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Report on selective prevention in the European Union and Norway

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Acknowledgement

This report is a commented compilation of country reports prepared by experts in a survey carried out between April and June 2003. The experts from 13 EU Member States (all but Belgium and Sweden), Norway and Slovenia were partly nominated by the respective national focal point of the EMCDDA's Reitox network. These experts gathered information available on specific areas of prevention and provided insight into the developments in their Member State. The information gathered was discussed by the experts and representatives of seven national focal points (DK, E, F, GR, IRL, P, N) during a meeting at the EMCDDA headquarters from 26–28 June 2003. This report is structured around the results of these discussions and subsequent complementary and improved information provided by the experts to September 2003. At the meeting, valuable contributions were given, providing a first exploratory overview of selective and indicated prevention, family-based prevention and community-based prevention.

As is the intrinsic nature of an expert survey, ratings and statements on the situation in a given Member State might not always fully represent the reality in this Member State and might not represent the official description of the situation.

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Executive Summary

In the European Union, concern has been growing about the increase in recreational drug use among young people (see 'Drug use amongst vulnerable young people', *Drugs in focus* No 10, EMCDDA, 2003 at <http://www.emcdda.eu.int/?nnodeid=531>) and 'Recreational drug use – a key EU challenge', *Drugs in focus* No 6, EMCDDA, 2002 at <http://www.emcdda.eu.int/?nnodeid=527>).

However, only a small minority of those experimenting with drugs progresses to problematic patterns of drug use – the majority stopping drug use after adolescence. In the absence of direct indicators of the imminent risk of problem drug use, the concept of 'vulnerability' is particularly important.

Prevention research has identified several 'vulnerability' factors which arise in certain groups and geographical areas relating to the transition to risky drug use patterns and to social exclusion. 'Selective prevention' focuses on these vulnerable groups and settings because they are often not reached by the values, messages and contents of universal prevention (i.e. prevention targetting the entire juvenile population). Selective prevention aims to prevent heavier addictive behaviours and social exclusion before needs for treatment arise.

In practice, selective prevention in the European Union focuses on young offenders, ethnic groups, school drop-outs or those at risk of early school leaving, experimenting young people and families at risk. In few Member States, responses are aimed at especially deprived neighbourhoods, but in others, political traditions do not allow risk assessment to be applied to targeted geographical prevention planning. These forms of ideological interpretation of the vulnerability concept ('labelling') may prevent groups or areas in need from benefitting from the relevant prevention resources. Interventions targeting specific geographical areas, considered at higher risk, are of relevance only in Spain, Ireland, Portugal and the UK and are officially mentioned only in Irish, Portuguese and British strategy papers.

This report contains information on general selective prevention measures targeting the above-mentioned vulnerable groups, concrete project examples with different levels of evaluation, but rarely evaluation results (which are reported to the EMCDDA by experts in Member States and through the European database EDDRA <http://eddra.emcdda.eu.int/>).

Content-wise across all these selective prevention responses there is a recurrent concern about social exclusion, lack of social (and sometime academic) competences as well as psychosocial deprivation. In terms of project delivery and organisation there are considerable differences between Member States. Tendentiously, Member States with strong traditions of prevention based on accepting youth or social work and with publicly supported risk-reduction strategies (D, E, A, UK) seem to be much more likely to have well-developed and numerous selective prevention activities in place. Interventions are rare and less sophisticated in countries that do not meet these two conditions, such as Greece, France and Italy.

Treatment centres in these three Member States have played a significant role in prevention work. This implies the risk of reducing selective prevention to 'early intervention' – i.e. catering for these young people only as they appear in treatment centres or otherwise begin to be visible to drug care or social services. From a preventive perspective this means acting too late: young people subjectively realise quite late that they are in trouble and ask for help or support. From a public health perspective it means prematurely pathologising problematic adolescent behaviour as to be treated and remedied by drug care services, which is not an adequate response to adolescents' dysfunctional behaviour patterns.

When looking at the design of reported interventions, there is a major discrepancy between the well-defined, concrete and often evaluated examples from some Member States and the often unspecific information about general provisions and prevention strategies in the remaining countries. In general, the level of evaluation is not very high, despite the potential for the creation of good evidence. In the setting of many of these selective prevention examples, the contact time and intensity with the target population would allow for deeper, albeit not

always standardised, data collection. In addition, as the prevalence and level of problem behaviours or drug consumption are higher in vulnerable groups than in the general population, the impact of an intervention can be more significantly demonstrated in an evaluation. Nevertheless, projects with a noteworthy evaluation component are available only in Spain, Ireland, UK and Germany, a pattern that is astonishingly similar to the situation in school-based universal prevention. Contrary to popular belief, the level of evaluation is a good descriptor of the overall quality of projects. It implies reflection on design and structure and the sequence of activities, contrary to the broad orientations and ideas of other projects with the risk of even well intended but untargeted activism.

Selective prevention approaches can be particularly powerful in the field of family-based prevention, given the fact that families are generally difficult to enroll in prevention projects and especially those in need hardly respond to universal prevention offers. However, only Spain, Ireland and the UK seem to dedicate an important share of prevention resources to vulnerable families and consider to this regard socio-economic variables.

Considerable concern was expressed by experts in some Member States about the blurred boundaries between selective prevention of drug problems and generic social interventions among vulnerable groups. These may not have a drug prevention rationale and no drug prevention services involved, but might nevertheless have a relevant preventive impact on drug problems as well. However, they would not be considered and reported within drug prevention strategies. This problem of variable drug-specificity of prevention interventions across Member States returns at several points of this compilation, for example concerning the responses to young offenders. In the UK any minor offences and petty crimes of adolescents are considered, whereas in other countries mostly offenders against *drug* laws are targeted.

There is an urgent need to include vulnerability concepts and the adequate selective prevention responses into public health and drug policies. The research evidence-base and the respective practice example from some Member States are now already provided: 'within the inherent limits and contradictions of the risk factors evidence-base, we have evidence enough to develop risk-reduction interventions in the environments, and among the populations, most vulnerable to harm associated with drug use. Directing research and intervention resources towards reducing the risk of harm associated with problem drug use should be considered the primary priority of national drug policy' (Rhodes *et al.*, 2003).

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Part I – Selective Prevention for high risk groups

1. Introduction

TERMINOLOGY USED

Selective prevention targets vulnerable groups, who are at a higher risk than mainstream youth of developing drug problems. It is an essential and effective complement to universal prevention activities that target all young people.

According to the classification of the *Institute of Medicine* (IOM 1994) at <http://casat.unr.edu/westcapt/bestpractices/bptype.htm>, prevention measures can be classified into

- **Universal:** directed towards young populations at large, without any differentiation in terms of vulnerability or risk behaviours of the target group,
- **Selective:** directed at defined vulnerable groups or implemented in identified risk settings (or areas).
- **Indicated:** directed at identifiable vulnerability factors on individual level, like children with ADHD, children of alcoholic parents, etc. Targeted prevention is however not subject of this report.

This categorisation is not fully congruent with the traditional public health classification in primary (preventing use), secondary (preventing abuse) and tertiary prevention (preventing resulting harm), and offers therefore an important potential for more conceptual clarity. It focuses on the status of the target group, i.e. whether is it under especial risk (selective prevention) or not (universal prevention) and not on objectives – as the public health classification does. This facilitates – also here, in this report – the presentation of interventions according to vulnerable groups or risk conditions, i.e. according to their practical working method, regardless of what might be the theoretical objectives (prevent use or prevent abuse?) of the interventions.

It does in the concept of selective prevention therefore not matter – and the reader will find on the following pages several interventions like this – if the youngsters in a given risk group actually already experiment with drugs or not (in the public health classification this would imply both primary and secondary prevention). What counts are the research-based criteria, which suggest that youngsters in a given group are under risk (or better: “vulnerable”), regardless of their actual stage of problem development. But beyond the common vulnerability factors, these “vulnerable groups” have also many biographical, cultural, socio-linguistic and psychosocial characteristics in common, which is again of big practical relevance for the development of targeted interventions.

Examples for universal prevention are regular school-based prevention interventions, but also large mass-media campaigns. In terms of objectives, universal prevention measures do have mostly a no-use orientation i.e. preventing or delaying the onset of any kind of substance **use**. The EMCDDA has provided several overviews on the situation of (school- and community-based) universal prevention approaches in member states (see the EMCDDA web site under <http://www.emcdda.eu.int/?nnodeid=1568> and a respective multilingual *Drugs in Focus* publication on school-based prevention under <http://www.emcdda.eu.int/?nnodeid=525>).

However, universal prevention approaches show most of the provable effects only with non-consuming (low risk) youth (Windle and Windle, 1999) and are less effective with high-risk youth. Also, high-risk groups and those already experimenting with drugs will not be adequately reached by universal prevention interventions, as these do not sufficiently address their specific needs: e.g. pupils with academic difficulties and beginning drug problems are likely to reject or detach themselves from school-based prevention programmes. To tackle the diverse vulnerability profiles of these groups, which are not and cannot be reached by universal prevention strategies, selective prevention approaches are an important additional pathway for prevention policy. Both universal and selective prevention strategies are necessary and they should complement each other: the




former in order to reduce among all reachable youngster the overall risks of initiation and experimentation (by promoting basic resistance and life skills), the latter to target specifically those groups which are not reached by broad-brush approaches, or which because of greater vulnerability and/or social exclusion need additional or alternative approaches, which are mostly more intensive too.

In reality, however, universal prevention in schools and communities is largely the dominant intervention model in member states and probably absorbs most of the resources for prevention. As put forward in Drugs in Focus N° 5 (<http://www.emcdda.eu.int/?nnodeid=525>), funding of these prevention interventions in the EU is rarely linked to quality control and evaluation. Consequently, already scarce prevention resources are not spent in a cost-effective way. If universal prevention policies would foresee and finance the implementation of evidence-based approaches **only**, more attention and resources could possibly be liberated and used for the development of more selective prevention activities. This is especially important in times of limited resources where priorities have to be set and not all needs can be met: under these perspectives also in the US literature, recommendations have been made to develop screening methods for identifying at risk youth and to involve those who are most in need in the respective (peer-led) interventions (Black et al. 1998). Existing cultural differences should be emphasised in prevention interventions, while the risk for stigmatisation should be born in mind (Sloboda 1999).

STRUCTURE OF THIS REPORT

A recent *NIDA* online publication (NIDA 1997, at http://www.ccapt.org/pdfs/dap_atrisk.pdf) and a related literature review (at <http://www.secapt.org/NewFiles/Lit%20Review%20for%20%20c9-Risk%20Youth.pdf>) give an overview on selective prevention strategies and research in the United States.

The present report aims to give an overview on the European situation, predominantly in the form of practice examples, some research background and expert opinions (ratings). The main importance lies mainly on the practice examples for interventions on different groups and settings. These examples, gathered from member states, Norway and Slovenia have been graded and marked alongside three categories:

-  • **P**romising practice example – there is no formal scientific evaluation, but observation of effects or outcomes by (e.g.) experts.
-  • **E**valuated good **P**ractice example – there is some formal evaluation, e.g. by questionnaires, or the intervention is based on an already evaluated experience. There is at least a process evaluation.
-  • **E**vidence **B**ased good **P**ractice – there is e.g. an external evaluation, evaluation with a control group or other scientific measures to increase the accuracy of findings.

This classification refers solely to the level of evaluation, not to the degree of success and not to the criteria of project design or coherence as they are used for the inclusion of projects into the EDDRA database. Some of the examples provided have been retrieved from EDDRA though and are marked accordingly with **EDDRA**.

Collection of intervention examples, possibly biased by policy

Selective prevention interventions are based on vulnerability concepts (see the following chapter), which include however a large scope of social factors and conditions. Therefore, the strong differences across member states in terms of social policies have a strong impact here: obviously, in most member states there are interventions and strategies that tackle e.g. the social exclusion of homeless youth or immigrants. But often, they do not belong to **drug policies**, do not take **drug** problems or risks into consideration (and into evaluation), and are not carried out under a perspective of **drug prevention**. These interventions might even have a positive effect in reducing drug problems or diverting drug careers, but in their planning, conceptualisation and evaluation this is not accounted for. The interventions presented in this report are restricted to those, which have – at least remotely – any reference to drug related issues. It would otherwise not be possible to gather all interventions from other social actors towards these risk groups. Therefore, if countries in this report are not reporting about interventions for certain risk groups, these interventions de facto might not exist; or it could otherwise simply mean that they are carried out, but **not within a drug policy**, i.e. not under a drug-specific perspective and are therefore not captured by drug information systems. However, also the latter finding can give an interesting insight, as it indicates to which degree drug prevention policies are integrating

and considering larger social contexts. A recent study on hidden young heroin users in the UK (Eggington and Parker, in *Drugscope* 2001) shows how important it is that services which are in contact with vulnerable (experimenting) youngsters are aware and trained about drug prevention and counselling issues during the long time gap before these youngster contact treatment services. It is therefore not a simple and value-free administrative idiosyncrasy if *drug* policies do not consider these vulnerable groups or if *social* policies do not include a drug-preventive perspective.

For Austria for instance, Haas et al. (2001) points out to the frequent problem of youngsters who experiment with drugs being excluded from youth services, thereby increasing their social exclusion, and calls for integrating approaches. Also Sloboda (1999) comments about how many of vulnerable youngsters are in fact visible in many settings, being in contact with services or programmes because of social, psychological or legal problems but without having an assessment of their substance abuse risk or stage. In such a situation, many occasions for selective and indicated prevention are missed.

“Vulnerability” doesn’t equal “to be in need of drug treatment”

Another issue are the sometimes-blurred edges to treatment interventions. Per se, the IOM classification eludes any overlap or confusion of prevention with treatment – contrary to the term “secondary prevention” which is in some countries a synonym to treatment. It also avoids confusion with the sometimes-used term “early intervention” which in some countries (and the ODCCP (2000) glossary of demand reduction terms) means early (in terms of addiction phases) treatment interventions, but in other countries means early interventions with regard to lifetime, i.e. first childhood interventions. Therefore, all experts participating in the survey preferred to only use the IOM classification in the future, because it proposes more accurate and practical categories. Still, in some member states and due to professional traditions, the vulnerability profile of experimenting youth is exclusively or excessively seen in terms of their drug use and the resulting dangers. Or, from a theoretical perspective, a too individualistic and pathologising concept is applied to these youth, as if they had personal deficiency, with a need of therapy. So arises a problem, as Rhodes et al. (2003) criticize, “that individualistic models of interpretation dominate, as do analyses which tend towards what may be termed a ‘deficit model’ of drug use. Individualistic models tend towards an explanation of drug use as a ‘problem’ of individuals requiring individualistic solutions. It is therefore striking that most research which takes the environment or context as its unit of analyses is less inclined to depict drug use as an outcome of ‘dysfunction’, ‘disorder’ or ‘pressure’.”

In some countries, though, treatment services are seeking to take charge of these youth, despite the fact that they are not necessarily regular or problematic drug users. If these interventions have also a preventive perspective or at least preventive components, they were nevertheless - in brief form - included in this report. However, by definition, selective prevention targets populations at risk that might (or might not yet) experiment with drugs, but does not focus on problematic drug users with an evident need for treatment. Therefore, regular treatment or harm reduction interventions for young people have not been included in this report. It is however not meant to deny the increasing need to establish appropriate treatment services that provide treatment options and conditions, which are suitable and acceptable for adolescent drug users in need for treatment.

Ratings

The ratings, which sometimes appear in this report, do reflect estimations and opinions of the experts who are supposed to have a broad overview on the practical relevance of certain approaches or concepts in their countries. They represent a first step to better contrast the conceptual differences between the member states in a process to adequately operationalise the rating categories and the data quality in the future. They should be read, bearing this restriction in mind, not as definitive assessment of the countries’ policies.

Prevention interventions in party settings are not included

A very important group of selective prevention interventions addresses party (or more general: recreational) settings. This intervention field has been extensively been dealt with in previous and current EMCDDA work (see more information on analyses and projects under <http://www.emcdda.eu.int/?nnodeid=1569>) and has

therefore not been included in this survey, despite the close relationship and congruence with selective prevention at large.

Two bibliographical reference lists

This report contains two bibliographies: one (by country) that has been delivered by the experts, which contains their proposals for additional reading on the situation in the member states and references to the project examples that have been collected by the survey. The other (general) contains the references for all introductory texts by the author.

2. Vulnerability and risk factors: theory bases for selective prevention

Recent research has paid attention to the fact that not all young people experimenting with drugs develop drug problems, but that among experimenters, particular groups are at an increased risk for developing serious and dependent patterns of drug use. The observation that only a minority of youth that consume and experiment with substances develop into substance abuser and experience serious drug-related problems has been attributed to differences in the vulnerability or in protective factors experienced by these adolescents. Some often-cited studies give comprehensive overviews on the relevance of risk factors identified by research (Hawkins et al. 1991, Hawkins, Catalano et al. 1992, NIDA 1997 and Lloyd, 1998), and are therefore not to be discussed here again. More recently, a European review of newer research findings (Rhodes et al. 2003) has added some additional aspects but corroborates by and large the existing knowledge. Most references are however based on North American research. Specific European research findings are very scarce in this area, be it on vulnerability factors or on concrete interventions.

Selective prevention is led by these specific research findings and applies the vulnerability models developed, i.e. combinations of known vulnerability factors, which allow identifying groups or settings at risk for problem drug use and intervening accordingly (see e.g. the intervention models of Catalano/Hawkins at <http://depts.washington.edu/sdrg/> and the CSAP (Centre for Substance Abuse Prevention) website on the cross-site evaluation of high-risk programmes at <http://www.health.org/govpubs/fo36/>).

However, mention has to be made that risk factors do not imply a linear and obligatory progression from a certain risk behaviour or risk condition to serious drug problems:

- Also youth without any vulnerability condition might get into problematic drug use; in other words: not **only** youngsters that belong to risk groups develop drug problems.
- Vulnerability (and protective) models are relevant in order to guide interventions where the probability of occurring problems is higher, but they are not meant to predict an individual's fate; in other words: not **all** youth at risk necessarily develop drug problems.
- The interaction of some risk factors and drug use levels can also be seen as circular (Winter 2002), as for instance early and intensive experimenting with drugs can be both cause and effect of truancy. This is especially the case for many psychosocial risk factors.

It is therefore important to be cautious with the use of concepts such as *risk factor*, *vulnerability* and *risk groups* and to stick to their use for intervention practice only, in order to avoid suspicion of social labelling and of simplistic gateway theories. Rhodes et al. (2003) point out the practical importance of risk factor research: “We need to focus on practicalities rather than causalities. Concentrating on problem drug use, which is pragmatic and cost-effective, vulnerability factors associated with youth development—such as school exclusion, truancy, offending, peer network involvement in drug use—indicate potential targets as well as delivery sites for intervention.”

According to the available knowledge base from literature and available experiences, several risk groups, conditions and settings can clearly be identified. In practice, some of these are already targeted by selective prevention interventions, however in few EU member states. Therefore, vulnerable **groups**, vulnerable **areas** and vulnerable **families** are the main parts that divide the chapter structure of this report.

The categories have been chosen for purely practical reasons and we are aware that there is always an overlap between categories and especially between the vulnerable groups: it might be often the same youngsters, who are excluded from school, who get into problems with the law and who are hanging out on the streets. The classification of interventions according to vulnerable groups (of youth), vulnerable neighbourhoods and vulnerable families, alongside with the respective vulnerability factors follow the logic of public health planning: which are definable areas where we can intervene? This is important with a view to the almost complete lack of tools, which directly assess the risk for drug abuse in youth at an early stage. Schmidt (2001, p. 103) has pointed out that in adolescents (contrary to adults) there are no clear and early signs of beginning drug abuse, that criteria used in drug treatment and within established instruments are too hard, i.e. appear in youngsters too late and that especially incipient drug-related problems of girls are not captured well by the few existing instruments. The vulnerability factors presented and used in this report serve under these circumstances as practical and research-based guidance tools for interventions. If drug use of youngsters alone is be used for decision-making, the danger is very high that youngsters with physiological (for that age) and transitory drug experimenting are wrongly classified (and stigmatised) as high-risk group (Schmidt 2001). As a matter of fact, as Sloboda (1999) mentions, there might be a peril of stigmatisation inherent to the vulnerability factor and risk-group approaches, but the actual reality in many member states, either to consider all experimenting youth as high-risk groups or to intervene only when youngsters get (very late in fact) in touch with treatment or judicial services, brings about even more risks of stigmatisation and exclusion. Apparently, prevention policies are often not planned according to vulnerability models, and prevention or youth services (Haas 2001, 2002) are often not prepared to deal with youth at risk. In a regional study in Germany (Schmidt 2001), the participating institutions (mostly treatment centres) indicated that they spend at maximum 5-10% of their working time for drug abusing youth, mostly because the demand is low: service provision didn't match the needs of the youngsters. Of the interviewed young drug users, none had ever received any selective prevention intervention. Girls showed however a lower threshold for seeking advice at institutions. Given the fact that – especially in the big member states – prevention services allegedly offer to a large extent psychosocial counselling based on local and individual needs (e.g. contrary to the implementation of prevention programmes) and that some member states face the challenge of vulnerable youth almost exclusively through treatment services (and approaches), findings like these raise concerns about the adequacy of policies for youth at risk.

There are in practice many different ways of approaching and intervening with these groups across the EU member states. This plurality reflects both different structural conditions and concepts in member states, but also the fact that it is still unclear what are the exact pathways of transition into drug problems and what are the interactions of genetic and environmental factors (Sloboda 1998). The latter is due to lack of research and to till now scarce experiences with risk assessment methods for youngsters, mentioned above.

With regard to evaluation, there are – at least in theory – several potentials for improving the evidence base of selective prevention interventions. As these interventions are selectively targeting those groups with a higher probability of developing drug problems and a higher prevalence of specific vulnerability factors and risk behaviours, intervention effects can also be identified more clearly and might more significant, compared to broad-brush interventions. For the evaluation of those projects this means concretely that due to a higher prevalence of problem behaviours in these groups, the effectiveness of interventions can easier be proven than for instance in universal school-based prevention.

In political reality however, the concept of vulnerability and of selective prevention is not largely applied within the EU. Only a few member states have included it in prevention policies and earmark resources for selective interventions, e.g. (UK example) under the policy objective *of reducing health inequalities and reducing social exclusion. [...] Youth programmes and interventions outside schools target children and young people who may be vulnerable to drug use. These include, young offenders, the homeless, those children looked after by social services and school excludees and truants. There are a large number of local drug education programmes and interventions that focus on these young people and their parents and carers. The programmes range from peer education to diversionary activities.*

Homeless young people are mentioned almost solely in UK papers (Drugscope 2000, Goulden & Sondhi 2001, Lloyd 1998) and prevention possibilities are discussed in non-European references (Banaag 2002), but

concrete prevention examples seem very hard to find within the EU. A respective chapter has therefore not been introduced.

For the same reason, no mention is made of interventions for girls or for boys alone in this report, even though it is largely known and acknowledged that girls at risk have different needs (Schmidt 2001), different risk profiles (National Center on Addiction and Substance Abuse 2003) and different prevention outcomes (National Cross Site Evaluation of High Risk Youth Programs).

The range of approaches used for selective prevention in the following practice is wide: from structural approaches (social inclusion) to very intensive personalised interventions, even some case management approaches, as postulated by Schmidt (2001). Cognitive approaches, i.e. to provide information about drug risks, have in this field a bigger importance than in good practice examples for universal prevention. Despite the discredit of the Health Belief Model and Ajzen & Fishbein's (1980) Theory of Reasoned Action in the prevention field in general, Gerrard et al. (2002) present new empirical support that the perception of vulnerability by youth is an important mediating variable between familiar and personal antecedents and drug use; and that this perception of vulnerability can be influenced by prevention interventions, at least in youth at risk.

However, the basis of evaluated interventions from which conclusions or guidelines for good practice could be drawn, is still too small, as the following chapters illustrate. But the following chapters also show that professionalism and evaluation are feasible in this field, at least in some countries, and that the potentials for further development of this prevention type within the EU are big and promising.

3. Truancy addressed: Alternative academic programmes for early school leavers

The following examples for interventions in member states are addressing the risks of further social exclusion and increased drug problems as a consequence of early school leaving or exclusion from school. Obviously, in many member states there are alternative academic curricula for early school leavers, but often there is no rationale of drugs (or delinquency) prevention underlying them. As in the following chapters, we focus mainly, if possible, on intervention examples that have some linkage to drug policies. Young people excluded from school or leaving it prematurely are more likely to be subject of social exclusion, homelessness and tend to get into more problematic drug use patterns (Drugscope 2000). According to the UK lifestyle survey (Goulden and Sondhi 2001) truants and excludees had higher and heavier levels of drug use than school attenders. Drug use seems to be only in a minority of cases the reason for exclusion from school (Powis and Griffiths 2001). In this group of adolescents, substance use by girls also seems to be in higher than in school populations (Goulden and Sondhi 2001, Home office 1999, Powis and Griffiths 2001). Social marginalisation, delinquency and drug use are interconnected. Prevention interventions therefore should address more social and behavioural dimensions than just drug use.

GENERAL REFERENCES FROM MEMBER STATES

Greece: The therapeutic programme *STROF* (of *KETHEA*) in a *Transitional School* focuses on adolescent drug users and organises educational courses addressed to adolescent drug users who have dropped out of school. More information on the treatment programme *STROFI* (not these specific courses) are found under http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=478.

Spain: Activities are usually focused on the integral development of youth at risk: workshops aimed to improve social abilities, training activities, courses or occupational workshops, programmes for juvenile employment, etc. Almost all the *Autonomous Communities* have preventive programmes for youth that usually come from special neighbourhoods. Services, equipment and diverse type of individual and group activities are provided for them.

Italy: Most of prevention programmes under the Law N° 285/97, and a lot of the new reformed and experimental schools are focusing on alternative curricula with a strong effort to involve work agencies and businesses even at a local level.

Portugal: For the prevention of school dropout, 441 000 € have been allocated in 2002 for social integration, vocational orientation, alternative school curricula and early professional training.

Finland: To prevent school dropouts that mostly occur after secondary school, it is possible to be at school for one more year, the so-called *tenth grade*. During that extra year the student has a chance to improve earlier grades and will also get guidance about further studies.

Norway: There are several alternative schools and schools curricula in Norway

IRELAND

P Youthreach

Target Group: *Youthreach* is specifically but not exclusively for 15 to 18 year-olds who have left school prior to achieving educational qualifications.

Strategy: *Youthreach* provides a programme of second-chance education and training, which is alternative to the national mainstream secondary education programme. *Youthreach* centres are typically based in local communities identified as having highest need. Currently there are over eighty centres located throughout Ireland. Participants receive an allowance for attending a *Youthreach* programme, which is calculated on the basis of the young person's age. There is also a small meals allowance and, where applicable, a travel allowance. The educational curriculum available across *Youthreach* centres tends to focus on developing the vocational skills of the young people in attendance. Thus, while developing their literacy and numeracy skills, participants of *Youthreach* programmes can take courses in, for example, woodwork, metalwork, horticulture and Internet and computer technology. The *Youthreach* Centres in *North Great George's* and Ballymun (both Dublin-based centres) for example, offer courses, which prepare participants for *Junior Certificate* examinations and *National Council for Vocational Awards* along with courses to prepare smaller numbers of young people for their *Leaving Certificate* examinations. Alongside the education/training offered by such Centres, *Youthreach* programmes also typically include a considerable amount of personal development and exploration where participants needs, interests and capacities are identified and incorporated into their educational and life plan.

Evaluation: no information.

P Cherry Orchard Equine Centre

Target Group: Young people between 10 and 21 in particular, though also education and training for people up to 25 years of age

Strategy: The interest of many young local people in working with horses was the starting point for developing this project in order to establish an educational aspect to entice young people back into the system. Several million Irish pounds were secured from the Department of Agriculture to build the Equine Centre, with the idea that it would be a partnership between the community and *Dublin Corporation*, *FAS*, the *VEC*, *Ballyfermot Partnership*, *URBAN Ballyfermot*, and the Irish Government. It is planned to open the centre in 2003.

EP LEBO Project: Cox's Demesne Youth and Community Project, Dundalk

Target Group: Potential and actual early school leavers (12-16 year olds)

Strategy: To provide an innovative programme for early school leavers to enable them to make choices regarding:

- returning to full-time education
- remaining within the education system
- accessing vocational training

A core programme built around personal development was implemented to help the young people make choices about the future in an informed and responsible way. Their main project '*The House*' had five elements:

- personal development (weekly group work sessions, building relationships of trust between the young people themselves, and between them and the staff)
- vocational skills (to improve not only job skills but also self-confidence)

- leisure/sport activities
- literacy/numeracy programme
- aftercare

Evaluation: Of the 30 young people who participated in the project in 1996-7, 11 have remained with the CDYCP. The status of the remaining 19 young people is:

- 2 returned to full-time education, 6 secured employment, 1 secured an apprenticeship, 3 accessed *Youthreach*, 1 accessed a place in the community training workshop, 1 is in residential care, 3 are in custody, 3 have not progressed, 1 died.

PORTUGAL

A matter of balance: Association for education and youth integration Setúbal



Target group: 15-20 youngsters, both genders, from 15 to 18 years old with uncompleted compulsory school, which impedes further professional training. They come from high-risk families having often risk behaviours for themselves and for others. In many cases they are in a pre-delinquency or even delinquency phase, they don't show any interest in school and have difficulties to learn or concentrate. In most cases emotional disorders together with risk families and environments causes them social exclusion.

Strategy: To give the target group (vulnerable youngsters that have left compulsory school) a new way of finishing school and at the same time change their social behaviour, e.g. unhealthy life styles. The *Project Forest School* includes, in groups or individually, several activities to promote personal and social skills, emotional balance, social values like self-esteem and the adoption of healthy life styles. There are activities of controlled risk (paragliding, escalating, trekking), study visits, several ateliers, thematic and information sessions with a nurse, floriculture, environment education lessons, meetings organised by youngsters, and indoors sport activities. These activities aim to stimulate and motivate in an active, innovative way the youngsters for the school classes during the afternoon. Several teachers of different disciplines have been assigned by the Centre of the education in Setúbal to implement school activities. The activities are coordinated with official school curricula.

Evaluation: Process and outcome evaluation. For the process evaluation there are reflection meetings with youngsters, progress reports and team meetings where the development of each case and the effectiveness of the methodologies used is discussed. The goal is to measure objectives such as: rules and routines, dissimulation, irresponsibility, introspection, family rejection, truancy/dropping out of school, free violence, aggressiveness, relational violence, delinquency, delinquency justifications, and drug use. Team spirit, punctuality, flexibility and perspectives of future are to be measured. At the beginning of the school year, the technical team of the project will revise the evaluation instruments used, having also created new ones for process and outcome evaluation. The goal is to effectively monitor individual progress. There are, among other instruments, a *personal characterisation form*, an *individual evaluation form* by activity, a *social form* and an *evaluation form of individual risk*. Evaluation results are expected by end October 2004.



UK

DPAS (Drug Prevention Advisory Service) conducted an evaluation of a drugs prevention programme for young people who have been excluded from school. The programme was part of the *Pupil Referral Units* who provide education for young people excluded from school. The programmes consisted of an assessment exercise to discover the pupils' needs; a drugs education course; a life-skills exercise and a range of diversionary activities. The evaluation found that drugs education programmes are clearly needed, but that short drugs education programmes are insufficient to deal with the problems that young people face who are excluded from school. Many of the young people were already taking drugs, implying that this group needs programmes implemented earlier, which identify and deal with problems (Powis & Griffiths 2001).

4. Prevention of truancy: Interventions with vulnerable groups in schools, including counselling offers

Interventions presented under this heading address several dimensions of selective drug prevention in schools. One is, with a view on the previous chapter, the prevention of early school leaving itself. Other dimensions are anti-social behaviour, academic underachievement, low bonding and attendance to school and impaired learning because of incipient drug use (Hawkins et al. 1991, 1992, Lloyds 1998). Selective prevention meets its challenge of selectively and positively addressing the main vulnerability factors for drug related problems especially in the school setting, where on one side the mainstream prevention messages are health promotion and no-use and where teachers are barely trained to carry out universal prevention activities but are not prepared to deal with “difficult” or experimenting youngsters (Parker & Eggington 2002) and where on the other side any drug-experimenting youngster is considered a case for drug or psychological treatment because of his alleged “personality gaps”.

Selective prevention interventions in the school setting are quite diversified according to different traditions in member states. In this setting, there is a visible impact of the interconnection of drug use and (mostly preceding for many years) antisocial behaviours (Tarter et al. 2002) and many projects address these issues together. In the literature it is therefore often postulated to start prevention activities by targeting antisocial behaviour in primary school or before; and some few encouraging results have been reported (Webster-Stratton 2001), however not from Europe.

GENERAL REFERENCES FROM MEMBER STATES

Denmark: Since the goal is to keep every child within the frames of the public school and keep the vulnerable children in their normal class together with their class mates, children at risk receive support by supplying the class with e.g. extra teachers, giving the identified children a separate curriculum for some lessons, and by providing special courses for children at risk or for dyslexic children.

Greece: The Ministry of Education while aiming at the promotion and support of health education has established *Youth Counselling Centres* as well as the *Centres of Diagnosis, Evaluation and Support*.

France: There has been a major investment in *Reference Points for the Prevention of At-Risk Behaviour in Schools* and the resolution of problems. Targeted counselling takes place during breaks, free time, during school hours and after school. Conceptually there is a major focus on professional training for school staff in order to handle deviant youth behaviour.

Ireland: The Irish *Education Welfare Act 2000* has established an expanded service for *Education Welfare Officers* to monitor the attendance of children of school-going age and to work in cooperation with the schools and the children’s families. However, this expanded service has been delayed in its implementation although it is hoped to be fully established in the near future.

Italy: Interventions are involving concerned families, especially the mothers. Alternative approaches are tutoring measures through older schoolmates or specific training for those teachers working in the “frontline”, i.e. a difficult relationship between school and social environment, which are not used to confront these pupils. Best results are achieved when high professionalism of teachers is associated with good learning possibilities of pupils by involving them in the use of materials, instruments and technologies.

Finland: Interventions usually are initiated and carried out very early as every school has a multiprofessional team (principal, nurse, the curator or the psychologist) that meets every week or second week and when needed. If the matter to be discussed concerns a student, the classroom teacher is also present. The parents are always by law informed and involved in the process. A large-scale national post-graduate training programme for teachers was launched in 2001. Locally, the programme is implemented in close collaboration with drug prevention authorities and NGO’s. It implies training of 38 hours. During the training, an action programme on substance abuse prevention (drugs, alcohol, tobacco) in schools is designed for the schools represented. Teachers are also trained to recognise and discuss drug use.

UK: The number of interventions is limited - some projects exist in areas with high levels of truancy.

GERMANY

Inside@school from the organisation Condrobs in Bavaria

Target group: Students at risk and with beginning drug problems

Strategy: To provide a steady and always available prevention service inside schools for all types of schools in Germany. Teachers are trained to run prevention measures on their own. The in-service training is conducted in practice in the every day life of the schools. The *Inside@school* - experts train teachers to be familiar with different methods for drug prevention, and during the project consultation and supervision for the teachers to handle “difficult” students will be available through the experts. There are counselling offers to guide the adolescents towards a self-responsible and self-determined way to handle addictive substances. Also other, not substance related problems like compulsive use of the Internet, anorexia etc. as well as legal (alcohol, tobacco, pharmaceutical drugs etc.) and illegal drugs are included. Cultural and gender differences are taken into consideration. The project is initially planned for three years and will be conducted at six urban secondary schools in Munich. The project is funded by the Municipality of Munich with 400.000 € per year. Networking of different schools is recommended.

Evaluation: The project will be evaluated (*FOGS*, Cologne) and a Manual will be written and published. It will be distributed to all teachers in Bavaria and the prevention experts in local communities. The Federal Ministry for Health and the Bavarian Ministry of State cover the costs for the evaluation research.

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Step by Step EDDRA

 **Target group:** Teachers, with a view to identify and support pupils at risk.


Strategy: *Step by Step* is a computer programme for early diagnosis and intervention at schools. It helps teachers who are confronted with problem pupils to find out whether or not these pupils use drugs. To achieve a professional kind of intervention, teachers are asked to use help-systems (e.g. helpdesks). The strategy of the intervention is similar to programmes of early diagnosis and interventions in big companies. Concerned pupils receive support and have to keep clear agreements with the teacher. The programme is based on theories of successful communication and theories of development of personal and social competences. The programme increases the ability of teachers to recognise specific kinds of behaviour and to select the appropriate strategies for early intervention. The programme and the handbook are adapted from a programme developed in Switzerland (Zentrum für Prävention - *ZEPR*A - St. Gallen).

Evaluation: 88 % of the teachers testing the programme felt more enabled to identify and classify problematic behaviour of pupils, 72 % of the test persons used the programme intensively, and 91 % of the test persons felt better supported in their every-day life at school.

EDDRA – link: http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=36

SPAIN

Socio-occupational inclusion Norte Joven EDDRA

 **Target group:** Youth at risk of drugs use, who need more than any other group training in general skills that will allow them to cope and face situations (not only related to drugs use), which put them under risk for drug use.

Strategy: To offer a social and labour skills training programme to develop skills and abilities in youths under drug use vulnerability factors, so that these youths may be able to handle social influences, cope with conflicts and problematic situations and be able make an adequate self-evaluation and to interact within different personal and group environments.

Evaluation: The qualitative evaluation used dynamic and participative methodology. It showed increases in dialogue skills, assertive communication skills, identification of peer group pressure situations, positive self-assessment of personal, social and labour possibilities, acquisition of more constructive and objective criteria in the administration of money and the organisation of leisure time, basic skills like listening, giving way, waiting for one's to speak, accepting rules and acquisition of knowledge on group processes: leadership, interpersonal conflicts, etc.

EDDRA – link: http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=2608

IRELAND

Stay in school EDDRA



Target Group: Children and young people between the ages of 10 and 15 within the St. Aengus parish area who have been identified as potential early school leavers and who could benefit from the range of interventions being provided by the *STAY* project. The participants on the project are primarily drawn from three local schools in the St. Aengus parish area: two primary schools and one second level school. St. Aengus parish is located in Tallaght, a suburb of Dublin. 1996 Census data showed that 41.7% of the adult population of Tallaght left school at or before age 15, this was in contrast to a national figure of 35%. Furthermore, the promoters of the *STAY* project had long recognised the link between early school leaving and drug misuse. Figures from the *Health Research Board's National Drug Treatment Reporting System* (1998) showed that there were 463 cases reporting for treatment for drug misuse with an address in the Tallaght area (8.2%) of the national figure. Of these 58.2% reported to having left school at or below age 15. In addition, 1998 *NDTRS* data showed that the proportion of first time contacts reporting for treatment with an address in the Tallaght area was approximately 9.9% of all first time treatment contacts.

Strategy: Development of a support network, provision of a needs based programme of activities, promoting active co-operation between home, school and community agencies; development of psychosocial skills. Specific objectives of the project are to enable participants to remain in mainstream education, to provide a needs-based programme of activities for the target group and to promote active co-operation between home, school and community agencies in pursuit of developing the personal and social skills of the participants. Activities offered through the *STAY* project include a homework support club, computer classes, art, cooking, first aid, drug awareness and a range of outdoor pursuits from canoeing to hill walking.

Evaluation: An external evaluation, which focused on the implementation process of the project, found that all participants who had participated in the project over the previous two years were still in mainstream education. The activities provided by the project were extremely well received by participants and this was reflected in attendance rates of over 90% at all activities. In addition, the project had to expand in order to accommodate the extra interest that emerged throughout the course of the project. Reports showed that the project was well known throughout the schools and within the overall community and an extensive network of support had developed between the *STAY* project and other organisations and projects working in the area. This extended support was proving invaluable to the developmental needs of the project on the one hand, while also giving added support to parents, teachers and children with concerns over substance abuse and factors that may predicate experimentation with drugs. Positive progress has been made in relation to the key objective of keeping participants in school, as all of the young people who joined the project in March 1998 were still within the formal education system when the evaluation was carried out in April 2000. This is a noteworthy achievement when one considers that a key factor in the criteria of selection onto the project was the identification of young people at risk of leaving school early. The *STAY-ON* programme, an extension of the *STAY* project, provides additional support to young people as they continue to progress through second level education. An up-to-date report on the project (Project Annual Report 2001) reports that two young people that the project worked with, had successfully completed their Junior Certificates in June 2001. In addition, three young people on the project successfully transferred to post-primary school. The attendance levels at activities organised by the project are excellent. An update on the evaluation findings (2000) would suggest that this positive reception is continuing as the project reports a 90% attendance at homework support clubs. Reports

from project staff indicate that young people are enthusiastic about their involvement in the project and are responding well to the various activities. Reports from parents, teachers and project staff suggest that the young people look forward to attending the project and feel their views/suggestions are being listened to in relation to the ongoing design and delivery of the overall project. They appear satisfied with the activities on offer and have displayed a sense of pride and self-belief regarding what they have achieved through their involvement in the project.

The project has worked with approximately 60 families since becoming operational in 1998 up until the evaluation in April 2000. In addition the evaluation found that the project has established extensive links with community agencies in the surrounding area. A joint recognition event to acknowledge the achievements of project participants was held at the end of the two summer programmes. 15 young people attended the recognition event with valid reasons for the non-attendance of others. Overall it would seem there is a high level of awareness about the project within the participating schools and the wider community.

In order to enhance this awareness, the *STAY* project organised a conference on educational disadvantage in September 1999, which was staged locally. The aim was to highlight the plight of educational disadvantage in the St. Aengus parish area and to bring awareness to the activities of the *STAY* project in seeking to tackle the issue among young people in the area. This conference was well attended and served to highlight the interest that exists at community level around issues of substance misuse and early school leaving. It would appear that the efforts by the *STAY* project to promote active co-operation between home, school and community agencies in pursuit of developing participants personal and social skills has been to a large extent, successful.

The engagement of family members with the project, the attendance of family members at special events organised by the project, the awareness of the project in local schools and the attendance of community and voluntary representatives at conferences/seminars organised by the project all indicate this key objective is being met by the project. An up-date on activities relating to this specific objective (Project Annual Report 2001) reports the number of parents attending parents' sessions is increasing and the number of parents expressing satisfaction with the projects activities also increased. In addition, the project has developed links with the Volunteer Bureau and the Liberties College. The amount of volunteers giving time to the project is increasing.

EDDRA – link: http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=2247



Jobstown Education and Training Strategy (JETS)

Target Group: From 156 fifth class pupils, out of an identified 32 young people at risk of early school leaving, 18 (9 male and 9 female) were chosen to participate in consultation with the *Home School Community*. Their characteristics were:

- Being withdrawn whilst others exhibited aggressive behaviour inside the classroom
- Having a record of erratic attendance and poor punctuality
- Showing an increasing level of absenteeism as they progress through school
- Showing low rates of participation in school activities
- Having older brothers and sisters who left school without any qualification
- Being academic underachievers or having academic difficulties
- Being recognised to have low self-esteem
- Having poor social skills
- Prematurely assuming adult responsibilities
- Being thought to be at serious risk of early school leaving

Strategy: To offer an integrated inter-agency response to educational disadvantage with the objective to decrease the levels of educational disadvantage, to improve retention in the formal school systems, and to intervene in the cycle of poverty and its links to education.

One of the specific objectives of *JETS* is to “develop an integrated approach between formal and informal systems in order effectively to respond to the problem of early school leaving” (from the Project Development Plan). The agencies that have come together to form this integrated response include: *Barnardos, Jobstown Community College, South Dublin Chamber of Commerce, St. Thomas Senior National School, the Tallaght*

Partnership and Youth Horizons. In the second summer project some of the young people were involved in the planning.

Evaluation: all 18 children still at school had “a significant achievement when one considers that the *JETS* classes were chosen because of the likelihood of them becoming early school leavers” (Rourke 1999, p.42). Though it was recognised that not all *JETS* classes progressing at same rate, and a minority are expected to leave the programme.

Ballymun Educational Support Team (BEST)

Target Group: young people between the ages of 8 and 15

Strategy: to tackle early school leaving, the support teams provide a range of supportive measures, both inside and outside school, with the aim of maximising children and young people’s participation in the education system. The teams provide in-school support at both primary and secondary level – where they work on a one-to-one or small group basis with children/young people who have been identified as being at risk. The teams also act as mediators between the pupil, their family and the school, for those children/young people who are experiencing ongoing behaviour difficulties in school and who are at risk of suspension. Thirdly, the team has developed an “*Out of School*” facility for children/young people, which have effectively left mainstream education. The number of places available on this “Out of School” programme is, however, limited to six young people at any one time.

The “Awareness FC” Drug Prevention Programme



Target Group: 5th and 6th class pupils (i.e. age 10-12) in the Finglas/Cabra area, a local drugs task force area with high levels of socio-economic disadvantage and hence large numbers of the at risk population.

Strategy: The programme operates within the school setting and consists of six weekly sessions of 90 minutes. The aims of the programme are to:

- increase the participants’ awareness of drugs and drug-related issues,
- encourage the participants to make informed decisions,
- discuss self-esteem among participants and
- highlight the need for drug awareness education.

The Programme also lists a number of key objectives. These include the assessment of participants’ knowledge of drugs and related issues, correcting misinformation, looking at drugs and related issues within the participants’ peer group, exploring choices, risks and consequences of drug-use, challenging the attitudes and behaviour of participants, including parents and raise their awareness of drugs and related issues and maintaining a community focus in the design and delivery of the programme.

The programme content includes the following components: *Drugs: What And Why*, Definitions, Self-Image, Decision-Making, H.I.V. and A.I.D.S. and a review/evaluation of the participation. A parallel parents programme is also offered.

Evaluation: Mark Morgan conducted an evaluation of the *Awareness FC* in 1999. Morgan employed a range of both quantitative and qualitative methodologies, appropriate to the research question being addressed, namely a content analysis of questionnaire responses, the facilitation of focus groups and conducting of open-ended interviews. Data was collected on the following:

- Student pre-tests/post-tests: the responses of the students immediately before and after participation in the programme.
- Students’ evaluations: the views of students in respect of the programme.
- Tutors’ self-evaluations regarding their own performance and the response of the group.
- Teacher evaluations, especially the views of teachers on the effects of the programme on their students.
- Parental evaluations, regarding the effects of the programme on their children and on themselves together with their perceptions of what might be done to enhance the programme.

Arising from his evaluation, Morgan (1999) noted that the programme as delivered by the *Finglas Youth Service* is well planned, implemented professionally and has achieved results that are extremely promising. Morgan (1999, p. 20) highlights that the programme is in line with those that have been shown in previous research to be most likely to bring about positive outcomes. Morgan recommends, inter alia, that the programme should be part of an integrated approach to the drug problem, in the context of the other work of the local Drugs Task Force and the other community efforts to deal with the drug problem. Furthermore, that the features of the programme which have contributed most to its success, as elicited in the evaluation process, should be developed and enhanced, thus according to Morgan, particular attention should be given to teamwork, planning, consultation and the community dimension of the programme (1999, 20).

AUSTRIA

Early detection in schools EDDRA



Target group: Demanding pupils with experimenting or heavy drug use and problematic behaviour. In the past the school directions' most common reaction was to report those pupils to the police and in some cases also to exclude them from school. These measures were not only inappropriate but they even increased the problem since it is known that dropouts are among the high-risk groups for intensive drug use.

Strategy: Prevention of addictive behaviour in youth at risk and/or with problematic behaviour by early detection and early intervention. Teachers are sensitised concerning early detection and intervention by means of a standardised model of action which can be used by all the different professions and facilities involved. Additionally, the teachers achieve competences to encourage youth at risk to solve their problematic situation with the support of specialised facilities. Early detection is a preventive model of action that emphasises the pedagogical approach, not the administrative one. It responds to signals of concrete behaviour and not only to drug use.

Evaluation: The vast majority of the participants have experienced the training as helpful. In most cases it even led to the setting up of internal school teams who continue to work together after the course and who organise specific activities. The objective of implementing a common model of action for the dealing with pupils who consume illegal substances could not be fully reached because of differences in ideology and commitment among those involved. Therefore at best it was possible that single teachers could reach an agreement about some concrete steps to be carried out. On a structural level, however, a common model of action for dealing with pupils who consume illegal substances was worked out together with the *Provincial School Council* of Tyrol. This guiding principle set up by public authorities was sent to all primary and secondary schools by a circular letter.

In every school the responsible school psychologist, teacher and school physician were involved, as well as the contact persons of regional drug services. In the trainings about 40 different services were involved. They visited the schools and took part in case conferences. Representatives of the drug help services (different institutions) have reached an agreement about a common way of consultation for pupils who are bound by law (§ 13 of the *Narcotic Substance Act*) to have consultations, which can be considered equal to the standardised model of action implemented up by the Provincial School Council. The feedback about the program indicates that the relationships between the internal and the external school help systems have been improved. At the moment it is unknown what kind of long-term effects and what results on the level of concrete everyday interventions can be expected.

EDDRA – link: http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=2088

PORTUGAL

SUB - RISCOS (Fundação Portuguesa - A comunidade contra a SIDA – Madeira).



Target Group: The project covers neighbourhoods of Funchal with high rates of deviant behaviours, drug experimenting/use and early school leaving. 60 children and youngsters (6 to 18 years), who show deviant behaviours and a high number of risk factors for drug use, have been identified by the local social services.

Strategy: *SUB-RISCOS* is a programme for the development of social thinking and of personal and social skills. Its objectives are to develop pro-social thinking and to promote personal and social skills in children and youngsters. It promotes qualification and training of professionals in prevention, so they can work in family, community and school systems. Active methods to promote interactive and cooperative learning are used, as well as small, heterogeneous groups to strengthen the feeling of mutual help. Additionally used methods are modelling, role-playing, positive rehearsal, group discussion, confrontation, creative activities in a group and development of critical thinking and discussion.

Evaluation: Explores the application and analysis of the programme, including pre-tests and pro-tests. The evaluation results are expected by end October 2004.

FINLAND

P Career planning class

Target Group: Students within last year studies in secondary school.

Strategy: Students at potential risk of dropping out from further studies are invited to attend a special class on regular basis where the participants get guidance in personal development and in focusing on goals for further studies. The programme is new and is offered to schools in the Greater Helsinki area.

Evaluation: The project has started in 2003; therefore no evaluation is done yet.

NORWAY

P New Start

New Start is a Canadian programme, which has a wide distribution and is offered to prisoners in several countries, including Norway. The material is based on a cognitive, psychological approach. On the basis of this programme, the National Training Centre in Hordaland has developed *KREPS* (creative problem solving), a programme aimed at pupils in junior secondary schools. The expert group (KUD/BFD 2000) is of the opinion that *KREPS* is a potentially promising initiative for junior secondary schools.

5. Young offenders

The projects presented in the following pages address problems of young offenders. Some of them target offenders *against drug laws* while other are directed towards young delinquents in a broader sense. The links between drug use and criminal offending are well documented and known: drug use is up to several times higher among juvenile offenders than among non-offenders (Goulden & Sondhi 2001). Besides this, there is substantial evidence that vulnerability factors for substance abuse and delinquency overlap to a very large degree (Hawkins et al. 1995). Causal relationships are therefore difficult to establish: young drug users and young offenders are more likely overlapping populations (Newburn 1999). This makes the criminal justice system an important setting for selective prevention interventions, not only concerning treatment provision to drug addicts in detention. The coordination between social (prevention) services and judicial services is a key factor and considered difficult as an evaluation of two pilot projects in the UK showed (Newburn 1999). In most member states there exist allegedly legal provisions to deal in an especially cautious way with young offenders (especially those first notified because of drugs offences), but detailed guidelines and concrete cooperation projects between services are seldom reported.

GENERAL REFERENCES FROM MEMBER STATES

Denmark: The Danish model of *SSP* (**S**chool, **S**ocial services and **P**olice) cooperation and coordination has close and continuous dialogues about both individual children and groups at risk, as well as about areas or communities with special problems; and they cooperate their separate actions. The *SSP* structure exists in almost every municipality.

Greece: About forty-five municipalities across the country have been in the process of setting up *Local Crime Prevention Councils*, which consist of social workers and of other specialised volunteers, as well as of representatives of the Municipal Council, the police and judicial authorities, the social agencies and the local enterprises. Among others, *Local Crime Prevention Councils* are responsible for providing the *Ministry of Public Order* with advice and consultation on the preventive and suppressive measures to be taken against crime in their respective municipalities.

- a) *Arsis*, a voluntary non-governmental organisation, offers its services to young people who have problems with the law.
- b) The counselling centre of the therapeutic programme *STROFI* (of *KETHEA*) is located in the Public Prosecutor's office and offers its services to adolescent drug users who have problems with the law.

Italy: Police refer youngster caught with drugs for personal use to the "*Prefect*" who invites the youngster and his/her family to a motivational interview with staff of the drug office that exists in every "*Prefettura*". These interviews aim at exploring motivations, assessing possibilities to prevent further offences and putting the youngsters in contact with therapeutic and rehabilitative structures in the area. There is a specific project with national coverage for youngster in the criminal justice setting offering prevention interventions and psycho-social support regarding drug problems. The prevention interventions consist of sports activities, vocational training with traineeships and occupational reinsertion measures. The psycho-social support measures are aiming at maturation, decision making (for changes) and at developing personal resources of the youngsters.

The major part of interventions concern hosting families for minors with criminal record problems or parents with the same background. There has been a recent initiative within the Milan tribunal to train adults capable of becoming tutors and legal custodians for foreign unaccompanied minors. Data are at present very limited and there is no known research being undertaken to fill this information gap.

Finland: The criminal acts committed by a person younger than fifteen do not come to trial and the person is not sentenced to a punishment. It is a matter for the social welfare authorities and the police to direct such a person towards a life without crime. A juvenile punishment may be imposed for an offence committed by a person over 15 but under 18. It consists of juvenile service, of at most 60 hours, as well as supervision. The objective is that young persons under 18 of age should be kept away from prison if possible because about 90 % of young people who have been in prison have been found to return there some day. Since the juvenile punishment programme was initiated, hundreds of reprimands have been carried out. About 200 young offenders are involved in the programme at the time, most of them convicted of theft, drug crimes and assault. Some of the minors have a record of as many as seven suspended sentences. Rapid intervention, conviction and sentence are preferred as beneficial for the rehabilitation of young offenders; a lengthy legal process is seen as conducive to continuing a criminal career. The juvenile punishment has its critics that say that the programme eats a large amount of resources for each young person involved.

GERMANY



FreD (Frühintervention bei erstauffälligen Drogenkonsumenten) EDDRA

Target Group: First notified young drug users. Many of these youngsters have first contacts with the criminal justice system because of drug related offences, even before their families know about their drug consumption.

Strategy: The project, co-ordinated by the *LWL* in Münster (www.lwl.org), offers early intervention with short duration and on a voluntary basis. As early as possible in the legal proceeding and in the biography of the young and growing up persons *FreD* offers a service to reflect upon drug consumption behaviour. It is carried out by drug care services, which are experienced with the treatment of teenagers. Beside the assessment of the own drug use pattern and the possibility to rate their personal risk, the project strives for the motivation towards a behavioural change with the target of reducing consumption and changing attitudes towards drug use. If a person is interested in the programme and before participating in it, a one-to-one motivational interview is held to explore the actual consumption level. With this process a possible manifest consumption situation can be assessed and treated by a comprehensive, distinctive and individual support service. Additionally, in the

motivational interview the decision about the participation at the 8-hour training course of *FreD* is taken. 8 Länder implement the programme.

Evaluation: The average age of *FreD* clients is 17.9, suggesting that the target age group is well reached (more than 80 % under 20). Most of the clients had previously not used any psychosocial counselling service. During the programme, an increase of problem solving, self-competence and knowledge about support offers could be found in the target group. Also the intensity of drug consumption slightly decreased and the re-offending rate was as low as 6,8%. Satisfaction with the programme was high was 87%. Key success factors resulted to be the intensive cooperation of the judiciary and care services.

EDDRA link: http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=2091. The full evaluation report in German is downloadable by End 2003 at <http://www.lwl.org/ks/>.

IRELAND



Finglas Village Project, Dublin

Target group: Males and Females 12-16 years old, who were referred for non-school attendance or criminal charges in the geographical area of Dublin (districts 9 or 11).

Strategy: Four-week day-assessment service. The *Village Project* is unique within Ireland in respect of the assessment framework it adopts. It is currently the only comprehensive day assessment service for young people at-risk, though it is envisaged that the *Village Project* will act as a model of best practice for future similar assessment services.

In all interactions with young people, their guardians/families, with external agencies and with one another, the *Village Project* team adopts a strengths-based approach, which is solution rather than problem focussed. The team holds as a basic presumption that people have within them a wealth of resources and abilities to address any difficulties they may be currently or have in the past experienced. This approach builds on the young person's (and his/her guardian's/family's) existing strengths and is purposely more active and involved in helping the young person develop and implement their own strategies for positive change in their lives.

The *Village Project* adopts an inclusive and participative approach. During the course of the assessment, consistent and active family involvement is encouraged and perceived as essential to the assessment process. Young people at the *Village Project* have an active voice in the assessment process and their personal views are recorded in each section of the Assessment Report prepared for the referring agency.

Care planning is a core element of the assessment process at the *Village Project*. In active collaboration with the young person (and his/her guardian/family where appropriate) the key worker develops a plan of care, which encompasses both long-term care objectives (over the course of the full four-week assessment) and short-term weekly achievable goals. The care plan addresses the physical, emotional, intellectual, social and personally identified goals of the young person and the strategies to be employed to achieve these goals. The short-term goals are decided at the commencement of each week – with the young person receiving a copy of the weekly care plan signed by both him/herself and his/her key worker – the care plan is reviewed at the end of each week and overall at the end of the assessment. The young person is actively and directly encouraged and praised in each and every step they take to achieve their stated goals. Each young person receives a certificate at the end of the assessment process outlining the goals they have personally achieved during the assessment process.

The *Village Project* employs a multi-disciplinary team with emphasis on team rather than role expertise. All members of the team act in the role of key worker to a young person, thus breaking down the role distinctions, which typically exist in many agencies working with young people. For instance, it is the key worker, as opposed to any other member of the team (director, psychologist etc.) who acts as the advocate for the young person and his/her guardian/family when liaising with external agencies.

Evaluation: Quantitative and qualitative evaluation, without control group (Hughes 2001). According to the evaluation results, the project is in line with successful international models and the assessment at the *Village Project*

- ... is a move away from purely residential assessment facilities for young people in Ireland,

- ... is a locally-based service, building links with community groups,
- ... is contextualised within the life of the young person (due regard is given to the influence of family, peers and the community),
- ... gives the youth an active role and a certain level of responsibility for the successful outcome of the assessment
- ... gives greater contact with families than was usual in residential models of assessment.

The reports presented to the courts are suitably comprehensive. As a conclusion, the service is prima facie highly cost-effective as it is a diversion of young people from high cost detention.

LUXEMBOURG

Street work - Juveniles in urban areas



Target group: Youngsters with risk behaviour, with coverage of about 200 per year (195 youngsters in 2001).

Strategy: The project is in development by *Médicins Sans Frontière: Solidarité jeunes*. It targets young people having offended against drug law by offering a psychosocial counselling including the parents or somebody from an involved educational institution. It's an intervention at an early stage with the objective to find solutions for reducing the occurrence of repeated offences together with the responsible educators. This includes factors independently from offence and drug consumption.

UK



Drug Outreach Workers In Youth Offending Teams

Target group: Young people cautioned or convicted of criminal offences in England.

Strategy: The *Youth Justice Board's Youth Offending Teams (YOTs)* work to prevent re-offending by children and young people. Drug and alcohol abuse is one of the major factors that puts young people at risk of offending. Every YOT has a drug worker; they assess young offenders for drug abuse and where appropriate, offer brief interventions and referrals to specialist young people services.

Size of intervention: national drug workers are placed in each of the 154 *Youth Offending Teams*.

Evaluation: On-going and reporting in Sept 2003.

NORWAY

ART



Target group: Aggressive and asocial adolescents.

Strategy: *ART (Aggression Replacement Training)* is a successful and well-documented risk-reducing programme, which comprises social skills training, anger control and training in moral reasoning. The programme is now operational in the Netherlands, Poland and Great Britain, where the British Home Office is planning a national *ART* programme. In Sweden, the *Barnhemmet Oasen* orphanage in *Aneby* and the *Ungdomsalternativet* youth centre in *Malmö* have achieved very good results with this approach.

Evaluation: The experience with *ART* extends over 15 years and with very encouraging results (Coleman et al 1991, Goldstein and Glick 1987; Curulla 1990; Gibbs et al 1992, Klein 1995). One of the results is that coercive measures in relation to the target group have been reduced.

6. Counselling (outside schools) for youth experimenting with drugs, including outreach methods and meeting points or cafés

In the previous chapters, projects were presented that include counselling to experimenting youth or to youth at risk while they are attending school or having collided with the criminal justice system. However, there are many situations and living conditions where it is more suitable to approach young people in more informal settings, especially when they cannot be reached otherwise. This would in theory also apply for the risk group of homeless young people (Lloyd 1998, Drugscope 2000, Goulden & Sondhi 2001), but through this survey and in EDDRA no projects were found that would address explicitly young homeless people.

Common characteristic of the projects included in the following chapter is a strong focus on identifying, approaching or attracting vulnerable young people with a view to provide counselling or referral to specialised services and to intervene at an early stage of problem development. Outreach work is in most member states traditionally conceived as reaching out for problematic drug users and is less associated with approaching vulnerable youth without severe drug related health problems. From some member states, centres for mobile youth or street work are reported, which are closely cooperating with all relevant help organisations so that assistance may be provided to drug-using adolescents and young adults at the earliest possible stage. In cases of crises, joint actions may be taken. These measures and their relevance for vulnerable and experimenting youth are intensively discussed e.g. in Austria and are foreseen to attain an increasing geographical coverage (Haas et al. 2001 and 2002).

In this intervention field, the practical and recurrent question is how to identify and to track those youngsters, who are at risk for passing on to problematic consumption patterns but who maybe cannot be reached at school or other formal settings. Attractive drop-in facilities and counselling facilities with a judgement-free attitude (Haas et al. 2001) are one important strategy option. In some member states, more pro-active approaches - "interventionist tracking" (Green 2001) - for vulnerable youth are applied, mostly through cooperation of different services (Green 2001) and social actors (Arbex Sánchez 2002). Possible options are more targeted studies with youth that analyse predictors for drug abuse rather than use (Kirkcaldy et al. 2003).

GENERAL REFERENCES FROM MEMBER STATES

Denmark: This approach is not a special priority but it is in increase e.g. in connection with street working

Greece: Some primary prevention agencies offer counseling and psychosocial support to adolescents, who are at risk and/or may be involved in drug use, and their families, especially in areas where there are no other health or drug services.

France: Specialised prevention outreach teams are present, sometimes in cooperation with schools, but they rarely develop specific strategies in the drugs field.

Ireland: The Irish *Health Advice Cafés* aim to provide a combined prevention and direct-access health service for young people. There is a need for more cafés for youth to drop into. A dedicated youth centre in Ballyfermot is planned to be established by *URBAN* Ballyfermot in 2004, which will feature a drop-in café aspect.

Italy: Local youth services provide in many cities mobile information and advice units, which travel around the locations where young people meet. Data are not available in published form on their work and there is no national data on the number of services operating or on their activities. Some drug services have also developed mobile units, aiming at preventing risk behaviours amongst irregular drug users and at providing alternative activities. One example can be found in Verona: the *Life Line Bus* (<http://www.autoaiutocorallo.org/>) project is a collaboration between the dependency department, the *Ce.I.S* of Verona, *Il Corallo* and the culture department of the Verona province. The bus travels within the Verona area and provides prevention material, advisory and counselling services in an informal setting, as well as audiovisual prevention material. Additionally it seeks to gather information and to monitor trends in youth culture, behaviour and drug use and to work with groups of young people exhibiting delinquent or

problematic behaviour. Within some municipalities are structures called *Informagiovani* with counselling functions for youth.

Finland: *Walkers youth cafés* provide early interventions and are currently operating in 24 localities. Adults play an important role in these activities as youth work professionals support and train volunteers. An effort has been made to develop the youth cafés into safe meeting places, where young people can interact within their group and with adults. Addresses and other information about the Walkers cafés can be accessed at http://www.asemanlapset.fi/tietopankki/in_english/.

DENMARK

P Recently some municipalities have gained good experiences by offering help to groups of young people with a starting cannabis problem via day-based centres, where the young are gathered in smaller groups (up to 10) and supported by a therapist or social worker. In the groups they are offered space and time to talk about their life, problems and drug use. The most supportive methods are considered: offering help, make specific and realistic plans for the future, and help to start education or to enter the workfield. The results imply that the young people at risk profit very much from adults who offer support, respect and who accept the young person under the young person's conditions. The results also imply that the increasing but not yet full blown drug problem "solves itself", if help regarding other problems (with school, family, friends offered) is offered and accepted. The specific support to establish integration to the education system or into the workfield has shown to be of great importance in order to prevent further social exclusion. A respective well-documented example can be found under http://www.drug-prevention.de/kop_tjek/tjek_eng/index2.htm.

Natteravnene (Night Ravens) are volunteer groups of parents walking the streets of the towns and city centres during the weekend nights to assist young people in alcohol and drugs-related trouble and to create a feeling of security. The *Night Ravens* don't enter bars and discos but stay in the streets. Their mission is to assist the young people and inform them about where to go for guidance.

GERMANY

P The brief-intervention manual on alcohol for family doctors called "*Kurzintervention für Patienten mit Alkoholproblemen - Beratungsleitfaden für ärztliche Praxen*" which has been published by the *Federal Centre for Health Education (BzgA)* in Cologne is under an evaluation process in Lower Saxony as a model region. Doctors will be trained during 12 seminars all over Lower Saxony during May until October of 2003. They will be interviewed 2 times. The results will be available at the beginning of 2004.

GREECE

Some primary prevention agencies offer counseling and psychosocial support to adolescents who are at risk and/or may be involved in drug use, and their families, especially in areas where there are no other health or drug services.

The Mobile Unit of Information "Pegasus" (KETHEA) offers counseling and support to drug users and their families who have not approached a treatment programme, as well as to drug users who are at risk to become drug addicts.

P
P
P The *Early Intervention Network PLEFSI* (of KETHEA) is addressed to adolescents from 13 to 19 years of age who use substances on an occasional/experimental basis, are involved in educational or occupational activities and have a supportive family environment. The Center focuses on preventing such adolescents from further involvement in drug use by intervening at the early stages of addiction.

The Prevention Centre of the prefecture of Aitolokarnania since 1998 runs a self-help group intended for young alcohol and recreational substance users, as well as for high-risk youths. The main aims of this programme include the provision of information and psychosocial support in young recreational alcohol and drug users, as well as their involvement in creative activities as alternatives to drug use.

EDDRA – link: http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=478

SPAIN



Hirusta EDDRA

Target group: Teenagers (14 to 21 years old) and their families who present numerous social and behavioural conflicts, among which may appear drug use.

Strategy: Since 1994, an increasing number of teenagers with initial drug use or other risk behaviours that didn't correspond to the profile of the traditional user of the service come to the *Proyecto Hombre* Centre in Bilbao. The main reason for consultation wasn't the problem of drug use alone, but also other problems related to family and school, or of personal kind linked to adolescence. Among them, aggressive behaviours, initiation in criminal activities, lack of academic performance, troubled family communication, absence of limits, and conjugal problems affect the teenagers most. *Hirusta* is a programme specifically dedicated to teenagers and their families in order to meet their specific necessities. The objective is to offer guidance and support to teenagers, their families and any community service working with them. Specifically, the programme aims to: 1) assess teenagers' risk level and to develop personal and social skills that allow to manage troubled and risk situations; 2) support and to offer treatment to the families of these teenagers, so that they can develop the necessary skills to manage the relationship with the troubled teenager; 3) be coordinated with other community services that work with teenagers in problematic situations. The activities are organised through training courses, specific workshops and awareness sessions. The activities addressed to families and/or teenagers in a special problematic or risk situation are information and guidance, assessment and individual and group intervention. The interventions with teenagers and their parents are developed separately. The approximate duration of the intervention is of 6 to 12 months.

Evaluation: It is above all a process evaluation of the intervention and an analysis of the target population's profile. An outcome evaluation protocol developed by an external entity is currently running. Since 1996 the programme has increased progressively the number of attended teenagers and families, going from 45 families and 36 teenagers in that first year, to 202 families and 94 teenagers in 2001. In 2002 it is estimated that the programme assists 674 persons. The most frequent reason for consultation is suspicion of drug use or manifest drug use. However, it is observed that the demand for this reason is diminishing along the years, while other problems, e.g. family conflict and aggressive behaviour begin to prevail. Around 10% of the intervention demands are derived to specific services, once the situation has been assessed. In 2001, with the objective of improving coordination and synergy with the socio-communal resources, 8 training-of-trainers activities were developed with the participation of 146 teachers. 2 courses for the parents of the pupils were carried out, with the participation of 40 persons. Lastly, 8 workshops for social mediators and technicians in the prevention of drug dependence were organised, with the participation of 186 professionals.

EDDRA – link: http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=2916

IRELAND

Ballymun Youth Action Project (YAP)



Target group: The Ballymun *Youth Action Project (YAP)* was established in 1981 after a number of young people from the Ballymun area died of drug related deaths.

Strategy: 1) To develop a community response to drug abuse. 2) To provide advice, information, and support to those who are addicted and to those living with addiction. 3) To develop preventative services, particularly in relation to young people at risk or vulnerable to drug abuse. 4) To engage in community education regarding drug abuse. 5) To work closely with other voluntary and statutory groups providing community services. 6) To facilitate research into drug abuse in the area.

The main programme consists of one to one counselling, group therapy, support groups advice, referral, outreach as well as prison, home and residential visits.

A recent innovation in the programme is *URRÚS* (Irish for “strength” or “confidence”), Ireland's Community Addiction Studies Training Centre, which was created by the *Ballymun Youth Action Project* to provide quality training on all aspects of drug abuse and addiction to meet the needs different target groups, including

voluntary community activists and professionals who encounter addiction issues in their work. *URRÚS* is a dedicated centre of learning, which brings together the Ballymun *Youth Action Project's* two fields of expertise - community work and drugs work. Integrating the concepts of community development in the design of effective responses to drug abuse represents a highly innovative approach, recognising that no single service can solve the problem of drug abuse. *URRÚS* makes available training to those who otherwise are excluded from other forms of education. It is also innovative in that *URRÚS* will have local people from the Ballymun *Youth Action Project*, involved in training other local people and professionals in the field.

Evaluation: no information

AUSTRIA



Train Waggon in Mödling **EDDRA**

Target group: Scene of young adults aged between 13-23 having problems with the misuse of alcohol, pharmaceutical drugs and Cannabis.

Strategy: *Waggon* is a youth counselling centre situated in a railway carriage in the front of Mödling railway station. Thousands of young people pass through the station everyday commuting to and from school. The *Waggon* youth centre offers various activities, support and counselling to young people, with a focus on 18 -20 year olds. It receives an average of 50 visits per day and provided 513 counselling sessions in 1999. Experience showed that young adults do not visit high-threshold institutions. They also do not like to visit authorities because of their specific institutional character as such. This low-threshold facility makes it easier for young adults to make use of professional assistance, counselling and accompanying. The young adults have to be given the opportunity and time to build up the necessary trust. As the development of gender identity occurs in the age range of *Waggon's* target group, gender specific offers are very important. Thus the young adults can choose between experts of different gender.

Evaluation:

The staff, options and dimension of the facility are used to a maximum level. The implemented strategies were further developed and complemented with discussion events and clearer communication of the rules in the meeting point. Consequently improved the mood between visitors, which had been burdened by a quarrel between Turkish and other groups. The young adults accept the counselling part of the centre positively. In 1999 the number of visitors was 10,179; three quarters of them were boys. In the same year the number of counselling sessions was 513. Work and family were the most important topics of discussion. Further topics concerned addiction, drugs, personal problems, schools, questions in the field of law, partnerships, etc.

EDDRA – link: http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=710

Lower Austria plans to expand its street work projects to more regions in the years to come. For 2003, mobile youth work activities will be intensified in Krems and in the Waldviertel region. Vorarlberg plans to run a special secondary prevention project that covers the whole province and closely cooperates with all relevant help organisations so that assistance may be provided to drug-using adolescents and young adults at the earliest possible stage.

Auftrieb (“Boost”) **EDDRA**

Target group: Young girls, boys and their parents, as well as other relatives in a worker satellite town of Vienna.

Strategy: Offering counselling, care, accompanying and crisis-intervention for youths and their relatives in a low-threshold counselling-centre beyond official institutions to prevent the development of problematic addictive behaviour. The counselling-centre is situated in the outskirts of the town on the premises of a former slaughterhouse, which has been adapted into a social centre that hosts different social services (e.g. youth-culture-house, emergency sleeping facility). This location fits the youth's needs: they like to spend their spare-time there and some of them live there. It promotes the establishing of contacts as a first step to offer assistance and paves the way to counselling-activities through getting to know each other without obligation. At the same time working with and for the parents is seen as useful addition to the youth work.



Evaluation: The offer is well accepted by the parents and by the youngsters. In 2000, counselling of young people (14 to 19 years) amounted to one fourth and of relatives to one fifth of the overall counselling work. The counselling of persons older than 19 years concerned one third of counselling work. Other contact-persons (educators, multipliers, lawyers, etc.) took up more than one fifth of the counselling. In 2000, the number of clients was 373, half of them for youth and half for addiction counselling. Topics addressed were conflicts in the family, problems at school - till refusal to go to school - personal crisis or questions regarding the choice of a profession. In many cases young people come to the counselling centre because of drug law offences. Young people mostly find their way to the counselling centre via their parents, relatives, acquaintances and teachers. The large number of parents and relatives counselled shows the despair and helplessness of relatives when the topic "addiction" or "threat of addiction" appears in the surrounding of the family. Following the demand, a parents group is offered continuously. The number of counselling-activities is increasing; the fear of losing one's face in calling on psychosocial help or of having to be ashamed (small town where families know each other) does hardly exist any longer.

Also the socio-political climate of the town has been influenced favourably. Discussions of young people with experts and politicians were organised, and as a result problems relating to young people and drugs have ceased to be taboo subjects.

EDDRA – link: http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=2086

UK

Out There Project



Target group: Young drug users aged 13 to 25 in Durham.

Strategy: The project recruits and trains peer educators to provide harm reduction information to young drug using friends through everyday conversations within their communities.

Evaluation: Evidence from interviews showed that peer educators have passed on useful 'harm reduction' messages and have accessed many young people who 'traditional' services have not yet engaged. Peer educators reported that the process of being involved in something they perceived as being worthwhile, mixing with other young people and having a sense of providing something for others, were the main factors which kept them motivated and interested. It was recommended that the recruitment process was narrowed down and made more specific, and that the project could broaden its aims to include education to help people stop using drugs rather than just reducing risk associated with use.

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Health Action Zone (HAZ) Pump-Priming Drug Misuse Prevention Projects



Target group: Vulnerable Young People

Strategy: It consists of 130 projects and initiatives in the 26 HAZs across England. HAZs are multi agency partnerships located in some of the most deprived areas in England and their aim is to tackle health inequalities through health and social care modernization programmes). They cover a wide spectrum of vulnerable young people thought to be a risk of misusing drugs (Department of Health, 2001).

Evaluation: The *National Drug Prevention Development Team* at the *Department of Health* has commissioned a research team at the University of Glasgow to conduct a national evaluation of pump-priming drug prevention projects in *Health Action Zones*. The evaluation began in January 2002 and was funded until June 2003. The main aims of the project were: to establish whether the pump-priming initiative has resulted in an expansion of effective and sustainable services; to strengthen the evidence base about drug prevention services for vulnerable young people; and to contribute to the development of guidance about best-practice models of intervention.

7. Alternative leisure time interventions and regular youth work, including sports activities

Approaches and interventions presented under this heading distinguish themselves from the previous chapter by their general objectives of providing different types of protective environments and by providing activities in order to keep vulnerable on the track of social inclusion. Many of them respond therefore to the need of sensitising youth work centres for the challenge of including “difficult” or drug-consuming youth (Haas et al. 2001) or even providing suitable alternatives for them in the organisation of (mobile) prevention services outside school (Haas et al. 2002). In Spain there is already an important tradition in providing alternative leisure time interventions and a considerable progress has been made in developing evaluation techniques for these interventions; as documented in a manual of Hermida & Secades (2002). Many of these intervention examples are however carried out in recreational (party) settings and were therefore not included in this report.

GENERAL REFERENCES FROM MEMBER STATES

Denmark: This approach is considered highest priority in policies, especially in leisure time activities and sports e.g. in the traditional football clubs. During the last years the range of sport activities has been broadened and includes informal sport options targeting children and young people at risk.

France: Municipalities, social centres and specialised prevention outreach teams develop leisure actions, namely holiday camps that allow contact with young people which are in a more difficult social situation.

Ireland: *Foroige* is a national youth organisation, which has over 525 clubs operating throughout the country. It also manages and administers twenty-eight different youth services and projects including the Tallaght and Blanchardstown *Youth Services*. These services/projects are run in conjunction with *Vocational Educational Committees*, *Health Boards*, the *Department of Justice* and *Area Partnerships*. The fundamental objective underpinning all of the work of *Foroige* is to enable young people to involve themselves consciously and actively in their own development and the development of the community in which they live (see also *Foroige Young Mothers Groups* in the family section (on page 56)).

Luxembourg: Different projects for youth at risk are in place: sports projects, youth centres and special projects from the national youth service in cooperation with *CePT* <http://www.cept.lu/> and other organisations.

Finland: There are only a few sport clubs that are especially targeting youth at risk. Sport club activities usually take place in the evenings and weekends, but at daytime for those who are not attending any school and are not obligated to do so (over 15 years old), there are “daycentres” and workshops in some municipalities. The sport clubs are however instructed by authorities in the drug prevention field to a) take responsibility of their members who are at risk to drop out or have dropped out from the club b) be more aware of the risks concerning youth and doping c) encourage a lifestyle free from alcohol and tobacco, especially when minors are taking part in training camps or festivities when victory is celebrated.

Norway: Some sport clubs pay particular attention to their role with young people at risk and the possibility of including them. But youth work and sport clubs define themselves primarily as cultural, political or constructive activities, not as prevention institutions

GREECE

Arsis

Target group: Young people at risk; for example young people who are facing problems such as inadequate support from the family, insecure family environment, family neglect or violation, truancy, problems with the law, as well as young people in care institutions.

Strategy: *Arsis* is a voluntary non-governmental organisation which approaches young people at risk. Its interventions are mainly carried out through:

- the *Support Centers for Young People*, where the following services are offered: information, counseling, career advising, legal advising, referrals to other agencies (for example educational institutions, institutions for vocational training), support to occupational and accommodation needs.
- the *Centers for Creative Activities and Communication* located in different places across Greece (Athens, Thessaloniki, Volos), where young people communicate, express themselves and participate in creative activities. The main aim of these Centers is the prevention of social exclusion of young people
- the organisation of productive workshops (e.g. handcraft workshops).

For more information about *Arsis* – in Greek only – see <http://www.arsis.gr>

Evaluation: no information

IRELAND

Ballyfermot Youth Club



Target group: Children and Youth, from very young up to 14.

Strategy: The project involves 250 children during the year with approximately 400 attending its *Summer Project*. The children are broken into groups of about 25 for activities such as bowling and swimming. Other activities include trips, hiking, and visits to pantomimes. Family work: A notable feature of this project is that parents of the children have to be involved and children are usually admitted only with the involvement of their parents. Staff and funding: Affiliated to the *Catholic Youth Council (CYC)*, which pays its insurance, this club is run by local children's parents as volunteers, and with the aid of an annual grant from the City of Dublin *Youth Services Board*.

Evaluation: Downes' (2003) review of extracurricular activities in primary schools in Ballyfermot, Dublin found that girls have very few options for such activities while boys' main participation in extracurricular activities was Gaelic football.

Cherry Orchard After School Project



Target group: Children 3 to 17, eleven of which are over 7 years of age, with seven being over age 12. Parents of these children are frequently addicted to alcohol and/or illicit drugs, many are in abusive relationships, some also have low I.Q, according to the full-time project leader. Those families who are in need of and wish for family therapy are referred to Cherry Orchard Family Care Centre.

Strategy: This project, located in Cherry Orchard since 1996, deals with 18 children from 9 families every day Monday to Friday. There is a file on every child and every child is on daily report. A strong childcare element occurs in this project with the children's laundry being washed in the house as part of their preparation for school. Other activities include storytelling and outings, while an individual activity plan or 'personal programme' is drawn up for each child often in the areas of remedial tuition, hygiene, work on the computers in the house and a special diet. Some of the older children also help with the younger children, for example, when bringing the children on outings. An important goal of the project is to provide an environment of security for the children. Three small rooms are available in the house for group work, as well as one to one work inviting children to talk about their day. Family work: Parents of the participating children are required to sign a consent form that the project has the right to communicate with the school on behalf of the family.

Evaluation:

Waiting list: At least 12 children. The project leader suggests that, with the assistance of the Home School Liaison teachers, they could fill the project 'ten times over'. The project struggles to obtain long-term funding despite the fact that there is a huge need for projects like this.

LUXEMBOURG

"Natur - Bewegung - Kreativität" (nature - mobility - creativity)



Target group:

Strategy: This project uses adventure education as a method for addiction prevention. It's an interregional project of Luxembourg and Rheinland-Pfalz (Germany) with juveniles and their educators from reformatories. It includes a four-day training for the educators (N=23) and an adventure week together with the juveniles (N=40 with 8 educators). The intervention is focused on social competence and life skills training with the challenge to transfer the experience in the every day setting of the reformatories.

Evaluation: The qualitative evaluation shows a high acceptance of the intervention and the participants (juveniles and educators) learned something for themselves. The juveniles reported about their new emotional and social experiences during the adventure week, which was also observed in the same way by the educators. The evaluation of the transfer into the setting of the reformatory based on a quantitative pre-post measurement showed, that the situation in the reformatory diminishes the developed social competences very soon. Only the quantity of conflicts between educators and juveniles declined. Report available from CePT (www.cept.lu).

FINLAND

AC Stoppi

Target group: Children and young people, who may be vulnerable to drug use.

Strategy: The non-governmental organisation *Stop Huumeille* (Stop to drugs) started in 2001 the sport club *AC Stoppi*. The sport activities are indoor bandy, football and at wintertime indoor football. The organisation offers also information, counselling and a number of creative activities.

UK

Positive Futures



Target group: Children and young people, who may be vulnerable to drug use. These include young offenders, the homeless, those children looked after by social services and school excludees and truants.

Strategy: 57 *Positive Futures* projects have been established to engage vulnerable young people in high crime areas within sport activities. These youth programmes and interventions outside schools are in line with the government's policy of reducing health inequalities and reducing social exclusion. There is a large number of local drug education programmes and interventions that focus on these young people and their parents and carers. The contents range from peer education to diversionary activities, with funding from a variety of sources within the voluntary and statutory sectors.

Evaluation: Initial results are very encouraging, showing reductions in criminal activity and truancy and improved community awareness. See additional information on page 49 in this report.

Website: <http://www.drugs.gov.uk/NationalStrategy/YoungPeople/PositiveFutures>

8. Ethnic groups

Addressing immigrants and ethnic groups in connexion with vulnerability factors for the planning of selective prevention intervention requires some caution and explanations. Ethnicity is by itself not a vulnerability factor for substance abuse problems. However, again with a view of practically guiding prevention interventions, ethnicity can be a useful construct for risk assessment, because vulnerability factors such as mentioned in the beginning of the report, like low academic and/or socio-economic status, social exclusion, impaired communication capacity and differing social norms and skills, as well as little involvement in community affairs often accumulate within some ethnic groups. It is acknowledged nevertheless that the relationship of drug problems with ethnicity is in reality more complex and strongly shaped by socio-economic status (Wallace 1999) and identity conflicts. For more information on the terminology used, the relationship on drug use, ethnic minorities and social exclusion, refer to a recent EMCDDA report (2002) at

<http://www.emcdda.eu.int/?nnodeid=1661>. All but one (*Southall Community Drugs Education Project*) interventions referred there are however about treatment services.

The ethnic groups affected by vulnerability factors are likely to be different in each member state (e.g. Russian-German repatriates in Germany, Maghreb immigrants in Spain), which confirms again that not ethnical or cultural difference alone constitute vulnerability. Therefore, not all member states report on the respective interventions. More targeted research and more political openness is needed to better explore and address this issue, without notoriously raising debates about political correctness. In non-European publications, aspects of ethnicity and cultural identity are more openly and directly addressed with regard to drug problems and prevention (Wallace 2002, 1999, Scheier 2001). Wallace and Muroff (2002) found that exposure to vulnerability factors as compiled by Hawkins and Catalano (1992) differs substantially between African American and white youth, the former being more exposed to contextual (economic and academic) vulnerability factors, whereas the latter were more exposed to individual (sensation seeking) and interpersonal (peer use) factors. The relationship to drug use was stronger for white youth. Addressing these issues is of high concern for prevention, for several reasons. Some ethnic communities themselves feel as being at higher risk (ongoing study for *Connexion* in UK in Chinese communities) and accordingly miss tangible responses for themselves. In addition, Scheier et al. (2001) showed that there is a big potential for (through prevention) influencing personal risk/protective factors even in conditions of high perceived neighbourhood risk among ethnic minorities: the influence of environmental factors (neighbourhood risk such as gang activities, fighting etc.) is strongly moderated by the presence of individual-level factors, which in turn are accessible to prevention interventions. Precisely, individual psychosocial factors, especially social skills and interpersonal relations can buffer the problematic socio-economic conditions that some ethnic communities might face.

GENERAL REFERENCES FROM MEMBER STATES

Germany: The LWL (2002) in Germany (www.lwl.org) coordinates a joint study/intervention to analyse the risks for drug abuse among immigrants, to identify risk and protective factors, and to develop targeted sensitive prevention intervention for and together with immigrants. Participating countries were Spain (Barcelona), Italy (Turin), Netherlands (Enschede), Belgium (Gent) and Austria. For the analysis of the situation *Rapid Assessment and Response* methods (RAR) were used. The manual can be downloaded in English and German from <http://www.lwl.org/ks/search/downloads/search1manuale/index.html>. This project is however mostly focused on recently arrived immigrants and less on established ethnic communities. There did not yet emanate any structured intervention examples from this initiative, beyond those already mentioned in this report. The Federal Centre for Health Education BZGA has a regularly updated Web-based information service with publications and project examples concerning migration and health (including drug addiction) at <http://www.infodienst.bzga.de/migration/index.htm>, however without evaluation or respective results.

Finland: In 2001, a plenary session of the Finnish Council of State approved an extensive action programme "*Towards ethnic equality and diversity – The government's action programme against discrimination and racism*". In the last decade, the significance to society of groups representing minority cultures has been further emphasised. In particular, this is due to increasing immigration to Finland. The new minorities (e.g. Ingermanland Finns, Africans, Asians etc.) are often however distinguished by a weak position as regards education, employment and housing. The ministry of labour has also an action programme for fostering good ethnic relations through culture. It contains among other things prevention and intervention. It can be downloaded in English from the Finnish Advisory board for Ethnic relations, www.mol.fi/etno.

UK: A recent DPAS paper (Sangster et al. 2002) discusses in detail issues of delivering services minority ethnic communities, but predominantly under a treatment service perspective. Downloadable at http://www.drugs.gov.uk/ReportsandPublications/Communities/1034592311/Delivering_drug_services_ethnic_communities.pdf.

GREECE

Combating social exclusion **EDDRA**



Target group: The programme is implemented in four municipalities in Northeast Attica, a disadvantaged region with a large number of socially excluded groups such as gypsies, repatriates from ex-USSR countries and political and economical refugees. The socio-economic and educational level is very low, and use and trafficking of drugs (especially of cannabis) is a common phenomenon. Also, other characteristics of the region are the bad physical and mental health of the residents, the large families, the occasional jobs and the poor living conditions. These parameters constitute a multidimensional and complex phenomenon, which together with the polymorph region and population hinder assessment and intervention.

Strategy: The innate mechanisms of the community are reinforced, so that it can confront and solve its own problems. The projects aims to strengthen the self-determination and self-action of the community, which are perceived as necessary for the attainment of the goals (enhancement of self-help, prevention of drug use). The notion of common elements and interests between different groups is also built up, in order to create a strategy of community leadership and education.

Evaluation: There were requests for addressing 8000 students, parents and teachers. After a selection of the most vulnerable and problematic groups, the programme trained 100 teachers, informed 300 parents and intervened in 250 secondary students with high-risk groups. The centre assisted approximately 250 families - members of vulnerable and socially excluded groups – in their contacts with public services. The Centre provided also: a) material support to 120 families with serious survival problems, b) counselling and/or psychiatric support to 70 clients, c) vocational guidance to 35 persons (20 male adolescents and 15 women aged 18-25 years old), d) workshops on creative occupation to 100 children and adolescents approximately as well as to women aged 15-35 years old. A subsidised training seminar was also organized for 20 unemployed ROMs in co-operation with the National Organization of Welfare.

EDDRA – link: http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=55, to date no more recent data are available

PORTUGAL



“Djibé” Irmandade e Santa Casa da Misericórdia de Santo Tirso, Oporto

Target group: Ca. 26 children (from 6 to 14 years old) and 23 parents/families of big gipsy communities with a low socio-economical level and a high rate of illiteracy. They are more susceptible to drug consumption. Children don't attend school long enough to reach a sufficient school level, leading to early school leaving.

Strategy: The project includes activities that promote the development of personal and social skills through workshops for theatre, painting, dance, music, informatics, swimming, capoeira, pottery, organisation of shows and exhibitions of work done by the gipsy children, cultural exchange, etc. The project aims to involve the gipsy families through their participation in some of the above activities and through trainings for parents.

Evaluation: Process evaluation is planned. Indicators are: number of youngsters that joined the project, adequacy of actions to the needs and expectations of youngsters, involvement of professionals from local institutions, effects of the project in the gipsy community and local population, identified obstacles during its implementation. Evaluation forms for the characterisation of individuals, surveys with the target population and regular meetings are used for the evaluation. Evaluation results are expected by end October 2004.

SPAIN



Sports for immigrants **EDDRA**

Target group: Immigrants coming from North Africa, from the Sub-Saharan Africa and from different countries of Latin-America, mostly youngsters accompanied by their families and even alone, living in a socio-economic and cultural situation which is particularly vulnerable to develop behaviour and adaptation problems in the new environment.

Strategy: Offer these youths an area and an activity to be shared with Catalan children and youths. The activity allowing this integration must be stimulating, attractive and must make interaction easy. Sports activities are suitable for this integration objective because they are motivating, playful and may be shared to have a good time, beyond the language and culture barriers. Also, the users of the programme can benefit from the sport practice, under both physical and psychological aspects (increase of self-esteem, decrease of the level of anxiety, aggressiveness and depressive symptoms; it regulates the cycle of sleep-wakefulness, promoting changes in the hygienic and feeding habits, favouring healthier lifestyles). It also enlarges the circle of interpersonal relationships of immigrant children and youths, by practicing sports at a gym outside their usual environment.

To prevent segregation and to promote the normal participation in the social environment of the place of residence is a specific protection factor for the immigrant community, which are particularly vulnerable for the development of maladjusted behaviours. The possibility of developing friendships or contacts with their non-immigrant coequals stimulates integration and the development of well-adapted behaviours.

Evaluation: The participants are teenagers with no family, except in one case, whose relationships, before participating in the programme, were limited to other immigrant boys. After the programme, 100% of the teenagers are integrated into the standard group of youths and initiate contacts with other teenagers of a different environment than theirs. 100% of teenagers included in the programme have begun sport activities: 76% on fitness, 8% on martial arts, 8% in aerobics and 8% in team sports. Before initiating the sport activities of the programme, 60% of the teenagers smoked tobacco and 20% hashish. Once they begin to practice physical exercise in a regular way, this consumption is reduced in all cases. They don't stop smoking, but 40% of the participants reduced by half their tobacco consumption.

EDDRA – link: http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=2918

Paco Nantera EDDRA



Target group: Moroccan minors, who at the beginning or at some time after their arrival in Spain live on the streets with other minors, in the majority without residential permits. The majority are intercepted by the local police and taken to Children / Youth Centres. Many have great difficulty in adapting to these centres, as well as difficulties with the language. Some inhale glue and consume hashish and alcohol. These immigrant minors are not able to adapt to the existing structures in Spain because they have not found there the consistent support that would help them in the social adaptation process, nor are they supported by the immigration policy (in obtaining residential papers and finding work). Profile: males, 12 to 18 years old; arriving in Spain clandestinely without any family. Frequently, these adolescents have behavioural problems due to the deficiencies suffered in their family of origin, and to other experiences suffered during the immigration process. These constitute generally high-risk situations that develop into serious behavioural problems such as delinquency and drug consumption.

Strategy: The "Paco Nantera" programme for Immigrant Minors is an indicated intervention, in accordance with the category of preventive programmes proposed by Gordon (1983), to the reality of adolescents immigrants of a Maghreb origin that arrive in Cordoba and to other cities of Andalusia. It offers specific interventions with migrant Maghrebine minors in a high-risk situation, valuing not only the behavioural difficulties but also the origin of them. The cultural characteristics are fundamental elements in the reconstruction of the identity and the project of life of these adolescents, thus these aspects constitute an exclusive peculiarity of this programme. The programme is executed within the context of a *Centre for the Protection of Minors*. The intervention group can include up to eight minors that live there and review their behaviour through day-to-day activities. Specific objectives are: 1. To have the majority of the adolescents finalise the programme, achieving the educational objectives for the different intervention areas. 2. To attend the minors referred by the child attention services of the Autonomous Government of Andalusia. 3. To allow for the social incorporation taking the necessary steps to their legal documentation (residency permit). The educational syllabus is established into two dimensions: psychotherapeutic and educational. The first includes a preliminary evaluation, individual sessions through which is executed the Individual Development Programme, and group interventions. The educational dimension is articulated through the *Individual Educational Project (IEP)* and incorporates 4 work

areas: formative and cultural, skills development and habits, recreational and leisure time activities and orientation. The programme lasts 6-9 months, although it can be extended if needed. Once the intervention has finalised, the Autonomous Government of Andalusia, that has the guardianship, decides: family regrouping, or diverting to other normalised educational centres.

Evaluation: There exist, for the evaluation, specific instruments such as the *Observation Protocol* and the *Educational Monitoring Report*. The evaluation is focusing on the educational processes. It is qualitative and continuous, through weekly meetings of the full intervention team. Monthly reports are forwarded to the responsible department for the minor. During the period 2001-2002, the Programme has received 20 immigrant adolescents of Maghreb origin and has discharged 9 adolescents (45%). Discharging means that they have complied with the desired educational objectives. 20% continued in the programme at the evaluation date, and 35% had voluntarily abandoned the programme. The improvement of the adolescents that complied with the objectives refers to the following areas: 1) Health: vaccinations, growth according to age, looking after their own health, etc. 2) Emotional: expression of feelings, increase in their self-esteem and self-confidence, coping with conflicts, strengthening affective bonds, etc. 3) Cognitive: development of intellectual and linguistic skills. 4) Social: development of social skills and integration in society, adequate use of free time. 5) Family: periodic contact with the family of origin. The inter-disciplinary and intercultural work of the programme has been valued very positively.

Only 20% of the adolescents attended to during the period 2001-2002, have obtained the residential permit that will allow them to normalise their situation once the programme has finalised. This fact has led to important uneasiness amongst the participating adolescents.

EDDRA – link: http://eddra.emcdda.eu.int:8008/eddra/plsql/showQuest?Prog_ID=2609

9. Other approaches

Recent research has brought additional vulnerability factors to light, which are however more relevant on an individual level than for groups. The respective prevention responses are therefore called **indicated intervention** (see introduction chapter) as these responses seek to early identify individuals at risk and tackle their specific vulnerability. The most obvious example is ADD (Attention Deficit Disorder, with Hyperactivity: ADHD): affected children have a several-fold higher risk for developing later on substance abuse problems, especially if they are not duly treated (Giedd 2003). Unfortunately, in terms of indicated drug prevention responses, there is not much information available in member states, despite the prevalence of ADD being estimated up to 17,8 % of children (Baumgärtel 1995) depending on method of ascertainment, diagnostic system, measures used, informants, and the population sampled. Projects that include children with ADD (Attention Deficit Disorder) among the target group are only known from Ireland (*Springboard Initiative*).

The vulnerability factors on individual level are commonly classified into

- internalising disorders: for instance depression and anxiety. Early adolescent depression for instance has a strong correlation with drug use (Silberg et al. 2003).
- externalising disorders: Conduct disorders like ODD (oppositional defiant disorder) and antisocial personality disorder.

There are several indications from recent research that there are also biological pathways and preconditions (especially psychiatric) for the development of more problematic drug use (Gerra 2002, Sloboda 1999). To an increasing extent, genetic influence on many of these vulnerable conditions has been confirmed, but there is a strong interaction with environmental (peers, peer selection) and family factors (Silberg et al. 2003). An example for this interaction is the research of Slater (2003) on the influence of sensation seeking as an individual trait on marijuana and cigarette use. In fact, sensation seekers are under increased risk for drug use but only in the presence of peer pressure and peer drug use. Low sensation seekers are however not at risk. Therefore there is a strong point to concentrate interventions on sensation-seeking youth and their peers.

10. Ongoing research projects about selective prevention

GREECE

- In the framework of the EU Project “New concepts and intervention strategies concerning secondary prevention of drug abuse”, OKANA investigated the needs of two target groups (street kids and members of techno party scene), as well as the available services for this population in order to make suggestions for setting up new services.
- The Educational Centre for the Promotion of Health and the Prevention of Drug Abuse (UMHRI/OKANA) conducted a pilot project in order to investigate the nature of the truancy prevention interventions and to make suggestions for the creation of services working on this area.

11. Summarised promising results or lessons learned in member states

DENMARK

As an overall results from experiences, evaluations and research, selective prevention is possible and successful if: ...

1. The young people at risk are met at their own conditions, that is not met with adult morals, claims and forced into any kind of help system.
2. The young people are offered adult support and advised in a respectful manner and with respect towards their own experiences and wishes.
3. The young people are given options instead of demands.
4. The young people are being reached out (e.g. by street workers) and thereafter supported not only to identify the help system but are taken by the hand and helped over the doorstep and all the way in.
5. The support given focuses on the young people's total social conditions or social problems and does not address the drug problem as the main problem.

GREECE

A *Leonardo da Vinci* research project (Aristotle University of Thessaloniki, 2000) assesses the needs of juvenile delinquents for vocational training. According to its results, only 4% of the young people who are in correctional institutions have been offered some kind of support from social services. The need for the development of psychological support services addressed to adolescents of this group and their families was stressed. More specifically, the introduction of a nine-year mandatory education programme based on the different age groups and group-specificities (e.g. adolescents who do not speak Greek) was suggested in order to facilitate the social and vocational rehabilitation of juveniles.

AUSTRIA

Youth scenes are changing very quickly and therefore professionals in this field are very fast considered too old or as office workers and are not accepted by the youngsters.

NORWAY

Anne-Marie Sørli has made a meta-analysis of existing knowledge based on an extensive examination of recent Norwegian and international research into school-based initiatives with a documented positive effect on serious behavioural disorders. Her conclusions include the following: “Of the pupil-centred action models, it is the explicitly conduct oriented and cognitive-conduct oriented change strategies that have yielded the best results. The following strategy stands out as the most promising: social skills development with the emphasis on skills training (encouraging empathy, self assurance, i.e. a wide range of social skills in relation to peers as well as adults) in combination with conduct correcting methods” (Sørli, 2000).

At present there are several programmes in use aimed at the prevention and moderation of conduct disorders. The common denominator for all these programmes is that they are rooted in cognitive behavioural analysis and social learning theory, where the clients undergo systematic training in cognitive, emotional and social skills that are capable of replacing previous asocial conduct and strategies.

Some of these programmes emphasise direct individual-focused actions, whereas others are more complex (multi-modal) action models that incorporate several strategies and action models aimed at the factors in the home, at school and other general conditions that are related to serious conduct disorders. Training of psychological skills is a central factor also in a multi-modal action model.

(NOU – 2003:4: Forskning på rusmiddelfeltet):

Subject	Programme with documented effects	Result
Prevention of alcohol misuse	School-based programmes with active participation (interactive)	Improved knowledge levels
Prevention of illegal drug use	School-based programmes with active participation (interactive)	Improved knowledge levels
Legal & political initiatives	Price-related interventions	Reduction in sale of alcohol
Law enforcement	Random alcohol testing	Reduction in deaths, injury and traffic accidents
Secondary prevention programmes geared towards risky alcohol consumption	Mini-interventions	Reduced alcohol consumption

12. Conclusions and recommendations from member states

Denmark

There is a need to offer better support to young people at risk with a beginning drug problem. At the moment, there is not a geographically even distributed system to deal with the increasing need for counselling and programmes for young people under the age of 18 with a beginning drug problem. The inefficiency in this area is mostly due to lack of professional insight in drug issues in the municipalities.

It would be very helpful if the knowledge about methods on how to reach and treat children at risk at the municipality level could be connected with the knowledge on targeted drug treatment, which is situated on county level. In other words, better coordination between the social interventions from municipalities and counties where beginning drug use among young people is in focus.

Germany

Instruments and criteria are missing that are necessary to detect vulnerable young people as a target group for selective prevention. There should also be more focus and more evaluation research on selective prevention and its effectiveness.

Greece

Specific interventions in order to approach young people at risk are still limited in Greece. Rather, treatment services for adolescent drug users cover the needs of young people who use substances on an occasional/experimental basis by preventing such adolescents from further involvement in drug use and intervening at the early stages of addiction. In addition, there is no official data about young people at risk, for example the number of truants in the country. Thus, it is important to assess the needs of the community and, especially the needs of people at risk, not only at national but also at regional level in order to further interventions to be planned and implemented. Moreover, further cooperation and networking between health, social, educational, drug and other related services are necessary.

Spain

Promote more evaluation in this area and provide resources for it.

Develop thereupon systems for the accreditation of selective prevention interventions

Consider these interventions as priority

Promote a better legal framework: protection laws for children, especially immigrant children.

Need of developing risk maps at a community level that might help to give priority to interventions in those areas that are most in need of them.

France

Prevention projects in this field are often carried out by small associations that don't have sufficient means to simultaneously develop research and evaluation. This impedes the assessment of several experiences, which might have interesting and promising potentials. It is therefore recommendable to avoid sudden changes in policies without a scientific and technical consensus and to allocate more resources to research in this area. At a department level project development (methodology, evaluation and training of actors), should be linked with a strong guidance from public authorities.

Ireland

Government services need to move more from a reactive approach to a needs-based ethos focusing on selective prevention.

The number of places for day assessment for youth at risk (i.e. expand projects such as the *Finglas Village Project*) needs to be expanded.

The need to go beyond the Local Drug Task Force Areas is now being recognised in the *National Drugs Strategy Action Plan*.

The high turnover of staff in many services could be at least partially remedied by a long-term strategy of educating and recruiting local people for local community services. This would also have the benefit of minimising the 'culture gap' between the service user and provider.

There is a need for more availability of speech and language therapy interventions for at risk children at an early age, and ideally onsite speech therapists in the schools.

Italy

There is a perceived need for investments in:

- Peer education,
- Protagonism,
- Co-operative projects, for instance participative projects in living and socialisation areas,
- Fostering the self-empowerment for young people,
- Intervention research,
- Education in conflicts, negotiation, achievement of different objectives according to the different interest groups (young people, adults, local community, educators, parents, families, ancient people),
- The establishment of standardised evaluation criteria,
- The definition of quality standards for prevention.

Luxembourg

The social network and situation of the risk population is an important influence variable for the success or failure of prevention projects. Interventions have to address this factor in order to assure an adequate transfer of learned experience from a prevention intervention into the every day setting. Therefore, also the social network in the setting needs to be the target of interventions. The focus solely on "risky" people distracts sometimes the view from the responsibility of their surrounding social network. To separate people at risk has always the danger of self-fulfilling prophecy.

Netherlands

The financing system of drug prevention and addiction care is too complex. At this moment prevention money comes from the municipalities. Funds are almost exclusively politically inspired, not evidence-based, not evaluation guided. At this moment the *National Court of Audit* is preparing a study on the complexity of the funding system. To alter it requires altering the law. This might however be the best solution for enabling quality driven drug prevention in the future.

The government should carry forward a clear national drug prevention vision. It should not deliver all task to the municipalities, that do it all in their own way (evidence-based or not, most don't even know what this is). Small municipalities do not have many officials with drug prevention responsibilities. Sometimes it is part of the responsibility of one person. Bigger cities have more officials working on drug prevention.

Much prevention activities are happening but few target group members belong to the actual target group. Many prevention workers have been trained once and few ever use evaluation in their daily prevention practice/projects. Training in evaluation is still needed as part of the overall educational courses.

Most projects are ad hoc, politically urgent, and there is money to gain. The result is often that many interventions are also realised ad hoc, without process evaluation or step-wise project design.

Austria

More efforts should be put in setting up risk zone mapping, in early detection and in selective prevention programmes

Portugal

Clear definition of the concept (of selective prevention) and dissemination of the respective strategies and models. There is a strong need for specific assessment and evaluation instruments

The training of the prevention professionals is essential, namely in the areas of methodologies, intervention strategies and evaluation.

Finland

There is no reason to establish a separate social system or institution around the drug issue, but the structures and strategies already established for drug policy can be reassessed and more attention should be given to the quality of the work. Competition about special resources may easily lead to a situation where the drug problems are exaggerated and become unnecessarily politicised.

UK

A crucial point to consider is that young people, who are using drugs and are at risk of developing problematic drug, tend to have multiple antecedents and co-occurring mental health, social and educational problems. Guidance to practitioners emphasises that drug issues need to be addressed as part of a wide range of predicaments and vulnerabilities. Therefore good interventions may not specifically target drug issues but instead a range of issues. Also, this approach calls for the integration of drug prevention work and multi-agency working by mainstream services rather than stand-alone interventions. For more on this see the *Health Advisory Service* report.

There is a need for many more well designed projects, which can be evaluated properly, and for much more co-ordination between funders and evaluators. Social services, health services (including general practitioners) and drug services are likely to engage a significant proportion of at risk young people. Arrest referral should engage a large number too, but is limited by restricted access to them while in police custody

Drug services are often characterised as not being young-person friendly and catering for older more entrenched users. However, a number of new services have been developed around the country (e.g. in Stoke and Newcastle). These tend to focus on family work, counselling and support.

There are a large number of indicated projects running in the UK through funding from the *Department of Health's Health Action Zone* initiative. These target school truants and excludees, young offenders, and young

homeless people. But these are not very co-ordinated and poorly evaluated. There are also issues concerning the implementation of projects. Some work is currently being undertaken to draw the key findings together, but this will not be completed until mid-summer/early autumn.

Norway

Especially we do need up-to-date and culture-sensitive understanding as well as programmes matched to young people in risk. In addition to that it is important to emphasize the possibilities and capacity of public schools to involve youth at risk in earlier stages of problem development.

Part II - Prevention in risk areas or zones

13. Instruments for risk assessment of areas or populations.

RISK ASSESSMENTS AT GEOGRAPHICAL LEVEL

The main reason for addressing this theme is, again, a practical one: for the public-health-wise optimisation of prevention policies it is a big challenge to clarify the question of *how much* of available resources should be concentrated on *which kind of* responses for *what* kind of problems (Stockwell 1999), or in other words to find constructs (as for instance vulnerable areas or groups) that help to allocate prevention interventions where they are probably most needed and have best chances of impact. On a theoretical and social level it is therefore not meant to argue here that drug problems and socio-economic status (poverty) are necessarily related. Smyth and Kost (1998) found that this often-assumed relationship has been examined by only a few studies and that the available research doesn't suggest a direct, causal relationship. A complex interrelationship between each socio-economic factor (unemployment, availability of drugs, violence) and the individual is acknowledged, however. A working hypothesis for public health interventions nevertheless must assume that many environmental vulnerability factors accumulate in certain geographical areas or neighbourhoods and that the resiliency of youth or communities can be fostered through interventions (see argumentation and references regarding ethnic groups on page 34) that concentrate on those areas. To use socio-economic variables in prevention planning is seen in some countries as classist or labelling, though.

Social groups with specific characteristics and socially disadvantaged neighbourhoods are likely to be subject to negative labelling in the population and mainstream culture. This happens however independently from and prior to expert assessments and prior to interventions targeted at these populations.

Identifying the vulnerable groups or neighbourhoods and their needs with the aim to tailor-make services to them doesn't substantially aggravate the existing labelling and discrimination, but it can yield specific benefits for the population. In view of the recent raise of selective prevention interventions within the SAMHSA (www.samhsa.gov.us) programmes, McGovern (1998) has analysed the conditions for addressing vulnerability while safeguarding ethical principles: "*excessive protection, involving the most stringent regulations around privacy and confidentiality, may rob individuals and communities of access to needed services and, paradoxically, of help that may assist them to be more self-determining*". The author's proposals to find a balance between overprotection and labelling include for instance the involvement of the concerned communities in planning, implementation and evaluation instead of imposing programmes; and the principle of beneficence: the identification of problems (e.g. research, surveys, mapping) should be proportional to the support (services) provided for the problems that have been identified.

As a principle, in any health and social system, labelling (e.g. being a *patient* or *pregnant* or *jobless*, and assuming the respective social role) has always been a necessary prerequisite for receiving attention, support and special resources. On the other side, "egalitarian" and broad-brush prevention strategies may accentuate social differences even more, because the better-off population segments (e.g. academic families) may have more skills to acquire the scarce resources for prevention than those in need do.

The difficulty and reluctance in some EU member states of discussing this issue without ambiguity probably explains the scarceness of related interventions and strategies, and a certain bias of the number of known interventions towards northern Europe.

Risk assessment at geographical level is carried out very rarely, and instruments for risk assessment have only been mentioned in this survey by

- Denmark – the SSP system, whose purpose is to make risk assessments in relevant school districts, local areas and municipalities),
- UK – the ASSET system to screen and assess young people passing through *Youth Offending Teams*. Also the *Connexions Partnerships* screens and assesses for at risk youth.

- Norway – the *Stiftelsen Bergenslinikkene* are developing a *Rapid Assessment & Response* toolkit jointly with the city of Bergen outreach organisation. The assessment toolkit is a tailored version of the *WHO RAR* model, designed to be used by street workers rather than researchers. This tool can be used for specific geographical or target group assessments.

In Ireland, recent research has been commissioned to develop such tools. Most member states responded negatively and reported fears from negative social labelling effects.

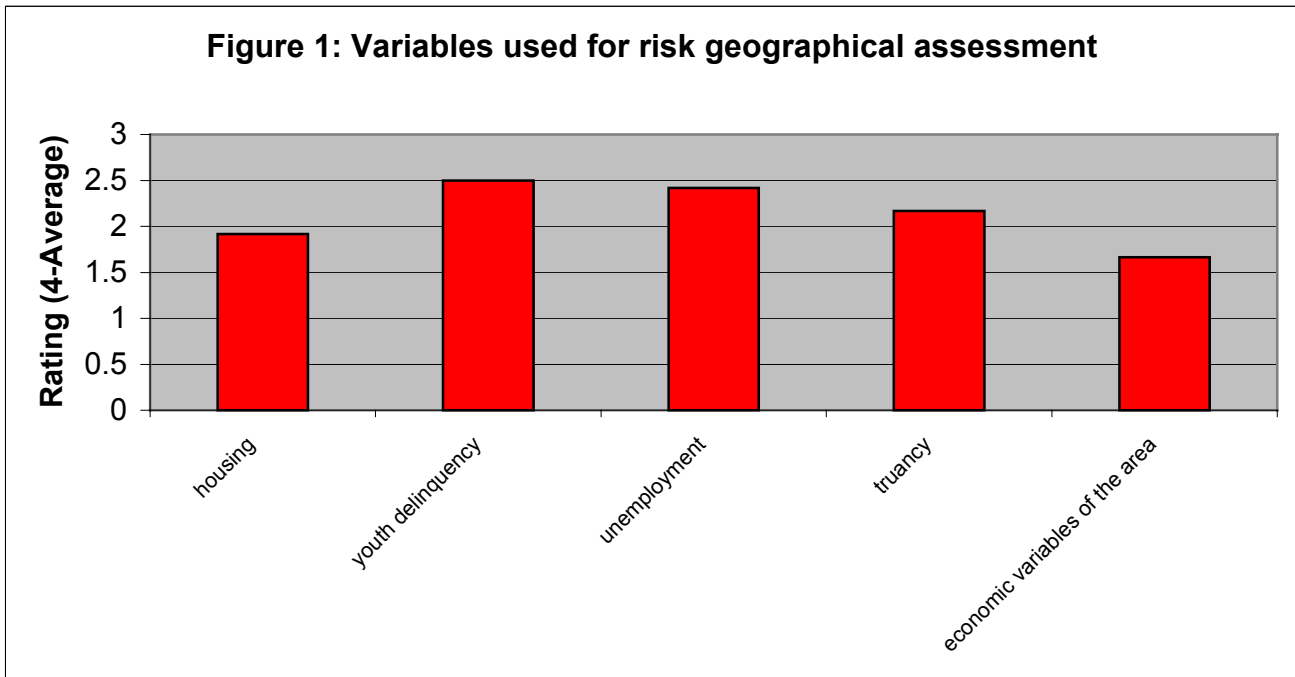
Practice examples about risk zone mapping in order to inform intervention planning are even more rare in Europe:

- France has established areas for priority intervention (*zonage d'intervention prioritaire*) and areas of priority education (*zone d'éducation prioritaire*). Crossing of data allows for the definition of areas at risk.
- Ireland: many intervention programmes and systems are based on geographical risk assessment: the *Local Drug Task Force* areas, the areas for the *Young People's Facilities and Services Fund*, but also down to the level of individual schools: designated disadvantaged schools are given lower pupil-teacher ratios.
- Italy (the Ministry for Education) is implementing drug prevention projects for disadvantaged areas in the three cities most considered at risk: Turin, Bari and Naples.
- Portugal has created the intervention programme *Choices* (<http://www.programaescolhas.pt>) in the most vulnerable neighbourhoods of the districts of Lisbon, Oporto and Setúbal. The Prevention Units know local realities through their work in the field and through local public services or NGOs that work in these geographical areas. They then identify the more problematic areas, on a social and economic level, which are considered priorities and needing more specific interventions in the field of early prevention in drug addiction.
- Norway mentions the Bergen *drug early warning project*, which links and analyses a variety of information sources: routine statistics, school surveys, media monitoring and key informant panels. Findings are widely disseminated on a six monthly basis to policy makers and practitioners in the city, in order to support evidence based and well informed practice. The early warning system includes a risk assessment of populations and young people, also by *RAR* (rapid assessment responses) methods.

In Denmark, risk zone mapping is done to a less extent because of the above-mentioned risks of stigmatisation and of narrowing the viewpoint of professionals.

In the UK, a number of interventions on community level have been introduced, which target young people, who are most at risk of social exclusion. Prevention efforts exist which target high-risk neighbourhoods. National interventions such as *Sure Start* and *On-Track* have been developed, which target families and parents in greatest need and attempt to address problems within families. Such interventions provide examples of attempts being made to identify and to reduce behaviour problems and family conflict and improve family management practices. Such interventions can be useful in avoiding the problems (or reliance) on targeting particular high-risk groups or individuals mentioned above. Resources are often targeted at parents and families with the greatest need. For example, more specialised parenting courses, training programmes, sources of information, counselling services and support are provided to families at risk.

Figure 1 shows the average rating (across experts from 11 countries) of the importance of geographical factors to assess risk (Rating categories were from 1 (very important) to 4 (not important); for this figure they were inverted (4-average) for better visibility).



VARIABLES USED FOR RISK ASSESSEMENT OF AREAS: EXPERIENCES IN UK

Housing

Prevention efforts exist, which target high-risk neighbourhoods as defined by public housing, high-density housing and deprived estates.

Youth delinquency

High-crime estates have been the target of prevention interventions e.g. *Youth Inclusion*, *On-Track*. Young people who offend are often regarded as being more likely to experiment with drugs or even be more predisposed to develop problem drug use later in life. Interventions such as *On-track* try to ensure that young people at risk are identified and targeted early in prevention (e.g. especially if an older sibling is offending).

Unemployment

Those families with a history of long term unemployment often benefit from targeted interventions in areas of severe deprivation e.g. reduce feelings of isolation and provide a 'stepping stone' to other avenues and opportunities i.e. volunteering work, increasing job opportunities; learning new skills or returning to education.

Economic variables of the area

There are interventions, which try to enhance the economic regeneration within the area by focusing on improving the support that is available to those on low incomes. There is the presumption that drug users face financial difficulties, which place immense stress on other family members or can lead to criminal activities to fund drug use.

There is a widespread awareness that economic deprivation impacts on drug use. Levels of funding from many national funding streams are dependent on the level of identified economic deprivation, health inequality, prevalence of drug misuse and crime statistics (e.g. *Health Action Zone*, *CAD*, *Positive Futures*). *Neighbourhood Renewal Fund Areas* get additional funding to improve economic prospects of areas, including tackling drug issues.

14. Several intervention examples targeting youth and families in at risk neighbourhoods

IRELAND

Local Drugs Task Forces (LDTF) occur in 14 areas identified as having the most urgent drugs problems and are mandated to develop comprehensive anti-drugs strategies in their area. The areas are basically urban ones: parts of North Inner City Dublin, South Inner City Dublin, Ballyfermot, Ballymun, Blanchardstown, Clondalkin, Coolock, Crumlin, Finglas/Cabra, Tallaght, North Cork City, Bray, Canal Communities and DunLaoghaire/Rathdown. As regards elsewhere in Ireland, the National Drugs Strategy 2001-2008 *Building on Experience* (Department of Tourism, Sport and Recreation) states: “There was no conclusive evidence available to the Review Group that any other urban area is currently experiencing a drugs problem comparable to that experienced within the *LDTF* areas. Consequently, the Review Group considers that it is not appropriate to create task forces of this kind in any other large cities/towns. However this is not to suggest that drug-related problems do not exist throughout the country and, consequently, the situation should be kept under review” (p.106). However, this report does suggest that new *Regional Drugs Task Forces* should be developed which would incorporate and expand the work of the current *Regional Drug Coordinating Committees*.

The Ministerial Task Force recommended that each *LDTF* should be mandated to draw up a profile of all existing or planned services available in the areas to combat the drugs crisis and to agree a development strategy that would build on and complement these services. It is centrally important that the *LDTFs* should provide a mechanism that enables local communities to participate with the State and voluntary agencies in the design and implementation of that strategy. It is a partnership between the statutory, voluntary and community sectors

The Young People’s Facilities and Services Fund (YPFSF) **National Report**

YPFSF was developed in 1998 to assist in:

- the provision of youth facilities, including sport and recreational facilities,
- the development of educational services in disadvantaged areas where a significant drug problem exists or has the potential to develop

The objective of this fund is to attract ‘at risk’ young people into these facilities and divert them away from substance misuse. It operates in the 14 *Local Drugs Task Force* areas and in a number of urban areas e.g., Limerick, Galway, Carlow, Waterford and Bray. Local development groups were set up in each area and comprise representatives from the relevant *LDTF*, Local Authority and VEC. Up to 2001, funding support has been given to over 340 facility and services projects, which offer developmental activities and educational programmes for young people who have traditionally found themselves outside the scope of mainstream youth work.

Young People’s Facilities and Services Fund (YPFSF)	The main aim of the fund is to attract ‘ <i>at-risk</i> ’ young people in disadvantaged areas into these facilities and activities and divert them away from the dangers of substance abuse.
The Springboard Initiative (see below in this report)	This initiative is supporting a range of pilot projects for children and young people at risk in disadvantaged areas in Dublin and around the country.
AIB Better Ireland Programme	A central part of this programme aims to give ‘ <i>at-risk</i> ’ children the opportunity to move from the chaos of a life centred on drugs or alcohol abuse. Support groups, promotion of life-skills and home maintenance are among the services that will address needs in this area.

The Shanty Project, Tallaght, Dublin

Target group: Largely women centred in the community of Tallaght West, in the top 1% of most disadvantaged areas in Ireland. Age range from 19 to early 60's, with average age 35. The vast majority of the local women are lone parents and social welfare recipients, including some asylum seekers. Most left the formal educational system at a very young age, some not even reaching secondary school. There are 450 participants in 23 classes (average size 15 in a class) per year.

Strategy: Starting point is courses on personal development and communication skills, basic literacy and numeracy training. These courses allow participants, the majority of who left school at 14/15 years, to proceed in a carefully planned progression route to mainstream education, training or employment. A second group of courses reflect the needs of the local community for training in leadership e.g. training for community drug workers and estate management courses. The third series of courses allows people to access further education. Some of past students have gone on to third level Colleges and Universities, gaining certificates, diplomas and degrees.

The programme has integrated the classes with an educational childcare centre *Rainbow House* that gives support to their children in order to help with intergenerational disadvantage. A full counselling service is provided with approximately 35% of the course participants having accessed the counselling dimension also. They work closely with local drug projects and work with methadone users (age 17-25) in providing personal development and education.

Evaluation: Self-evaluation, no control group. Continued attendance is seen as a key criterion of the success of the project. 400 out of the 450 who attended in the past year have continued over the year, which is a very impressive number given the characteristics of the target group. There has been no independent evaluation, to-date, of the project although gains in women's self-esteem are reported by the women and by staff.

Ballyfermot *Psychological Support Service* is a planned service between *URBAN*, Ballyfermot (an E.U. funded organisation), Ballyfermot *Local Drugs Task Force*, *Ballyfermot Partnership*, and the *South Western Area Health Board* which will be genuinely community based and focusing on prevention, early detection and early intervention with an interdisciplinary team of a family therapist, clinical psychologist with experience working in a community based setting, childcare workers, a speech therapist and a youth worker. Part of the team will be based in the local schools and will engage in group work for the purpose of referring children who are particularly at risk and withdrawn. A feature of this service is the involvement and skill development of parents of children with speech and language difficulties and/or Attention Deficit Hyperactivity Disorder (ADHD) (see Downes 2003). It is expected that this service will be established by the end of 2003.

PORTUGAL

(Re-)Inventing Time on the Street. Community Centre of Esmoriz



Target Group: it consists of 96 children, 26 teenagers, 49 young adults, 55 parents from socially deprived fishermen neighbourhoods in the beaches of Esmoriz and Cortegaça. They belong to socially disadvantaged groups and show several family problems. There are family dysfunctions present and wrong or insufficient, even inexistent, communication within the family. The target group is characterised by few social and personal skills and where children and teenagers show signs of academic failure and risk of abandoning school.

Project Objectives: To decrease the number of street children and youth in the beaches of Esmoriz and Cortegaça. To give alternatives to the life in the streets. To increase social and personal skills. To promote integration in family and community. To promote family communication.

Strategy: Activities on two levels: individual - with all the members of the family, strengthening social and psychological support, and at group level - through information sessions to parents/adults, stressing social and psychological support to parents/adults and cultural-educative activities, pedagogical and sportive activities with children and youngsters; sessions to help develop skills for primary school children. There are partnerships with local community in the implementation of the project. Active and participative methods are employed: group dynamic, role-playing, role-reversal, modelling. Personalised support and home visits are included.

Evaluation: There is process evaluation through daily activities records, regular team meetings, meetings with other local actors who interact with the project and through meetings/contacts with the Prevention Unit of Aveiro (IDT). The quantitative indicators of every activity are registered on a monthly basis. The evaluation includes tests (before and after) and questionnaires. Behaviour and attitude changes (pre-post) of a part of the target population covered, especially children, are analysed. Evaluation results are expected by end October 2004.

UK

Positive Futures: National Report



Target group: Young people aged 10-19 yrs known to be criminal offenders or at risk of criminal offending who reside in top 20% of deprived neighbourhoods in England and Wales.

Size of intervention: It has national coverage with a total of 67 projects and 25,000 young people involved since 2000.

Strategy: Diversionary activities involving sport and emphasis on football and team sports. There are activities seeking to build interpersonal skills and self-esteem. Links also made with education, training and employment through individual projects. Positive futures uses sport to reduce anti social behaviour, crime and drug use among young people in local neighbourhoods. Local projects provide sporting programmes, which include participation, coaching and competitive elements, as well as an inclusion programme based around social responsibility, self-awareness and drug prevention. The projects promote positive attitudes and lifestyles, long-term involvement in leisure activities and healthy living.

Evaluation: First wave of projects: "We have found much good practice and evidence - both quantitative and qualitative, of positive impact on individuals and local neighbourhoods. With other complementary initiatives, most notably *Youth Inclusion Programmes*, there have been positive impacts in terms of decreases in youth offending and in terms of increasing participation in sport. There are many case profiles demonstrating how sport has been the catalyst in re-engaging individuals in society by providing motivation and self-belief. The success of any project of this nature stands or falls almost entirely on the skills and enthusiasm of the project leader and the core staff who deliver the programmes. Longer term funding is needed to attract and retain the right calibre of people and to give them sufficient time to establish trust with the young people who are likely to benefit most from the scheme. A longer-term commitment is also needed if quantitative monitoring is to be effective. The quantitative evidence base demonstrating impact on crime is patchy while that for drugs misuse is thin. This should be recognised as inevitable given the short time the projects have been running, the difficulties with availability, and interpretation, of appropriate statistics from the police and health authorities and the limited resources that project leaders have had to work with. Given the number of other influences and interventions at play in any area, it should also be recognised that it would be both unrealistic and inappropriate to try and isolate the *Positive Futures* project as the 'cause' of a social change relating to the *Positive Futures* project objectives. In comparison, the qualitative evidence base is strong. The views expressed in our structured interviews with project leaders, deliverers, partners, the evidence of the case studies (and from our conversations with some of the young people themselves), when taken together, make a resounding case for the value of the project."

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Summer Splash Programme



Target group: 9-17 year olds living in socially deprived areas.

Size: A national project funded by the government. In summer 2002, 296 areas ran *Summer Splash* programmes involving over 91,000 participants.

Strategy: Provides supervised diversionary activities including sport and arts to young people living in high street crime areas during summer holidays.

Evaluation: Information on numbers involved and activities undertaken. Crime figures were analysed to assess the programmes' impacts. Across all schemes analysed there was a 5.2% reduction in local crime rates over summer holiday periods.

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Connexions National Report

Target group: young people aged 13-19.

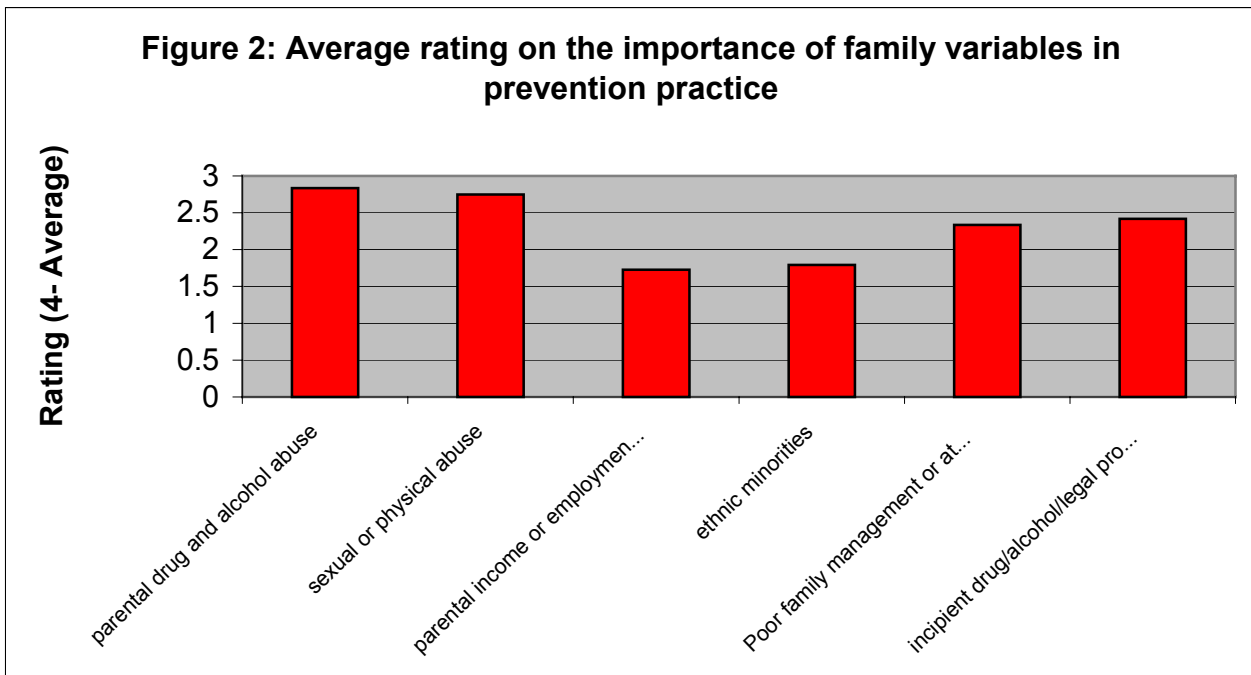
Strategy: Established in April 2001, *Connexions* is a support and advice service for young people aged 13-19 that incorporates the screening of young people at risk and makes referrals to specialist drug services. 27 partnerships are now operational and the remaining 20 coming on stream by 2003. This service is primarily delivered through a network of personal advisers who co-ordinate with specialist support services (Drugs Prevention Advisory Service, 2000). The budget allocation for Connexions Advisers in 2002 – 2003 is € 1.6 million.

Evaluation: OFSTED is responsible for the inspection of the *Connexions Strategy*. Local *Connexions Partnerships* will include the *Careers Service* and other services (e.g. youth, probation) with the intention of encouraging young people up to the age of 19 to continue in education, training or employment (www.ofsted.gov.uk/inspect/index.htm).

Part III - Prevention for families at risk

The influence of family environments on pathways to drug abuse are largely known; however the importance of the different variables (family attachment, drug using parents, drug using sibling, alcohol abuse in the family, family conflict) is controversially discussed.

The following figure 2 shows the average rating (across experts from 11 countries) of the importance of family



factors for prevention practice (Rating categories were from 1 (very important) to 4 (not important); for this figure they were inverted (4-average) for better visibility).

Repetti et al. (2002) have compiled a comprehensive and detailed overview on the influence of genetic, emotional and environmental factors (but not of sexual abuse) on the offspring of risky families. Socio-economic status seems to be the most important influence factor, conditioning the other factors including genetics. In line to the undertone of this report they conclude that “focusing on family characteristics that represent risk factors for (the exacerbation of) major physical and mental health disorders can provide the basis for early intervention that may at least partially offset the potential for cascading risk that may accumulate over the lifetime”.

Due to the professional bias of drug treatment services, especially the issue of drug using parents has got much attention in public discourse, but should be dealt with caution, as drinking and social problems in the family are better-confirmed predictors of adolescent substance abuse than parental illicit substance use (Burkhart 2000, Velleman and Orford 1993a/b, Mohr 1998). In addition, sub-groups of non-consuming adolescents have been found, which were identified as being resilient on the basis of having (one or both) alcohol-abusing parents (Mohr 1998). Many interesting and big studies examine drug use as outcome variable (e.g. McArdle et al. 2002) rather than drug abuse. This limits the usefulness of their results for developing prevention approaches that target families at risk, because risk factors for use are often not the same as for abuse.

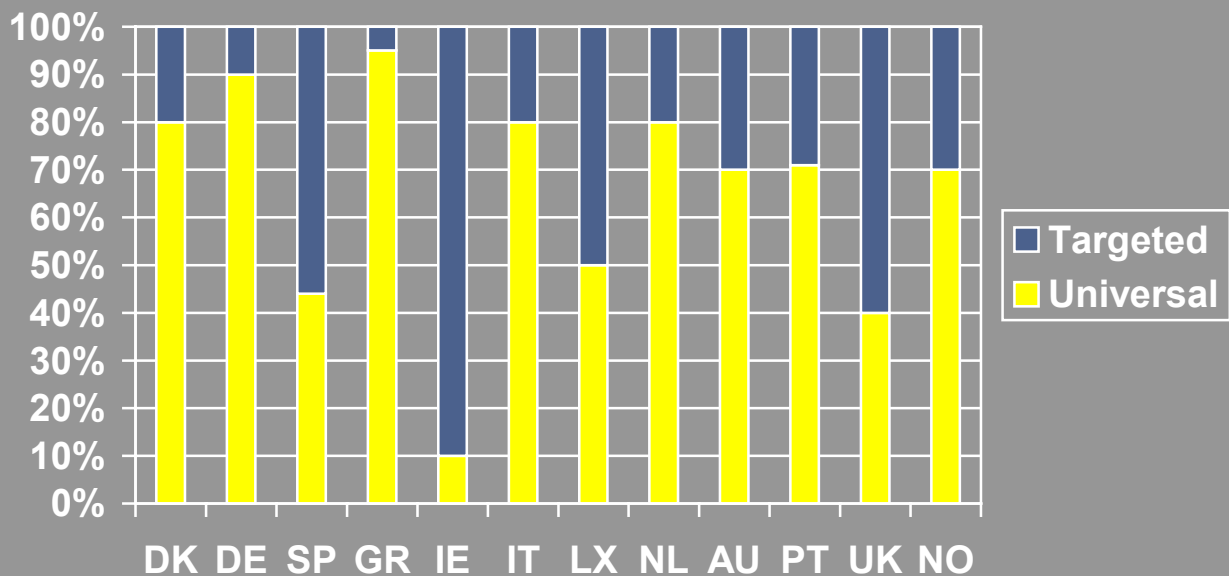
The abovementioned conditions have made it difficult to compile intervention examples for this chapter. In analogy to the prevention examples for vulnerable groups, probably many interventions do exist within broader social policies that target families at risk, but that don't have any rationale of **drug** prevention. They are therefore not mentioned in this report.

On the other side, there are many typical interventions by drug care service, namely those that narrow the concept of “family at risk” down to the drug abuse of parents, omitting other relevant prevention and

vulnerability aspects. Due to the different weight given in member states to these options, it was not possible to have a balanced picture of selective prevention interventions for families at risk.

Another issue of relevance is the relative importance given to selective family-based prevention in the different member states (see Figure 3). The experts were asked to estimate how important is selective compared to universal family-based prevention in terms of prevalence of actually available or known interventions. The values differ considerably across member states. The differences in the expert rating coincide however with the information from other sources about family-based prevention in the European Union.

Figure 3 - Expert rating on the relative importance of universal vs. selective family-based prevention



15. Practice examples for family interventions

GENERAL REFERENCES FROM MEMBER STATES

Denmark

An example for personal development training approaches is the project *Voksenvenner* (Adult friends) for children where responsible, normal (i.e. not professional) adults offer guidance, support and friendship to the child at risk, if the parents do not have the efficient personal and mental resources or are at risk themselves.

Germany

The National Federation for parents of adolescents with and at risk of drug addiction (*Bundesverband der Elternkreise drogengefährdeter und drogenabhängiger Jugendlicher, BVEK*) has recently launched a study on the conditions and needs of families at risk that attend parents self-help groups (BVEK 2003).

Italy

There are approaches of domiciliary assistance. These are community-based education interventions with families, carried out by community workers in order to reinforce education and to strengthen family ties. They include training offers for parents and self-help groups for parents with offspring at risk.

Under www.cnca.it (Sections *Minori, famiglie di accoglienza, famiglie in rete*) recent data are available on hosting families which give time to other families in difficulty and which are organised in networks. These

projects are a in consolidation phase and focus - for a beginning - on problems of families where parents have been condemned to prison terms. They are developing networks to provide help and support. These are experimental projects with limited funding period.

Luxembourg

Solidarité Jeunes by *Médecins sans Frontière* is a programme for adolescents having offended drug laws, and their parents or educators. About 200 adolescents and their parents participate every year (e.g. in 2001: 195). The adolescents receive psychosocial counselling. This includes the parents or somebody from an involved educational institution. The families are reached through the court of justice or the school. The objective is to intervene at an early stage and to find solutions for reducing the occurrence of repeated offences together with the responsible parents or educators. This means - in the sense of a broader family therapy - also to target other factors than the offence or drug use alone.

Netherlands

There is an older (from 1998-1999) project in EDDRA: *Parents for Parents* (http://eddra.emcdda.eu.int/eddra/plsql/showQuest?Prog_ID=573). However, it is a simple prevention programme aiming to stimulate 10 parents to talk about drugs and drug use within their family, including training in communication skills.

The homeparty, a more recent EDDRA project (http://eddra.emcdda.eu.int/eddra/plsql/showQuest?Prog_ID=2269), targets active parents (mothers) who recruit other parents in the neighbourhood to start homeparties at their own address. These parents are trained to increase parenting skills in deprived neighbourhoods among parent groups that are difficult to approach or access. Unfortunately, this project has not been scientifically evaluated.

Finland

Compared to alcohol problems, drug abuse has been relatively rare in Finland. In addition, drug use usually involves young people, who as adults often abandon drugs but not alcohol. Family violence is primarily associated with alcohol abuse. In the most serious cases, children may be taken to custody. There is a system to equalize the extensive costs of child welfare services so the client will receive appropriate services, irrespective of the costs incurred. The municipality receives compensation if the child welfare costs of a family exceed EUR 25,000. This compensation covers both custodial and non-institutional services for the family and child. In the 1999 statistics on Helsinki, 31 per cent of the placements and custodial cases, enforced on the bases of the Child Welfare act, resulted from drug or alcohol abuse in the child's home environment. If the information concerning Helsinki is generalised to the rest of Finland, a total of 1.250 children or young people were placed outside their homes. The problems of children and young people today are more profound, complex, sever and longer-lasting than before. There is an increasing need for care outside home and it is harder to face and treat the problems (Hakkarainen et al. 2000).

UK

It is more difficult to identify the provision of family based drug prevention initiatives because of the nature of the work that is often delivered. Apart from the examples of the government interventions and other work listed below little is known about the coverage of programmes because most do not report to the same central organisation.

Sure start is a multi-million pound initiative, which targets families in greatest need. It targets parents and children under the age of 5 and aims to ensure that children get the best start in life and help children grow up with the skills they need to make the most of school. Such an intervention was introduced to try and reduce the interconnected problems such as poor educational achievement, health, housing or unemployment, which exist. There are 250 *Sure Start* projects run nationally and each project has been successful in targeting parents and children locally.

There has been a growth in the number of parenting programmes which are run, but it is not clear exactly how many exist, as they are provided through different service providers such as youth justice; social services; CAMHS; social services, education and the voluntary sector. Such courses often cover a variety of topics, which may or may not include drug prevention messages.

IRELAND

Cherry Orchard Family Care Centre



Target group: Families at risk in a local drug task force area with traditionally very high levels of substance abuse.

Strategy: The activities including family work are based on a flexible approach to the needs of each family with an individual plan for each. The centre works with roughly 80-85 families per month. Families' evaluation of the service they received is also part of the programme. A notable feature of its client group is the slight predominance of men attending: 55% were male and 45% female in 2000, 51% male and 49% female in 2001. Frequently they are in the 16 - 20 age group and have needs as individuals, partners and co-parents. It takes referrals from GPs, Social Workers, Public Health Nurses, Probation Officers as well as schools.

Evaluation: Identified gaps are the need for an outreach worker with regard to prevention, as well as outreach follow-up for families who have finished with the therapeutic intervention.

Springboard Projects:



Target group: Families at risk. 90% of families derive their income either partly or wholly from social welfare payments. The average number of children per family is 3.8 (higher than national average of 2.6). 34 families (19%) have 6 or more children. One-parent households are over-represented by a factor of nearly four and two parent households are under-represented by a factor of nearly two compared to Irish national average. 4 in 10 mothers were in employment in May 2001. 94% living in family home when first in contact with Springboard but 17% have lived away from home at some time in the past. 14% come from the travelling community. The vast majority (77%) of households live in accommodation, which is rented from the local authority. Two thirds of families (66%) are known to the Health Boards who, in turn, are a significant source of referrals. 66% is "an exceptionally high figure, given that most families would not be known to the Health Boards in their area, particularly not to the Social Work Department" (McKeown et al 2001, p.16). 28% of parents experienced emotional abuse as children, while 22% had parents with an alcohol problem and experienced domestic violence (20%) or physical abuse (20%). Main problems experienced by parents are managing the children (53%), couple/marital problems (46%) as well as debt problems (36%) and psychiatric illness (25%). The majority of children (61%) are in the 7-12 age group with one quarter in the 2 - 6 age group; the average age is 8.8 years. 35% of the children never see their biological father. 66% do not participate in organised out-of-school leisure activities. A significant minority of children have dropped out of school (21.7%) and one quarter of children experience neglect and/or witness domestic violence.

Size of intervention: There are 14 family support projects in evaluation (3 additional *Springboard* projects which started in 2000 not included in evaluation), all located in cities or large towns. The programme worked intensively with 207 families between January 2000 and May 2001,

Strategy: *Springboard* projects typically involve one-to-one sessions with the child for assessing needs and meeting therapeutic goals. This is 11% of total intervention time and amounted to average of 12 hours per child. Contents of interventions are one-to-one talking, counselling and helping, arts, crafts and outings, as well as after-school activities. Group work consists either of focused sessions for the purpose of meeting therapeutic goals or of activity based programmes to acquire life skills and developing support networks. Family work evolves around mainly family meetings and outings as well as through general support and encouragement to address family issues. This is 16% of total intervention time and average 17 hours per child. Drop-in means that the child visits the centre and engages in unstructured activities such as meeting others, participating in recreational activities and generally having fun. This is 10% of total intervention time, in average 10 hours per

child. It involves listening and talking, offering information and advice, providing a playroom as well as dropping into the child's home for a visit.

Evaluation: Research of McKeown et al 2001: both quantitative (no control group) and qualitative evaluation.

- One quarter of all children (25%) showed clinically significant improvements in their *Strengths and Difficulties Questionnaire* (SDQ) symptoms while attending *Springboard*.
- More than half the children (55%) and more than four in ten parents (44%) believe the child's problems are "much better" since coming to *Springboard*.
- 8 out of 10 children and parents perceive the projects as helpful.
- One quarter of parents and teachers believe that the children are less burdened by their SDQ symptoms, while about one third see the child as less burdensome to others.
- The average school attendance is 84% and has changed little since contact with *Springboard*. "The school-related aspects of children's lives cannot be left solely to the pioneering interventions of *Springboard* but require a more focused approach by the schools themselves, working in tandem with parents and other agencies" McKeown et al (2001, p.34).
- In the opinion of Health Boards, the proportion of children deemed to be at moderate-to-high risk of abuse or going into care was halved when attending *Springboard*.
- There was a reduction in stress levels (*General Health Questionnaire*) of 43% of the parents.
- 23% of parents recorded improved parenting capacity.
- Over 90% of professionals think that *Springboard* is good or very good in dealing with families, mothers and young children but is less effective in working with teenagers and especially fathers.

McKeown et al. (2001, p.33) conclude that a clinically significant improvement has been experienced by one quarter of all children and that "*Springboard* itself might best be regarded as a benchmark against which the performance of other interventions with vulnerable children could be judged, particularly in an Irish context".

More information: Department of Health and Children: Dublin, see www.doh.ie/publications



Ana Liffey Drug Project, Children's Project, Dublin

Target group: The *Children's Project* aims to promote and support high quality parenting and enhance the quality of life for children whose parents use drugs. It was also apparent that a number of parents had concerns around contacting statutory services for support with childcare issues.

Strategy: As the *Ana Liffey Drug Project* was able to outreach to drug-using parents who often found it difficult to engage with statutory services, it was considered appropriate that a joint voluntary/statutory response to the needs of drug-using parents would prove effective. Objectives are to support and skill up drug using parents in caring for their children, to meet the emotional needs of the children by the provision of therapeutic programmes with the maximum involvement of parents, to support pregnant drug users and their partners in preparing for parenthood, to facilitate and support the role of extended family members in assisting supporting drug using parents in the care of their children, ensure that appropriate alternative care is available for the children if their parents are unable to care for them, within their extended family or community and to provide support to children and their extended family members following the loss of one or both parents through death, imprisonment or prolonged absence. The project is designed specifically with children as its focus. This is a very necessary and innovative addition to childcare management as there was no specific programme to address children's emotional and developmental needs. Core services of *Ana Liffey Children's Project* include: family support, advocacy, access visits, parenting interventions, outreach, group and individual work, including counselling.

Evaluation: Downes & Murray's (2002) qualitative evaluation (with some quantitative aspects, though no control group. Interviews with individual clients, children, external professionals and project staff) concluded that the *Children's Project* does reach a target group that otherwise is unlikely to be reached by other services. The client-centred ethos of the *Children's Project* is clearly vindicated by the responses of the clients. The overwhelmingly positive experience provided by the project contrasts with other *Health Board* initiatives

according to the clients themselves, and thereby illustrates the success of *Ana Liffey* in reaching many marginalised people who are alienated from other State bodies.

The Talbot Centre, North Inner City Dublin



Target Group: young people, children and their families in the *North Inner City Drug Task Force Area*.

Strategy: The *Talbot Centre*, established in 1983, is a drug prevention and education project, targeted at those under 21 in the *North Inner City Drug Task Force Area*. The *Talbot Centre* children's project, has shifted its focus from primarily working with children to working with children and parents together. They concentrate their resources on intensive support to a small number of families who are in contact with them for some time. A key principle is working systemically i.e. not to work with the child or young person in isolation from the context in which they live and so includes the larger context of their lives such as their families, schools, community etc.

Its ethos is to work in a holistic, qualitative, client-centred and systemic way. The principles underpinning the service are ease of access, local availability, flexibility and the development of innovative and integrated responses following best practise guidelines. Family referrals include parent support, parenting education, parent-child sessions (cooking, art), school liaison, family trips, family therapy, and referral to other services. Individual referrals include one-to-one support, advocacy, counselling, family work, family therapy, prison visits, and referral to other services. Strong working liaisons include those with the prison service and Probation and Welfare. Within the family intervention programme, particular goals and objectives were agreed with each family depending on their needs and they played a core role in deciding these targets. Families designed the plan of action whilst staff supported and facilitated the programme. This sharing of responsibility between staff and participants empowered them to recognise their own strengths. The goal of the programme was to support families in expanding their parenting skills in a non-threatening environment. Often parents need affirmation from staff to help them recognise the parenting skills they already possess.

Evaluation: Self-process-evaluation, mostly on number of referrals.

Foroige: Young Mothers Groups



Target Group: Young mothers from areas characterised by high rates of long-term unemployment, poor infrastructure of community amenities and facilities, high incidences of early school leaving and various social problems associated with unemployment and the lack of an adequate income. They are aged 16-24 with some older members having progressed onto leadership roles within the group. They did not achieve as much as they might/should have educationally on account of a) leaving school because they were pregnant, b) not progressing educationally because they had to bring up their child and/or c) not being able to return to education because of the unavailability of appropriate childcare. They have no significant out-of-home employment experience with much of the work that has been secured being of a temporary, unskilled or part-time nature. They are socially isolated, many living by themselves with their baby/child and receiving limited support from the father of the child.

Strategy: Foroige initiated the setting up of eight *Young Mothers Groups* in four different areas in Ireland: 3 in Blanchardstown, Dublin, 2 in Tallaght, Dublin, 2 in Ballymun, Dublin, 1 in Cork city (The Glen). Each group aims for membership of 12-15 members.

Programme contents are the provision of information on issues like women's health, social welfare entitlements, first aid, further training and education opportunities, sport and recreational activities like swimming, aerobics, bowling, orienteering; arts and crafts like glass printing, woodwork, leather craft, printing, patchwork; childcare matters with sessions organised around issues like parenting skills, child health and child development; personal care and grooming with sessions taking place on skincare, nutrition, diet and aromatherapy; trips and outings to places of historical interest, family attractions, residential centres. There are planning and evaluation sessions at which the group members either planned their activities for the next period of time or reviewed the way(s) in which the group and the activities had developed over the previous 2-3 months.

The groups are firmly rooted in the communities where the young mothers live. It is understood that access and travel are major issues for women with young children. Therefore, rather than the activities taking place in a

centre which might require a bus or taxi journey, the venues are within walking distance for mothers and children/babies, living in the selected areas and housing estates.

Evaluation:

Rourke (1998, p.9) concludes from his interviews with the participants: "Involvement in the Young Mothers Group has had a major impact on the confidence and self-belief of virtually every woman who was interviewed during this review process. The group helped to reassure them that the very task of raising a child was a major responsibility and achievement, and was not something that should be lightly cast aside as lacking in value or worth. The groups also gave the young women the confidence to express their own views about different issues/subjects and to stand up for themselves when dealing with bureaucracy or officialdom. The groups also made the women more aware of their own potential and there are many examples of women that would not have previously thought about continuing education and employment but who have now joined various courses. The non-threatening nature of the activities which took place during the group sessions helped to break down some of the psychological barriers which existed".

PORTUGAL



ECOS, Viana do Castelo

Target group: Parents and families with familiar dysfunction low socio-economic level and poor housing. Adults or parents in these families have drug or alcohol problems as well as insufficient parental skills and roles.

Strategy: Psychosocial support of vulnerable families with involvement of the diverse institutions such as the local social security centre, the youth protection committee, etc. through psychological family and individual counselling. Training groups for parents promote parenting, social and personal skills. In these groups, active participation methods are used, for instance a pedagogical game by the project coordinator, "searching the family treasure".

Evaluation: Process and outcome evaluation, still ongoing. Process evaluation instruments are attendance and desistence forms as well as logbooks (evaluation of sessions and training by the parents, individual and group self-evaluation). Outcome evaluation is done by the *Identification of Emotions Form* (for children and parents), *Inventory of Parenting Practices* (for parents and children), and *Perceived Social Support Questionnaire* (degree of use of available social services). The evaluation results are expected by end October 2004.

UK



"On Track"

Target group: Families living in high crime, high deprivation communities in England and Wales, with children aged 4-12, who are thought to be at risk of becoming involved in crime as they grow up.

Strategy: This is a *Home Office* crime prevention project, which aims to tackle the causes of crime. It aims to help in 22 local areas. Partnerships of the key statutory and voluntary agencies provide a range of preventive services, which include help with parenting, parenting training, home visiting, pre-school education, home school partnerships and structured pre-school education to reduce this risk. *On-track* seeks to identify these children as soon as possible, and they and their families will be given support during the child's formative years. Each project is managed by a local partnership including the main health, educational and social service providers, youth offending team, the police and relevant voluntary sector organisations. The projects build upon and link together existing services and initiatives for children and families. There are 22 *On Track* projects in England in high deprivation areas, each covering around 2,000 children.

Evaluation: The effectiveness and cost-effectiveness of the arrangements is being evaluated.

NORWAY



The Ministry of Health and Social Affairs supports Webster-Stratton's prevention programme for children aged between 3 and 8 with conduct disorders. The programme, which is empirically supported, addresses parents,

the child and the school. The programme is manual controlled and is based on modern knowledge of conduct analysis/learning theory, developmental psychology and group processes. At present the programme is being built up in Trondheim and Tromsø through regional centres for child and adolescent psychology, and a plan will be drawn up to introduce the programme to other parts of Norway. Therapists are certified through a three-part procedure of which the first component, a three-day workshop, will be part of this continued education course.

At present, the Ministry of Children and Family Affairs is funding the establishment of *PMT* (Parent Management Training – Patterson, Reid & Dishion 1992; Webster-Stratton 1996; Webster-Stratton & Herbert 1994) and *MST* (Multi-systemic therapy – Henggeler et al 1998) in all of Norway's counties.

PMT is a school-based and family-based multi-modal action model for children aged between 6 and 14. According to Sørli, the programme is one of the most promising action models we know today (Sørli 2000).

MST also includes an intensive, time-limited and family-based programme for adolescents aged between 12 and 17 who are either at risk of developing serious behavioural problems, or have already developed such problems. The programme is aimed at young people and their families and is conducted in the local environment where all available resources are involved in the work. (Rogaland College, June 2001).

16. Promising results or lessons learned in family-based selective prevention

GREECE

Although prevention professionals report that they have difficulties in approaching parents, universal family-based prevention is quite widespread in prevention practice in Greece. This may be due to the fact that there is educational material which can be used in such programmes and which may foster their implementation.

IRELAND

There is a shift from treating the child in isolation to treating the child and family together (e.g., *Talbot Centre, Springboard*). *Springboard's* family support projects work better with the 7-12 age group than with older groups (McKeown et al, 2001). It is important to give scope for the family to be active in choosing the goals of the programme designed for them. There is need for more support for families with children with Attention Deficit (Hyperactivity) Disorder to be involved in behavioural programmes involving the child's home and school behaviour as an alternative to taking Ritalin. It is important to have at least a partnership between voluntary and statutory services for those service users who have extreme distrust of statutory services in order to reach a client group (children of addicts and ex-addicts), which may not otherwise be reached (see *Ana Liffey Drug Project Children's Project*). Crèche/childcare facilities for increased involvement of lone parents are needed.

LUXEMBOURG

Parents who come to the parents meeting are glad to have an exchange. Parents have mostly the feeling of being alone with family conflicts or decisions concerning juvenils. In the exchange with the others, they get the understanding, the these conflicts are normal developments and concerns also other families. The most difficult point is to motivate parents to come to a parent meeting. Therefore meetings with low thresholds concerning the topic and duration are needed at first to get them.

FINLAND

A central principle of drug prevention and intervention directed at young people is to involve the family at the earliest stage possible, whether it takes place in school, in a wider context of youth work or in terms of community programmes. To support these activities, the *A-Clinic Foundation* has published a popular drug prevention guidebook for parents. Many treatment facilities emphasise the role of the family and close support persons in the drug treatment process. Both in residential treatment but also in outpatient services, family-centred therapy is gaining more ground, as seen in the increasing supply of education in the field. Self-help groups have been established for persons close to drug abusers. Anybody whose relative or friend is a drug

addict may participate. The non-governmental organisation “Free from drugs” has organised three-year networking project to prevent drug use among youth, by supporting the parents and by creating regional networks for parents, authorities and volunteers. Two intermediate reports and final report have been published on the project: *Pilvi vai Pouta-aitoa yhteistyötä etsimässä 2000* (Cloudy or Sunny-looking for a genuine cooperation).

UK

Research evidence has suggested that parents need the following:

- Increased confidence;
- Information about drugs (or reassurance that they are not ignorant about drugs);
- Guidance on talking to their children;
- Skills and coping strategies;
- Support when it goes wrong;
- Knowledge of where to get help.

More needs to be done to encourage parents that they have a role to play in educating their children about the dangers of drugs and can be using in terms of providing information about drugs to their children; reinforcing work done in schools; and influencing drug-related attitudes and behaviours.

There are benefits of supporting parents. From the few studies that have focused on parents the following findings have been made:

- Parents should be encouraged to talk to their children about drugs;
- The vast majority of children are glad that their children have talked to them;
- The children’s confidence in their parents is increased;
- For many it triggers the first ever family debate.

Velleman (2000) identified the following results of working with parents:-

- Increased knowledge, confidence and communication skills
- Increased general parenting skills
- Increased intergenerational trust
- Increased ability to positively influence children
- Sustained effects on parents.

NORWAY

In June 2000, an expert group appointed by the Ministry of Education, Research and Church Affairs (KUD) and the Ministry of Children and Family Affairs conducted an assessment of programmes and initiatives aimed at reducing problem conduct and developing social skills (Report: Assessment of programme and initiatives aimed at reducing problem conduct and developing social skills; the Ministry of Education, Research and Church Affairs and the Ministry of Children and Family Affairs 2000). The report states:

“The results from initiatives aimed at improving social skills indicate that if we want to address conduct disorders in children and young people, it is likely that every action should contain a component that is aimed explicitly at the social skills of children and young people, their conduct and understanding of how their own actions affect and are affected by others.” (p. 24).

The committee adds (p. 27) *“However, except for in alternative schools, it appears that concrete or practical skills training has been surprisingly little emphasised in such combined actions.”*

17. Conclusions and recommendations about prevention with families at risk

DENMARK

It seems that the knowledge and intervention from nursery teachers and school teachers at the earliest stage possible is crucial. These professionals often see very early signs of things starting to go wrong and have good knowledge of the abuse situations. Giving these professionals better possibilities for taking action might save some from getting into serious trouble later in life.

GERMANY

Compared to school intervention programme, the family as a place for preventive measures is neglected. This statement is valid as well as for research as for the practice. This perception is known since the beginning of the 90ies but there have been no significant changes. New priorities should be set. Preconditions are the development of adequate concepts and measures.

GREECE

As the emphasis is put on the implementation of universal family interventions and there is little experience regarding targeted interventions, it suggested that the needs of families at risk must be assessed in order for targeted interventions to be gradually developed.

IRELAND

It is important that information collection be child-centred and consult the children/young people themselves (see e.g., Downes & Murrery 2002; Downes 2003; & the National Conjoint Child Health Committee Report (2000, p.30) 'Get connected: Developing an adolescent friendly health service) with regard to services that are for their welfare').

FINLAND

On the basis of different interventions, it is hard to argue for a single notion of the family. Through the influence of economic and social factors, and of the prevailing political, cultural or religious traditions, the family has been shaped in a diversity of ways and naturally faces different challenges or living conditions. In the preventive work, and especially when interventions are carried out, it should be more emphasized that the families are not all the same.

UK

Parents should be considered as a target group in their own right. The government has focused a lot of time, money and resources recently in trying to reduce youth disaffection and have introduced a number of interventions, which target young people 'at risk' (of offending behaviour or developing drug problems). However, more needs to be done to promote and prioritise family based drug prevention initiatives within the UK and ensure that a more focused approach is adopted. More work is needed in encouraging organisations to working directly with parents or families in providing drug prevention strategies such drug awareness sessions and skills based work for parents. Parents have been reported to say that they feel that they know very little about drugs, and often are fearful about their children's potential drug-using behaviour (Vellerman, 2000). Parents need to be encouraged more that they can prevent their children from using and misusing drugs as they act as models for their children.

There are some examples of successful work with families which is already taking place within UK but more needs to be done to ensure that the development of family based interventions is taken seriously. There is an acknowledgement that more can be done to develop such strategies and in future it would be good to outline how different initiatives have met some of the challenges outlined above.

There is a need for more co-ordinated and structured drug education prevention approaches, which include family-based prevention. The introduction of national prevention initiatives, which provides parents with the support they need, could reduce the need for interventions which assist families in crises or at risk, who often need extra support at difficult times in their lives.

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