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COMPREHENSIVE SCHOOL BASED PREVENTION INCLUDING PEER PROGRAMMES

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Summary

Our team was asked to develop a model programme to prevent alcohol and drug related problems in school population. The programme based on the participation of trained peer leaders has been developed and tested. The next step required the intergration of this peer programme into the broader framework of school based prevention. Such effective prevention schoud be based on the following components:

– Assessment of the situation at a school,
– Participation of trained peer leaders,
– Involvement of parents and relatives,
– Identification of the children at risk and their needs (adapted inventory by R. E. Tarter was used). This schould be followed by specific interventions
– Positive alternatives including problems solving, relaxation training with elements of yoga and stress management, social skills, etc.
– Counselling and treatment if appropriate
– Alcohol and drug school policy
– Cooperation with wider community, authorities, etc.

Original topic–aimed materials for children and teachers have been printed. The above mentioned programme and the pilot study of the adapted inventory by R. E. Tarter are discussed in more detail in this paper.

Key words: Peer Programme – School–Based Prevention – Tarter's Inventory Alcohol and drug Prevention

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K. Nešpor, L. Csémy, H. Pernicová: VŠESTRANNÁ PREVENCE VE ŠKOLNÍM PROSTŘEDÍ ZAHRNUJÚCI PEER PROGRAMY

Souhrn

Náš tým byl požádán, aby vytvořil modelový program prevence problémů působených alkoholem a jinými návykovými látkami na školách. Připravili a testovali jsme program za účasti předem připravených vrstvevníků (peer program). Další krok vyžadoval intergraci peer programu do širšího rámce prevence na škole. Efektivní prevence ve školním prostředí by měla zahrnovat: Posouzení situace na škole, účast předem připravených vrstveníků, účast rodičů a příbuzných, identifikaci dětí a dospívajících se zvýšeným rizikem i jejich specifických potřeb (k tomu jsme použili adaptovanou verzi dotazíku R. E. Tartera). Pak by měla následovat specifická intervence. Důležité jsou pozitivní alternativy zahrnující řešení problémů, ralaxační trénink s prvky jógy a zvládání stresu, nácvik sociálních dovedností, podle potřeby poradenství a léčba, pravidla ve vztahu k alkoholu a drogám ve školním prostředí a spolupráce s širší společností.

Připravili jsme řadu souvisejících tištěných materiálů pro děti a dospívající. V této práci popisujeme podrobněji uvedný program včetně pilotní studie týkající se dotazníku R. E. Tartera.

Klíčová slova: Peer program – Prevence ve školním prostředí – Tarterův dotazník – Prevence problémů působených alkoholem a drogami

In nineteen ninety, soon after the political changes, we started the non–governmental programme FIT IN with the main objective to prevent alcohol a drug related problems especially in children and adolescents. Since then many books, booklets and leaflets were produced; the printing run is at about 0,5 million at present. Some of the FIT IN publications related to the school based prevention are summarised in tab. 1.

Tab. 1: FIT IN Programme school–based prevention publications

Handbook for Peer Leaders of the Programme FIT 2001 – Club for the Third Millennium. Authors: Nešpor, K., Fischerová, D., Csémy, L., Pernicová, H. Published by: BESIP, Prague 1994, p. 54, Target population: Peer leaders 12 – 14 years old

AIM: Small handbook for peer leaders including some exercises and the answers on most common questions. Price: Free of charge

The Secret Report from the Planet X–III. Author: Nešpor, K. Published by: Sportpropag, Prague 1994, p. 58. Target population: 10 – 14 years old. Aim: offering positive peer models embedded in a science fiction story. Price: Free of charge

Girls and Boys Talk Smoking, Drinking and Drugs. Author: Nešpor, K. Published by: Portál, Prague, 1995, p. 125. Target population: 10 – 14 years old. Strategy: Positive teenage models involved in the prevention of substance related problems. Price: About 2 US $.

Alcohol, Drugs and Your Children. How to Prevent, to Recognise and to Deal with Problems. 3rd Enlarged and Revised Edition. Authors: Nešpor, K., Csémy, L. Published by: Sportpropag, Prague 1995, p. 160. Target population: Parents. Aim: offering relevant information, positive peer models, information about professional help and self–help. Price: Free of charge or less than 1 US$

Prevention of Substance Related Problems at Schools. Handbook for Teachers. Authors: Nešpor, K., Csémy, L., Pernicová, H. Published by: BESIP, Prague 1994, p. 54. Target population: Teachers. Aim: prevention handbook for teachers. Price: Free of charge

Beside this the FIT IN programme is involved in the production of self–help manuals (books "Am I concerned as well? How to Overcome Alcohol Related Problems" and "Gambling as an Illness") and traffic safety (posters, leaflets, the booklet "Alcohol, Drugs, and Traffic Safety.").

In nineteen ninety–three the Education Research Institute Prague invited us to develop a model school–based preventive programme. We familiar with the meta–analysis by Tobler (1986) summarising 143 adolescent drug prevention programmes. According to Tobler's meta–analysis peer programmes turned out to be the most effective with normal population, while the positive alternatives the most effective with high risk adolescents. These results were confirmed by meta–analysis by Bangert–Drowns (1988). Perry et al. (1989) in their WHO collaborative study demonstrated that peer programs were useful in Australia, Chile, Norway, and Swaziland. One of the important findings of this study using two interventions and one control group was that the results of teacher–led education without peer involvement was in some countries worse than in control groups in which no intervention took place.

That is why our team developed a programme using trained peer leaders (aged about 13) who would later implement the programme in theirs one year younger schoolmates. We described our experience with this programme in our previous paper (Nešpor, Csémy, Pernicová, 1994). This programme was accepted by the Czech Ministry of Education and our team was invited to further cooperation. Our task was defined in a following way:

1. To adapt the peer programme for high school students.
2. To integrate the peer programme into broader framework of systematic school–based prevention.
3. To include preventive strategies that could be used in high–risk populations for which peer programmes are not effective.

Let me describe how we dealt with these challenges.

1. The adaptation of the peer programme for high school students aged about 14 – 15

There are several differences in approach to twelve– and to fifteen–years old target populations.

– The older students are can communicate more effectively, and they carry stronger potential to become sophisticated peer leaders.

– On the other hand the older students have usually already had their personal experience with legal and sometimes even illegal drugs. Moreover, they can also have certain fixed beliefs and attitudes which may not be exactly health promoting.

– They more often tend to discuss the content of preventive programme more and are less likely to accept it as it is. It is important to give them rational explanations related to the elements of the programme and let them discuss them. The peer leaders should be ready to answer questions and to explain their answers.

– High school teachers often see themselves particularly as an experts in on their fields (e.g. physics or some foreign language) than as educators in a broader sense of the meaning. That is why some of them might seem to be less willing or keen to be actively involved in the prevention programme. But the participation of teachers is the crucial element of any school–based preventive programme, that is

why the motivation of high school staff may be even more important than that of elementary school level. At least one member of the school staff should be able to organise preventive programmes, and should be familiar with the methodology and content of effective prevention.

We trained about 70 peer leaders (most of them 16 years old) and with some of them we implemented the programme in 128 students (most of them 15 years old). We continued with the basic scheme of 4 units (standard Czech unit lasts 45 minutes) of the training of peer leaders and 4 teaching units of the implementation of the programme in slightly younger schoolmates. Longer training and implementation would be useful but it could limit the use of the programme because of practical difficulties. The techniques and approaches used in younger children like motivation training, brainstorming, role playing, relaxation, self–help, social and refusal skills, life style considerations, and the ability to resist advertisement of addictive substances can be used. But it is useful to modify the programme in several ways:

– *Refusal skills* which were rated as the most useful element of the programme for younger children, were accepted less favourably by older students. That is why we associated the 13 ways how to refuse alcohol and drugs with non–verbal communication (quick refusals), communication skills (polite refusals), assertivity (strong refusals), and life style choices. To get the information which of the refusal skills are being commonly used, we asked the students to describe anonymously how they refused alcohol, tobacco and drugs in real life situation before the implementation of our programme. Some of them did not respond at all, other stated that nobody offered them addictive substances which was unlikely, still others described the context of the situation instead of the refusal technique, and two of them reported that they yielded to the pressure and accepted eventually. The most frequently used refusal techniques were quick refusals like "No, I don't want it." or "No, thanks" (15 refusals). Other frequently used approach was the refusal with explanation, e.g. "By no means, my trainer would be angry with me" (14 refusals). Strong refusals like "I don't want. Go away – you are crazy!" were also common (7 refusals). Other refusals appeared seldom: Refusal with the postponement (1 refusal), repeated stereotyped refusal known from assertivity training (1 refusal), refusal for ever ("No, I don't want to learn smoking. It is bad for health." – 1 refusal). Some types of refusals (the refusal by avoiding, by ignoring, the refusal with the gesture, offering a positive alternative, the refusal with the changing the topic of conversation and refusal as the help) were not reported at all.

– *The peer leaders' answers* to the students' questions were considered as the most useful part of the programme. To be sure, that the answers would be correct after comparatively short training, we asked students to give their anonymous questions in a written form. Usually two peer leaders prepared their answers with the possible help of an adult during the time when the rest of participants were involved in other activities. The prepared answers (not necessarily to all questions) were presented at the end of the sessions.

– *Basic relaxation training* as a stress management technique was considered to be the most pleasant element of the programme (Satyananda, 1990; Nešpor, 1994; Nešpor, Výletová, 1995). We used simple yogic relaxation technique (sha-

vasana) in sitting. Older students accepted relaxation even better than the elementary school children.

– *Slogans.* In the last hour of the programme we asked participants to create slogans promoting healthy life style which can be used in radio broadcasting. We used many of these slogans in our FIT News, which is an 6 minutes programme broadcasted every 14 days on Czech State Regional Radio. Participants served in this way as positive peer models in media.

– *Peer leaders.* We again confirmed our previous experience that the quality of peer leaders is of crucial importance. The peer leaders need not be necessarily brilliant, as long as they are sincere and frank. Fortunately we met young people of this kind.

2. The integration of the peer programme into broader framework of systematic school–based prevention

Teachers. The agreement with the principal of the school and brief meeting with the school staff was a necessary step in the programme that preceded the training of peer leaders. Beside this we published a book about school–based prevention for educators (Nešpor et al., 1995) containing the information about the rationale and the method of our peer programme. We also published several papers in various journals for teachers (e.g. Nešpor et al. 1994) dealing with this topic.

Parents. The involvement of parents of the children without manifest problems is not easy. Our peer leaders were instructed not to use their skills in their smoking or drinking parents because they may better respond to their own peers, if at all. In this way we avoided problems with the parents of enthusiastic peer leaders. According to our possibilities we distributed the book "Alcohol, Drugs and your Children" (Nešpor, Csémy, 1992) among parents. In 1995 the third printing of this book (printing run 90 000) was published for the Czech Ministry of Education.

Positive alternatives for high risk adolescents and early intervention in substance use disorders. We will deal with this subject in more detail in the next section. It is important that all children know where to seek help for various problems including those related to addictive substances. This help should be nonstigmatizing, available and acceptable. We have cooperated with one help–line for children in Prague and with so called "pedagogical and psychological counselling offices" working in every Prague district. We also offered to students printed materials with relevant telephone numbers and addresses. Still we are aware that this may not be enough and that the adolescent at higher stage of risk may not use these otherwise useful services.

Healthy rules related to addictive substances at schools. We did not clearly specify these rules; they should be negotiated between the school and parents and with participation of students, if possible. But we suggested certain principles. It is the choice of parents whether they allow their child to attend a questionable disco or not. But they must allow their child to attend school. That is why the schools should be safe and drug–free as far as possible. The rule "No alcohol, no drugs and no tobacco at school and the events organised by it" seemed to us very reasonable. If this rule is not respected by as student, there should be appropriate, which means also not excessive, sanctions, and the problem should be dealt with not only by the school but also by the student 's parents.

Crisis management. It is common that many schools have become interested in prevention only after some visible problem took place. However unpleasant such occurrence may be, at the same time it creates the motivation to use preventive programmes at such schools. This can be illustrated on an example.

A 16 years old dropping out student became psychotic as the result of methamphetamine use. She told her father about her drug use and that it took place with her schoolmates. The father informed the school; its principal was not sure what to do. We advised to inform the staff about the situation and about the drugs that were involved. We also advised to inform the parents of the students who might be at risk and in more general terms all parents during regular meeting with them. It was possible to provide the parents of the students from that class with our book "Alcohol, drugs and your children". Beside this we advised to inform students about the rules related to the drugs at school environment and about the possibility to find out–patient help, if they wish, even anonymously. We also advised to take substance related problems seriously and to organise a systematic preventive programme instead of relying on haphazard actions, as that school used to do in the past.

Community based prevention or healthy alliances. Systematic school based programme requires self–sufficiency of the school in primary prevention. This, of course, can and should be combined with the cooperation with other experts, like mental health professionals, if there are some special needs. Some of possible allies of schools are mentioned bellow.

Tab. 2. Possible allies of schools in prevention of substance related problems

Employers, health care, help–lines and crisis intervention centres, influential persons in local communities, international cooperation, media, law enforcement, local authorities, media, non–governmental organisations, other schools and/or universities, parents, peers, psychological counselling, religious organisations and church, research institutions, self–help groups, social services, trade unions, youth organisations.

We do not expect that every school will cooperate with everybody mentioned above. But schools should search for useful allies, and we would be glad if our list inspires them in this respect.

3. Early identification of high–risk adolescents and early intervention

Unlike so called normal population high risk adolescents are very heterogeneous group. Because of this the first step should be to identify the specific needs of individual adolescents, and only after that to suggest and to implement an intervention.

We used for this purpose adapted inventory by R. E. Tarter (Tarter a Hegedus, 1991). This inventory seems to us easy enough to be used not only by psychologists, but also by medical doctors, social workers or even educationalists. Its other advantage is a broad view considering different areas of adolescents' life. To use this North American instrument for our purpose in the central Europe demanded certain modifications. We moved the Domain 1 Substance Use at the end of the inventory and Domain 10 at its beginning. The purpose for this was to start with less

sensitive questions and to end with the most sensitive ones; this is common clinical practice. Beside this we would not like to emphasise substance related problems too much. We mentioned the Domain 1 of the original inventory also beer as an alcoholic beverage. We also included tobacco, hashish, MDMA, and skipped PCP, which is not, as far as we know, used by adolescents, in this country. We included also gambling as an addictive problem quite common among Czech adolescents. We replaced the question 19 of the original version "Are you a loner" which is similar to question 18 of this Domain, by the question "Did you ever run away from home or from some facility for longer time than 48 hours?" The reason for this was that running away in our culture something associated with increased risk. The importance of problems like this has been emphasised by the WHO Street Children Project. In Domain III Health Status we included as question 11 "Do you have any long–term painful illness?" because of the risk of harmful use of analgesic drugs, and the question 12 "Do you have any long–term illness that is a disadvantage to you when compared with peers?" At the beginning of the Domain VI Family system we included the formulation "If you lost contact with your family in last 12 months, you can answer for the time before that. If even this is not possible, please skip this Domain." We included also heroin which is available in our country in the question 1 of this Domain. Beside this we included 3 additional questions in this domain related to family system: About physical punishments, sexual abuse and mental illness in parents. We included at the beginning of the Domain VII the sentence: "If you did not attend any school during last 12 months, please answer for the previous period." We added at the beginning of the Domain VIII the sentence: "If you never had any paid work, please skip this Domain". We also included two additional questions (about difficult relationships with peer workers and about lack of aims in this area). We had one linguistic problem. Negative answer to a negative statement may have different meaning in Czech language and in English. We have resolved this problem by using the expressions "It is right" or "It is not right" instead of "Yes" or "No" in the original English version.

In addition we used the experience of many colleagues, other professionals, and teachers, and prepared a list of possible interventions for problems in specific areas (e.g. mental health problems, social competency problems, school performance and adjustment, etc. Of course they should not be used mechanically. They are meant as a reminder or an inspiration for people working with adolescent clients. We supplemented the inventory by the feedback form for us asking the professionals working with this instrument for their comments. We used these comments to improve it. At present we have the 17th version, and probably it is not the last one. We also consider the possibility to use adapted version of the inventory with the list of suggested interventions as a self–help instrument.

Piloting the Czech version of the inventory

The modified Czech version of Tarter's inventory was piloted during the first seven months of this year. The main goal of pilot study was to examine feasibility of the instrument in clinical practice and counselling. According to results of the pilot study slight changes will be made in the structure of inventory and more precisely designed study will be performed.

The inventory was administered to 108 adolescents during the pilot study. The modal age was 16 year, range 11 through 20. Grammar school students were 77 subjects ("school subsample"); the out– or inpatients treated due to substance use related problems were 31 subjects ("clinical subsample"). The sample is not representative, therefore the results described below should be taken as preliminary ones.

The first comparison of the two subsamples was based on the frequency of used (misused) substances. The clinical subsample is characterised by misuse of illegal substances. Especially methamphetamine, cannabis, and sedatives were among the most preferably chosen substances.

The coefficients of correlation of substances used in the clinical sample suggest strong relationship between alcohol use and smoking on the one hand, and the association between use of cannabis and the use of other drugs (methamphetamine, opiates, sedatives). The reason for limitation on clinical sample is because the use of substances in the school subsample was reported with very low frequency, exception was the use of alcohol and cigarette smoking.

As a second step in our exploration of results of the pilot study we compared two respective subsamples through ten problem domains. Differences of mean percentages are statistically significant for all domains with the only exception of social competence. The difference between subgroups is, of course, most evident in the case of substance use. Of the other domains there are important differences in the domains of school related problems, relations to friends and peers, leisure time.

Also the coefficients of correlations suggest that the highest correlation of substance use is with the school problems and problems with friends and peers. This is valid for the clinical subsample as well as for the school subsample. These results might lead to conclusion that school and peer relationships are very sensitive regarding the substance use problems. Therefore it might be also hypothesised that in the school setting the substance related problems could be early identified, and prevented, if there is effective school based preventive program established. The last question we introduced was logically if the inventory could be used as the instrument for early identification of specific problems of youngsters. On the basis of percentages in ten problem domains the mean problem percentage was computed. For the clinical sample the mean problem percentage was 34. Among the school sample we find 10 % of those with the mean problem percentage of 34 and higher. We can speculate, that these subjects are at higher risk. The individual problem profile is useful identifying in which of domains the problems are highest.

Despite the results of the pilot study with the Czech version of the Tarter's inventory briefly mentioned above are rather preliminary, we believe that the instrument is very useful especially for early identification of problems among school aged adolescents. The advantage of the instrument is that the problem profile can contribute to plan some of specific interventions.

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