

# Part 4: Health Promotion & Primary Prevention

## Introduction

Health promotion and primary prevention include interventions that promote health and strive to prevent the initiation of IDU. Research evaluating prevention programs demonstrates their cost-effectiveness, with each dollar invested in prevention saving ten dollars in treatment costs (1).

The traditional model of disease prevention is based on three approaches: primary, secondary and tertiary prevention (2):

- **Primary prevention**, the major focus of this pillar, aims to prevent disease (or a high-risk outcome) before it occurs. In the case of injection drug use, primary prevention efforts are intended to reduce the risk that an individual will start using injection drugs.
- **Secondary prevention** reduces the complications of a disease by intervening as early as possible. This approach to prevention would include early detection of blood-borne diseases like HCV and HIV as well as other supportive initiatives intended to reduce other harms associated with injection drug use.
- **Tertiary prevention** efforts are supportive, rehabilitative or treatment directed at those individuals with a known disease. This may involve treatment and recovery services for addictions or supportive care for persons living with HIV/AIDS.

Expanding on the traditional model of prevention, primary prevention strategies can target different populations. Strategies may be directed at the population as a whole, at specific groups or at specific individuals (3).

- **Universal prevention** strategies consider the entire population at-risk for drug use. Strategies may be directed at national, local community, neighborhood, or school levels and can incorporate a variety of health promotion activities.
- **Selective prevention** strategies target sub-groups of the total population who may be at greater risk for initiating injection drug use. Higher-risk populations might include children of adults who use alcohol or other drugs, youth who have dropped out of school, youth from high drug use or low income neighborhoods or youth who have experienced abuse.
- **Indicated prevention** strategies target people who have started to use injection drugs, are at risk for continued use, and are exposed to the health risks associated with IDU. Indicated prevention aligns most closely with the principles of harm reduction.

The concept of health promotion is perhaps best captured by the Ottawa Charter (4). This model offers a series of actions for promoting health across a range of individual, community, and provincial or national policy levels. The marriage of population health and health promotion offers a valuable strategic framework from which to build programs or plan activities to improve the health and well-being of communities.

The Ottawa Charter has been integrated into a model for *population health promotion* to extend the concept to specific levels of action and to incorporate determinants of health (5). The model offers a who-what-how approach to planning around population health promotion (See figure 4.1) and is useful for considering as the working group under this pillar moves forward into action. On the far right side of the model, the five action strategies of the Ottawa Charter are listed. The top of the model represents the different targets for these actions: individuals, families, communities, sectors and systems, and societies. Social, structural, economic and individual determinants of health are listed on the front of the model as the 'what' to strengthen, enhance or target in population health promotion. The model is founded upon evidence-based decision making and an explicit recognition of values and assumptions that inform population health promotion actions (5).

Each of the three approaches to primary prevention (universal, selective and indicated) can be considered from the perspective of this model. As stakeholders consider the recommendations offered in this strategic planning document, it is helpful to keep the elements of health promotion and the determinants of health offered by the model in mind.

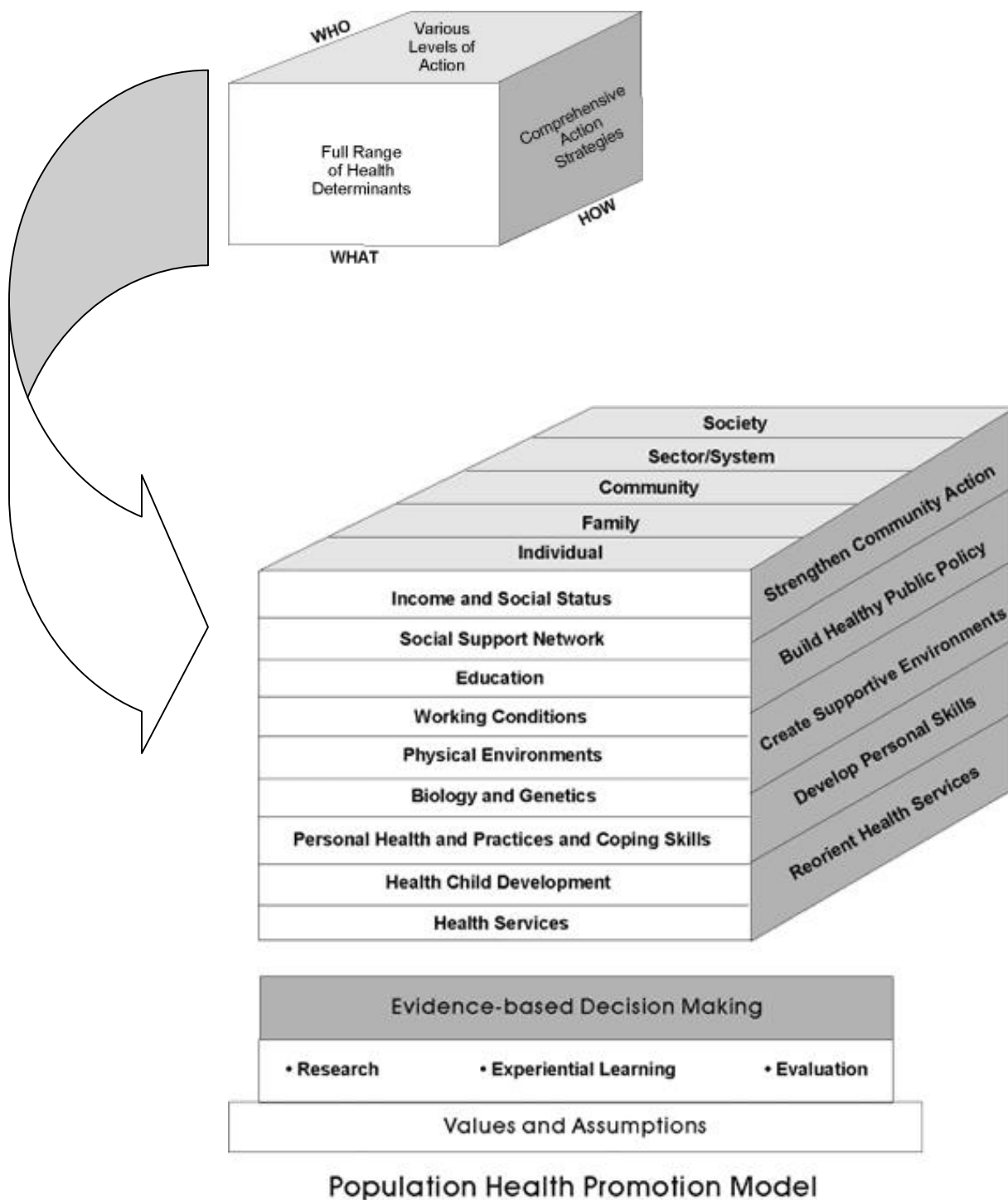


Figure 4.1: Model for Population Health Promotion—Who, What and How?

# Best Practices in Health Promotion & Primary Prevention

Research and evaluation of health promotion and primary prevention programs demonstrate a need for comprehensive approaches that address all aspects of the model for population health promotion presented above (6, 7). In the context of this strategic planning framework, primary prevention seeks to prevent the initiation of injection drug use. Because of this, the main focus of primary prevention efforts is on children and youth. The community as a whole, including IDUs and their families, are also important target populations for health promotion and primary prevention.

Health Canada conducted a comprehensive review of the literature and research related to develop a set of best practices in the prevention of substance use among young people. They offer four principles of effective substance use prevention programs (7). These principles (Figure 4.2) are discussed in more detail below.

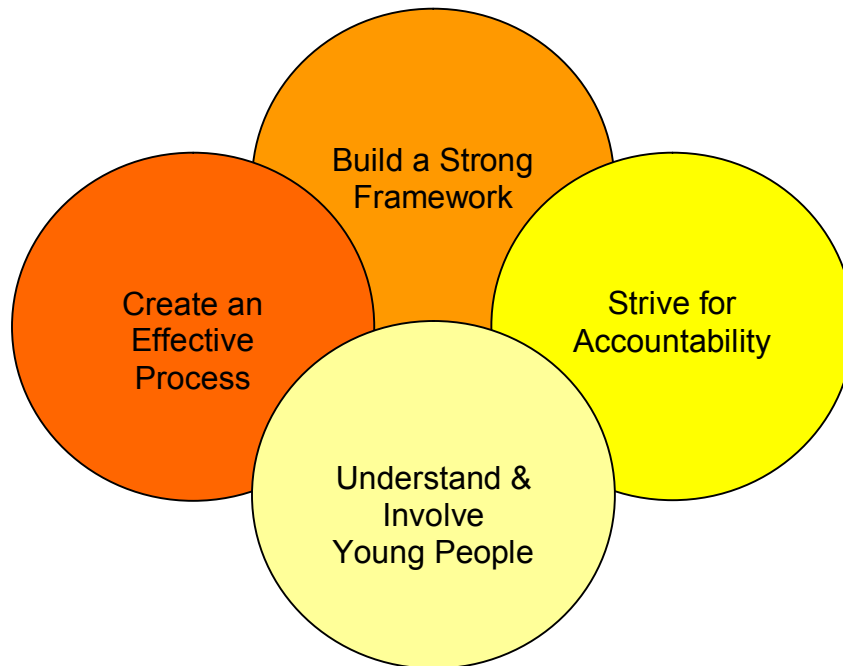


Figure 4.2: Principles of Effective Prevention Programs

## **1. Building a Strong Framework**

Effective prevention programming builds on comprehensive partnerships, addresses risk and protective factors related to substance use, and ensures appropriate duration and intensity of programs (7).

### *Comprehensiveness*

Ensuring comprehensiveness in prevention programming is particularly important because of the multiple, complex individual, family, school, community and society factors that contribute to substance use. Comprehensive partnerships link prevention activities to other, complementary efforts to promote holistic approaches, reduce duplication of services, and maximize the benefits of multiple points of entry into coordinated programming. For example, classroom instruction can be coordinated with peer helper programs, parent education, supportive school policies, mentoring programs for at-risk youth, and community awareness campaigns (7). Interventions can be coordinated at multiple levels and can incorporate groups who haven't played a traditional role in substance use prevention, including urban planners, housing authorities, shopping mall management, and employment policy makers (8).

At a broader level, comprehensiveness needs to consider organizational policies and regional, provincial or federal regulations that contribute to preventing substance use (9). The enforcement of minimum-age drinking laws, for example, contributes to preventing the use of alcohol among youth. Addressing the basic determinants of health is another key to broad-level comprehensive prevention. Finding food, stable housing, job training, educational support, and personal counseling are daily challenges for youth living on the street (10). Street youth who are coping with addictions may have even greater needs and can often resort to crime as a means for supporting their drug use (11). Comprehensive prevention acknowledges these complex contexts, adapts to the needs of the targeted populations, and ensures that programs are coordinated across multiple levels.

### *Addressing Risk and Protective Factors*

An important consideration in building a strong framework for prevention programming is an understanding of individual, family, community, and societal factors that may put someone at greater risk and those that build individual resiliency to initiating injection drug use (See Table 4.1 for examples). These factors can be considered risk and protective factors respectively. Effective prevention programs enhance protective factors while reducing risk factors for initiating the use of injection drugs (12). Because risk and protective factors are specific to any given community, it is important that prevention efforts address all forms of drug use (13), particularly those that are known to be circulating in the local community (12) and be tailored to the unique contexts and concerns of the community (14).

Table 4.1: Examples of Risk Factors and Protective Factors across Domains (15)

<b>Level of Influence</b>	<b>Risk Factors</b>	<b>Protective Factors</b>
Individual	Early aggressive behavior	Impulse control
Family	Lack of parental supervision	Parental monitoring
Peer	Substance abuse	Academic competence
School	Drug availability	Anti-drug use policies
Community	Transient neighborhoods	Strong neighborhood attachment
Society/Environment	Poverty	Strong social policy

### *Duration and Intensity*

The third component of building a strong framework is ensuring that prevention programs are appropriate in both duration and intensity, as determined by the community's unique needs and concerns (7). Success in prevention programs tends to erode over time, requiring regular re-evaluation of programming (16). Building prevention programming with five-year strategic plans may be one way to ensure that the community's needs are met over time. The intensity of prevention planning is also determined by developing an in-depth understanding of the current state of substance use in a community. The better this is understood, the more prevention efforts can be tailored to meet the needs of the community.

## **2. Striving for Accountability**

Accountable prevention programs are based on accurate information, set clear goals and objectives, build monitoring and evaluation into programs, and take steps to address sustainability from the beginning.

### *Accurate Information*

Reliable, local information on the nature of substance use and the problems or challenges associated with it is a critical consideration in creating accountable prevention programming. The factors that contribute to substance use are complex and stem from a wide range of social determinants of health (15, 17), including stigma, marginalization and discrimination (18, 19). Regular, ongoing reviews of the nature and extent of substance use among the population of interest enhances program evaluation and can contribute to responsive prevention program planning (7).

### *Goals and Objectives*

Clear, realistic, time-limited and measurable goals specific to particular populations or target groups are invaluable resources for facilitating evaluation and maintaining perspective in prevention programming. The prevention program may have an overall goal of preventing substance use among youth, but creating more specific objectives by age categories may be helpful for ensuring flexibility.

### *Monitoring and Evaluation*

Both the process and outcomes of prevention planning and programming should be considered integral to accountability. Resources for conducting evaluations need to be planned for in advance and built into budgets and timelines.

### *Addressing Sustainability*

Long-term sustainability should be incorporated into prevention planning and programming from the outset. This means that committed funding and resources will be consistently available. A formal work plan, timeline and budget that address defined responsibilities and long-term funding needs should be developed as part of the initial planning process for prevention programs (7). Sustainability is also promoted by ensuring that prevention programs meet needs identified by the community and involve active participation of a diverse range of stakeholders (20).

## **3. Understanding and Involving Young People**

As emphasized earlier, youth are a major focus of prevention efforts related to injection drug use. Further to this, active involvement of youth is a foundational recommendation in this strategic planning framework (See Recommendation F-4). The psychosocial development of youth and youth perceptions of substance use are also important to understanding and involving young people in prevention planning and programming.

### *Psychosocial Development*

Late childhood psychosocial development and the stages of adolescent development are important considerations for prevention programming. In late childhood, individuals develop confidence in their ability to learn and become diligent in acquiring new knowledge and skills. Successfully developing this confidence contributes to healthy identity formation as an adolescent. Conversely, when a child's confidence in their abilities is not nurtured, they may feel inferior and develop a low sense of self-esteem and inadequate identity formation (21).

Healthy childhood development contributes to healthy adolescent and adult development. Prevention programs should start as early as preschool (22), enhance family bonding and relationships (23), and attempt to promote social-emotional learning in elementary schools (24) in an effort to promote healthy childhood development. At the middle, junior or senior high school levels, social and academic competence are important risk and protective factors among youth (25). Major life transitions (e.g. move to high school or parents' divorce) can also influence healthy adolescent development and should be given consideration in prevention planning (26, 27).

### *Youth Perceptions of Substance Use*

Achieving credibility is critical to successful prevention efforts aimed at youth. Programs need to be aware of the way in which young people view the benefits and risks associated with substance use. Youth may initiate substance use because of reasons similar to adults, such as stress relief; but there are needs specific to adolescent development that youth may feel are satisfied with the use of substances. These needs include taking risks, demonstrating autonomy and independence, developing distinct values separate from parental or societal authority, signaling entry into a peer group, seeking exciting experiences, and satisfying curiosity. It is important for prevention efforts to acknowledge perceived benefits of substance while working with youth to weigh these perceived benefits against perceived risks in an unbiased, judgment-free way (7).

### *Involve Youth*

Involving youth in prevention efforts facilitates young people to see themselves as their own best resource for preventing and minimizing harmful effects associated with substance use. Youth can participate in data gathering, program planning and implementation, and monitoring and evaluation of prevention initiatives. Doing so enhances the possibility that prevention efforts will be effective (28).

## **4. Creating an Effective Process**

Prevention programming involves a process of partnering, coordinating and planning. Ensuring successful prevention programs are developed through this process requires investment in a few key areas: developing credible messages, combining knowledge and skill development, building on interactive group processes, and giving attention to leader/teacher qualities through training.

### *Credible Messages*

Messages delivered through prevention efforts can be explicit and implicit. It is important that both are considered realistic and credible by the targeted populations. Equally important is the delivery of the messages by credible messengers (7). Implied messages are translated through the structural approach to prevention. For example, excluding youth from prevention planning sends a message that their views are not valuable to the process. Additionally, drug information provided through prevention efforts must be scientifically accurate, objective, non-biased and presented without value judgment. The use of fear-arousing messages accompanied by incorrect or exaggerated information can generate skepticism, disrespect and resistance toward advice on substance use or any other risk behaviour (9).

### *Knowledge and Skill Development*

Knowledge without skills does not provide the foundation individuals need to develop resiliency and other protective factors that prevent substance use. Skill development accompanied by accurate, objective information is therefore a central element for effective prevention programming. Skills such as decision-making, goal setting, stress management, assertiveness, and communication are important, broader life skills that



promote healthy coping for youth. Knowledge shared through prevention efforts should be practical and useful rather than theoretical (29).

### *Interactive Group Process*

Engaging multiple stakeholders, include youth and youth-based organizations, in skill development activities and discussions can contribute to greater effectiveness in prevention programming. Prevention programs demonstrating the greatest effect use an interactive group process that involves peer-to-peer rather than instructor-to-youth activities (30). This type of programming incorporates creative activities such as role-play, simulations, service-learning projects, brainstorming, cooperative learning and peer-led dialogue. The effectiveness of interactive group process is demonstrated across drug types and across cultural groups (7).

### *Leader/Teacher Qualities*

Selecting and training leaders or teachers who are competent, empathetic, and have an ability to engage youth has a direct impact on program effectiveness at the point of delivery. The teacher or leader needs to be accepted and respected by the target group, requiring teachers to be comfortable in a facilitative role. Training can be provided to teachers and leaders to demonstrate and discuss interactive teaching techniques. Alternatively, youth can serve as leaders or co-teachers and contribute to creating an environment appropriate for initiating discussion and exploring sensitive issues related to substance use (7).

## Prevention Recommendations

The following recommendations have been developed from strategic planning, relevant reports and supportive literature. Each recommendation offers specific, concrete strategies for stakeholders to consider. Short-term strategies are those that build upon existing resources and infrastructure, whereas long-term strategies require additional support or funding for implementation.

### Prevention Recommendations

- P-1 Strengthen programs which address the major social determinants leading to injection drug use.
- P-2 Develop a social marketing campaign to reduce stigmatization and discrimination of people living with HIV/AIDS and of injection drug users.
- P-3 Develop school-based prevention program from kindergarten to grade 12
- P-4 Enhance skill and esteem building programs for youth and families.
- P-5 Enhance positive community-based prevention programs for at-risk youth.

### **Recommendation P-1**

Strengthen programs which address the major social determinants leading to injection drug use.

#### **Background**

Drug use is a response to social breakdown, offering users a mirage of escape from adversity and stress. In order to numb the pain of harsh social and economic conditions, users turn to drugs, which in turn further pushes them down the social gradient. Some of the major social determinants that have been associated with IDU include: poverty; inadequate housing; lack of education and/or job training and employment opportunities; child abuse; family violence; involvement in the sex trade (31).

Social and economic circumstances strongly affect an individual's health and life trajectory. The social gradient reflects material, physiological and psychological disadvantages and manifests in the effects of insecurity, anxiety and a lack of social integration. Thus in dealing with drug problems, not only is support and treatment for the user and family needed, it is also essential to tackle the patterns of social deprivation in which the problems are rooted. The social factors that breed drug use must be changed in order for other prevention, harm reduction and treatment services to be effective. The complexities of the social circumstances that generate addictive behaviors such as drug addiction must be targeted. Thus an effective IDU strategy must be supported by the broad framework of social and economic policy. Recognizing and acknowledging these concerns is an important first step in stabilizing the conditions that surround the lives of IDUs. The early identification of these socioeconomic determinants should be an important component of prevention programs.

Some social determinants that have been linked to IDU are:

- *Housing*: A major risk factor for IDU is a lack of affordable and safe housing. The IDU problems in Vancouver in 1995 were strongly associated with needle sharing linked to unstable housing (32). Many IDUs in Saskatchewan are a transient population, moving from city to town to reserve, and do not have safe, affordable and adequate housing (31).
- *Poverty*: There is a high association between people living in poverty and increased risk of IDU and acquiring blood-borne pathogens. This is particularly highlighted in the Aboriginal community (31).
- *Child abuse*: Studies have shown that men and women who use injection drugs often have similar histories including poverty, neglect, sexual and physical abuse and emotional problems (33-35).
- *Sexual abuse*: Survivors of sexual abuse often have the following characteristics: chronic depression, re-victimization (adults who were sexually abused as children are more likely to be abused in their adult relationships), sexual compulsivity, and dependence on substances (36). A study in Vancouver found that a history of sexual abuse was one of the strongest predictors of needle sharing among IDUs (32).

- *Family and Social Environment*: A large number of children are growing up in deprived circumstances or dysfunctional families, where there is poverty, substance abuse by parents, family breakdown and physical, emotional and/or sexual abuse (37). Children coming from these backgrounds are more likely to be involved in deviant behavior in childhood and more likely to develop issues with substance abuse later (38).

### **Suggested strategies for this recommendation:**

#### ***Short-term Strategies***

1. Establish a working group under the prevention pillar with participants representing community, partner agencies and service providers.
2. Develop an IDU social determinants framework to guide planning decisions by collating information (quantitative and qualitative) about the social determinants associated with IDU (e.g. quantitative--proportion of IDUs who are homeless or have inadequate housing; qualitative--types of housing that are available to IDU).
3. Share the IDU social determinants framework with all members of the prevention pillar and then with stakeholders in other pillars.
4. Use the IDU social determinants framework to review programs that address the social determinants of health across all sectors and determine enhancement needs.

#### ***Long-term Strategies***

1. Encourage all stakeholders to review policies, explore strategies and commit resources to address the major social determinants of IDU identified through the IDU social determinants framework.
2. Some strategies to start with and build upon are as follows:
  - *Housing*: Strengthen existing safe, adequate and affordable housing initiatives (e.g. QUINT).
  - *Poverty*: Target families living in poverty and provide them with opportunities for further education and job training (e.g. vocational programs, job skills training, or General Education Diploma education). Support should be provided in both urban and rural areas.
  - *Child/sexual Abuse*: Effectively coordinate and facilitate access to addictions agencies, physicians, mental health and other social services in a case management approach.
  - *Family and Social Environment*: Strengthen programs that enhance family bonding and parenting skills.

**Expected Outcomes**

1. The social determinants of IDU are widely acknowledged amongst all stakeholders and addressed as an encompassing part of an IDU strategy.
2. Programs which address the major social determinants leading to IDU are strengthened and enhanced according to local needs.

**Potential Lead Agency or Partner Agencies**

- CHEP
- City of Saskatoon
- QUINT
- Saskatoon Community Foundation
- Saskatoon Health Region--Public Health Services
- Saskatoon Regional Intersectoral Committee
- Station 20 West
- University of Saskatchewan
- YWCA Crisis Shelter

**Recommendation P-2**

Develop a social marketing campaign to reduce stigmatization and discrimination of people living with HIV/AIDS and of injection drug users.

**Background**

The United Nations Programme on HIV/AIDS (UNAIDS) considers stigma and discrimination associated with HIV and AIDS to be the greatest barriers to the prevention of further infections; the provision of adequate care; and support and treatment (39). HIV/AIDS-related stigma is the devaluation of people living with or associated with HIV/AIDS, while HIV-AIDS discrimination is the unfair and unjust treatment of an individual based on their real or perceived HIV status (39).

In other words, stigma is the marking or labeling of an individual and discrimination is the resulting action or treatment of that individual. Stigmatization and discrimination against IDUs, people living with HIV/AIDS (PLWHA) and HCV positive people is common across all levels of society from within their own families to the community, health care workers and the government. Widespread HIV/AIDS stigma is further compounded by the layering of other stigmas such as the route of infection (e.g. IDU, sex work) and personal characteristics (e.g. ethnicity).

In cases where an injection drug user is HIV and/or HCV positive, the existence of co-stigmas presents as a particular challenge to be addressed (40). HIV positive drug users bear the double stigma of being involved with an illegal activity regarded as morally disdainful as well as having an infectious disease.

In the course of conducting the HIV cluster investigation in the SHR, it became apparent to PHS that there remains significant fear of discrimination and stigma associated with a new HIV diagnosis. The stigma and discrimination stands in the way of people protecting others from being infected with HIV. It also prevents people from coming forward to get tested for HIV. On a global level, this stigma and discrimination has been attributed to propelling the HIV/AIDS epidemic.

Studies across the globe have shown that stigmatization and discrimination is prevalent amongst health care workers and counselors. Medical treatment for HIV positive users can be delayed, refused or inadequate and breaches of confidentiality are common (41). Thus the fear of discrimination by the very system meant to treat and care for these marginalized individuals is a significant barrier to voluntary testing and/or disclosure of drug use. This can result in misdiagnoses or unfavorable drug interactions and is a significant barrier to reducing drug related harm.

Recent research has suggested a positive social function of stigma within the population at large (40). Researchers present stigma as an enduring social process which results in negative outcomes for some individuals but in some circumstances may be a positive driving force at the population level. An example of this is the apparently successful orchestrated stigmatization of smoking (social marketing campaigns) which appears to have reduced the population burden of morbidity and mortality attributed to tobacco.

The IDU Continuum of Care Report recommends that all stakeholders need to support community ownership of drug abuse issues and their participation in change, through the use of age, gender and culturally appropriate and diverse media strategies (following successful campaigns such as tobacco, drinking and driving) (42).

**Suggested strategies for this recommendation:**

***Short-term Strategies***

1. Review current social marketing campaigns about HIV/AIDS, HCV, IDU in the SHR and nationally.
2. Plan a social marketing campaign for the SHR by identifying:
  - a. Target audience (e.g. IDU; healthcare workers; general public).
  - b. Intent of message (e.g. reduce stigmatization and discrimination amongst healthcare workers; reduce fear of voluntary testing and disclosure of drug use amongst IDU). Set clear objectives for each message delivered.
  - c. Appropriateness of message (e.g. age, gender, culture appropriate). Use models appropriate for target audience (e.g. avoid the use of authority figures to target high-risk youth, instead use young models who appeal to them and who they can relate to) (43).
  - d. Available resources in the community and from service providers.
3. Explore the potential for establishing a drug users groups in the SHR to develop a response from the ground up and enable users to advocate for their own needs.
4. Develop educational resources for general distribution, such as pamphlets or information sheets, to raise community awareness about the realities of social determinates of health and their role in contributing to IDU.

***Long-term Strategies***

1. Build upon existing campaigns to include the following elements:
  - a. Promote IDU as an addiction to drugs, a condition with complex physical, social and psychological subtexts; a treatable biomedical and psychological disease. By adopting the stance that drug addiction is often associated with mental illness, it shifts IDU from a moral focus to a health focus (44). This reduces the associated stigmatization and discrimination of IDUs and the illegal status of their activities.
  - b. Constantly promote the ideals that IDUs can recover and have fulfilling lives without drugs, by actively capturing and disseminating stories about successful recovery (e.g. National Drug Awareness Week, local newspaper).
  - c. Efforts should be made to change the perception of HIV and HCV from being fatal diseases, to being chronic diseases. Promote awareness of new developments in HIV/AIDS treatment.

- d. Foster consistent public education which clearly explains HIV transmission risk and its non-discriminatory nature.
  - e. Use positive images of people living with AIDS (PLWA) and encourage and support them to tell their story.
  - f. Use syringes, condoms and other preventive health tools in the context of a social marketing strategy that links behavior change or correct behavioral information to services.
  - g. Support recovering addicts to talk about their life experiences in settings such as talks at schools, interview in local newspaper/radio.
  - h. Use a diverse range of information, education and communication materials (IEC) such as television, radio, newspaper, art exhibitions, printed materials.
2. Develop in-service training for service providers of IDUs in areas such as the underlying social determinants of IDU, principles of harm reduction, and prevention strategies.
  3. Work with policy makers to advocate for stronger and broader policies against stigmatization and discrimination.
  4. Continue a consistent and sustained marketing campaign over time as stigma and discrimination are deeply rooted.

### **Expected Outcomes**

1. Increased access by IDUs to testing and treatment facilities and uptake of harm reduction techniques.
2. Improved HIV contact tracing and partner notification by PHS.
3. Improved quality of services for IDUs by all stakeholders.

### **Potential Leading agency or Partner Agencies**

- AIDS Saskatoon
- City of Saskatoon
- Persons Living with AIDS (PLWA)
- Saskatchewan Health
- Saskatoon City Police
- Saskatoon Health Region—Public Health Services
- Saskatoon Regional Inter-sectoral Committee



### **Recommendation P-3**

Develop a school-based prevention program from kindergarten to grade 12.

#### **Background**

Research demonstrates that early risk factors for drug abuse include aggressive behavior, poor social skills, and academic difficulties (22, 45). In this context, establishing prevention programs that intervene as early as preschool and continue throughout the school years is an important and effective approach for addressing related risk factors at different stages of development (15).

School-based prevention programs generally focus on enhancing skills such as building peer relationships, practicing self control, developing coping skills, practicing drug refusal skills, building appropriate social behaviors, and building peer relationships. Opportunities to enhance such skills are recommended for integration within the school's goal of enhanced academic performance (15).

Effective school-based programs are comprehensive, offer early intervention, project a clear no-use message, employ appropriate strategies for different populations, and implement their program within a broader community-wide prevention effort (46). A school-based drug prevention program includes the educational programs, policies, procedures and other experiences that contribute to achieving broader health goals of drug use and abuse prevention (47). Components of an effective school-based drug prevention program may include:

- Development and delivery of formal and informal curriculum in health to equip students with information about drugs, the life skills required to deal with situations without resorting to drug use, the skills to resist pressure to use drugs, and an understanding of what drugs are.
- Promotion of a safe and healthy school environment.
- Clearly communicated policies and procedures that provide care, counseling and support for all students and promotes a cooperative partnership between students, staff, parents, related professionals, agencies and the police, thus facilitating a safe and supportive school environment.
- Strategies to ensure that all members of the school community contribute to and support school policies and procedures relating to drug matters.
- Professional development and training for staff involved in drug education and school policy enforcement.
- Provision of appropriate health services and support for students, including appropriate information and support for parents, particularly those with children involved in drug use.
- Involvement of family and the community in the planning and delivery of programs.
- Continuous monitoring and evaluation of the school's approach to drug abuse prevention and the management of drug use incidents.

Drug prevention curricula based on the Social Influence Model (SIM) has shown to be the most promising prevention approach to date in changing student drug-use attitudes and behavior (46). This model is based on the premise that youth who abuse drugs do so in response to social pressures from peers, family, and the media, as well as from internal pressures such as the desire to be 'cool' and popular. Programs based on the SIM model provide information on the health and social consequences of drug abuse as well as life skills and resistance training to arm students with the skills to resist pressures to use. In particular, peer-led prevention programs are demonstrated to be highly effective.

In the SHR, only two service agencies (The Saskatoon Public School Division and the Regional Intersectoral Committee on Human Services) report involvement in universal primary prevention activities, mainly in the form of health education in selected schools (48). Public health nurses visit schools in the SHR to discuss tobacco and alcohol prevention; however, they often do not discuss details about illicit drugs due to limited space in the school health curriculum. Some public health nurses reported that they have little experience with teaching about some of the illicit drugs or about injection drug use among youth.

Participants at the Stakeholders Meeting in October, 2005 supported the development of an integrated, kindergarten to grade 12 school-based prevention program. Stakeholders indicated that the program should include active parental involvement and the use of facilitators with life experience (recovering drug users). Suggestions of issues to include a school-based curriculum included:

- Health risks associated with injection drug use.
- Social influences related to initiation of injection drug use.
- Programming with positive role models.
- Skill building and resistance training.

### **Suggested strategies for this recommendation:**

#### ***Short-term Strategies***

1. Review current school-based drug prevention curriculum, teaching resources and school drug policies in order to identify areas of strength and areas requiring enhancement.
2. Review models of successful school-based drug prevention programs and principles. The following reports are suggested as a starting point:
  - a. Alcohol and drug prevention programs for youth: What works? (6).
  - b. Schools: School based education for drug abuse prevention (47).
  - c. Preventing drug use among children and adolescents: A research-based guide (15).
  - d. SAMHSA Model Programs: Matrix of model programs at a glance ([www.modelprograms.samhsa.gov/matrix\\_all.cfm](http://www.modelprograms.samhsa.gov/matrix_all.cfm)).

3. Explore the possibility of linking school-based drug prevention programming to HIV/AIDS awareness programs which are mandated by Saskatchewan Learning.

### **Long-term Strategies**

1. In collaboration with Saskatchewan Learning, develop a suitable school-based education program model for kindergarten to grade 12 for schools in SHR.
2. Develop and incorporate a monitoring and evaluation component to assess impact and effectiveness of the school-based education program.
3. Particular areas of focus for each school level could include:
  - a. *Kindergarten level:* develop prevention programs with a focus on risk factors for drug abuse such as aggressive behavior, poor social skills, and academic difficulties (22).
  - b. *Elementary School level:* develop programs with a focus on improving academic and social-emotional learning to address risk factors for drug abuse, such as early aggression, academic failure, and school dropout. Skills to be emphasized include: self-control, emotional awareness, communication, social problem-solving and academic support particularly in reading (49). A key area to be addressed in this age group is reading ability, as evidence shows that the inability to read by the third or fourth grade is a major risk factor for school failure, which in turn is strongly associated with drug abuse (50).
  - c. *Middle/Junior High and High School level:* develop programs with a focus on increasing academic and social competence. Skills to be emphasized include: communication, self-efficacy and assertiveness, peer relationships study habits and academic support, drug resistance skills, reinforcement of anti-drug attitudes, and strengthening of personal commitments against drug abuse (25, 51).
4. Prevention planning efforts should particularly focus on fostering self-esteem in the 7-12 year old age group as non-injection drug use often commences between 10 and 14 years of age, with users moving onto IDU between the ages of 15 and 19 (52). Prevention efforts should also target key risk periods for drug abuse during major physical and social transition periods (e.g. puberty, moving, divorce, entry into elementary/middle/high school, or leaving home (15)).
5. Build interactive and peer-led techniques into program delivery. Meta-analysis studies have shown interactive techniques such as peer discussion groups and parent role-playing to be far superior to non-interactive methods (51).
6. Provide professional development for teachers and public health nurses in IDU and other related substance abuse issues.
7. Advocate for a uniform policy in the SHR on substance use and possession on school property.

### **Expected Outcomes**

1. A research-based school-prevention program model is developed for schools in SHR from kindergarten to grade 12. This would include teacher training, school drug policy, community partnership.
2. Youth and children in the SHR have consistent access to reliable information about the risks of drug use.
3. Drug use among youth and children in the SHR decreases, as demonstrated by ongoing research and evaluation of strategies employed.

### **Potential Lead Agency or Partner Agencies**

- Communities for Children
- EGADZ Youth Centre
- Greater Saskatoon Catholic Schools
- Royal Canadian Mounted Police—Drug Awareness
- Saskatchewan Health
- Saskatoon Health Region—Public Health Services
- Saskatoon Indian & Métis Friendship Centre
- Saskatoon Public Schools
- Saskatoon Regional Intersectoral Committee
- Saskatoon Tribal Council
- White Buffalo Youth Lodge

#### **Recommendation P-4**

Enhance skill and esteem building programs for families.

#### **Background**

Early childhood development within the family environment is considered one of the most crucial influential factors affecting behaviour later in life. A variety of factors can impede family bonding and interfere with the sense of security required for normal healthy development. Early risk factors associated with drug abuse in the family domain include (15):

- Lack of mutual attachment and nurturing by parents or caregivers.
- Ineffective parenting.
- Chaotic home environments.
- Lack of a significant relationship with a caring adult.
- A caregiver who abuses substances, suffers from mental illness, or engages in criminal behavior.

Conversely, families can serve a protective function against drug abuse when families (15):

- Can create strong bonds between children and their families.
- Can support active parental involvement in a child's life.
- Offer supportive parenting that meets financial, emotional, cognitive, and social needs.
- Can set clear limits and consistent enforcement of discipline.

Critical developmental periods may heighten the role of risk or protective factors. For example, mutual attachment and bonding between parents and children occurs during the developmental stages of infancy and early childhood. If it does not occur during this period, strong positive attachments are unlikely to develop later in life. Prevention programs must therefore capitalize on these critical periods to solidify the bond between parents and their children by offering family-based programs.

The enhancement of social and personal skills for families within a supportive environment can strongly influence attitudes and promote behaviors that are consistent with a healthy lifestyle. Family-based prevention efforts may include a focus on providing support for the development of (15):

- Family communication skills.
- Developmentally appropriate discipline styles.
- Firm and consistent rule enforcement.
- Other family management skills.
- Emotional, social, cognitive and material support.

## **Suggested strategies for this recommendation:**

### ***Short-term Strategies***

1. Conduct an environmental scan of existing family and parenting programs in Saskatoon to identify strengths and areas for enhancement, with emphasis on meeting the needs of high-risk families or families experiencing crisis.
2. Review the universal family-based program *Strengthening Families Program for Parents and Youth 10-14* and determine its applicability for Saskatoon. This program has demonstrated positive results and has been successfully replicated across different ethnic subgroups in both urban and rural settings (53).
3. Strengthen partnerships with local schools, day cares, play schools, churches and health agencies as venues for the dissemination of information and the provision of education about substance abuse to parents of young children.

### ***Long-term strategies:***

1. Based on the results of the environmental scan, develop a suitable and sustainable family-based program model for Saskatoon.
2. Ensure that the family-based program includes a monitoring and evaluation component to assess impact and effectiveness.
3. Components of the family-based program could include:
  - a. Intensive support to substance abusing parents to improve their parenting skills and substance abusing behavior.
  - b. Youth and family recreation programs with activities that involve the whole family (54). An emphasis should be made on family bonding through providing opportunities for joint parent-child participation in activities (55). Some programs have used incentives such as meals, transportation, small gifts, and sponsoring family outings, due to the difficult nature of retaining family involvement (56).
  - c. Selective prevention to target programs at particular high risk groups (e.g. families coping with poverty, children of known drug users) that are implemented by those who have experienced the same challenges.
  - d. Adequate and ongoing support to youth who drop out of school to help them complete their education and find meaningful employment.
  - e. Efforts to ensure families are safe places through addressing issues such as domestic abuse, parenting support, and early learning and childcare. Programs should offer: parenting skills; practice in developing, discussing and enforcing family policies on substance abuse; as well as training in drug education and information (54).
  - f. Efforts to improve family communication through interactive techniques such as modeling, role-playing, and rehearsal (55).

- g. Efforts to strengthen family bonding through skills training on parent supportiveness of children, parent-child communication, and parental involvement (57).
- h. Efforts to enhance parents' monitoring and supervision skills through training on rule-setting, techniques for monitoring activities, praise for appropriate behavior and moderate, and consistent discipline that enforces family rules (57).
- i. A skill building approach that supports the development of positive identity and enhanced self-esteem with elements such as: skills to build a healthy lifestyle, tools for anger and stress management, and assertiveness skills (15).
- j. Informational sessions in various formats such as mini-workshops, creative exercise, art therapy, psycho-drama, individual counseling, group work and family therapy in a variety of venues (15).
- k. Efforts to incorporate culturally appropriate teachings about traditional skills, practices, and ceremonies (58).

### **Expected Outcomes**

1. A research-based family prevention program model is developed for Saskatoon that is built upon existing initiatives.
2. Families in the SHR have consistent access to the information and services they need to build effective parenting skills and create healthy family living environments.

### **Potential Lead Agency or Partner Agencies**

- Communities for Children
- Family Healing Circle Lodge
- Project Hope
- Saskatoon Health Region—Public Health Services (Parenting Program)
- Saskatoon Tribal Council
- Teen Challenge Saskatchewan

## **Recommendation P-5**

Enhance positive community-based prevention programs for at-risk youth.

### **Background**

At-risk youth are those likely to experience drug use, truancy, school problems or violence during their childhood or adolescence. By adolescence, children's attitudes and behaviors are well established and not easily changed. Prevention efforts must therefore start early because delaying intervention until adolescence may make it more difficult to overcome risks.

Research highlights that key risk periods for drug abuse occur during major transitions in children's lives. For example, risk periods may include times when youth experience changes in physical development or in social situations (e.g. parents divorcing, moving, or entering high school). These transition periods represent times of heightened vulnerability for the initiation of high-risk behaviors, including initiation into drug use (15).

Positive community-based prevention programs have been shown to be highly successful in reinforcing the value of youth in the community. It is essential to explore ways of reaching youth who have dropped out of school, lack adequate and positive adult supervision and who do not have access to positive community activities. Positive community-based prevention programs can support at-risk youth to develop personal and social skills that are inconsistent with substance abuse.

A number of service providers in the SHR (Street Health Program, AIDS Saskatoon, Egadz, and Saskatoon Gay and Lesbian Health Services) provide health education to individuals and groups with identifiable risk factors that predispose them to problematic substance use. Their experiences and programs should be used as the basis for enhancing positive community-based prevention programs for this population.

### **Suggestions of ways to approach recommendation:**

#### ***Short-term Strategies***

1. Review existing programs for at-risk youth in Saskatoon and identify strengths and areas for further enhancement.
2. Review Canadian programs for at-risk youth and determine applicability to Saskatoon.
3. Strengthen existing programs such as Saskatoon Community Youth Arts Programming (SCYAP), Core Neighborhood Youth Co-op (CNYC), Saskatchewan Native Theatre Company, and after school activities (sports, drama, arts and music).
4. Combine efforts with the recommendation on school-based prevention programs (recommendation P-4) to target the general school population at key transition points. Such interventions do not single out high risk populations and hence reduce discrimination and stigmatization of at-risk youth and promote bonding to school and community (26).



5. Enhance street outreach programs designed to prevent at-risk youth who are currently using drugs from moving onto more harmful drugs or drug use methods.

### ***Long-term Strategies***

1. Enhance youth recreational activities by offering positive community spaces to at-risk youth to provide a sense of belonging, support system, mentorship opportunities, and other healthy, fun and meaningful activities.
2. Program peer-led interventions (59) into the development of alternative programs (60).
3. Advocate for the delivery of prevention programs by a trusted leader and/or former IDUs, whom youth respect, in a mentored and supported environment (61).
4. Diversify implementation of prevention programs to reach at-risk youth through multiple channels such as schools, clubs, faith-based organizations and the media. Prevention messages should be consistent across all settings to reinforce objectives and influence peer norms (62).
5. Explore a combination of network, peer-driven and individual approaches to changing behaviors within peer groups amongst at-risk youth (63).
6. Offer alternative events that focus on building a culture of peer norms against the use of alcohol and illicit drugs (63).
7. Enhance and expand initiatives that create vocational or skills training for youth, such as those currently offered by the Core Neighborhood Youth Co-op and the Saskatoon Community Youth Arts Program.
8. Ensure that the role of adults participating in youth-based community development is of affirming the work done by youth. Adult volunteers can be a positive presence for youth, letting them know that there are adults in the community who care about them and are willing to contribute their time and energy (61).
9. Adopt an empowerment model in prevention programming to focus on youth strengths rather than deficits. Such an approach also promotes collaborative prevention efforts and fosters capacity and skill development among both youth and their communities.

### **Expected Outcomes**

1. Opportunities for youth to become actively involved in alternative activities within the SHR grow, as demonstrated by the enhanced capacity and youth participation in programs such as SCYAP or the CNYC.
2. At-risk youth will be channeled into more positive community pursuits and have a greater sense of belonging in the community.
3. Drug use among youth and children in the SHR decreases, as demonstrated by ongoing research and evaluation of strategies employed.

**Potential Lead Agency or Partner Agencies**

- Communities for Children
- Core Neighborhood Youth Coop
- Greater Saskatoon Catholic Schools
- Saskatoon Community Youth Arts Program
- Saskatoon Health Region—Public Health Services (Healthy Growth & Development)
- Saskatoon Public Schools
- White Buffalo Youth Lodge





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