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Drug Education Best Practice for Health, Community and Youth Workers: A Practical and Accessible Tool-Kit

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Drug education best practice for health, community and youth workers: A practical and accessible tool-kit

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Abstract

Objectives: Drug education is delivered by a broad spectrum of multi-disciplinary practitioners within the fields of health promotion, drug prevention and treatment, social care, and community and youth work. However, drug education is often misunderstood or conflated with drug information and/or drug prevention. This ambiguity of understanding is problematic and, when coupled with drug education being delivered by practitioners who may not have formal training in drug education, can result in poor delivery, poor participant engagement and poor outcomes. This paper provides conceptual clarity for practitioners on drug education, differentiating it from other approaches to drug issues.

Methods: The paper draws from a selection of international literature on drug education best practice to simplify and make this information available for the use by practitioners.

Results: International best practice quality standards on drug education, suitable for use in community and youth settings are identified.

Conclusion: The paper offers support to health, community and youth workers by providing best practice guidance on drug education with children, young people and adults.

Keywords

Best practice, drug education, drug prevention, guidance, practitioners

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Introduction

Drug education is implemented by a broad spectrum of multi-disciplinary practitioners within the fields of health promotion, drug prevention and treatment, social care, and community and youth work. While drug education has a long history (Bosworth and Sloboda, 2015), it is often confused with drug information and/or drug prevention (Darcy, 2018). Those working in youth and community contexts are often unclear about the difference between drug education and drug prevention (O'Reilly, 2019), and others are unclear about 'what works' in drug education (Warren, 2016: 7). This is not helped by the fact that the two terms are sometimes used interchangeably within the literature (Kiely and Egan, 2000). The issue is compounded by best practice manuals for drug education and drug prevention that are overly complex, filled with jargon and hard to operationalise by the average practitioner. In an evaluation of one best practice manual for drug education, respondents found the language within the manual 'too wordy' and difficult (Mannix-McNamara and Moynihan, 2013: 13). Thus, the purpose of this paper is to help fill an identified gap (O'Reilly, 2019) and provide clarity for health, community and youth workers on drug education and practical guidance, in an accessible format, on how to develop and deliver drug education programmes for/in community and youth settings.

Drug education and drug prevention – what is the difference?

The confusion between drug education and drug prevention (O'Reilly, 2019) is unsurprising, given drug prevention has become an umbrella term used to encompass a broad range of activities, strategies, interventions and programmes (European Monitoring Centre for Drugs and Drug Addiction [EMCDDA], 2017; Scott et al., 2009). It is possible to find examples where the term prevention is used to refer to drug education programmes (EMCDDA, 2017; Faggiano et al., 2014). However, the meanings, functions and practices of drug education and drug prevention are quite different (Darcy, 2020). It between drug education and drug prevention is important as it can help reduce the use of inappropriate and ineffective responses to drug issues. It also allows for appropriate measurement of a programme's effectiveness (O'Reilly, 2019).

The history and evolution of drug education and drug prevention in the West are outlined elsewhere (see Bosworth and Sloboda, 2015; Faupel et al., 2014; Midford, 2000). However, throughout the evolution of drug education and prevention, a fundamental conceptual problem continues to arise, that is, the blending together of drug education with drug prevention (Darcy, 2018, 2020). There are examples of evaluations of drug education programmes, which demonstrate they were ineffective in drug prevention (Faggiano et al., 2014; Gorman, 1998; Midford, 2000; United Nations Educational, Scientific and Cultural Organization [UNESCO], 1995). This is unsurprising if evaluations are conceptually blurred, set against unrealistic expectations and evaluated against incorrect criteria. In many local and regional contexts, drug education has been subsumed within drug prevention. This is problematic from conceptual and practice standpoints. Drug prevention is typically concerned with interventions (EMCDDA, 2017). The word 'intervention' derives from the Latin *intervenire*, which means to come between or interrupt. Interventions are well placed within a prevention framework, which seek to interrupt a pattern of drug use. However, drug education does not have to have an intended prevention outcome (Darcy, 2020) and so applying the term intervention to drug education can cause confusion. Drug education is best understood as a programme that includes knowledge and activities with a particular *learning* aim. The aim of a drug education programme may be to bring about *new understanding* about particular drugs or increase knowledge and understanding of drug-related harms within a population. The aim of drug prevention on the contrary may be to bring about behaviour change within a population (EMCDDA, 2013, 2017 by). In this case, the effectiveness of a drug prevention programme is measured whether

it brought about the intended behaviour change (e.g. 'reduced drug use') (EMCDDA, 2013: 32). However, drug prevention may also take place in situations by where there is no current drug use but a risk of drug use; in these cases, there is no behaviour to change, but rather future possible behaviour to prevent. When drug education is subsumed within drug prevention and its effectiveness measured behaviour change, this becomes problematic, as the programme will no doubt be deemed ineffective because it will fail to bring about any behaviour change (Almeida et al., 2017). Rather, drug education should be measured using educational frameworks (O'Reilly, 2019). From this standpoint, it is vitally important that drug education be differentiated from drug prevention and measured appropriately (O'Reilly, 2019).

Throughout this paper, drug education is understood as 'a systematic process of teaching and learning that involves imparting and acquiring knowledge about drugs to achieve understanding' (Darcy, 2020: 5). The purpose of this process is to help the programme participant to navigate their social worlds more safely, especially in contexts where drug use can occur (Darcy, 2020). It is essential that drug education is developmentally appropriate and that it has clear and achievable learning outcomes. It is important to stress that learning outcomes for a drug education programme should not seek to prevent, delay or reduce drug use. These are the aims of drug prevention, which is understood as 'planned interventions that work to prevent or delay the onset of drug use' by individuals or groups (Darcy, 2020). Drug prevention can include programmes that work to help participants to stop their drug use and/or that aim to reduce the harms of drug use (Darcy, 2020). Furthermore, drug prevention is not always about drugs; it can take a broader and more holistic approach. A drug prevention programme may focus on external factors, such as sociocultural, environmental and/or familial contexts that influence drug use (Darcy, 2020).

Drug information, in contrast, is understood as just that, information about drugs provided in films, leaflets, posters, booklets, factsheets, handouts and/or awareness campaigns. It is important to stress two things: (1) drug information is not the same as drug education (Drug and Alcohol Research and Training Australia [DARTA], 2015) and (2) giving information alone does not lead to behaviour change (Almeida et al., 2017; Cahill, 2003). Harm reduction is another term that is often placed under the umbrella of drug prevention and refers to interventions that seek to lessen the harms of drug use on individuals, communities and societies (EMCDDA, 2017). The purpose of distinguishing and detangling the terms drug education and drug prevention is not to say they are mutually exclusive. Rather, the goal is to provide conceptual clarity to aid with forming aims and outcomes for programmes that can be appropriately and correctly measured and evaluated within youth and community contexts. Drug education and drug prevention while different, are complementary and, where appropriate and feasible, should be used concurrently. They each form part of a holistic approach to tackling drug use issues and problems. However, there should be clearly demarcated aims, objectives and intended outcomes for each relevant component.

Reist (2009) has highlighted how drug education has 'suffered from a lack of clear goals' (p. 4). Thus, the drug education component of a programme should have a clearly stated educational aim and an educational tool for measurement, while the prevention component of a programme can have a preventive aim and a preventive measurement tool.

Drug education and best practice standards

While there exists considerable guidance on best practice for drug education and drug prevention programmes (e.g. Drug Education Workers Forum (DEWF), 2007; EMCDDA, 2010, 2011, n.d.; Scott et al., 2009; United Nations for Office for Drugs and Crime [UNODC], 2015) and important

evidence reviews (EMCDDA, 2015; Faggiano et al., 2014; McBride, 2003; Stead and Angus, 2004), these guiding documents are complex and dense. The fact that practitioners remain unclear about drug education and prevention (O'Reilly, 2019), that ineffective programmes continue to be widely used (Warren, 2016), and that drug education programmes are implemented and evaluated based on prevention outcomes (Faggiano et al., 2014) suggests that best practice guidance documents have not been disseminated to those working on the ground or that they are perhaps inaccessible, impractical and unuseful to some practitioners. There is a need to combine relevant aspects of these documents in a way that is useful for practitioners.

Ineffective approaches and practices to avoid

Bosworth and Sloboda (2015) identify four factors to explain why many interventions (including drug education) aimed at abating drug use and drug problems have been found to be ineffective; these include (1) programmes not having a theoretical base, (2) inadequate programme design, (3) no evidence-base underpinning the programme and (4) programmes being inappropriate for the setting in which they are used. In addition, there exist a number of approaches and practices that previously featured in drug education which are now, based on robust evaluation, widely accepted as being ineffective and inappropriate. These are detailed below in order to help practitioners when designing drug education.

Scare tactics. Trying to scare participants by showing them graphic images or telling them drug-related horror stories or sensationalising and over-playing risks is now widely viewed as ineffective and inappropriate (Department of Education and Science [DES], 2010; DEWF, 2007; UNODC, 2015; UNODC and World Health Organization [WHO], 2018; Utrip and Mentor, 2012). Similarly, prison aversion programmes (such as 'Night Tours') involving young people being brought to police stations or prisons in order to scare them have also been evaluated and found to cause more harm than good (Petrosino et al., 2000; Regional Centre for Healthy Communities [RCHC], 2015). While a young person may have an emotional reaction to a horror story, it does not mean that the young person will change their behaviour (RCHC, 2015).

Testimonials or guest talks. Talks from people who no longer use drugs or who have previous experience of addiction are also to be avoided (DARTA, 2015; DES, 2010; UNODC, 2015; UNODC and WHO, 2018; Utrip and Mentor, 2012). Testimonials and personal accounts of drug use and addiction, while engaging human interest stories and powerful tools in therapeutic contexts (Pienaar and Dilkes-Frayne, 2017), are most often counter-productive, particularly when used with young people (DARTA, 2015; UNODC and WHO, 2018). Young people often come away from such talks remembering details of the events contained in the talk but without relating the stories to their own behaviour or without any reflection on, or intention to take on board, what they have heard (Wakefield, n.d.).

One-off talks and/or assemblies. Talks and/or assemblies featuring experts, such as police or medical professionals, are recognised as being ineffective for the purposes of persuading young people not to take drugs (DARTA, 2015; DES, 2010; Midford, 2000; UNODC, 2015; Utrip and Mentor, 2012). This type of event/activity is ineffective because it involves participants passively listening (which does not equate with understanding or acceptance of what is said) and may fail to consider the needs and interests of the participants (Utrip and Mentor, 2012). Moreover, the guest speaker may not be trained as an educator and as a result may not deliver in a way that is conducive to learning and understanding.

Information-only programmes. Interventions and activities that rely on presenting participants with 'the facts' cannot be understood as being drug education (DARTA, 2015). Programmes relying on information only are to be avoided (DES, 2010; Stead and Angus, 2004; UNODC, 2015; UNODC and WHO, 2018; Utrip and Mentor, 2012). Presenting participants with information does not ensure they will understand it, nor does it mean that participants will accept the information presented to them as being true (Darcy, 2020). Giving information alone to individuals or groups does not lead to clear-cut changes in behaviour (Almeida et al., 2017). Unfortunately, information-only programmes continue to be employed and are often requested by schools in response to a student drug use issue that has emerged (Jones, 2017; Reist, 2009). It is important in such circumstances that the school be made aware of best practice guidelines in relation to this and that they are sign posted to other relevant local services such as community addiction teams, local drug counsellors and youth services.

Lecture-based (didactic approaches). Lecturing participants on the harmful effects of drugs or trying to convince them that drug use is morally wrong is also considered ineffective (DES, 2010; UNODC, 2015; Utrip and Mentor, 2012). Conversely, normalising drug use (e.g. agreeing to statements such as 'everyone smokes weed' or 'everyone tries it') should be avoided (DES, 2010). Using the right language when talking about drug use is very important; this is because the way in which we talk about, describe and understand phenomena, such as drug use, is often value-laden (Dziegielewski and Jacinto, 2016).

Refusal. Programmes that work towards teaching young people how to 'say no to drugs' or that perpetuate the message 'don't do it' have long been recognised as outdated (DES, 2010; UNODC, 2015; Utrip and Mentor, 2012) and ineffective (Wakefield, n.d.). Rather, drug education programmes should focus on equipping children and young people with the necessary social skills so that they can safely traverse situations in which drug use may be occurring (Darcy, 2020).

Effective approaches and practices to adopt

There is a considerable body of literature detailing what works in relation to drug education and prevention (Cahill, 2003; EMCDDA, 2010; Faggiano et al., 2014; Kiely and Egan, 2000; Mentor, 2015; Munton et al., 2014; Stead and Angus, 2004; UNESCO, 1995, 2011, 2015, n.d.; UNODC, 2015; UNODC and WHO, 2018; Warren, 2016). The following approaches and practices are recognised as effective across this body of literature.

Multi-component programmes. Programmes that take a holistic approach to drug education are more likely to be effective than those that focus on one particular set of issues (UNODC, 2015; Warren, 2016). Programmes that include the development of personal and social skills, the development of coping skills and decision-making skills, and resistance skills are to be encouraged (DES, 2010; Mentor, 2017). Young people need guidance in learning how to navigate adolescence and solve problems (UNESCO, 1995). In this way, an effective drug education programme would not only include opportunities for developing new understandings of drugs and drug-related harms but also opportunities to explore how to safely navigate social situations in which drug use occurs. An effective multi-component programme might also include parent programmes, policy activities, media campaigns and/or environmental components (DEWF, 2007; Warren, 2016).

Interactive programmes. These are well recognised as being more effective than passive learning approaches (Mentor, 2015; UNODC, 2015; UNODC and WHO, 2018; Warren, 2016). Programmes

that incorporate active learning and participatory teaching strategies have been identified as having greater intended result (DES, 2010; Mentor, 2015, 2017; Scott et al., 2009). Allowing opportunities for learners to interact with one another through group work and collaborative learning, and facilitating opportunities for discussion and reflection are well-recognised approaches. The more actively involved the participant is in the programme, the more effective that programme is likely to be (Warren, 2016).

Structured programmes. Structured approaches have been established as having better outcomes than programmes that are sporadic and disorganised (Mentor, 2017; UNODC, 2015; UNODC and WHO, 2018). Evidence suggests that effective drug education programmes involve a series of structured sessions, which are then boosted by follow-up sessions, across multiple years (Mentor, 2017). One factor that can impact the effectiveness of a manualised programme is 'implementation fidelity' (Warren, 2016: 27). This is concerned with whether a programme is delivered as intended. Problems can arise when consideration is not given to the impact of a programme in a manual format being changed in order to adapt to cultural or geographic factors (EMCDDA, 2017). In such cases, meanings can be lost and intended outcomes unmet. Just because a response was affective in one location, does not mean it will be affective in another, as the EMCDDA (2017: 161) contends, 'regardless of the evidence that exists to support the use of a response option, it is unlikely to be effective if it is implemented poorly'.

Appropriateness. Age, developmental level and culture need to be considered in the delivery of any drug education programme but especially in relation to programmes for children and young people (Cahill, 2003; DES and National Council for Curriculum and Assessment [NCCA], 1999; James, 2011). Programmes that are not pitched to the appropriate age and developmental level will at the least be ineffective and at the most cause more harm than good. It is never too early to talk to a child or young person about drugs, if the conversation is age appropriate (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). For example, for children under 10 years of age, it is appropriate to talk about staying safe around medicines or potentially harmful substances in the home, such as detergents or other cleaning products (DES and NCCA, 1999). For older children (11 + years), it is appropriate to talk about how medicines and alcohol can be harmful when misused (DES and NCCA, 1999). For children 11–12 years of age, it is appropriate for them to begin understanding that illegal drugs are harmful substances that are prohibited, by law, from being produced, sold or bought (DES and NCCA, 1999).

Drug education programmes aimed at primary school children below the typical age of initiation to drug use (this age can vary by geographic location) should not introduce drugs to them that they do not already know, rather they should focus on supporting 'general personal, emotional and social skills' (UNESCO, 2017: 37). Primary and secondary school drug education programmes should operate within the frameworks and guidelines of national school curricula (DEWF, 2007; Warren, 2016). Drug education programmes for young people should be made relevant to youth culture(s) and 'reflect in real terms the realities and experiences of the target group' (DEWF, 2007: 51).

Risk. An emphasis on risk in relation to drug use should focus on short-term rather than long-term consequences (Mentor, 2017). Over-playing the dangers of drugs can enhance the status of drug-taking for some young people (Cragg, 1994); it also risks framing drug-taking in a way that can be perceived by some as a 'rite of passage' (James, 2011: 8). Drug education programmes should focus on the immediate risks of drug-taking (Mentor, 2017), such as a drug potentially containing contaminants, taking an unknown drug, not knowing the strength of a drug, the immediate effects of drugs and the increased risks when taking more than one drug (Health Service Executive [HSE],

2019). When talking about illegal drugs, it is beneficial to focus on the fact that illegal drugs are made without quality controls (HSE, 2019). Emphasise the reality that when someone buys an illegal drug, they have no way of knowing whether it is the drug they have been told it is (HSE, 2015, 2019). The person using drugs has no way of knowing how strong the drug is or whether it contains other harmful substances (HSE, 2019). A key message to get across to children and young people is that every time someone takes an illegal drug, they are taking a risk. It is important to make children and young people aware that drugs affect everyone differently (Ana Liffey Drug Project, 2010). Just because one person takes a drug and appears 'ok', this does not mean another person will have the same reaction to that drug (Ana Liffey Drug Project, 2010).

Dispelling misconceptions. This is an important component of effective drug education programmes (Mentor, 2017). Dispelling misconceptions adopts a social norm or normative education approach to correcting myth-understandings, challenging commonly held drug myths and providing informed counter-viewpoints (Darcy, 2019).

    While the above guidelines are not intended as being exhaustive, they offer a guide. There may be other factors warranting consideration in relation to ensuring the effectiveness of a drug education programme especially in a youth and community setting.

A caution before beginning programme delivery

While this article offers practitioners best practice guidance on delivering drug education, a specific framework for delivery is not provided. Rather, some general points about delivery are made. It is important to recognise that simply reading this article will not equip a health, community or youth worker with all the necessary skills and proficiencies to deliver drug education programmes (cf. Scott et al., 2009). Much in the same way that someone reading a medical encyclopaedia does not qualify them to give medical advice or diagnose disease, reading a paper on drug education does not qualify someone as a drug educator. Anyone intending on delivering a drug education programme needs appropriate training to do so. What this article provides is some conceptual clarity and best practice guidance to inform and support practitioners before and during programme delivery. This is all the more relevant in situations where training is difficult to access or where there is a lack of standardisation/professionalisation within the field (O'Reilly, 2019). Those who have completed training to deliver drug education programmes should also participate in continuing professional development to keep up-to-date on new developments within drug education. However, in some locations, there may be a significant dearth of training opportunities for those seeking to become drug educators and practitioners have expressed concerns about the 'lack of focus, time and resources' allocated to drug education (O'Reilly, 2019: 10). Therefore, there will be cases where practitioners are tasked with delivering drug education despite adequate training or resources. This is not ideal and should be avoided; however, limited resources and other constraints can often result in a 'needs must' scenario. In such cases, it is hoped this article provides some useful guidance and clarity.

Terminology and preparing for delivery

Throughout this article, the term 'delivery' has been used rather than 'implementation'; however, elsewhere the two terms are often used concurrently (James, 2011). Within the fields of health and drug prevention, the term 'implementation' is generally used and there is a considerable body of scholarship and guides on implementation science (e.g. Burke et al., 2012; Fixsen et al., 2005; Meyers et al., 2012; Nilsen, 2015; Villalobos Dintrans et al., 2019). In education, the term delivery

is more typically used (McSporran and King, 2005). As this article has focused on drug education for youth and community settings, the term delivery is therefore employed.

There are a number of important considerations before the delivery of any drug education programme. Scott et al. (2009) provide a useful list of 'principles related to programme elements, content and delivery' (p. 13). This list includes ensuring the programme is comprehensive, active and skills based, of sufficient quantity and quality, and theory driven. It should also encourage the development of positive relationships, be socio-culturally relevant, be tailored to the needs of the group, be delivered by trained staff, and ensure that that both delivery and impact are evaluated (Scott et al., 2009: 13–15).

The EMCDDA (2011) suggests the first consideration in developing a drug education programme is a 'needs assessment' (p. 36). This can be achieved through a needs analysis, informed by participants and other relevant stakeholders such as parents, guardians, teachers, youth workers and community representatives. A needs analysis might establish the level of drug misinformation within a group, levels of drug knowledge, the types of drug myths believed by participants, or the types of drugs that are, or potentially are, being used.

Once a needs analysis has been completed, an appropriate programme must be identified or developed. If the need identified is drug prevention or harm reduction, then the response must not be limited to drug education (UNESCO, 1995). When developing a drug education programme, it is important to refer back to 'effective approaches to adopt' and ensure that any programme delivered to young people is appropriate and in line with national curriculum frameworks for social, personal, health and well-being education (DES, 2018). In providing a programme to an external organisation, it is important to complete a programme/service agreement, which details the programme being delivered, how it will be implemented and an agreed method of evaluation and outcome measurement (DEWF, 2007). An important question to ask the availing organisation is whether they have a drug policy and to request a copy of this as it will help with the development of your programme (Mentor, 2015). It is important to discuss the ethos of the programme to ensure it aligns with the ethos of the availing organisation (DEWF, 2007).

Once a programme agreement has been completed, programme planning can begin. If the programme has been developed for a particular group, it is advisable to pilot the programme with a small sample of participants and evaluate (Almeida et al., 2017). It is also important to remember when developing an evaluation method or measurement tool for a drug education programme that the focus is on educational outcomes. For example, what have participants learned and how do we know they have learned this? Pre- and post-tests may be used to measure the learning that takes place during a drug education programme (Darcy, 2019). Paper surveys may be systematically administered at the beginning and end of the programme to measure participant's drug knowledge before the programme commences and after completion (Darcy, 2019).

When using programmes or materials developed by others caution should be exercised (Sheehan, 2018). If you are using a training manual developed by someone else, ask yourself, have you been trained to deliver the programme? Some manual-based programmes have been designed to be delivered without any specific training, while others require the completion of training to ensure programme fidelity.

Engaging outside agencies or organisations to provide drug education on your behalf should be done cautiously (DES, 2018). It is essential that external service providers are thoroughly vetted with respect to child protection, conflicts of interests and compatibility of religious ethos and/or ethical standpoints (DES, 2018). When using an external organisation to deliver a drug education programme, ensure that a service-level agreement is in place. There are organisations who provide free drug education and prevention materials and programmes based on ineffective methodologies and which have ulterior motives for providing such services (Sheehan, 2018). When engaging the

services of an external drug education provider or using other people's drug education materials, check whether these adhere to best practice guidelines, and if so, which guidelines? The EMCDDA (n.d.) provides a useful *Best Practice Portal* on their website, with a comprehensive range of resources around delivery, evidence and standards.

Programme delivery

When engaging participants in youth or community settings, it is important that participation is voluntary (Cooper, 2018; Lee, 2003). Drug education programmes that are delivered to children and young people require both consent from parents and guardians, and assent (informed agreement) from the children and young people (DES, 2018). In order to obtain consent and/or assent, participants (and their parents/guardians) must be provided with information in advance about the programme so that they can make an informed decision concerning participation (DES, 2018).

Before the programme begins, it is important to establish boundaries (Newton et al., 2019); this can be achieved by having a working agreement (or contract) with participants. This is especially important for programmes with children and young people (Newton et al., 2019). A working agreement may include being respectful towards other participants, not sharing personal information/ stories, not asking each other questions about personal drug use, not sharing information with other children or young people (who might be too young to understand), respecting different opinions, listening and having fun, and so on.

Children and young people will often ask adults whether they have ever taken a drug (Muller, 1989). It is important to maintain professional boundaries and remember that it is not appropriate for an adult delivering a programme to share personal stories of their own drug use. To do so would be to provide a personal testimony of drug use which as outlined earlier in this paper is ineffective in the context of a drug education programme with children and young people.

Throughout the delivery of the programme, there should be ongoing evaluation and reflection. Once the programme has been completed, a detailed evaluation and review should take place (Scott et al., 2009). In keeping with principles of youth and community development work (Cooper, 2018; Lee, 2003), it is important to acknowledge participant participation. This can be achieved by presenting certificates of completion, or similar, at the end of the programme.

Conclusion

This paper set out to provide best practice guidance for delivering drug education to children, young people and adults in youth and community contexts. The paper drew from a selection of international sources on drug education best practice in order to bring such work together for easy use by practitioners. The paper distinguishes between drug information, drug education, drug prevention and harm reduction to promote conceptual clarity for practitioners. It is hoped that those working in the field find this clarification and the best practice guidance provided useful.

However, the paper offers a guide only; it is not an exhaustive tool for drug educators. Practitioners delivering drug education programmes should ensure they keep up-to-date with advances in the field. The EMCDDA (n.d.) *Best Practice Portal* may be helpful in this respect. International standards for drug use prevention contain a wealth of information and guidance relevant for drug educators (UNODC and WHO, 2018). As previously stated, prevention has become an umbrella term used by others to include drug education. While it has been argued here that prevention and education are separate approaches with different aims, some international standards for drug use prevention contain information relevant to drug educators and so practitioners should familiarise themselves with these.

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