Life Education

Our Evidence Base

March 2017

Life EDUCATION

Our Program

The Life Education program is a broadly focused health and drug education program delivered in preschools and schools across Australia.

Individual modules cover a range of different learning areas and issues.

Life Education program content

Pre school	Primary school	Secondary school
• Safety • Healthy eating • Physical activity • Hygiene • Sleep • Empathy and respect • Relationships • Positive communication	• Body knowledge • Safety • Healthy diet • Physical activity • Puberty • Respectful relationships • Cybersafety • Safe use of medicines • Smoking • Alcohol • Other drugs	• Tobacco • Alcohol • Other drugs • Puberty • Relationships • Sexual health • Identity

Our specialist Educators work with schools to identify which module is most relevant and appropriate for each class or student group. Our Educators also tailor the content and delivery of the selected module to best meet the needs of the school and / or individual class.

Highly interactive and engaging educational sessions are delivered to students by our Educators, either in the school classroom or on the school grounds in our specially equipped mobile classroom. The mobile classroom is used to provide students with a distinctive, engaging, hands-on learning environment and experience. Character devices – like our mascot Healthy Harold the Giraffe – and interactive storytelling approaches are used to engage younger children and help them to connect with and explore the ideas being covered in the sessions. A range of digital and interactive tools are also used to support student learning.

The Class Teacher is provided with supporting resources relating to the module that they can use to deliver preparatory and follow up activities with their students to complement the Life Education led session. These resources include student workbooks as well as digital tools and games that students can use in the classroom and at home as part of their homework and more generally.

Life Education also makes resources available online to help parents and carers support the healthy development of their children, and facilitates information sessions for school parents and carers to assist them to increase their knowledge, provide them with an opportunity to talk with one another and develop strategies to help them to raise healthy children.

Our Evidence Base

A summary of the evidence base underpinning our program and demonstrating its effectiveness is presented in this document.

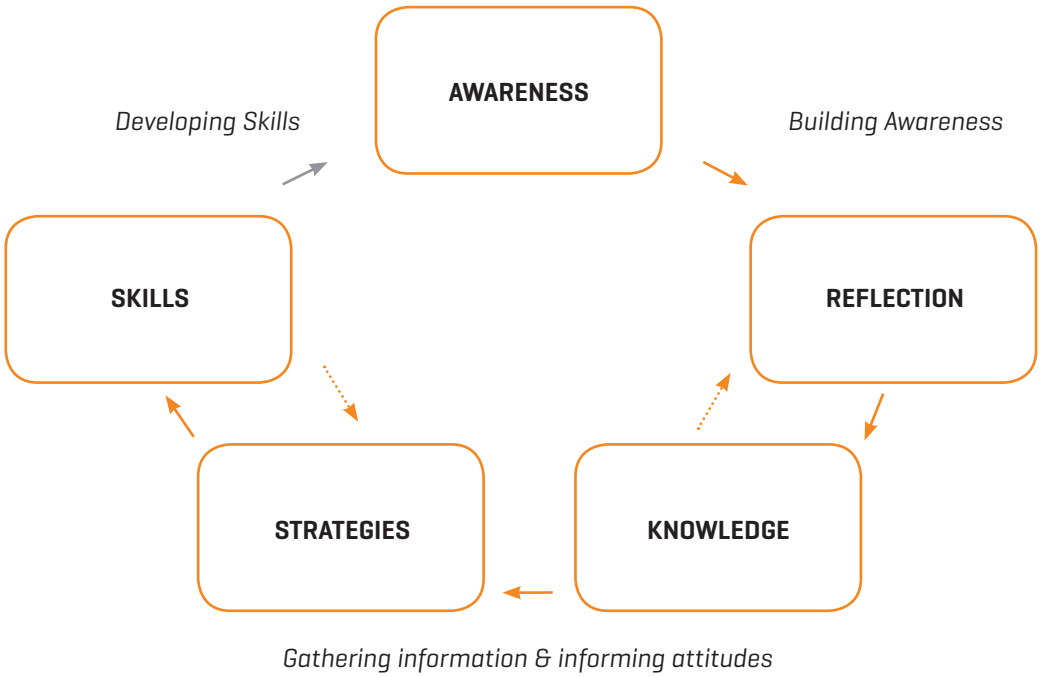
For ease of reference, we have broken down the presentation of this evidence base as follows:

Program Outcomes	What are the outcomes that our program seeks to achieve, against which its effectiveness will be assessed?
Program Logic	What is the relationship between the inputs and activities that comprise our program, and our sought after program outcomes?
Program Theory	What is the theory that explains the relationship between these activities and outcomes – both immediate and longer term?
Program Design	How well is our program aligned with the common features of school drug and health education programs that have demonstrated effectiveness?
Program Evaluation	Has the implementation of our program generated the outcomes that we seek to achieve?

Program Outcomes

What are the Outcomes that our program seeks to achieve, against which its effectiveness will be assessed?

The outcomes our program is seeking to achieve are educational in nature. Our program seeks to move students around a 'Learning Cycle'.



The program seeks to –

- Build **AWARENESS** of the general topic or issue(s) being covered
- Encourage **REFLECTION** on how the topic or issue affects the students
- Provide students with the information and **KNOWLEDGE** that they need to understand and respond to the ideas and / or issue(s) being covered
- Help students to identify and develop **STRATEGIES** to apply those ideas and / or respond to those issues and
- Help students to start to develop the **SKILLS** and confidence that they need to apply those strategies on a day to day basis.

The program's more immediate outcome is to empower students by building their capacity to make informed, safer and healthier choices. Empowerment is considered in quite practical terms as a cluster of attributes, such as the awareness, knowledge, understanding and motivation as well as the strategies and skills that collectively enhance the student's capacity to make these choices. These attributes are sometimes described in the health promotion literature as 'predisposing factors' which can influence future behavioural choices and actions.

Program Logic

What is the relationship between the inputs and activities that comprise our program, and our sought after program outcomes?

A program is a series of activities supported by a set of resources intended to achieve specific outcomes among particular individuals.

The following logic model describes how the Life Education program fits together – in a simple linear cause and effect sequence.

Program Elements
· Review student needs with school and teaching staff and identify target learning outcomes · Identify and deliver tailored, age appropriate educational sessions to students · Provide teachers with classroom resources to undertake preparatory and follow up classroom activities to complement educational sessions · Provide information sessions and resources to help parents support their children's development

Pre-session	Educational Session	Post-session
· Educator meets with school coordinator and teaching staff to identify student needs · Select modules · Discuss learning objectives · Tailor individual sessions to school / student needs · Class teachers use Life Education resources to conduct preparatory sessions with students	· Educational sessions are conducted with students · Information session is conducted with parents	· Class teachers use Life Education resources to conduct follow up sessions with students · Students use workbooks and digital learning activities in class and at home · Parents use online resources

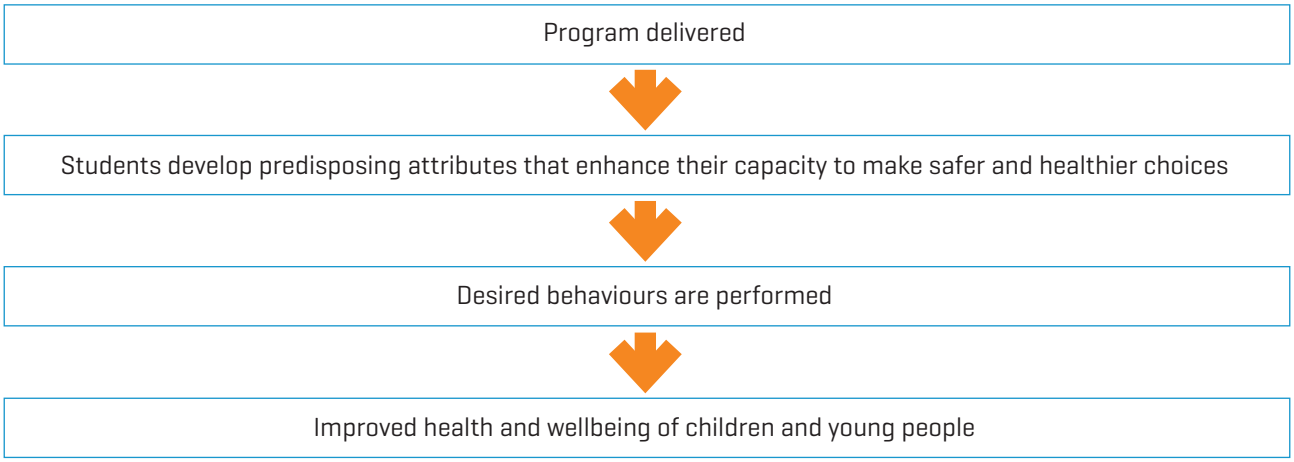
More Immediate Individual Capacity Building Outcomes
Strengthen pre-disposing attributes in students by: · Building Awareness · Encouraging Reflection · Providing Information · Building Knowledge and Understanding · Developing Strategies · Developing Skills and Confidence

Program Theory

What is the theory that explains the relationship between these activities and outcomes – both immediate and longer term?

A program's theory is the hypothesis that explains why the program is expected to work – why the program's activities should lead to the intended outcomes. To be credible a program's theory should go deeper than common assumptions about how certain activities lead to outcomes. It should explain the theoretical basis for the program, with research evidence provided to support the causal connections being relied upon.

The following diagram provides a simple outline of the causal logic underpinning our program.



The following is a summary of the findings of Erebus International which, in its report dated March 2017, responded to the following research questions –

- *How valid is the theory underpinning the Life Education program?*
- *Is there a causal relationship between the development of the program's sought-after outcomes / attributes within an individual, and their subsequent choices and behaviours?*
- *Is there evidence in the relevant literature to support this relationship?*

Erebus concludes that the theory underpinning the Life Education program is sound and consistent with contemporary research on the development of health promoting behaviours. The report indicates that the Life Education program model draws on some long-established and well-respected theories in the psychological literature on motivation and behaviour that argue that all behaviours, including health and lifestyle choices, are largely learned ie. that through learning an individuals' capacity to make more informed, safer and healthier choices can be enhanced, and that factors such as awareness, knowledge, skills, attitudes and values can predispose individuals to behave in certain ways. The emphasis in Life Education's program on the development of skills, attitudes and values also recognises that increasing knowledge alone is insufficient to ensure that wise choices and appropriate behaviour follow.

These concepts are important in the context of school education because they imply that behaviour is modifiable, and therefore both positive behaviours can be reinforced and negative behaviours discouraged through appropriately structured and delivered educational programs.[1] Ajzen's (1991) Theory of Planned

Behaviour and more recent Reasoned Action Theory (Ajzen and Fishbein, 2005) recognise the complex relationship between cognitive learning and ultimate behavioural outcomes, and that behaviour is mediated through both "behavioural intention" and "perceived behavioural control". According to Ajzen, behavioural intention is an immediate antecedent of behaviour that provides a robust indication of an individual's readiness to perform a given behaviour. The theory holds that an individual's intention to perform a behaviour is determined by two factors:

- specific attitudes toward the behaviour in question – their positive or negative feelings about performing the behaviour, a function of their beliefs regarding the expected consequences arising from the behaviour, in turn a function of their assessment of both the desirability and likelihood of these consequences, and
- subjective norms – their perceptions about how people they care about will view the behaviour in question, a function of whether they believe others think the behaviour should be performed or not, and how motivated they are to comply with these views.

Perceived behavioural control refers to a person's perceptions of their ability to perform a given behaviour, a function of the perceived ease or difficulty of the behaviour as well as their capacity to undertake it. The more resources and opportunities individuals believe they possess, and the fewer obstacles or impediments they anticipate, the greater should be their perceived control over the behaviour and the greater their sense of "self-efficacy" (Bandura, 1986).

Erebus concludes that there is evidence in the relevant literature to support there being a causal relationship between the development of the program's sought-after outcomes / attributes within an individual, and their subsequent choices and behaviours.

Life Education's own understanding of the limits of what it can realistically achieve acknowledges that the relationship between individual "capacity-building" and a behavioural outcome is not direct and linear. There are many factors outside the direct control of the individual that also influence behavioural choices and actions. As Bronfenbrenner's (1979) ecological framework for human development argues, an individual's predisposition to behave in certain ways is reciprocally influenced by a range of factors operating at multiple levels – at the peer level, the family level, within school and at the broader community and cultural levels.

Download a full copy of the Erebus Report

[1] What is meant by 'appropriately structured and delivered' is discussed separately in the Erebus report – which is summarised in the following section of this document under 'Program Design'.

Program Design

How well is our program aligned with the common features of school health and drug education programs that have demonstrated effectiveness?

There is evidence to draw upon in identifying the common features of school health and drug education programs that have demonstrated effectiveness.

The following is a summary of the findings of Erebus International which, in its report dated March 2017, responded to the following research questions –

Given the immediate outcomes the Life Education program is seeking to achieve –

- *What are the critical design features of school education programs that have been most effective in achieving these outcomes, and*
- *How well or otherwise does the design of the Life Education program align with these features?*

Erebus synthesized the various relevant studies and summarized the key principles of effective practice as follows:

Summary of Principles for Effective School Health and Drug Education

Key Principles	Elements
Comprehensive and evidence-based practices	School practice based in evidence A whole school approach Clear educational outcomes
Positive school climate and relationships	Safe and supportive environment Positive and collaborative relationships
Targeted to needs and context	Culturally appropriate and targeted Recognition of risk and protective factors Consistent policy and practice
Effective Pedagogy	Timely programs within a curriculum framework Programs delivered by teachers Interactive strategies and skills development Credible and meaningful learning activities Relevant program content Quality of program implementation

A more detailed description of these key principals, prepared by Erebus, is provided as an Appendix.

Erebus concluded that the design of the Life Education program aligns well with the critical design features of school education programs that have been most effective in achieving positive outcomes.

Erebus further concludes that it is apparent that Life Education does the things it can control to a high standard, consistent with best practice, including:

- its program is based on sound theory
- its comprehensive approach rather than a focus on a specific issue
- the age appropriate and sequential nature of its program
- the quality of its content and its alignment to the curriculum
- the professionalism and expertise of its Educators
- the tailoring of its program content and delivery to best meet school or class needs
- the interactive nature of its program and level of engagement with students.
- its focus on developing knowledge as well as motivation, strategies, skills and confidence
- the support provided the class teacher
- the increasing support provided to parents
- its regular evaluation to collect evidence on the quality and impact of its delivery

Erebus acknowledges that the Life Education program is designed, and clearly intended to complement and support rather than replace the class teacher in the delivery of health curriculum objectives. Provided that schools implement the Life Education program as it is intended to be used, that is, not as a stand-alone program, but as a complementary health education resource, Erebus concludes that the Life Education program is designed consistent with best practice approaches.

Download a full copy of the Erebus report.

Program Evaluation

Has the implementation of our program generated the outcomes that we seek to achieve?

In 2012 we worked with The Centre for Program Evaluation at The University of Melbourne to review our program and identify options to evaluate it.

In 2013 we engaged specialist consultancy, Regina Hill Effective Consulting Pty Ltd, to build on that work and develop an evaluation system and toolset which included a suite of student, teacher and school coordinator feedback surveys designed to evaluate the quality and impact of Life Education's educational sessions and the supporting resources that Life Education provides to schools.

The system and toolset were piloted in late 2013. The pilot collected and reviewed data from 9 schools in Queensland, New South Wales and Victoria. The toolset was updated based on learnings from the pilot and rolled out on a broader basis in 2014. This saw data collected from 5,246 students in 53 primary schools from across Queensland, New South Wales, Victoria, South Australia, Western Australia and the Northern Territory. This data was collected from students one to two weeks after their participation in the educational session delivered by our Educator. Feedback was also collected from 241 teachers from 45 schools, as well as 28 school coordinators.

The key findings of this evaluation, prepared by Regina Hill Effective Consulting, were as follows -

The Life Education program works to strengthen the pre-disposing factors that can help children and young people to make safer and healthier choices. The evaluation demonstrates that the Life Education program is effective in helping students to:

- *Build their awareness and understanding of how different things can influence their safety and health*
- *Value their safety and health and that of those around them*
- *Develop attitudes that can pre-dispose them to make safer and healthier choices*
- *Identify strategies and build confidence and skills that can help them to deal with peer and community pressure and be safer and healthier.*

The evaluation demonstrates that the educational sessions delivered in primary schools by Life Education, and the supporting resources made available to class teachers, play a valuable role in supporting schools to build students' awareness, knowledge and skills so that they can make safer and healthier life choices.

Download the Executive Summary of this Evaluation (15 pages)

Download the full Program Evaluation Report dated November 2014 (150 pages)

Our system of data collection was further developed during 2015. Continuing to work with Regina Hill Effective Consulting, a pre-session survey was introduced for completion by students immediately before their participation in the educational session delivered by our Educator. This survey tested, amongst other things, student's preexisting disposition to engage in behaviours to keep themselves safe and healthy. A post-session survey was then completed by students immediately after the session to test whether, based on what they had learned in the session, they were more likely to adopt safer and healthier behaviours.

Survey data was then collected throughout Term 3 and 4 2015 from 8,658 students in 136 schools across Queensland, being students in Year 4 and over that had participated in modules covering healthy eating, physical activity, smoking, and alcohol.

This evaluation demonstrated, amongst other things, that the sessions delivered by Life Education are effective in developing students' disposition to adopt safer and healthier behaviours, with most students expressing positive attitudes towards the adoption of safer and healthier behaviours because of what they had learned in the session.

The more module-specific key findings of this evaluation were as follows -

- *In the pre-survey 71.8% of students said that they chose **healthy food** all or most of the time. After the Life Education session, 84.9% of students indicated they would choose healthy food all or most of the time. Over 90% of students said that they thought that they were more likely to think about what they eat and to eat healthy foods because of what they had learned in the session.*
- *In the pre-survey only 46.8% of students said that they participated in **physical activity** daily. After the Life Education session 64.9% indicated that they would exercise daily. Over 85% said that they thought they were more likely to be physically active because of what they had learned in the session.*
- *In the pre-survey 78.8% of students said they definitely would never **smoke**. This increased after the Life Education session to 85.2%. Over 90% of students said that they thought that they were less likely to smoke because of what they had learned in the session.*
- *The session was effective in helping students to understand the effects of **alcohol** generally and help them think about how to stay safe around alcohol and be confident to make safer decisions about alcohol in the future. More than 86% of students indicated they thought they would be likely to make safer decisions about alcohol in the future because of what they had learned in the session.*

The evaluation demonstrates that the educational sessions delivered by Life Education play a valuable role in helping schools to strengthen the understanding and disposition of students to make safe and healthy choices.

Download the Program Evaluation Report dated February 2016 (98 pages)

In Term 3 and 4 of 2016, Teacher and Student surveys were conducted in 5 Queensland primary schools, relating to the delivery of 2 modules that form part of the Life Education program – *All Systems Go* and *On the Case.*[2]

381 students were surveyed from across 19 classes. They completed a pre-program survey prior to the Life Education school visit, and a follow up survey some 6 weeks after the Life Education school visit. This 6 week delay allowed class teachers to conduct follow up classroom based teaching and learning activities, drawing on the resources provided by Life Education. It also allowed time to pass to determine to what extent students recalled the content of the Life Education program over time. Teachers completed a survey assessing the relevance, quality, and effectiveness of the Life Education program for each of the 19 classes involved in the evaluation.

This evaluation, once again conducted by Regina Hill Effective Consulting, indicates that the Life Education program was effective in achieving its sought- after outcomes ie. to develop in students the predisposing attributes necessary for them to make safer and healthier choices.

Most students indicated a significant change in both understanding and disposition to apply what they had learned, as a result of their participation in the program. They were able to identify practical steps that they could take to be safer and healthier following the program and were more likely to make healthy life choices.

[2] These modules were selected on the basis that they were representative of Life Education's broader health and drug education program, and allowed more detailed feedback to be collected from students by focusing on the middle and upper primary school student cohort. *All Systems Go* is a middle primary school module that aims to increase student's understanding of how the body works and help them to make informed choices about how to stay safe and healthy by eating well and being physically active. *On the Case* is an upper primary school module that aims to increase student's awareness of the effects of smoking and help them to identify strategies to deal with second hand smoke as well as pressure to smoke.

- *9 in 10 students indicated that ASG had helped them in a tangible way to understand how the foods they eat affect their health (92%), to reflect on what they eat (90%) and to be more likely to think about their diet when they make eating decisions (93%). They indicated that they felt like they could make healthy choices about what to eat (84%) and that they would be more likely to eat healthy food based on what they had learned (86%).*
- *Over 9 in 10 students indicated that OTC had helped them to learn about the effect that smoking has on the body (91%), that it had played a role in getting them to think about how smoking was affecting people they knew (84%) and to know what to do if someone offered them a cigarette (85%). Most students said that they thought that they were less likely to smoke because of what they had learned in OTC (88%).*

Teacher feedback confirmed that the Life Education program plays a valuable role in helping schools to deliver health and safety education and to strengthen the understanding and pre-disposition of students to make healthy and safe life choices.

- *4 out of 5 of the teachers surveyed indicated that they thought that the need for health and safety education across their class was significant or very significant. Over 70% of teachers indicated that they thought that Life Education had made a significant or very significant contribution to their ability to address that need.*

All teachers agreed that the overall Life Education program had improved students' health knowledge and made a positive contribution towards their health and wellbeing. Most also agreed that the program had also contributed towards helping to build a healthier school community

Download the Program Evaluation Report dated February 2017 (41 pages).

Appendix 1: Synthesis of Principles for Effective School Health and Drug Education

Key principle	Comment
Comprehensive and evidence-based practice	
1. School practice based in evidence	**Base health and drug education on sound theory and current research and use evaluation to inform decisions.** · Drug education needs to be based on research as to effective curriculum practice and the needs of students (Midson, 2000; Ballard, et al., 2002). · Effective programs are based on an understanding of contemporary theory and research evidence as to what causes drug use and what factors provide protection (Ballard et al., 1994; Dusenbury and Falco, 1995) · Drug education needs to be based on what works. Evidence-based practice within a school involves staff: using current theory and research to determine programs that are appropriate to their students; staying informed about effective curriculum practice; applying professional judgement to implement and monitor programs; and evaluating outcomes to determine their impact. Regular evaluation of the school's drug education processes and outcomes is critical, providing evidence of the value of activities and informing future school practice. (Meyer and Cahill, 2013) · Drug education needs to be based on research, effective curriculum practice and identified student needs. The selection of drug education programs, activities and resources should be made on the basis of an ability to contribute to long term positive outcomes in the health curriculum and the health environment of the school Ballard, et al., 2002).
2. A whole school approach	**Embed drug education within a comprehensive whole school approach to promoting health and wellbeing.** · Tackling drug-related issues in isolation and only at a classroom level is less likely to lead to positive outcomes. Drug education activities are best understood and practiced as part of a comprehensive and holistic approach to promoting health and wellbeing for all students. Through a whole school approach schools can provide a coherent and consistent framework for their policies, programs and practices. (Meyer and Cahill, 2013)
3. Clear educational goals, objectives and outcomes	**Establish drug education outcomes that are appropriate to the school context and contribute to the overall goal of minimizing drug-related harm.** · When schools establish agreed goals and outcomes for drug education they have a common understanding for consistent and coordinated practice. The process of ensuring that those goals and outcomes are clear and realistic supports schools in achieving targets within their sphere of influence. (Meyer and Cahill, 2013). · Objectives for drug education should be linked to the overall goal of harm reduction (Midson, 2000) · The concept of harm reduction encompasses a range of strategies, including non-use, which aim to reduce harmful consequences of drug use. Harm minimisation forms the basis of Australia's drug strategy (Ballard et al., 1994)
Positive school climate and relationships	
4. Safe and supportive environment	**Promote a safe, supportive and inclusive school environment as part of seeking to prevent or reduce drug-related harm.** · A safe and supportive school environment is protective for young people against a range of health-related risks, including substance use problems. A positive climate within and beyond the classroom fosters learning, resilience and wellbeing in students and staff. An inclusive school provides a setting where students, staff, families and the broader community can connect and engage in meaningful learning, decision-making and positive relationships. (Meyer and Cahill, 2013) · School policies and practices should reinforce the objectives of drug education programs (Ballard et al., 2004).

5. Positive and collaborative relationships	**Promote collaborative relationships between students, staff, families and the broader community in the planning and implementation of school health and drug education.** · Schools that use collaborative processes whereby students, staff, families and the broader community are consulted, are more likely to provide relevant and responsive drug education. Broad approaches that integrate school, family, community and the media are likely to be more successful than a single component strategy. Strong relationships with families, external agencies and the broader community can enhance students' sense of connectedness, and support access to relevant services. (Meyer and Cahill, 2013) · Broadening school-based education by including family, community and media components will reinforce desired behaviours by providing a supportive environment for school-based programs (Ballard et al., 1994) · Mechanisms should be developed to involve students, parents and the wider community in the school drug education program at both planning and implementation stages (Ballard et al., 2002; Dusenbury and Falco, 1995)
Targeted to needs and context	
6. Culturally appropriate and targeted drug education	**Provide culturally appropriate, targeted and responsive health and drug education that addresses local needs, values and priorities.** · Drug education needs to be relevant to all students. In providing programs, schools should be sensitive to the cultural background and experience of students. Diverse components of identity, including gender, culture, language, socio-economic status and developmental stage, should be considered when providing drug education that is targeted to meet students' needs. (Meyer and Cahill, (2013; Stead and Angus 2014) · Drug education should be responsive to developmental, gender, cultural, language, socio-economic, and lifestyle differences (Midson, 2000; Ballard, 2002) · Drug education programs that are sensitive to the different backgrounds of the young people they target will be more relevant and effective (Ballard et al., 1994; Dusenbury and Falco, 1995)
7. Recognition of risk and protective factors	**Acknowledge that a range of risk and protective factors impact on health and education outcomes, and influence choices about drug use and healthy behaviour.** · Drug education should be based on an understanding of the risk and protective factors that affect young people's health and education. Schools that recognise the complexity of issues that may impact on students' drug use are in a better position to provide relevant drug education. (Meyer and Cahill, 2013)
8. Consistent policy and practice	**Use consistent policy and practice to inform and manage responses to health and drug-related incidents and risks.** · The school's discipline and welfare responses should protect the safety and wellbeing of all students and staff. Policies and procedures to manage drug-related incidents and support students who are at risk are best determined through whole school consultation and implemented through well-defined procedures for all school staff. Vulnerable students may require additional support from the school and relevant community agencies. Retaining students in an educational pathway should be a priority of care for students who are at risk. (Meyer and Cahill, 2013) · Drug education messages across the school environment should be consistent and coherent (Midson 2000; Ballard et al., 2002)
Targeted to needs and context	
9. Timely programs within a curriculum framework	**Locate programs within a curriculum framework, thus providing timely, developmentally appropriate and ongoing health and drug education.** · Drug education is best taught in the context of broader health skills (Midson, 2000; Ballard et al., 2002) · Drug education programs are best provided within a clear curriculum framework for achieving student learning outcomes. Drug issues should be addressed within a broader health context relevant to students concerns and stage of development. The timing and continuity of drug education across students' schooling is critical. Programs should commence before young people start to make decisions about drug use, be developmentally appropriate, ongoing and sequenced, and provide for progression and continuity. (Meyer and Cahill, 2013) · Drug education programs which are part of multi-component and 'environmental' programs are likely to be more effective than those delivered in isolation. Environmental approaches such as improved classroom management and alternative groupings of pupils are promising approaches, as is whole school health promotion (Stead and Angus, 2014) · Drug education is best delivered before behavioural patterns are established (Midson, 2000) and when prevalence of use by young people is still very low (Kelder et al., 1994) · Drug education programs should be immediately relevant, developmentally appropriate and have sequence, progression and continuity (Midson, 2000; Ballard et al., 2002)

10. Programs delivered by teachers	**Ensure that teachers are resourced and supported in their central role in delivering health and drug education programs.** · Drug education in schools should be conducted by the teacher of the health curriculum (Ballard et al., 2002) · Teachers are best placed to provide drug education as part of an ongoing school program. Effective professional development and support enhance the teacher's repertoire of facilitation skills and provide current and accurate information and resources. (Meyer and Cahill, 2013). Teachers should be trained and supported to conduct drug education (Midson, 2000) · Appropriately trained and supported peer leaders and visiting presenters can complement the teacher's role (Meyer and Cahill, 2013; Midson, 2000) · Peers, teachers and other professionals can all be effective deliverers of drug education programs providing they deliver to a high standard and are perceived as credible and trustworthy by students (Stead and Angus, 2014). · The classroom teacher, with specific knowledge of students and the learning context, is best placed to provide contextual drug education. Programs are most successful when teachers receive training and support, particularly in undertaking interactive teaching activities (Ballard et al., 1994; Dusenbury and Falco, 1995) · Drug education programs and resources should be selected to complement the role of the classroom teacher (Midson, 2002) · Drug education programs and resources should be selected to complement the role of the classroom teacher with external resources enhancing not replacing that role (Ballard et al, 1994; Ballard et al., 2002).
11. Interactive strategies and skills development	**Use student-centred, interactive strategies to develop students' knowledge, skills, attitudes and values.** · Skills development is a critical component of effective drug education programs. Inclusive and interactive teaching strategies have been demonstrated to be the most effective way to develop students' drug-related knowledge, skills and attitudes. These strategies assist students to develop their problem solving, decision-making, assertiveness and help-seeking skills. Inclusive methods that ensure all students are actively engaged are the key to effective implementation of interactive strategies. (Meyer and Cahill, 2013) · Interactive teaching techniques should be used (Midson, 2000) · Drug education should be highly interactive. Non-interactively delivered programs are consistently less effective (Stead and Angus, 2007) · Techniques such as role play, group discussion and joint activities promote active involvement in the learning process (Dusenbury and Falco, 1995)
12. Credible and meaningful learning activities	**Provide accurate health-related information and meaningful learning activities that dispel myths about drug use and focus on real life contexts and challenges.** · Students need credible and relevant information about drugs and the contexts in which choices about drugs are made. They need to engage in meaningful activities with their peers, examine the social influences impacting on drug use and encounter normative information about the prevalence of use, which is typically lower than students expect. (Meyer and Cahill, 2013) · Programs must be credible and useful to students, which means they need to be provided regularly at different stages of schooling (Ballard et al., 1994; Dusenbury and Falco, 1995)

13. Relevant program content	**Provide content that is of immediate practical relevance to young people in decision making** · Content which is of immediate practical relevance to young people in their decision making about drug use provides the basis for interactive skill development (McBride et al., 2000) · Both generic programmes (addressing all drugs) and single-drug programmes can be effective. If generic programmes are implemented, care needs to be taken to ensure that messages about the effects and risks of different drugs do not cause confusion or give the impression that because some drugs are particularly risky, others are safe (Stead and Angus, 2014) · Information on normative student drug use should be provided. This gives young people an accurate indication as to the extent of drug use in their peer group, which is typically lower than expected (Midson, 2000; Dusenbury and Falco, 1995) · Programs should address the values, attitudes and behaviours of the community and the individual. Responsible decisions by students about drugs are more likely where peer and community groups demonstrate responsible attitudes and practices (Midson, 2000; Ballard et al.,1994) · Programs should acknowledge the interrelationship between individual, social context and drug in determining drug use. The drug experience is influenced by these three components and effective education programs need to deal with these influences in an integrated manner (Midson, 2000; Ballard et al.,1994; Ballard et al., 2002) · Drug use that is most likely and most harmful should be emphasised. Generally, school based drug education should concentrate on lawfully available drugs because their use by young people is more likely. While illicit drug use disproportionately attracts media attention and public concern it should be addressed in particular contexts or subgroups, where it is prevalent and harmful (Midson, 2000; Ballard et al.,1994) · Drug education should be based on a social influences approach, specifically including resistance skills and normative education elements. Programmes based on these approaches have proven consistently to be more effective. Normative education – examining and challenging perceptions of the prevalence and acceptability of drug use •in particular is a significant mediator of programme effectiveness. (Stead and Angus, 2014)
14. Quality of program implementation	**Health and Drug education programs should be delivered to as high a quality as possible** · Drug education programs should demonstrate adequate coverage, sufficient follow-up and ability to achieve long-term change (Midson,2000) · An adequate intervention, complemented by ongoing follow-up or strategically time 'booster' sessions is needed to counter effect decay and the ongoing influence to use drugs. Stand alone and one off interventions are not likely to be effective (Ballard et al., 1994; Dusenbury and Falco, 1995) · Drug education programs need to be of sufficient length to achieve impact (Stead and Angus, 2014) · Drug education programs should be implemented as intended (Midson,2000) · Monitoring should, be undertaken to ensure programs are delivered in the intended manner, as failure may occur because of inadequate implementation, rather than as a result of any deficiency in the design of the program (Dielman, 1994). · Drug education programs should be evaluated to provide formal evidence of the worth of the program in contributing to short and long term goals as well as improving the design of future programs. The quality of evaluation studies should also be assessed (Ballard et al., 1994; Dusenbury and Falco, 1995)

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