curriculum as they could be, and although there are many resources available for use in alcohol education classes, teachers do not necessarily have access to the resources, or are not aware of how to use them. Professional development and teacher training in alcohol education (in the context of Health Education) has emerged as an issue nationally.

- NCADA funding plays a significant role in supporting alcohol education programs through its seeding funding. The project has identified areas in which there is an opportunity for further funding to provide continuity for a successful initiative which would otherwise cease to operate.

- The issue of teaching resources and their use has also emerged as an issue. The project found that many teachers were unaware of the resources which are widely available and would appreciate more systematic information about resources. The gaps in resources for use in alcohol education were seen to be inadequate resources which utilise the concept of harm minimisation; and resources for use with specific groups of young people.

- The area of alcohol education is of interest to the education, health and community sectors, as well as to industry. However, presently there are few mechanisms in place to enhance the development of programs, research and other initiatives through intersectoral cooperation, reducing replication and improving the links between education, research policy and industry. The project has identified a degree of interest in facilitating cooperation across these sectors.
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Appendix 1: Terms of Reference of the Research Project

The Alcohol Education in Australian Schools Project, undertaken by the Youth Research Centre for the Australian Brewers' Foundation, has aims and objectives which were set out in the project proposal: Health Education in Secondary Schools: A Focus on Alcohol.

Aims

These aims were to:

• document the known research on health education in secondary schools in Australia, with particular reference to alcohol education;
• document the extent of programs operating in schools;
• document the perspectives of health educators and other commentators on the place and future of health education; and
• assess gaps in the research and recommend priorities for further attention.

Objectives

The objectives of the research were to:

a) provide a substantial and systematic discussion of the current state of knowledge about alcohol education programs in secondary education, in the context of Health Education;

b) place this discussion in the context of contemporary perspectives on Health Education for young people in the education system and in the community; and

c) on the basis of a) and b), provide a research brief for further research and program development on alcohol education for young people.
Appendix 2: Mixed Messages in ‘Harm Minimisation’ Materials

<table>
<thead>
<tr>
<th>Framework Reference</th>
<th>Context</th>
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<tbody>
<tr>
<td>Caring about Myself</td>
<td>Values — Relationships</td>
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<tr>
<td>Positive Use of Free Time</td>
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<tr>
<td>Keeping Mentally Active, Learning New Skills</td>
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<table>
<thead>
<tr>
<th>Suggested Year Levels</th>
<th>Suggested Minimum Time</th>
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<tbody>
<tr>
<td>8-10</td>
<td>50 minutes</td>
</tr>
</tbody>
</table>

Prerequisites
Drugs — What Are They and How Harmful Are They? (p. 60)

Learning Goals
- To examine the range of reasons why people use drugs
- To explore alternatives to drug taking that do not have harmful effects

What Is Needed?
Nothing

Strategies
Individual work and class discussions

What To Do
1. Individually, students list about five socially acceptable things they like to do.
2. For each activity on the list, they select adjectives that best describe their feelings during or after participating in these activities.
3. If they wish, class members then offer, in turn, one activity and an adjective from their lists. A list of activities is compiled on the board, followed by a list of adjectives. As a class, students match the adjectives with the activities.
4. Students use brainstorming to list the reasons that are typically associated with drug taking. An adjective is selected that would describe the feeling associated with drug taking for each particular reason (see Teacher’s notes).
5. In a final discussion, the two lists of adjectives are compared to show that although there are a variety of reasons for people taking drugs, there are other ways of achieving the same ends without causing the physical or psychological damage associated with drug taking.

Follow-up
Activities in the area of sport and fitness

TEACHER’S NOTES
It is unrealistic, indeed undesirable, to expect people not to use drugs at all. Rather it is preferable to look at why they take drugs, and suggest ways in which the misuse of drugs can be avoided. This activity is based on Producing a Natural High (see References).

EXAMPLE OF ACTIVITIES AND FEELINGS

Activities
- Going to the beach
- Playing sport
- Reading
- Mucking around
- Talking to friends
- Watching TV
- Going out with friends
- Going to discos

Feelings
- Excitement
- Feeling good
- Relaxed
- Happy
- Comfortable
- Sense of belonging
- Quiet
- Sociable
- Escaping

From: Drug Education: A Personal Development Approach - Post Primary
Victorian Ministry of Education, 1989
For what reasons might people refuse alcohol?

Focus
To understand the ways people take responsibility for their own actions.

Key Ideas
1. Record three different responses to the invitation to have an alcoholic drink—non-assertive, aggressive and assertive.
2. Make a list of the reasons people may not refuse an alcoholic drink.
3. Explain the advantages of not drinking alcohol at this party.
4. Draw the next frame of this scenario. Make up a cartoon about this party, predicting some of the possible outcomes.
5. Look at decision making models and relate this situation to the model.
6. List other situations in which people may choose to say "no!"

Cross Reference
Personal Development Framework: Health Education Reference.
Association With Others.
* Balance between acceptance and assertiveness.
* Assertiveness without aggression.
* Putting pressure on others; some consequences.
Being Myself.
* Accepting responsibility for my own decisions and actions.
Caring About Myself.
* The effects of tobacco, alcohol and other drugs on the body; personal and social options and responsibilities.
Drug Education: A Personal Development Approach - Primary; Page - 73.

Integrated Subjects
Health, Language Arts

From: The Happy Healthy Harold
Life Education Centre Book 6, Castle Hill
For what reasons might people refuse an alcoholic drink?
Appendix 3: Example of One School’s Course Outline

16th March 1993

Dear Parent/Guardian

Health Education is now a compulsory part of the curriculum of all state schools. Students in Grades 9 and 10 have two periods per cycle timetabled for the subject "Health" and all other grades have health matters incorporated in their subjects.

The TCE syllabus will be studied in grades 9 and 10 and the units covered include:-
* Personal Development
* Personal Relationships and Sexuality
* First Aid
* Individual and Community Health

The main aims of the course are to encourage responsible behaviour amongst young people by teaching decision making and communication skills to promote the rights of individuals.

The following topics will be covered;-
* Communication
* Self-concept, self awareness
* Relationships, (the way people mix and match in society, relationships with parents and other teenagers)
* Decision making in the areas of personal relationships, human sexuality and reproduction
* Contraception and Family planning
* Sexually Transmitted Diseases including AIDS
* First Aid
* Use and Abuse of drugs

The course studied in Grades 7 and 8 is concerned with the relationship between the individual and health. Some of the concepts which form the syllabus studied in grades 9 and 10 are introduced and discussed.

In line with Education Department policy, teachers conducting the classes will adopt a neutral stance on all the issues.

Any parents who wish to discuss the content material or the approach to be used are invited to do so by contacting Mrs Browning.

Yours sincerely


R. Browning
Coordinator of Health Education

J. Davidson
Principal
Appendix 4: Western Australian Unit Outline

YEAR 9 HEALTH EDUCATION

UNIT 5231 & 5241

PERSONAL HEALTH IN A MODERN SOCIETY - 5231
HEALTH AND MY LIFESTYLE - 5241

SEMESTER 1 - 5231:

TERM 1:

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<tr>
<th>Unit Objectives</th>
<th>ASSERTIVENESS (6 lessons)</th>
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<tr>
<td>5.1 - 5.42</td>
<td>Skills</td>
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<td>6.1 - 6.26</td>
<td>Cognitive</td>
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<table>
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<th>RELATIONSHIPS (8 lessons)</th>
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<td>9.1 - 9.18</td>
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TERM 2:

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<table>
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<th>CONCEPTION/PREGNANCY/BIRTH (6 lessons)</th>
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UNIT DOMAINS

<table>
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<tr>
<td>Affective</td>
<td>25%</td>
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</table>

A Focus on Alcohol
SEMESTER 2 - 5241

NUTRITION (6 weeks) (12 lessons)
2.1 - 2.14 File Skills/Affective 20
3.1 - 3.24 Test Cognitive 10
12.1 - 12.36
13.1 - 13.36
16.1 - 16.26

CANCER/LIFESTYLE DISEASES (5 weeks) (12 lessons)
15.1 - 15.40 Test Cognitive 10
18.1 - 18.16

DISABILITIES/BAD CASES (3 weeks) (6 lessons)
21.1 - 21.26 Attitude Affective 10
17.1 - 17.34

RECREATION (4 weeks) (8 lessons)
1.1 - 1.26 Attitude Affective 10
4.1 - 4.28 Assignment Skills/Cognitive 20

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YEAR 9 HEALTH EDUCATION

UNITS 5231 & 5241

PERSONAL HEALTH IN A MODERN SOCIETY - 5231
HEALTH AND MY LIFESTYLE - 5241

SEMESTER ONE:

5231  This unit is designed to enhance students' knowledge, attitudes and skills in several essential aspects of personal and social health. The issues addressed in this unit include:  sexuality and drug awareness.

UNIT OBJECTIVES:  5.1, 6.1, 7.1, 8.1, 9.1, 10.1, 11.1, 19.1, 20.1, 22.1, 23.1, 24.1

SEMESTER TWO:

5241  This unit examines the direct relationship between lifestyles and optimal health and wellbeing. The lifestyle factors addressed in this unit include:  the role each individual in assessing health risk factors, individual exercise and dietary practices and methods of minimizing the incidence and effects of disease; reducing the incidence and effects of accidents, and examining the special needs of the disabled in our community.

UNIT OBJECTIVES:  1.1, 2.1, 3.1, 4.1, 12.1, 13.1, 14.1, 15.1, 16.1, 17.1, 18.1, 21.1

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A Focus on Alcohol
Youth Research Centre

The Youth Research Centre is located within the Department of Social and Educational Studies in the Institute of Education at The University of Melbourne.

It was established in 1988 in response to a recognised need by the youth affairs sector for relevant and up to date research on the issues facing young people today.

As part of the university, the Youth Research Centre draws on the research skills, knowledge and experience of senior academic staff.

The aims of the YRC are to:

• conduct relevant, coherent and reliable research on young people in Australia, with a state, national and international focus;
• assist with the development of policy and the implementation of initiatives based on research findings;
• develop strong links with the youth affairs sector, with particular attention to helping to identify and address the sector's research needs;
• facilitate communication between educators, researchers, policy makers and youth workers;
• support the research activities of university staff and post-graduate students who have a specific interest in youth affairs; and,
• enhance the professional development of staff and students by assisting them to be informed about the broader context of young people's lives.

Youth Research Centre Activities

To fulfil its aims, the Youth Research Centre undertakes a broad range of activities, which are primarily research based.

The YRC has particular expertise in research on education, transition pathways, social justice, gender equity and employment issues as they affect young people.

The main YRC activities are:

• undertaking research and publishing the outcomes in a manner accessible to policy makers and the youth sector;
• providing information and policy advice to governments and other organisations;
• assisting and encouraging individuals or groups who work with young people.

Other YRC activities include:

• undertaking small projects for groups lacking the capacity or opportunity to do so themselves;
• providing a base for post-graduate students wishing to undertake Masters or PhD research on topics related to young people and the youth sector;
• enabling academics to participate in established YRC projects, and/or undertake their own research on youth related issues;
• maintaining a youth sector resource library;
• publishing series of Working Papers and Research Reports;
• conducting public seminars and conferences on a variety of issues relevant to those working in the youth sector.