3.1 Prevention of drug use

Drug prevention programmes involving mass social marketing and school-based interventions focused on the deterrence paradigm are not efficient in reducing levels of drug use. More efficient drug-prevention initiatives include community-based interventions that seek to address the underlying socio-economic causes for drug use, and peer-based interventions.

Why is effective drug prevention important?

Drug use is a widespread global phenomenon. While drug use occurs among diverse subpopulations, young people consistently report higher than average levels of drug use compared with other subpopulations. Data suggest that young people most often initiate cannabis use, and a minority of young people who use drugs also report using a variety of other illicit substances, including methamphetamine, cocaine, and heroin, among others.

Drug use may lead to a number of prevent health consequences, including the transmission of blood-borne infections such as hepatitis B and C and HIV through use of non-sterile injection equipment, death from overdose, and exacerbation of existing psychiatric or physical illnesses. Given the potential for the manifestation of such health harms, a key objective of international and national drug control strategies is focused on the prevention of drug use.

Drug prevention is codified within the mandate of the UNODC. However, despite a consistent allocation of substantial government resources towards drug-prevention interventions, available evidence indicates that the rates of drug use among young people remain at high levels, and are largely unaffected by the prevention approaches tried so far. It is therefore necessary to move away from ineffective drug-prevention interventions, and focus on those interventions that have had more positive outcomes on levels of drug use and reducing harms.

The effectiveness of current prevention approaches

As explained in detail in Chapter 2 of the Guide, most national drug policies have traditionally been guided by the principle of deterrence – the belief that tough law enforcement and severe sanctions against people who grow and use drugs will reduce drug production and use.
prevention have been based on the same principle of deterrence, which assumes that people who use drugs will stop consuming drugs if they are told about the negative effects of use and the penalties they risk by using them.

As demonstrated throughout this Guide, there is no evidence that suggests that drug policies based on deterrence have resulted in a reduction in the initiation of drug use among young people, or in a reduction in the production of crops destined for the illicit drug market. A similar observation can be made in terms of drug prevention, although some prevention approaches have been shown to be more promising than others.

**Ineffective prevention approaches**

Despite their popularity with politicians wishing to ‘send a tough message’ about the risks of drug use, mass social marketing interventions and school-based prevention programmes have been expensive and ineffective in reducing drug use among the population groups they sought to target, and may even have negative effects on the prevalence of drug use. Evidence suggests that such prevention approaches should be avoided.

**Social marketing interventions**

One of the most popular approaches to preventing drug use among young people is the implementation of social marketing campaigns. These campaigns can take a variety of forms, although they most commonly feature the dissemination of anti-drug public service announcements via the television and radio. Recently, however, social marketing campaigns have expanded in scope to take advantage of new media. For example, internet-based videos and web pages devoted to conveying anti-drug messages have become an increasingly important and sophisticated aspect of prevention interventions.

The vast majority of social marketing interventions, including anti-drug public service announcements, are based on social cognitive theory and its derivations, including the theory of reasoned action, and the theory of planned behaviour, all of which are based on a specific contiguous relationship between intention and behaviour.

The bulk of scientific research on drug prevention conducted to date has focused on social marketing and school-based approaches. With respect to social marketing, a recent systematic review of all scientific evaluations of anti-drug public service announcements found that these interventions had been largely ineffective, and may in fact encourage drug use (see Box 1).

**Box 1. The National Institute on Drug Abuse’s anti-drug social marketing campaign**

An evaluation commissioned by the United States’ National Institute on Drug Abuse (NIDA) on a national anti-drug social marketing campaign that has cost US$1.3 billion since 1998, found that:

- this campaign had no effect on young people who had already started using cannabis
- higher exposure to the campaign may have significantly increased the rate of initiation of drug use among targeted young people
- the campaign may have weakened the perception of anti-cannabis norms among targeted young people
• while other favourable and unfavourable changes in drug-using behaviour were observed among targeted young people, there was no indication that the campaign itself was responsible for these changes.15

While the United States’ Office of National Drug Control Policy disputed these findings, a United States Government Accountability Office audit declared the initial evaluation sound.16

**School-based prevention interventions**

School-based anti-drug interventions have been evaluated extensively, particularly in the USA, since at least the 1970s,17 though their inclusion in the education system of the USA dates back as far as the 19th century, according to some researchers.18 The most popular of such prevention interventions is no doubt the Drug Abuse Resistance Education programme, commonly known as DARE (see Box 2).

**Box 2. Drug Abuse Resistance Education and the ineffectiveness of school-based prevention**

Drug Abuse Resistance Education, also known as DARE, was introduced in 1983 and is the largest of the school-based programmes, now operating in over 75% of all American school districts, as well as in 43 countries internationally.19 DARE and similar school-based interventions are based on the gateway theory of drug use, which claims that the use of drugs such as alcohol, tobacco or cannabis predicts the subsequent use of ‘harder’ drugs such as heroin, cocaine and amphetamines,20 as well as on theories of self-efficacy, which promote the development of interpersonal and social skills that reduce the vulnerability of young people to peer influence for the initiation drug use.21

A number of evaluations investigating the effects of DARE have observed limited effects of the programme in the long term. One 5-year randomised controlled trial, which observed the drug habits of high school seniors exposed to DARE in the seventh grade as compared to a control group, found no significant differences between the DARE-exposed group and the non-exposed group in terms of the frequency, recency and prevalence of use of a variety of drugs after 5 years; the only statistically significant exception was the rate of hallucinogen use in the last 30 days among the DARE-exposed group, which was almost triple that of the non-exposed group.22

Another 6-year DARE randomised controlled trial carried out across 36 elementary schools and 300 high schools found no statistically significant relationship between young people’s drug use and exposure to the DARE programme when measured over the entirety of the 6-year study period.23 Other studies have corroborated these results.24

Finally, multiple meta-analyses of DARE studies have concluded that the programme’s positive effects are negligible or non-existent.25 The fact that DARE is still so widely implemented despite clear evidence of its ineffectiveness is a good illustration that many policy makers are more interested in the symbolism of drug prevention campaigns, rather than their impact.
**Promising prevention approaches**

Although the interventions presented below need to be further evaluated, they do show promising results in terms of drug prevention.

**Community-based interventions**

Community-based prevention programmes often involve a number of stakeholders and multiple components, applied either in sequence or simultaneously. These programmes generally seek not only to change specific behaviours, but have broader goals oriented towards comprehensive community empowerment and change, focusing on strengthening the protective factors (e.g. strong and positive family bonds, success in school performance, good social skills, opportunities for employment, etc) that will reduce the problem of drug use among communities, especially young people. In this sense, they are technically not only drug-prevention programmes but wider social and community-development approaches. This broad set of goals is consistent with the large set of stakeholders needed to implement such a programme. While the makeup of those involved varies between communities, a number of young people and family organisations, media, community groups, schools, law enforcement, faith-based organisations and government are all often involved as stakeholders in many of these programmes. The creation of such coalitions enables the pursuit of community-empowerment goals that seek to create agency among community participants, in contrast to the notion of community members as passive recipients of public health prevention programmes.

Community-based approaches have become increasingly popular to prevent drug use among young people. It should be recalled that, because the interventions are concerned primarily with building skills that can be used towards community empowerment, it is often difficult for evaluators to identify specific outcomes that can be analysed within the usual timeframes allotted for evaluation. Indeed, community empowerment is a long-term outcome that can be difficult to evaluate. Community-based prevention strategies also often include a complex set of components, which will interact to prevent drug use, adding to the complexity of evaluation of these interventions. However, these long-term programmes have shown encouraging results in addressing the risk factors that lead to drug use, and strengthening the protective factors that reduce the risks of use within a community.

One example of a community-based programme in the UK is discussed in **Box 3**.

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**Box 3. The Positive Futures programme in the UK**

One example of a community-based intervention targeting broad socio-environmental factors is the Positive Futures programme, which was implemented in the UK by Sport England, The Youth Justice Board and the United Kingdom Anti-Drugs Co-ordination Unit in 2000. This programme utilised sport and other activities to engage with young people aged 10–19 years, identified as at risk of initiating drug use.

An evaluation of Positive Futures reported that young people enrolled in the programme reported improved social relations, higher educational performance, and higher levels of employment. The Positive Futures programmes have been widely expanded and welcomed in many UK communities, and are popular with participants and politicians alike. However, despite broadly positive qualitative evaluations, no statistical analyses have been conducted about the programmes’ outcomes, and little is therefore known regarding the mechanism of change, and the effect of the intervention was never quantified. For instance, no data on the effect of Positive Futures on patterns of drug use among young people have yet been reported.
**Peer-based interventions**

Peer-based prevention interventions seek to engage directly with affected community members in order to connect with marginalised individuals at risk of drug use. While peer-based components have become increasingly integrated into social marketing preventive interventions through social networking, stand-alone peer-based preventive interventions are nevertheless present in a number of different settings. All peer-based preventive interventions involve engaging members of a specific group (‘peers’) to act as educators. In principle, peers simply need to belong to the same group in order to act as, and be perceived as, peer educators. In practice, peer educators can be co-workers, schoolmates, team-mates, or people who use drugs within a drug-using network, among others. Peer-based approaches are often perceived to have an increased capacity to convey preventive messages to otherwise hard-to-reach groups. To date, little scientific research has been undertaken on peer-based drug prevention.

The small number of evaluations of peer-based interventions for drug prevention may partly be a result of the fact that, similar to community-based preventive interventions, peer-based interventions often have outcomes such as information delivery or increases in general self-confidence that do not necessarily constitute the primary objective of drug prevention. Further, evaluations of peer-based preventive interventions undertaken among people who use drugs have typically focused on interventions for the prevention of drug-related harm rather than preventing drug use itself. Despite the limited evidence base, research has indicated that peer-based interventions may be successful in reducing rates of drug use (see Box 4).

**Box 4. A peer-based intervention programme among young Thai amphetamine users**

There has been a proliferation of amphetamine use in Thailand since the 1990s, particularly among young people. Simultaneously, risky sexual behaviours among this population group have increased. A randomised behaviour trial study was conducted to evaluate the effects of a peer network intervention and a life-skills intervention on methamphetamine and HIV risk behaviours among 18–25 year olds in Chiang Mai, Thailand. The study found that a peer-educator, network-oriented intervention was associated with reductions in methamphetamine use, increased condom use and reductions in incident STIs. The study concluded that small group interventions were an effective means of reducing methamphetamine use and sexual risk among Thai younger generations.

**Conclusions**

Despite the availability of a variety of preventive interventions implemented so far, rates of drug use (i.e. cannabis, cocaine, heroin and amphetamines) have remained steady or increased in major markets across the world, and do not seem to have been influenced by the drug-prevention campaigns implemented by governments. This may be the result of a primary focus on fear and deterrence for drug prevention, as is the case for most drug control policies focusing on harsh law enforcement and severe punishment mechanisms. This has led to a preference for prevention approaches that do not have a resonance with young people’s lived experience, and that do not target the factors that mostly impact on individuals’ decisions around drug use – fashion, peer pressure, emotional welfare and social and community equality and cohesion.

Evidence demonstrates that mass social marketing campaigns and school-based programmes seeking to sensitise the population and young people about the harms caused by drugs have been ineffective in reducing drug use or raising the age of initiation to drug use. Some studies have even shown that such prevention programmes could, on the contrary, increase the prevalence of drug use among the target population group, by raising awareness or curiosity around particular drugs.
Studies analysing the effects of community-based interventions or peer-based prevention programmes have shown more optimistic results, although more research is needed to truly assess the impact of these interventions on the prevalence of drug use.

**Recommendations**

A re-oriented drug-prevention paradigm should prioritise the following drug-related outcomes:

1) drug-prevention interventions should both identify the underlying social causes of drug use and work to address them through health and socio-economic programmes, in particular through community-based prevention intervention programmes

2) drug prevention interventions should prioritise education and information provision through peer-based programmes

3) governments should explore new drug-prevention programmes based on evidence.

4) implementation plans for drug-prevention interventions should systematically include scientific evaluation of process and outcomes, in order to measure the effectiveness of drug-prevention programmes.

**Key resources**


**Endnotes**


