Peer Education:
From Evidence to Practice

An alcohol and other drugs primer

Joanne McDonald, Ann M Roche,
Mitch Durbridge, Natalie Skinner

National Centre for Education and
Training on Addiction

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"AOD peer education
involves sharing and providing information about alcohol and other drugs to individuals or groups.

It occurs through a messenger who is similar to the target group in terms of characteristics such as age, gender or cultural background, has had similar experiences and has sufficient social standing or status within the group to exert influence."

www.nceta.flinders.edu.au

In 1999–2000, the National Centre for Education and Training on Addiction (NCETA) and the Youth Advisory Forum (YAF) jointly conducted a project entitled:

Youth for Youth
A Project to Develop Peer Educator Skills and Resources for Peer Education

The final report of the Youth for Youth project is available on the NCETA website:

www.nceta.flinders.edu.au

This monograph is an extension of the work initiated during the Youth for Youth project. The initial project was funded under the Community Partnerships Initiative of the National Drug Strategy. The writing of the monograph was jointly funded from the initial grant with additional financial support from NCETA. Printing of the monograph was funded by the South Australian Department of Human Services.

Foreword

As we progress further into the 21st Century, it is becoming increasingly apparent that many social problems are escalating. Problematic alcohol and drug use, especially among young people, is one area of considerable concern. Patterns of drug use and their associated problems are becoming more complex and more difficult to manage. This is a problem that is impacting at a global level.

The increasing use of psychoactive substances by younger and younger people is a worrying trend. It is evident that different approaches will be required to address these problems. It is also apparent that there has been insufficient application of good rigorous science to many areas of health care, including the prevention and management of alcohol and other drug problems. It is incumbent upon those with the responsibility in the alcohol and other drugs area to support and encourage the application of evidence-based practice.

This book on Peer Education is an excellent example of how to translate best evidence into meaningful action. What is provided here is a bridge between the researcher and the practitioner. The background literature on drug education generally, and more specifically peer education, is reviewed together with the underpinning theoretical models that support strategies such as peer education. The reader is then provided with a user-friendly guide in ways to implement peer education. Importantly, however, this information is offered with all the appropriate cautions and caveats that should ideally accompany the translation of science into practice. Clearly, this is an area where there is no "one size fits all" solution.

The South Australian Department of Human Services is pleased to support this resource. It is an indication of our commitment to increased knowledge and understanding in this important area of health and social policy.

Dr Tom Stubbs
Executive Director
Metropolitan Health Division
Department of Human Services

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Authors' Biographies

Joanne McDonald is a Project Officer at the National Centre for Education and Training on Addiction (NCETA). Her formal academic background is in psychology. Joanne began working at NCETA in 2000 as Project Officer for the Youth for Youth Project, a peer education project aimed at providing training and resources for peer educators. Since completing the project, she has worked on a range of activities, including organising major events, such as the 2001 and 2002 Workforce Development Symposia, editing and writing publications, and redevelopment and management of the NCETA website.

Ann Roche is Professor and Director of the National Centre for Education and Training on Addiction (NCETA) at Flinders University, Adelaide, Australia. She holds a Masters in Education and a PhD and has over 25 years experience as a researcher, educator, policy analyst, and as a consultant for government and non-government bodies including the World Health Organization. She has published widely in the alcohol and other drugs area including peer-reviewed papers and books on drug education. She is a member of the InterGovernmental Committee on Drugs' (IGCD) National Advisory Committee on School Drug Education.

Mitch Durbridge joined NCETA in April 2002 as a part-time Project Officer to work on this monograph. Prior to that, Mitch worked with the Staff Development and Training Unit at Flinders University as a Project Officer involved in the development, implementation and evaluation of training and professional development programs. Mitch currently works for the Port Adelaide Central Mission as a Community Support Worker, assisting people with mental illness to develop and maintain independent living skills. Mitch holds a Bachelor of Psychology (Honours) and plans to undertake a Masters in Psychology.

Natalie Skinner is a Lecturer at the National Centre for Education and Training on Addiction (NCETA). In 2002, Natalie was awarded her PhD in Psychology from Flinders University titled "The Dynamics of Threat and Challenge Appraisals Prior to Stressful Events". Natalie also has teaching and research interests in the areas of Organisational Psychology, Social Psychology and group processes. In her current position as Lecturer at NCETA she is developing projects on attitudes towards illicit drug users and team-based approaches to evidence-based practice.

Part A

Introduction

Chapter 1
Context and Structure

Context

Problematic AOD use impacts across all age groups but is of particular concern among young people (Bangert-Drowns, 1988; Elliott and Lambourn, 1999; Bleeker, 2001; Spooner et al., 2001), especially high risk groups such as marginalised or homeless youths (Fors and Jarvis, 1995). Recently we have seen an increased prevalence of drug and alcohol use among young people (Higgins et al., 2000). The age of initiation into drug use has been falling (Higgins et al., 2000; Degenhardt et al., 2000), risky patterns of consumption are high (Australian Institute of Health and Welfare, 2002), and many young people possess limited knowledge and skills to recognise and minimise AOD-related harm (Schippers et al., 2001). The costs associated with the problematic use of alcohol and other drugs (AOD) are widely recognised and include the enormous economic, social and personal costs to society (Collins and Lapsley, 2002).

Patterns of AOD use by young people are of particular concern as many life long patterns of behaviour are usually established during adolescence and young adulthood, including AOD use, coping styles, and patterns of responding to stress. Therefore, adolescence and early adulthood are opportune times to prevent, reduce or modify risky behaviours associated with problematic drug use.

While the urgency and seriousness of problematic alcohol and drug use are well recognised (Broadbent, 1994; Bleeker, 2001), responses are often limited to broad media campaigns and traditional school-based education. Yet it is increasingly recognised that neither of these approaches exerts a substantial, consistent or sustainable impact on young people's attitudes and behaviours (Bangert-Drowns, 1988; Coggans, 1997; Bloor et al., 1999). There is evidence to suggest that peer education is an effective strategy to support sustained change in problematic AOD issues among young people (Tobler, 1986; Bangert-Drowns, 1988; Perry and Grant, 1988; Tobler, 1992; Black et al., 1998; Mellanby et al., 2000). This document examines the extent to which peer education offers a viable alternative or complementary strategy to address problematic AOD use among young people.

While the term "peer education" can be applied in a wide range of contexts, this monograph is concerned with peer education about alcohol and other drugs for young

people. Young people are commonly defined as those between age 12 and 25 (Child and Youth Health, n.d.; Office for Youth, n.d.; Youth Substance Abuse Service (YSAS), n.d.) and this is the definition of youth applied here. The term "adult-led" is used in this volume to refer to provision of education about alcohol and other drugs by people other than peers, particularly teachers, parents or health professionals.

Structure

The purpose of this monograph is to provide a comprehensive overview of peer education. The monograph presents and clarifies the meaning of peer education, reasons for using peer education, theories of behaviour change applicable to peer education, and guidelines for the development of peer education initiatives.

The monograph is divided into the following parts:

Part A: Introduction
Part B: Understanding Peer Education
Part C: Guidelines for Conducting a Peer Education Initiative
Part D: Future Directions

Parts B and C form the main body of the monograph. Part B examines the key conceptual, empirical and theoretical issues related to peer education. Part C provides comprehensive guidelines for planning, implementing and evaluating peer education initiatives. Future directions for peer education are considered in Part D. The content of each of these three parts is described in greater detail below.

Part B: Understanding Peer Education

Chapter 2: What is Peer Education?

We begin by exploring the meaning of the term "peer education". The importance of clarifying the meaning of peer education is highlighted and a definition proposed which encapsulates common themes found in the literature. The concept of peer education is further deconstructed by considering the meaning of the terms "peer", "peer educator", and "drug education". The aims of peer education are also examined.

Chapter 3: Why Use Peer Education?

Chapter 3 explores reasons for using peer education. The chapter begins by presenting the case for peer education. Patterns of use among young people and the limitations of adult-led drug education highlight the potential value of peer education. The rationale for peer education is outlined, followed by evidence of the efficacy of peer education.

Chapter 4: Theoretical Models Applicable to Peer Education

This chapter explores various social psychological theories that have been used to explain the mechanisms underlying peer education. Each theory is briefly described, followed by its implications for peer education. The theories discussed include:

- Social Learning Theory
- Social Identity Theory
- Diffusion of Innovation Theory
- Social Comparison Theory
- Cognitive Dissonance Theory
- Health Belief Model
- Theory of Planned Behaviour
- Trans-Theoretical Model of Change.

Part C: Guidelines for Conducting a Peer Education Initiative

Part C provides practical, user-friendly guidelines for the development of effective peer education initiatives. These guidelines are based on four key stages of conducting a peer education initiative: planning, evaluation, preparing peer educators and implementing peer education. Each of these stages is described in separate chapters.

Chapter 5: Planning Peer Education Initiatives

Chapter 5 focuses on the three key tasks involved in planning peer education initiatives. The first is identification of the parameters, needs and characteristics of the target group. The second is development of appropriate aims and goals[1]. A framework for effective goal setting is presented. The third component of planning a peer education initiative is to address administrative issues. This includes developing a budget, seeking support, forming an advisory group, appointing a coordinator and developing systems to enhance retention of staff and peer educators.

Chapter 6: Evaluation

Evaluation is an essential component of peer education that needs to be planned at the outset. Chapter 6 outlines the process of evaluation and provides guidelines to plan and implement an evaluation strategy. Topics covered include the meaning of and reasons for evaluation. Various aspects of evaluation presented include designing an evaluation strategy, understanding evaluation methodology, selecting measurement tools, and interpreting and reporting findings. The chapter also lists some useful references that provide further information about evaluation.

Chapter 7: Selecting, Training and Supporting Peer Educators

This chapter addresses issues concerned with peer educators themselves, including selection, training and support. Selection issues include development of selection criteria and the selection process. Training issues include the setting and length of training, the trainers, pre-training preparation, content and delivery of peer educator training. Strategies for supporting peer educators before, during and after they engage in peer education activities are also included in this chapter.

Chapter 8: Implementing Peer Educator Activities

Chapter 8 is concerned with the activities of peer educators once they have completed peer educator training. Peer education approaches are flexible and adaptable and may range from the highly formal and structured to more informal and dynamic styles of delivery. This chapter presents four sample formats for peer education, namely planned group sessions, dissemination of resources, opportunistic interactions and creative approaches that utilise popular culture. The second half of this chapter provides guidelines for peer educators to follow when planning and preparing to undertake peer education activities.

Part D: Conclusion

Chapter 9: Where To From Here

The concluding chapter outlines potential future directions for peer education. It includes summary recommendations for future peer education initiatives, suggestions for further research into peer education and ideas for development of resources to support the AOD field to implement peer education.

Notes

[1] The terms “aim” and “goal” are often used interchangeably and will be used in this way throughout this monograph.

Part B

Understanding Peer Education

Part B forms the first half of this monograph and is concerned with the key conceptual, empirical and theoretical issues underpinning peer education. It aims to provide the reader with a clear understanding of peer education, what it is and is not, the advantages of doing it and its theoretical underpinnings. The three chapters in this section are:

Chapter 2: What Is Peer Education?
Chapter 3: Why Do Peer Education?
Chapter 4: Theoretical Models Applicable to Peer Education.

Chapter 2
What is Peer Education?

Peer education is widely used, popular and intuitively appealing (Backett-Milburn and Wilson, 2000; Bament, 2001). It is based on the premise that it is possible to harness the naturally occurring influence of peers on young people's knowledge, attitudes and behaviour (Ward et al., 1997; Bailey and Elvin, 1999; Shiner, 1999; Turner and Shepherd, 1999). At the broadest level, peer education can best be conceptualised as learning from one's peers. However, this generic conceptualisation leaves many important questions unanswered, such as:

1. Who is a peer?

    - What are the defining characteristics of peers?
    - What is a peer group?

2. What is a peer educator?

    - How does a peer educator differ from a peer?
    - What are the roles of a peer educator?
    - What type of peer educator can exert influence?

3. What is drug education?

    - How does peer education differ from other types of drug education?
    - What are common approaches to peer education?
    - How is peer education delivered?
    - In what settings does peer education occur?

4. What are the aims of peer education?

    - What is the underlying ideology?
    - What does peer education aim to achieve?

Although a substantial literature has addressed peer education, significant ambiguity is evident with regard to the meaning of peer education and related terms. This chapter stresses the importance of clarifying the meaning of peer education. It teases out common themes among definitions and posits answers to the questions posed above.

Clarifying Meaning

There is evidence in the literature of a lack of conceptual clarity regarding peer education (Gray, 1996; Shiner, 1999; Bament, 2001). Indeed, this is one of the first impressions gained from even a cursory scan of the literature. In addition to considerable variation in how the term is used, many authors do not define explicitly what they mean by peer education. Clarification of the meaning of the term peer education is necessary to:

- facilitate consistency in use of key terms
- encourage explicit statements about the different types of peer education used
- promote clarity for all those involved in peer education initiatives
- facilitate evaluation of effectiveness of peer education
- facilitate identification of key elements of effective peer education
- guide development of effective peer education initiatives
- separate effective approaches from ineffective approaches
- discontinue use of ineffective approaches
- facilitate decisions regarding whether or when peer education is an appropriate strategy
- engender support for peer education, including new and continued funding
- provide information to funders of peer education initiatives about what they are supporting

(Shiner, 1999).

Common Definitions

Peer education is best understood as an umbrella term that refers to a range of activities (Shiner, 1999). Definitions of peer education fall roughly into three categories, as shown in Box 2.1.

1. Those that are simple and reflect a commonsense understanding of peer education, namely young people teaching other young people
2. Those that describe a particular approach to peer education in detail
3. Those that attempt to cover all approaches to peer education in detail.

There are a number of common themes found in the definitions given in Box 2.1, namely that peer education:

- involves information sharing and information transfer about drug-related issues
- attempts to influence knowledge, attitudes or behaviour
- occurs between people who share common characteristics (particularly age, but gender, cultural and educational background are also important) and have similar experiences
- relies on influential members of a social group or category.

Box 2.1: Definitions of Peer Education

Category 1: Simple Definitions That Reflect a Commonsense Understanding of Peer Education

"…the sharing of information, attitudes, or behaviors by people who are not professionally trained educators but whose goal is to educate."
(Finn, 1981)

"…the process of sharing information among members of a specific community to achieve positive health outcomes."
(Bleeker, 2001)

"[Peer education involves] those of the same societal group or social standing educating each other."
(Svenson et al., 1998, p7 cited in Parkin and McKeganey, 2000)

"The term peer education is primarily used to describe education of young people by other young people…"
(Shiner, 1999)

"sharing our experiences and learning from others like us."
(Robins, 1994, p2 cited in Shiner, 1999)

"… peer education is a fancy term for an everyday occurrence…namely, individuals communicating with each other."
(Carpenter, 1996 cited in Parkin and McKeganey, 2000)

Category 2: Definitions That Describe a Particular Approach in Detail

"All peer programs have two integral parts woven into the program format: (1) a knowledge component based on recent, credible facts about both the immediate and long-term consequences of drug use, and (2) a group situation that promotes peer support for not using drugs."
(Tobler, 1992, p20)

"…peer education is essentially 'the formalisation of day to day' experiences that form the interactional processes of everyday lives."
(Trautmann, 1995 cited in Parkin and McKeganey, 2000)

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"Youth educate their peers or younger children on personal/life skills or on pertinent societal issues such as drug abuse, HIV/AIDS, or prejudice. Youth learn important skills related to designing and delivering effective presentations or workshops, ranging from one-time presentations to intensive, semester-long programs."
(Goldsmith and Reynolds, 1997 cited in Lezin, n.d., p3)

Category 3: Definitions That Attempt to Cover All Approaches in Detail

"… the term has generally come to mean the targeting and selecting of members of a particular group or social network, to inform them and encourage them to pass on accurate information to others with similar characteristics. Peer education initiatives generally focus on health education and prevention activities, and often aim to promote safer and healthier lifestyles."
(Ward et al., 1997)

"The use of same age or same background educators to convey educational messages to a target group…Peer educators work by endorsing 'healthy' norms, beliefs and behaviours within their own peer group or 'community', and challenging those which are 'unhealthy'."
(United Nations Office For Drug Control And Crime Prevention, 2000).

"Peer education activities can involve a wide range of informal and formal influences that are difficult to capture…"
(Backett-Milburn and Wilson, 2000)

"[Peer education] is a process which attempts to build on the existing information exchange [between young people about sensitive issues such as sex and drugs]"
(FPEP, 1997, p6 cited in Parkin and McKeganey, 2000)

"[Peer education] takes place anywhere where people share information…in social groups. [Peers are similar in age and status and] in some way identify with each other."
(Fast Forward, 1997, p55 cited in Parkin and McKeganey, 2000)

"Peer education typically involves training and supporting members of a given group to effect change among members of the same group. Peer education is often used to effect changes in knowledge, attitudes, beliefs, and behaviors at the individual level. However, peer education may also create change at the group or societal level by modifying norms and stimulating collective action that contributes to changes in policies and programs."
(Population Council, n.d., p1)

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"...peer-interventions…generally can be grouped into two major categories: peer support and peer leadership. In peer support programs, peers interact as equals…In peer leadership programs, the peers still interact with one another, but some are designated leaders because of their training and the roles they take within the group."
(Lezin, n.d.)

"…it involves training groups of people to pass on information to others who are seen to be in the same peer group, so as to encourage the adoption of health promoting behaviour(s)".
(Bament, 2001, p1)

"Peer education typically involves training and supporting members of a given group to effect change among members of the same group. Peer education is often used to effect change at the individual level, with the aim of modifying a person's knowledge, attitudes, beliefs, or behaviors. Peer education may also effect change at the group or societal level by modifying norms and stimulating collective action that contributes to individual change as well as changes in programs and policies."
(Population Council, n.d., p2)

Our preferred definition of peer education is given below and encompasses many of the common themes identified above:

"AOD peer education involves sharing and providing information about alcohol and other drugs to individuals or groups. It occurs through a messenger who is similar to the target group in terms of characteristics such as age, gender or cultural background, has had similar experiences and has sufficient social standing or status within the group to exert influence."

Who is a Peer?

What are the Defining Characteristics of Peers?

It is commonly assumed that any young people of a similar age can be regarded as peers. However, while age is important, this may not be the defining characteristic of "peerness" (Shiner, 1999). "Peerness" includes:

- shared characteristics, such as age, gender, ethnicity, culture, subculture, place of residency
- similarities in experience, including drug-related experience, lifestyle and educational background
- group membership

(Shiner and Newburn, 1996; Shiner, 1999; Parkin and McKeganey, 2000; Population Council, n.d.).

What is a Peer Group?

Group membership is a complex and dynamic phenomenon that varies between group types and situations. People use sophisticated sets of criteria to determine whom they consider to be and accept as a peer. Young people generally belong to several groups, each of which may be defined by different characteristics (Shiner, 1999). The various groups to which a young person belongs may include:

- close friends
- acquaintances with common interests
- a wider group with common characteristics who may not be known by the young person

(Coleman and Hendry, 1990 cited in Shiner, 1999).

Each of these groups exerts a degree of influence, which may compound or conflict with the influence of other groups with which a young person identifies.

What is a Peer Educator?

How Does a Peer Educator Differ From A Peer?

A peer educator is a young person who possesses the necessary characteristics to be considered a peer, is credible and influential, and has received peer educator training (Lezin, n.d.). The latter point is particularly important as training provides the peer educator with information about AOD-related issues and skills in facilitation, delivering education, providing information and/or influencing social norms.

What are the Roles of a Peer Educator?

Peer educators may adopt various roles, such as facilitator, counsellor, information source (including referral to other information sources), support worker or tutor (Gonzalez, 1990; Milburn, 1995; Prendergast and Miller, 1996; Coggans, 1997). These roles can be categorised as either peer support or peer leadership. The peer support role places the peer educator and other young people as equals. In this role, the peer educator may engage in organised activities, such as health promotion initiatives, hotlines or resource centres, or exert opportunistic or spontaneous influence, for example they may act as a role model (Badura et al., 2000) or simply discuss drug-related issues in spontaneous, everyday situations (Gore, 1999).

The peer leadership role is more directive. In this role, the peer educator is placed in the role of leader or expert (Lezin, n.d.). Peer educators may act alone or with a teacher or other adult present (Klepp et al., 1986). The peer leadership approach is the more common conception of peer education.

What Type of Peer Educator Can Exert Influence?

Effective peer educators are young persons who naturally exert an influence on the target group. Two questions may be asked to identify influential young people:

Who are Natural Leaders and Helpers?

Natural leaders and helpers within the social network are good candidates for peer educators. The rationale for using existing leaders is that peer educators can capitalise on the influence they already exert on their peers. Helpers are those that people tend to turn to for advice and support, and as such are likely to have more opportunities to exert an influence (Wiist and Snider, 1991).

Will a True or Near Peer Exert More Influence?

A true peer is someone who is considered to be a member of a particular group by both themselves and members of the group (Gore, 1999). True peers are virtually identical in terms of the characteristics that define their peer group. In contrast, near peers share many characteristics of the true peers but differ in some way, such as being slightly older (Wiist and Snider, 1991; Cripps, 1997) or possessing greater power or status for communicating messages (Population Council, n.d.).

There has been some discussion in the literature about whether a true or a near peer is more effective in the role of peer educator. Cripps (1997) suggests that young people find near peers to be more credible. Near peers are likely to be perceived as possessing greater knowledge or experience, and hence greater credibility. For example, slightly older peers may be seen to have more experience of life in general as well as more

drug-related experience. Young people may also feel that near peers are better integrated into wider youth culture than themselves (particularly if the recipients still attend school but the peer educator has already left school) and as such are able to provide more accurate, first hand information about youth culture, including drugs (Fors and Jarvis, 1995; Cripps, 1997). Similarly, young people who have had some relevant drug experience are frequently seen as credible information sources. Near peers who are known to have received appropriate training may also have enhanced credibility. In contrast, young people may believe true peers do not possess sufficient knowledge. For example, Cripps (1997) found that young people believed their true peers to be "untrustworthy" in terms of knowledge. They were seen to have limited life experience, and therefore lacked real life knowledge of drugs, regardless of whether they had been trained to deliver drug education or not.

What Is Drug Education?

How Does Peer Education Differ From Other Types of Drug Education?

The extent to which peer education differs from other types of drug education varies according to how it is conceptualised and implemented. The main difference may simply be the involvement of a peer educator. In some initiatives, peer education is understood to be virtually identical to other types of drug education except that it is conducted by a peer of those who receive the drug education, instead of being run by an adult, such as a teacher or health worker. Adult-led peer education that relies heavily on interaction between recipients is also sometimes referred to as peer education. A frequently cited example of this understanding of peer education is found in Tobler's meta-analyses (1986, 1992) which compare "peer programs" to other types of drug education. However, the term "peer education" is more commonly used to refer to peer-led drug education than adult-led drug education that incorporates peer interactions. In view of this, the term "adult-led" will be used throughout the monograph to distinguish peer education from other types of drug education.

Peer education may also differ from adult-led education on a number of other variables, such as the way education is delivered, the setting, scope and sometimes content, for example:

- delivery, eg peer education may be more opportunistic, unstructured and informal than adult-led education (discussed in further detail below)
- setting, eg peer education is more likely than adult-led education to occur in informal settings, such as during social occasions, in cafes, at events etc (discussed in further detail below)
- scope, eg peer educators are not trained and experienced mental health workers

or educational professionals, therefore they cannot be expected to operate at the same level as professional teachers or mental health workers

- content, eg given the often opportunistic nature of peer education, peer education is more likely to provide information in chunks relevant to the recipients' immediate needs, than to be delivered as part of a structured and integrated curriculum.

Various aspects of peer education are examined below, including delivery, setting, approaches and aims. There is considerable overlap between peer education and other types of drug education, including school drug education (represented graphically in Figure 2.1). Much of the information below is applicable to other types of drug education.

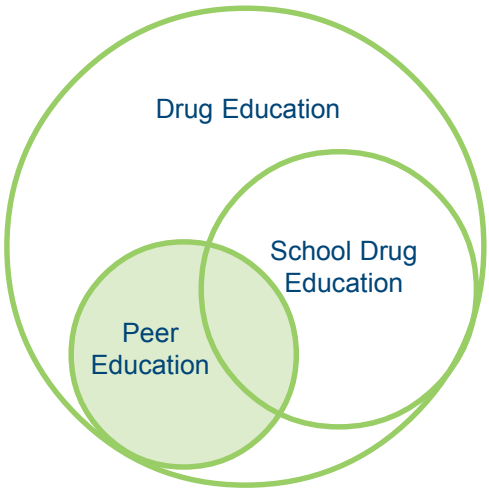

Figure 2.1: The Relationship Between Peer Education and Other Types of Drug Education

What Are Common Approaches to Peer Education?

It is difficult to discuss approaches to peer education without also referring to approaches to drug education in general. This is because of the considerable overlap between the two. A brief description of some of the main approaches to drug education is outlined below and then related to peer education.

The drug education literature describes a range of approaches[1] to drug education, each is based on certain assumptions about how to influence the drug-related behaviour of young people.

Essentially five approaches have been described (outlined in Box 2.2):

- information-based
- affective
- information-based plus affective
- psychosocial
- alternatives.

Box 2.2: Five Approaches to Drug Education

Information-based Approaches

The information-based approach, also referred to as "knowledge only", is the earliest drug education approach and is often abstinence oriented (Coggans, 1997). The earliest of these approaches were based on fear arousal, assuming that if young people were frightened by the possible negative consequences of drug use, they would decide not to use drugs (Coggans, 1997). Later information-based approaches were more factual and unbiased, but still assumed that if young people knew all the facts, they would choose not to use drugs (Coggans, 1997; Tobler, 1992). These two forms of information-based approaches have been found to be ineffective in preventing drug use (Kinder, Pape and Walfish, 1980 cited in Midford, 2000). Some of the more recent information-based approaches have incorporated a harm reduction orientation and provide young people with accurate information about risks and safe drug use practices (Coggans and Watson, 1995). Harm reduction approaches measure success in a variety of ways, including reduced harm and ability to make informed decisions, rather than just drug use.

Affective Approaches

The affective approach was developed in the 1970s, following lack of success of early information-based approaches (Wragg, 1991; Midford, 2000). This approach was based on the assumption young people used drugs because of psychological factors, such as lack of interpersonal and communication skills and low self esteem (Ellickson, Bell, Thomas, Robyn and Zellman, 1988 cited in Wragg, 1991). The affective approach focused on enhancing personal and interpersonal skills, and often did not address drugs or related issues. The results of affective programs have been equivocal at best, and do not support the contention that "effective living" is a key strategy for drug prevention (Blum et al., 1978; Kraus, 1979; Goodstadt, 1980; Schaps et al., 1981; Battjes, 1985; Hansen, 1993 cited in Midford, 2000).

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Information-based Plus Affective Approaches

Later initiatives combined the information-based and affective approaches, resulting in an approach that provided drug information and addressed psychological issues. However, this combined approach also had a limited impact on drug use (Schaps et al., 1981; Glyn, 1983; Hawkins et al., 1985 cited in Coggans and Watson, 1995).

Psychosocial Approaches

In the 1980s, attention turned to psychosocial approaches, including peer resistance and peer refusal skills training, social innoculation, life skills or social skills training (Wragg, 1991). Peer education is often described as a psychosocial approach. These approaches are based on the assumption that young people use drugs as a result of influences from media and peers (Midford, 2000). Pyschosocial approaches acknowledge, address and utilise the psychosocial influences on drug use (Foxcroft et al., 2003). Unlike previous approaches, which have little or no theoretical basis, psychosocial approaches are based on a number of psychosocial theories (Wragg, 1991) as described in Chapter 4. In general, psychosocial approaches have been more successful in meeting stated aims and objectives than other approaches (Flay, 1985 and Botvin and Wills, 1985 cited in Wragg, 1991). It has been suggested that some well designed and implemented psychosocial education programs have been able to prevent or delay onset of drug use (Dusenbury and Falco, 1995; White and Pitts, 1998 cited in Midford, 2000).

Alternatives Approaches

Alternatives-based initiatives have two key components (Tobler, 1992). The first is provision of drug free activities. The second is development of personal competence. The rationale for the alternatives approach is that young people will be less likely to use drugs if they have alternative forms of satisfaction and are not bored or frustrated (Tobler, 1992; Coggans and Watson, 1995). Drug education initiatives based on the alternatives have been found to increase self esteem and community participation, but have not been shown to impact on drug use (Silverman, 1990 cited in Coggans and Watson, 1995), although high intensity and well financed initiatives appear to be effective with current users (Tobler, 1986).

Peer education initiatives may adopt one or more of these approaches, although we suggest that peer education may be most powerful when it adopts a psychosocial approach. In practice, however, it is not uncommon for peer education initiatives to adopt a less effective information-based approach that substitutes a peer educator for

an adult teacher (eg Baklien, 1993; Mellanby et al., 2001). In some initiatives, peer educators may also organise and implement drug-free social activities for their peers, such as an all ages concert or event (eg Komro et al., 1996).

How is Peer Education Delivered?

Delivery of peer education is often described as either formal or informal. Formal activities are structured and planned, similar to traditional classroom teaching. In these formal programs, education is a didactic and structured encounter focused on information transfer between student and educator in which the educator is placed in the role of "expert" (Prendergast and Miller, 1996; Gore, 1999). Formal peer education often occurs in schools (Bament, 2001).

Informal peer education involves a range of activities that diverge from the traditional classroom model. These include:

- informal, unstructured group discussions
- dissemination of resources and advice at events
- activities that draw on popular culture, such as music, drama, art (Ryan et al., 1999)
- spontaneous, everyday conversations with friends, acquaintances, family, or even strangers (Gore, 1999).

The dichotomisation of peer education into formal and informal may not be the most appropriate depiction of peer education activities. Instead, peer education can differ along a number of different dimensions, including:

- planned / unplanned (spontaneous, opportunistic)
- structured / unstructured
- use of existing social networks / other group structures
- traditional learning methods / innovative learning methods
- didactic / interactive
- theoretical / practical.

The activities of peer educators may rely on processes such as:

- information transfer (eg didactic, lecture style presentation)
- interaction (eg discussions)
- practical activities (eg role plays)
- modelling (eg observation of others)
- popular culture (eg music events, theatre productions, artwork)
- opportunistic intervention (eg spontaneous conversations).

In What Settings Does Peer Education Occur?

Peer education for young people may occur in a variety of settings (Bleeker, 2001). These include:

- educational institutions, eg schools and higher education institutions such as colleges and universities (Bleeker, 2001)
- community settings, eg:
  - youth centres (Bleeker, 2001)
  - drug agencies, health agencies, outreach services (Hunter et al., 1997; Bleeker, 2001), clinics (Todts, 1996)
  - clubs (Weiss and Nicholson, 1998)
  - shelters (eg for runaway or homeless youth) (Fors and Jarvis, 1995)
  - the workplace
  - juvenile justice centres (Miller, 1996)
- social settings, including entertainment events, sports and recreation venues, coffee shops etc (Turner and Shepherd, 1999; Bleeker, 2001)
- locations where users, particularly injecting drug users (IDUs), are likely to congregate, such as clubs, raves, parks and public toilets.

The first documented use of peer education for young people about alcohol and other drug use was conducted in US schools in the late 1960s (Ward et al., 1997). A high proportion of peer education initiatives are still conducted in educational institutions, including schools (eg Kim et al., 1992; Baklien, 1993; Komro et al., 1996; Harrison, 1996; Black et al., 1998; Elliott et al., 1999; Bailey and Elvin, 1999; Bloor et al., 1999; Webster et al., 2002) and higher education institutions (eg Haines, n.d.; Grossman et al., 1994; Gooding, 1996; Lindsey, 1997; Badura et al., 2000).

The most appropriate setting for a given peer education initiative is determined by the needs and characteristics of the target group (Bleeker, 2001). For instance, educational institutions may be the most appropriate setting for peer education initiatives that aim to reach a large number of young people. In contrast, community settings such as shelters, AOD and health agencies and youth centres may be more appropriate for socially excluded, marginalised or at-risk youth. Indigenous and culturally and linguistically diverse young people may also be more appropriately contacted in community settings (Shiner, 2000). An outreach form of peer education may occur through informal networks, with the peer educators accessing people where they tend to congregate (Turner and Shepherd, 1999).

Peer education initiatives that are informal, interactive and collaborative are well suited to social or community settings. Initiatives that rely on the natural processes such as social influence and cultural diffusion are perhaps best suited to social settings. Formal, classroom-type activities are more suited to institutional settings such as schools, universities or community organisations (Shiner, 2000).

What are the Aims of Peer Education ?

Peer education initiatives may differ in terms of their aims. The aim of a peer education initiative may be considered on a number of levels, including:

- ideological
- functional, ie anticipated outcomes eg knowledge, attitudes, skills, behaviour.

What is the Underlying Ideology?

The aims of peer education initiatives are shaped by their underlying ideological orientation. Drug-related ideologies fall along a continuum from abstinence to harm reduction. An abstinence approach may also be referred to as "primary prevention" and harm reduction as "secondary prevention" (Crompton, 2003). Strictly abstinence-based initiatives aim to prevent any drug use (Ming, 1995; Weiss and Nicholson, 1998). Strategies may include providing information on the dangers of drug use, with the expectation that this knowledge will result in the decision not to use drugs. Abstinence initiatives may also aim to prevent drug use by equipping young people with skills to resist peer pressure, such as learning refusal skills (Rollin et al., 1994) or giving young people the skills and confidence to leave situations where others are using drugs (Weiss and Nicholson, 1998). Other initiatives may aim to delay onset of use or minimise use (Perry and Grant, 1988; Coggans, 1997).

At the opposite end of the continuum, drug education underpinned by a harm reduction philosophy aims to reduce drug-related harm. Harm reduction focuses on the "harm" rather than drug use. Strategies adopted may include providing accurate information about drugs and associated risks, safer drug use practices, aetiology of drug use and promoting more accepting attitudes towards drug users (Fors and Jarvis, 1995; Gray, 1996; Harrison, 1996; Coggans, 1997; Hunter et al., 1997). Harm reduction initiatives are based on recognition that abstinence may not be a goal for some young people (Prendergast and Miller, 1996). The skills taught in harm reduction initiatives include accessing and assessing the quality of information, and communication and decision making skills. In addition to facilitating informed decision making and reducing risk taking, the knowledge and skills provided in harm reduction initiatives are expected to give young people confidence to discuss AOD issues with other young people (Ming, 1995; Ward et al., 1997).

Ideally, the ideological perspective applied in a given peer education initiative is one that is both credible and relevant to the target group, and will be determined largely by the group's needs and characteristics, including age, gender, drug-related experience and the specific drugs they are likely to use. For example, an abstinence-based approach to alcohol education would probably not be credible for a group of inner city young people in their late teens who spend a lot of time with young adults and regularly drink alcohol. Conversely, a harm reduction approach addressing issues such as the

importance of using clean needles is unlikely to be relevant for younger adolescents in their early teens who have little or no experience of either licit or illicit drugs.

What Does Peer Education Aim to Achieve?

Peer education initiatives may target the group's knowledge, attitudes, values, beliefs, skills or behaviour. Initiatives may also differ in what they aim to change about a particular variable, for example:

- Knowledge: may aim to enhance knowledge about:
  - social and physical effects of various drugs
  - legal and ethical issues
  - prevalence of drug use
  - prevalence of drug-related harm
  - sources of help etc
- Skills: may aim to enhance skills to:
  - recognise and respond to drug-related problems among family, friends and acquaintances
  - respond to overdose
  - make informed decisions
  - resist peer pressure
  - avoid drug using situations
- Behaviour: may aim to:
  - prevent, stop or reduce drug use
  - delay onset of drug use
  - prevent increase in drug use
  - prevent resumption of drug use
  - prevent transition to more harmful drugs or practices (eg injecting)
  - minimise risky behaviour and harmful practices
  - increase frequency of looking out for and helping friends experiencing drug related harm
  - minimise impact of drug use on school, work or interpersonal relationships.

Each of these aims may be equally valid, but they need to be appropriately matched to the circumstances and scope of a given peer education initiative. Important considerations include:

- whether the planned aims are achievable and measurable
- what strategies are required to meet the aims
- how achievement of aims will be assessed
- whether it is possible to adequately assess achievement of stated aims
- whether sufficient time and resources are available to implement appropriate strategies and adequately assess achievement of aims
- whether the aims are appropriate for the target group.

Summary

Peer education is an umbrella term that is used to refer to a wide and diverse range of activities. There is lack of clarity in the literature and in general about the meaning of peer education and related terms (such as peer and drug education) and what peer education involves. However, common themes can be identified. The definition of peer education given in this monograph attempts to capture these themes.

The meaning of peer education can be further clarified by exploring what is meant by the terms "peer", "peer educator" and "drug education", and by examining the various aims of peer education initiatives. To reiterate, a peer is someone who is similar to the target group on a number of key characteristics, such as age, gender, educational background, etc. A peer educator is a peer who is credible, influential and who has received training to help them fulfil their role.

Peer education overlaps with other types of drug education, including school drug education, but differs in the following ways:

- peer education is more likely to be opportunistic and spontaneous
- peer education is more likely to occur in informal settings
- peer educators cannot be expected to operate at the same level as trained and experienced mental health or educational professionals
- content of peer education may be delivered in isolated chunks that are relevant and meaningful to recipients, instead of through a comprehensive curriculum.

The next chapter examines the reasons for using peer education, including:

- as a response to patterns of drug use among young people and limitations of adult-led education
- demonstrated efficacy of peer education.

Notes

[1] The term "approaches" is used by Coggans and Watson (1995), whereas Wragg (1991) uses "models" and Tobler (1992) uses "modalities". In this monograph we will use the word "approaches".

Chapter 3

Why Choose Peer Education?

Peer education represents one strategy among many that may be used to address young people's drug use. This chapter identifies potential benefits and advantages of peer education in terms of the:

- need for peer education
- rationale for peer education
- demonstrated efficacy.

Need

There is a clear need for effective and targeted strategies to address patterns of unsafe drug use and drug-related harm among young people. Peer education can be an effective strategy to address young people's drug use. It can avoid many of the limitations and disadvantages of traditional adult-led drug education.

Patterns of Use Among Young People

Considerable concern exists, both in Australia and internationally, about drug use by young people. The potential for young people to incur harm from unsafe drug use has been well established by research on prevalence, age of initiation into drug use, patterns of consumption and drug-related harm among young people. A brief review of this research follows.

Prevalence

Prevalence of licit and illicit drug use among young people is high and generally continues to increase, both in Australia (Commonwealth Department of Health and Family Services, 1996; Higgins et al., 2000; Degenhardt et al., 2000; Australian Institute of Health and Welfare, 2002) and globally (Perry et al., 1989; Bauman and Phongsavan, 1999). For example, an Australian Institute of Health and Welfare report found that 70% of 14-19 year olds reported consuming alcohol (Higgins et al., 2000). The 2001 National Drug Strategy Household Survey reported that two thirds (66.3%) of 14-17

year olds had consumed alcohol in the last year, and almost one in five (18.2%) drank on a weekly basis (Australian Institute of Health and Welfare, 2002). Young people are at greater risk of acute alcohol-related harm compared to other age groups (Stockwell et al., 2001). Among 14-19 year olds 20.5% reported consuming alcohol at high-risk levels at least monthly, compared to 13.4% among all age groups (Australian Institute of Health and Welfare, 2002).

The 2001 National Drug Strategy Household Survey revealed that 34.3% of Australians aged 14-19 had used cannabis, 24.6% in the last year, 13.3% in the last month and 9.1% in the last week (Australian Institute of Health and Welfare, 2002). Comparison between the 1993 Household Survey and the 1994 Urban Aboriginal and Torres Strait Islander Peoples Supplement found that frequent use of cannabis is higher among Indigenous Australians than the general population (Commonwealth Department of Human Services and Health, 1994). In the 14-24 age group, 15% of Indigenous young people use cannabis at least weekly, compared to 10% of the general population, and 24% use at least monthly, compared to 17% of the general population. The 2001 Household Survey also found that 8.4% of 14-19 year olds had used amphetamines, 6.2% in the last 12 months and 2.9% in the last month. Table 3.1 shows the prevalence of reported use of a range of illicit drugs by Australians aged 14-19 (Australian Institute of Health and Welfare, 2002).

Drug Type	In lifetime	In last 12 months	In last month	In last week
Illicits	37.7	27.7	-	-
Illicits except cannabis	16.7	11.8	-	-
Cannabis	34.3	24.6	13.3	9.1
Prescription (for non-medical purposes)	7.3	4.4	-	-
Hallucinogens	4.2	2.4	0.4	0.1
Heroin, methadone and other opiates	1.7	0.9	-	-
Amphetamines	8.4	6.2	2.9	1.2
Ecstasy, designer drugs	7.0	5.0	2.1	1.0
Cocaine	2.6	1.5	0.3	0.1
Inhalants	2.9	1.0	0.4	0.1
Injecting drugs (for non-medical purposes)	1.4	0.6	-	-

Table 3.1: 2001 National Drug Strategy Household Survey: Reported Drug Use by 14-19 year olds (Australian Institute of Health and Welfare, 2002)

The ubiquitous nature of drug use has lead to claims that drug use, including illicit drug use, is becoming an increasingly normalised part of youth culture (Coggans and Watson, 1995; Allott et al., 1999). The high prevalence of drug use is a significant social and population health issue because prevalence of use is positively correlated with prevalence of drug-related problems (Makela et al., 1981 cited in Perry et al., 1989). One way of reducing morbidity and mortality associated with substance use among adults is to prevent use of these substances among adolescents (Letcher and White, 1999).

Age of Initiation

The age of initiation into drug use is steadily declining, particularly for high prevalence drugs such as alcohol, tobacco and cannabis (Commonwealth Department of Health and Family Services, 1996; Australian Institute of Health and Welfare, 1999; Higgins et al., 2000; Degenhardt et al., 2000). The declining age of initiation is a concern as age of first use is potentially a good indicator of longer-term harm (Foxcroft et al., 2003). Findings from the Illicit Drug Reporting System indicated a decrease in the age of initiation into injecting drug use (Breen et al., 2002). One study of Indigenous injecting drug users found that half of the participants were younger than 16 when they first injected (Larson, 1996 cited in Holly, 2001). A survey of Australian secondary students' use of illicit substances found that 13% of 12 year olds had used cannabis at some time (Letcher and White, 1999). Among Indigenous Australians, 64% of those who had ever smoked had tried their first full cigarette by age 16 and 36% before age 14 indicating younger age of initiation among this this population than the general population (Commonwealth Department of Human Services and Health, 1994).

The National Drug and Alcohol Research Centre undertook research to compare age of initiation into drug use by people born in successive decades from 1940 to 1984. Research findings revealed that those born in more recent decades reported a younger age of first use for licit and illicit drugs compared to those born in earlier decades (Lynskey and Hall, 1998; Degenhardt et al., 2000). Of those born between 1980 and 1984, 56% reported alcohol use by age 15, compared to 16% of those born between 1940 and 1944. For cannabis use, 31% of those born between 1980 and 1984 reported cannabis use by age 15 compared to 4% by those born between 1940 and 1959.

Patterns of Consumption

Not only are growing numbers of increasingly young people using drugs, their consumption patterns are also cause for concern. This is particularly the case for alcohol (Roche, 2001). Young people consume more alcohol than other age groups

(Lowe, 1999; Leigh, 1999; Roche, 2001). In addition, binge drinking and drinking at unsafe or risky levels are widespread among youth. Roche and Watt (1999) report that 70% of 17 year old Australian university students reported drinking to intoxication at least once a week. Compared to all other age groups, those aged 14-19 reported more incidents of memory loss following drinking, at least weekly (4.4%) and at least monthly (10.9%) (Australian Institute of Health and Welfare, 2002).

Drug-Related Harm Among Young People

It has been estimated that 33% of all deaths for people aged between 15 and 34 are directly caused by drugs (Hawthorne, 1992 cited in Ryan et al., 1999), with alcohol accounting for 33% of drug-related death in young people (Ryan et al., 1999). Alcohol has been found to account for 5% of all deaths among young people world wide (Murray and Lopez, 1997; Jernigan, 2001 cited in Foxcroft et al., 2003). In addition, the three leading causes of death among young people – unintentional injuries, homicide and suicide – have all been linked to alcohol (Chassin and DeLucia, 1996; Zubrick et al., 2000). Projections of drug mortality indicate expected increases (Victorian Department of Human Services, 1999).

Shanahan and Hewitt (1999) found that nearly 70% of young people between 15 and 17 years of age had witnessed alcohol-related violence in the last three months. Physical injury, property damage, date rape and suicide are all associated with problematic alcohol use. A consequence of increased risk taking behaviours and potential for violence related to alcohol is that young people experience more acute harms from alcohol than other age groups (Leigh, 1999). Many young people have limited knowledge and skills for recognising and minimising AOD-related harm (Schippers et al., 2001). Limited skills in this area, combined with heavy consumption, result in high levels of associated risk taking behaviours, such as unsafe sex practices, drink driving (Ryan et al., 1999) and violent behaviour.

Limitations of Adult-led Drug Education

Drug education is widely held to be an important strategy to address problems associated with drug use by young people. As outlined below, however, adult-led drug education is significantly constrained by a range of factors including appropriateness, scope and transferability.

Appropriateness

Drug education in schools and other institutions can be constrained by policies within these settings. In most settings, adults are constrained in regard to the information they can provide and the way they can interact with young people (Mellanby et al., 2000). In particular, some harm reduction messages may be considered inappropriate and seen to encourage drug use. However, for some young people, particularly those

who are already using, such messages may be required to prevent or reduce drug-related harm. In some circumstances, it may be appropriate and acceptable for peer educators to address sensitive harm reduction issues. For example, it may be difficult to attempt to encourage existing users, particularly injecting drug users, to reduce or cease drug use. In this situation, it may be appropriate for peer educators to provide information about issues such as less harmful routes of administration, safe injecting procedures and the importance of obtaining drugs from a safe and reliable source.

Scope

Much adult-led drug education occurs in schools or other institutions and therefore excludes young people outside these settings, including school leavers and disenfranchised youth, such as homeless individuals or those incarcerated in juvenile justice settings (Miller, 1996). This is an important issue because these young people are at high risk for problematic and harmful drug use. Problematic adolescent drug users are under represented in school-based initiatives because of low commitment to school, frequent absence, truancy or dropping out (Tobler, 1992; Crompton, 2003).

Transferability

Adult-led drug education typically occurs in an artificial environment, most often a classroom. However, drug use is influenced by a range of factors, and the skills and knowledge gained in the formal learning environment may have limited transferability to the natural, social environment of young people (Hawthorne et al., 1992; Gorman, 1998; cited in Webster et al., 2002; Paglia and Room, 1998). It is important to recognise that drug education is likely to have limited transferability unless supported by social norms outside the learning environment (Tobler, 1992). In contrast to adult-led education, peer education is more readily carried out "in situ", at least for informal, spontaneous peer education (as described in Chapter 2). Peer educators can provide information, advice, support and modelling in real life situations where drug use or related issues occur.

Effectiveness

Early reviews of school-based drug education initiatives found that drug education can be successful in changing knowledge, but is usually less successful in changing attitudes towards drugs, drug use and drug users or changing behaviour (ie drug use) (Bangert-Drowns, 1988). Bangert-Drowns (1988) suggests that drug education remains popular in schools, despite limited evidence of effectiveness, because it serves other functions, such as reassuring parents and the community that schools are responding to their concerns about drug use by young people. Even more concerning, schools are likely to select drug education approaches based on the outcomes they would like to achieve, rather than evidence for effectiveness of these approaches (Midford, 2000).

Rationale for Peer Education

The rationale for peer education is discussed below. The specific issues of credibility, decreased threat, role modelling, ongoing contact, access to hidden populations, cost effectiveness and benefits for peer educators are addressed.

Credibility

It is widely believed that peer educators will be seen as more credible than adults when delivering drug-related information because young people are more likely to share characteristics with peer educators (eg age, dress, language style, interests, membership of social groups). People tend to identify more with others who have the same characteristics as themselves (Gore, 1999; Miller, 1995; Perry et al., 1989). This effect is particularly strong if information is conveyed by an individual whose opinion is highly valued within the social group (Baklien, 1993; Power, 1994). People also tend to perceive those they identify with to be more credible sources of information regardless of the objective accuracy of the information (Harrison, 1996) (see Box 3.1 for further explanation of the various facets of credibility).

The influence of the social group is particularly strong for young people (Prendergast and Miller, 1996). Most young people begin to immerse themselves in youth culture as they enter adolescence. Within youth culture, young people share the same social language and exchange social information including information about drug use. They also tend to interact less with their parents and other significant adults and more with their peers during this period (Spooner et al., 2001). Some also develop strong, if transient, oppositional tendencies. As a consequence, other young people seem more credible and have a greater influence, whereas adults are seen as less credible and therefore their influence diminishes (Jessor, 1982 cited in Fors and Jarvis, 1995; Mudaly, 1997; Ward et al., 1997). The result is a credibility gap in which adults are seen as less credible sources of information about youth culture, which is essentially social information about the world of young people and drug use (Cripps, 1997; Fors and Jarvis, 1995).

Decreased Threat

Young people may perceive peer education as less threatening than adult-led education. The changes in identification that occur during adolescence not only impact on the credibility of young people as information sources, but also as confidants. Young people are likely to talk to their peers about their concerns because they feel understood and less embarrassed (Douthwaite, 1997). In contrast, they may avoid seeking help or advice from adults (including health workers and services) in case they lose control over the solutions to their problems or confidentiality is not respected (Broadbent, 1994; Cripps, 1997; Parkin and Haynes, 1998). Consistent with this argument, there

Box 3.1: Credibility in Drug Education

Credibility is a central issue in drug education. There are three dimensions of credibility: messenger-based credibility (comprised of person-based and experience-based credibility) and message-based credibility (Shiner and Newburn, 1996). The messenger is the person delivering drug education. The message is the content and ideology of the drug education program.

Messenger-based Credibility

A messenger's credibility is determined by the audiences' perception of their personal characteristics and drug-related experience (Perry et al., 1989; Miller, 1995; Miller, 1996; Cripps, 1997; Gore, 1997).

Person-based Credibility

Credibility is enhanced when a messenger's personal characteristics (eg language, dress style, method of interaction, age) match those of the target audience, and are consistent with expected characteristics of someone delivering drug education.

Experience-based Credibility

Four dimensions of experience impact on credibility: age, drug experience, social experience and training. Young people often expect those who are older to have more experience and hence more knowledge (Harrison, 1996; Cripps, 1997). Drug experience (eg as a current or ex-user) also increases credibility. It is important to recognise, however, that the drug-related experiences of the messenger and audience should be with a similar drug, environment and locality (Cripps, 1997). In general, users see ex-users as the most credible sources of drug-related information, whereas non-users are more likely to recognise formal study and experience working with drug users as valid sources of knowledge (Douthwaite, 1997).

Similarity in terms of social experience impacts on credibility in a comparable fashion to drug experience. Young people generally see others with similar social experience to be credible sources of social information about the peer group and/or social drug norms (Cripps, 1997). Finally, AOD-related training may enhance the credibility of an individual in the role of teacher and educator (Douthwaite, 1997) because training is seen to increase their knowledge of the relevant subject.

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Message-based Credibility

The credibility of the message will be increased if it is culturally relevant, targeted and non-judgemental. A message is more likely to be perceived as credible if it is consistent with and relevant to the culture of the target group in relation to the meaning of drug use (Gonzalez, 1990; Coggans and Watson, 1995; Mundy, 1997). For instance, many young people see drug use as a normal part of youth culture (Blackman, 1996 cited in Crompton, 2003), particularly use of more recreational drugs, such as ecstasy (Sparam et al., 1996 cited by Crompton, 2003). Many young people also see drug use as fun, social (Broadbent, 1994) and functional (Perry et al., 1989). Therefore, young people are more likely to perceive a message as credible if it acknowledges the reasons some young people may choose to use drugs and if they are non-judgemental and based on accurate facts (Miller, 1995; Tobler, 1992; Parkin and Haynes, 1998). In contrast, messages based on fear arousal or abstinence often contradict young people's experience and knowledge of drug use, and are therefore likely to be viewed as unconvincing and biased (Broadbent, 1994; Coggans and Watson, 1995; Shiner and Newburn, 1996; Coggans, 1997; Cripps, 1997; Mundy, 1997). Consistent with this argument, Broadbent (1994) found that young people are generally more willing to enter into discussion about harm minimisation than abstinence. It is also important to target education to meet the needs of different groups according to the type of drug use (licit or illicit), and user (experimental, recreational, normative or problematic users), and readiness of users to change their behaviour (Tobler, 1992; Coggans and Watson, 1995; Mundy, 1997).

is evidence that young people who have had negative experiences with adults and institutions such as schools respond better to peer educators than to adults (Prendergast and Miller, 1996).

Role Modelling

Role modelling is a well established and powerful method of learning and subsequent determinant of behaviour (Bandura, 1977; Bond and McConkey, 2001). Peer educators are likely to be effective role models for young people because their behaviour provides social information relevant to young people.

Ongoing Contact

There is some evidence that peer education may have a more widespread and longer-term impact on the target group than other forms of drug education (Jay et al., 1984 and Kelly et al., 1991 cited in Turner and Shepherd, 1999). Peer educators may have

ongoing social interaction with the target group. Ongoing contact can reinforce learning, facilitate additional opportunities to share information, and model desired behaviours. Peer educators may also interact with a broader cross section of the target group during their everyday lives than would occur during classroom drug education (Baklien, 1993; Miller, 1996; Prendergast and Miller, 1996; Ward et al., 1997).

Access to Hidden Populations

Peer educators carry their message beyond the classroom into their social environment. Peer education also frequently occurs in environments outside the classroom. Peer educators may therefore encounter young people belonging to hidden populations of users, such as non-stereotypical injectors (eg middle class, higher socioeconomic status (SES) people who are not readily identified as injecting drug users) and Indigenous youth.

Cost Effectiveness

An important advantage of peer education is its potential cost effectiveness (Turner and Shepherd, 1999). The cost effectiveness of peer education is attributed to the low costs of paying peer educators, which is less than the remuneration required for adults. Often, peer education initiatives rely on volunteers. While peer education initiatives can be costly to establish and sustain (Population Council, n.d.), the costs are seen as fairly modest given the potential size of the target audience (Parkin and McKeganey, 2000).

Benefits for Peer Educators

In addition to the benefits enjoyed by participants of peer education, there is also evidence that peer educators experience considerable benefit (Bangert-Drowns, 1988; Badura et al., 2000; McDonald et al., 2000). Benefits for peer educators may include increased self confidence and ability to voice their own thoughts and opinions (Backett-Milburn and Wilson, 2000). Other benefits reported for peer educators include:

- increased self esteem
- enhanced sense of self efficacy
- increased knowledge and skills about health and drug-related issues
- development of planning and presentation skills
- development of leadership skills
- development of skills in accessing and assessing information and resources
- development of valuable experience that may facilitate later job seeking efforts.

Demonstrated Efficacy

The Peer Education Evidence-base

There is a great deal of published literature dealing with peer education, however the evidence-base for the effectiveness of peer education is limited and difficult to interpret. A significant portion of the literature is concerned with describing peer education. In addition, many papers that claim to report on outcomes or effectiveness actually only report one or more of the following:

- Feedback from participants to organisers about the peer educator initiative (eg Baklien, 1993; Bleeker, 2001), including organisation of the initiative, training of peer educators and the experiences of the participants. Feedback may have been sought from peer educators, participants, or others such as project staff, teachers or parents and collected through ratings of satisfaction, enjoyment or level of interest.

- Benefits for peer educators, such as changes in their knowledge, attitudes, behaviour (eg Baklien, 1993; Bloor et al., 1999; Badura et al., 2000; Smith, 2000; Bleeker, 2001) or skills, including development of the ability to voice their own opinion (Backett-Milburn and Wilson, 2000) and leadership skills (Badura et al., 2000). Benefits for peer educators have also been assessed using personal or social measures, such as self esteem (Badura et al., 2000) or confidence (Backett-Milburn and Wilson, 2000; Bleeker, 2001).

- Extent of participation in peer education activities (eg Baklien, 1993; Miller, 1996; Backett-Milburn and Wilson, 2000; Smith, 2000). Participation may be measured through amount and type of contact between peer educators and the target population, including participants in peer education activities, schoolmates, friends, family. This may include the number of:

  - participants that attended peer education activities
  - peer educators that participate in peer education activities
  - activities in which peer educators participate
  - peer educators who speak with others
  - people peer educators speak with about alcohol or other drugs conversations peer educators have and amount of time amount of time peer educators engage in these conversations.

Only a relatively small number of studies report on the outcomes of peer education. Some studies have specifically examined peer education, in comparison to either a control group or adult-led education. Others have examined school-based drug education, including the use of peer leaders as a variable.

These studies can be categorised as:

- evaluations of outcomes of a drug education initiative among participants or the target group (Wiist and Snider, 1991; Fors and Jarvis, 1995; Smith, 2000; Mellanby et al., 2001; Webster et al., 2002)
- individual studies, including randomised controlled trials (Perry and Grant, 1988; Perry et al., 1989; Botvin, 1990 cited in Black et al., 1998)
- narrative reviews (Mellanby et al., 2000)
- meta-analyses[1] (Tobler, 1986; Bangert-Drowns, 1988; Black et al., 1998; Tobler et al., 1992).

Research that has examined outcomes of peer education has:

- addressed a range of drugs, mostly tobacco, cannabis, alcohol and to a lesser extent, illicit drugs, as well as other health-related issues including sexual health, oral health and testicular cancer
- targeted young people ranging from age 10 upwards
- been conducted in schools (and at least one was conducted in shelters)
- been undertaken in a range of countries, including Australia, United Kingdom, Finland, Norway, Swaziland, United States, Chile.

Does Peer Education Work and How Does It Compare To Adult-led Education?

A central issue for any drug education initiative concerns its effectiveness. At one level, peer education can be considered to be effective if it meets its stated aims. Overall, research into the outcomes of peer education suggests that it is an effective strategy. There is also evidence to suggest that peer education is at least as, or more, effective than adult-led drug education. However, research in this area is not conclusive, largely because studies differ in terms of:

- evaluative rigour
- use of pre and post test measures
- randomisation of participants to control (no education) or education groups
- comparison of peer-led groups with adult-led and control groups
- sample size.

In addition, many initiatives are poorly designed, do not adhere to planned implementation, have little administrative support, have high attrition rates[2], and do not have adequate comparison between groups and over time (Foxcroft et al., 2003). Failure to comply with implementation requirements or to maintain "program fidelity" is referred to as a Type III error, which in turn may increase the probability of a Type II error – falsely concluding that peer education is ineffective (Black et al., 1998; Green and Tones, 1999).

Evidence for efficacy of peer education, including comparison with adult-led drug education, is examined below. In particular, the impact of peer education on knowledge, attitudes, skills, behaviour and different target groups is addressed together with the characteristics of effective peer education.

Impact of Peer Education on Knowledge, Attitudes, Skills, and Behaviour

It has generally been found that peer education can exert a positive influence on knowledge, and to a lesser extent attitudes and skills, and at times behaviour. This conclusion has been supported by three meta-analyses (Tobler, 1986, 1992; Bangert-Drowns, 1988).

Tobler found that the effect size of the impact of peer education on knowledge was twice the size as the effect on attitudes, skills or drug use. Similarly, Bangert-Drowns (1988) found that only knowledge and attitudes effects were reliably different from zero.

Knowledge

While short-term effects of peer education are generally positive, the evidence for a long-term impact on young people's knowledge of drugs and related issues is mixed. Some studies report that peer education significantly enhanced participants' knowledge when measured immediately after the intervention (Fors and Jarvis, 1995) and at two months follow-up (Perry and Grant, 1988). However, in other studies no significant difference was found at six month follow-up between students in peer-led drug education compared to a control group (Webster et al., 2002).

A review of experimental studies, including randomised controlled trials, found that peer education was as effective (Perry et al., 1989; Clarke et al., 1986 cited in Mellanby et al., 2000) or more effective (Botvin et al., 1984, 1990 and Laiho et al., 1993 cited in Mellanby et al., 2000) than adult-led education in increasing knowledge about drugs and drug-related issues among participants.

Attitudes

There is evidence to suggest that peer education can improve drug-related attitudes, and that it may do this more effectively than adult-led education. A randomised controlled trial conducted over four countries found that participation in peer education improved attitudes significantly compared to both those who participated in adult-led drug education and those who received no drug education (Perry and Grant, 1988; Perry et al., 1989). Similarly, Fors and Jarvis (1995) found that young people visiting shelters for runaway/homeless youths in the South Eastern United States were significantly more willing to accept responsibility for actions immediately following

peer education, whereas those who participated in adult-led education showed no significant change, and those who did not participate in any drug education were found to be significantly less willing to accept responsibility. Bangert-Drowns (1988) found that studies reported greater impact on attitudes when peer leaders were used, although the exact nature of attitude change was not specified.

The extent to which the positive impact of peer education on attitudes is sustained over the longer term is unclear. For instance, in evaluating the impact of a peer education initiative, Webster et al. (2002) found that peer education did not influence participants' attitudes about alcohol and tobacco over time (six months follow-up). Rather, they observed more lenient attitudes towards these substances.

Three of the seven studies examining attitudes in a review by Mellanby et al. (2000) found peer-led groups to be more effective in influencing attitudes towards substances or stopping use than adult-led education (Botvin, et al., 1984; Botvin, 1990; Laiho et al., 1993). No studies found that adults were more effective than peers in altering attitudes. While not assessing drug-related attitudes, Mellanby et al.'s (2001) evaluation of the A PAUSE (Adding Power And Understanding in Sex Education) initiative found that peer leaders were more effective in establishing conservative attitudes and norms about sexual behaviour compared to adults.

Skills

Only one study was identified (Perry et al., 1989) which assessed the impact of peer education on skills. The skills examined by Perry et al. were skills in refusing alcohol, measured by self reported degree of confidence in saying "no" in various situations. An analysis of data from four countries (Australia, Chile, Norway and Swaziland) showed no significant differences between peer-led, adult-led or control groups among drinkers, or between peer-led and control groups for nondrinkers. However, the data from Australia indicated that the peer-led initiative resulted in significantly higher skill scores compared to teacher-led education among nondrinkers, and higher skill scores for peer-led compared to teacher-led and control group (no education) initiatives with drinkers.

Behaviour

Some research evidence suggests that peer education may influence behaviour in the short-term and may be more effective than adult-led drug education. However, the evidence is variable.

Peer Education vs Controls (no drug education)

Studies by Perry and Grant (1988) and Perry et al. (1989) found that peer-led initiatives resulted in significantly less alcohol use than no intervention. These findings are

supported by Mellanby et al.'s (2000) review in which nine of 11 studies that examined behaviour found peer-led interventions to be more effective than no intervention. However, not all studies are consistent. For instance, Webster et al. (2002) found that peer education did not influence participants' use of alcohol and tobacco, and use and enjoyment associated with alcohol and tobacco use increased over time (at six months follow-up). Bloor (1999) also found that peer education had no significant impact on nonsmokers and regular smokers. Peer education also did not seem to influence ex-smokers immediately post intervention, but at three months follow-up, those who participated in peer education were significantly less likely to have resumed smoking.

There is some evidence that peer education may change intended behaviour. Fors and Jarvis (1995) found that young, homeless people reported greater intentions to help a friend use community resources following participation in peer education, whereas those who participated in teacher-led or no education exhibited no changes in intentions to help a friend. Smith (2000) examined the community wide effects of peer-led sex education. One year after the education initiative, a community wide survey revealed a 2.6 fold increase in condom use at last intercourse.

Peer Education vs Adult-led Drug Education

A meta-analysis conducted by Black et al. (1998) found that peer initiatives impacted on drug-related behaviour significantly more than adult-led initiatives across a range of drugs. Peer education produced a greater reduction in cigarette smoking, drinking (especially excessive drinking) and cannabis use than adult-led education (Perry and Grant, 1988; Botvin, 1990 cited in Black et al., 1998). In Mellanby's (2000) review, seven of 11 studies found peer interventions to be significantly more effective than adult-led education in influencing health related behaviour, however four studies found no significant difference. One of Mellanby's studies found that adult-led interventions resulted in higher alcohol use than was found in the control group. Wiist (1991) found modest support for peer education and reported that smoking education conducted by influential peers within social cliques resulted in greater prevention of smoking compared to teacher-led, peer education conducted by model students[3] and control groups, although this difference was not statistically significant at six and 12 month follow-ups.

In a meta-analysis of 90 studies, Rooney and Murray (1996 cited in Cuijpers, 2002a) examined school-based, peer-led and social influence initiatives aimed at prevention of tobacco use with follow-up data at one year or more. They found that initiatives using an untrained same-age peer as a leader had larger effects at post test than those with adult leaders (Cuijpers, 2002a). A meta-analysis conducted by Bangert-Drowns (1988) found that peer-taught students reported less drug use than adult-taught students, though the difference was not statistically significant.

Cuijpers (2002b) examined 12 studies that compared peer-led drug prevention initiatives to the same initiatives led by adults. Overall, peer-led initiatives appeared

to be more effective than adult-led initiatives, but only over the short-term. This may indicate that short-term behaviour changes represent only a short-term delay in the onset of drug use by non-users and a short-term reduction in amount used (Cuijpers, 2002a). However, the quality of these studies was questionable, and the interventions and target groups differed considerably among studies. Nonetheless, Cuijpers (2002a) concludes that a peer leader is one key characteristic of effective drug education initiatives (Cuijpers, 2002a).

Black et al. (1998) suggests that the greater impact of peer education compared to adult-led education occurs because peer initiatives are more interactive, whereas teacher-led initiatives are more didactic, and peer educators received more training and monitoring than adults.

Impact of Peer Education on Different Target Groups

There is evidence to suggest that the success of peer education is influenced by characteristics of the participants, such as:

- gender
- age
- users, non-users or ex-users
- drug type.

Gender

A number of studies have found greater success for peer education with young women compared to young men (Wiist et al., 1991; Bloor et al., 1999; Mellanby et al., 2000). Among ex-smokers, peer education reduced the likelihood of relapse for female but not male ex-smokers (Bloor et al., 1999). Similarly, Wiist et al. (1991) found that for young women peer education resulted in a higher smoking prevention rate at six month follow-up than no intervention or drug education delivered by adults or model students. Wiist (1991) found no significant differences between the four comparison groups (peer educators, model students, teachers, no intervention) among young men. One of the 13 studies in Mellanby et al.'s (2000) review found that only young women showed a positive change in health related behaviour as a result of peer education.

Age

Some studies have reported that the effects of peer education appear to be more powerful for younger age groups, around ages 10-13 (Fors and Jarvis, 1995; Weiss and Nicholson, 1998; Bloor et al., 1999). One explanation for such findings is that this is about the age when young people are most likely to begin experimenting with a variety of drugs and are therefore susceptible to greatest influence (White and Pitts, 1997).

Weiss and Nicholson (1998) found that peer education appeared more effective in delaying initial or repeat substance use among young participants (aged 11-12) than those aged 13-15. Similarly, Fors and Jarvis (1995) found that among runaway/homeless youth the effects of peer education were most powerful with the youngest group (age 10-13), but there were no significant differences between age 14-16 and age 17-19. Bloor et al. (1999) also found that peer education significantly reduced relapse among year 8 (aged 12-13) ex-smokers, but did not impact on year 9 (aged 13-14) ex-smokers.

Tobler (1992) maintains that successful prevention efforts must be developmentally timed. For instance, initiatives using group interaction to enhance acquisition of skills, including refusal skills, were most effective with the junior high age group (aged 12-14 years). Whereas older adolescents benefited more from initiatives that utilised personal interactions in small groups to share ideas, feelings and experiences.

Users, Non-users and Ex-users

Peer education has been found to be more successful in influencing behaviour among ex-smokers than regular or nonsmokers, but equally effective in enhancing knowledge and influencing behaviour among drinkers and nondrinkers. Bloor et al. (1999) found that ex-smokers who participated in peer education were significantly less likely to have resumed smoking three months after peer education than those who did not participate in peer education. In contrast, there was no impact on regular smokers or nonsmokers. However, Perry et al. (1989) reported that peer education was more likely than either adult-led or no intervention to improve knowledge and reduce alcohol use among both drinkers and nondrinkers.

Characteristics of Effective Peer Education

A general conclusion emerging from narrative reviews and meta-analyses is that peer education can be effective (Tobler, 1992), and that unsuccessful initiatives tend to be poorly designed and implemented and insufficiently supported (Black et al., 1998; Green and Tones, 1999; Green, 2001). The following section identifies the key characteristics of peer education initiatives with greatest demonstrated effectiveness. It is drawn from research examining peer education and school-based education which has included peer education.

It is crucial that the characteristics of effective peer education are widely understood so that resources can be directed towards initiatives that are likely to be successful, and to minimise the use of ineffective peer education strategies.

Delivery

Interactive initiatives have been found to be significantly more effective than didactic initiatives (Bangert-Drowns, 1988; Cuijpers, 2002a; Zickler, 2002). Interaction provides the opportunity for contact and communication and exchange of ideas in a non threatening atmosphere (Tobler et al., 2000 cited in Cuijpers, 2002a). Common interactive strategies include class discussions, small group discussions, role plays and games.

Length of Educational Initiative

Rooney and Murray's (1996) meta-analysis (cited in Cuijpers, 2002a) found that initiatives with 10 or fewer sessions and those that were distributed over a longer period (ie 10 or fewer sessions with more time between sessions) were most effective.

Selection of Participants

Bangert-Drowns (1988) found in their meta-analysis of 33 studies, that students who volunteered to participate in drug education reported lower drug use than students who were required to participate. However, Tobler's (1992) meta-analysis of 143 studies did not find any significant differences for method of selection in the drug education initiative. These variable findings may be explained by the different type of meta-analyses conducted. Tobler used a classic or Glassian meta-analysis, whereas Bangert-Drowns used a study effect meta-analysis. Classic meta-analysis is more tolerant of methodologically flawed studies than study effect meta-analysis. So, while Tobler included more studies, the technique used by Bangert-Drowns is more rigorous. The effect of voluntary or mandatory participation in drug education is therefore ambiguous and warrants further attention.

Drug Type

Studies that examined the impact of peer education on different types of drugs were limited to tobacco and alcohol. No studies were identified that examined the impact of peer education on use of other specific types of drugs. Hence, no definitive conclusions can be drawn about the implications for other drug types.

Tobler (1992) found that initiatives targeting tobacco were the most successful. Initiatives that only targeted tobacco had a greater impact on tobacco use than initiatives that included tobacco among a range of drugs. In contrast, alcohol initiatives were not particularly effective and targeting only alcohol did not improve results.

In contrast to Tobler's findings, Rooney and Murray (1996 cited in Cuijpers, 2002a) found that initiatives that addressed tobacco as well as other substances were effective. Despite the different findings about whether tobacco initiatives are more effective if

other drugs are included, there is good evidence to suggest peer education can effectively impact on smoking behaviour.

Location

Tobler's (1986) meta-analysis found no differences between urban, suburban and rural populations in relation to the impact of peer education on knowledge, attitudes, skills or behaviour.

Summary

Research into drug use by young people indicates cause for concern in relation to prevalence of use, age of initiation into drug use, patterns of consumption, skills and knowledge for reducing harm, and social and economic costs of problematic drug use.

There are limitations to adult-led drug education in terms of appropriateness, scope, transferability and effectiveness. Peer education may be a suitable approach to fill the gaps resulting from limitations in adult-led drug education.

A number of arguments are presented in the literature to support the use of peer education. These include the credibility of peer education, decreased threat from peer educators, impact of role modelling, ongoing contact between peer educators and target group, potential for peer education to access hidden populations, cost effectiveness and benefits for peer educators.

Peer education has been found to exert a positive influence on knowledge and, to a lesser extent, skills, attitudes and behaviour. A number of studies, reviews and meta-analyses have found peer education to be more effective than adult-led education or no drug education. The characteristics of the target group, such as gender, age, and drug experience, have been found to impact on the effectiveness of peer education. A number of characteristics of effective peer education have been identified in the literature, including interactive delivery of peer education, a drug specific focus and programs of limited duration.

The following chapter outlines a number of social psychological theories and explanatory models that have been applied to peer education.

Notes

[1] Meta-analyses are particular statistical techniques for analysing and summarising findings across a number of studies. They can provide an indication of the collective strength of research findings (Bangert-Drowns, 1988).

[2] Attrition refers to the proportion of participants who did not receive the intended intervention or were not assessed at follow-up (Foxcroft et al., 2003).

[3] Wiist and Snider (1991) used the term "model students" to describe peer educators who were not members of the participants' social clique or peer group.

Chapter 4

Theoretical Models Applicable to Peer Education

The theoretical basis of peer education is rooted within the psychological literature. Early peer education was based more on intuition and observation, rather than sound theoretical principles (Turner and Shepherd, 1999). However, various social psychological theories help explain the impact that peer education may have on young people's drug-related attitudes and behaviour.

The central purpose of peer education initiatives is to influence or modify young people's knowledge, attitudes or behaviour. In many cases, the end goal is to modify particular behaviours. It is commonly assumed that enhancing knowledge on a particular topic will influence attitudes and ultimately behaviour. However, such a linear knowledge-attitude-behaviour relationship is not consistently supported by research evidence (Allott et al., 1999). These interrelationships are complex and not always unidirectional in nature.

Behaviour change is influenced by a number of factors related to the individual (eg pre-existing knowledge, attitudes and beliefs), the social environment (eg group and cultural norms, peer influence, family influence) and cognitive factors (eg self esteem and self efficacy). A clear understanding of the factors most likely to impact on behaviour change is pivotal to the success of peer education initiatives. Outlined below is a brief overview of well established psychological theories of behaviour change and their implications for the development of effective peer education initiatives. Each theory is described only briefly as more detailed discussions are available elsewhere (Festinger, 1954; Bandura, 1977; Vander Zanden, 1980; Ajzen and Madden, 1986; Grube, 1986; Mackie et al., 1990; Wilder, 1990; Rosenstock, 1990; Ajzen, 1991; Grodner, 1991; Prochaska and DiClemente, 1982; Prochaska et al., 1992; Kaplan et al., 1993; Rogers, 1995; Grube and Voas, 1996; Armitage et al., 1999).

Social Factors

Social Learning Theory (Bandura, 1977)

Overview of Theory

The first theory used to explain and support peer education was Albert Bandura's Social Learning Theory (1977). Social Learning Theory is concerned with how the social environment influences an individual's behaviour. It places particular emphasis on the importance of modelling. Bandura (1977) argued that social behaviours are learnt by observing the behaviour of others in the social group. Specifically, observation of others provides information on the likely consequences of particular behaviours. At one level, a particular behaviour will be performed if it is seen to result in a positive outcome for the person engaging in that behaviour (Vander Zanden, 1980). Factors influencing the likelihood of behaviour change include characteristics of the model (how influential they are) and the perceived nature and severity of the consequences (reward or punishment) of behaviour. As shown in Figure 4.1, an individual conducts an unconscious cost-benefit analysis when deciding whether or not to engage in a particular behaviour. The individual's perception of outcomes is a key factor, regardless of whether this judgement is an accurate reflection of actual outcomes.

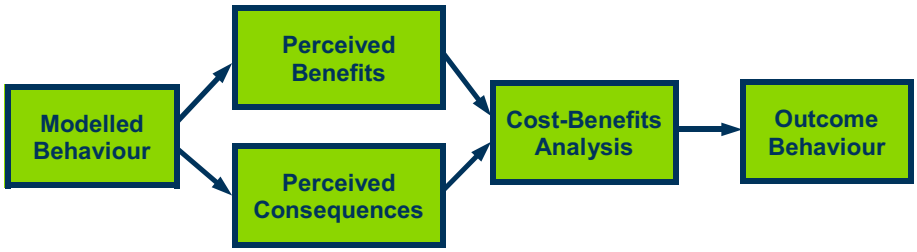

Figure 4.1: The Relationship Between Perception of Consequences and Behaviour

Implications for Peer Education

Young people spend a considerable amount of time with their peers and are greatly influenced by peer group norms regarding drug use and perceived outcomes (Fors and Jarvis, 1995; Cripps, 1997). From a Social Learning Theory perspective, the increased influence of peers and the diminished influence of adults during adolescence suggests that peer education should be more influential than adult-led education.

Social Learning Theory also reminds us that young people's decisions related to drug use, like other social behaviours, will be shaped by observing their social group. Specifically, a young person is more likely to use drugs if they perceive other individuals' drug use to have positive and attractive results. The outcomes of smoking illustrate this point. One observer may notice the negative physical consequences of an initial attempt to smoke, including coughing, watery eyes, sore throat or

embarrassment. While another observer may focus instead on approval of peers, acceptance and group inclusion. Social Learning Theory suggests that the latter individual is more likely to begin smoking than the former.

A pivotal challenge for peer education is to provide opportunities to model desired behaviours. Social Learning Theory also indicates the importance of ensuring that peer educators have ongoing social contact with the target group.

Social Identity Theory

Overview of Theory

Social Identity Theory is based on the concepts of in-group and out-group influence. It is well established that people are more strongly influenced by individuals with whom they share a common social identity (eg gender, culture, work or sporting groups) (Wilder, 1990). This shared social identity forms the foundation for in-group membership (ie belonging to a peer group). In contrast, out-group members are perceived to differ on important characteristics.

Group membership influences behaviour through two main mechanisms: social influence (norms and expectations) and information influence. A defining characteristic of groups is the presence of norms that indicate appropriate beliefs, attitudes and behaviours for group members. Social influence in relation to in-groups operates through a number of channels including exposure (frequency of contact with group members) and social comparison (modelling of appropriate/desirable attitudes and behaviours) (Wilder, 1990). However, group membership does not guarantee adherence to the group's normative beliefs and behaviours. The degree to which an individual conforms to group norms depends on their desire for acceptance and status within the group (rewards) and a wish to avoid rejection by the group (punishment).

Information influence is a second powerful source of group influence, and concerns the dissemination of information to individual members. Information influence refers to the influence of the message content (Wilder, 1990). There is evidence to suggest that information influence is strongest when the messenger is an in-group member. Messages conveyed by in-group members are likely to more strongly engage the listener's attention, who in turn is likely to spend greater effort processing and considering the information (Mackie et al., 1990).

Implications for Peer Education

Social identity research suggests that peer educators are more likely than adults to be perceived as in-group members. In addition, peer educators who match the target group in relation to key social and personal characteristics are more likely to be perceived as in-group members than peer educators who only match the target group

on a single characteristic, such as age. Given this, careful selection of peer educators is required to optimise the probability of effectively influencing young people's drug-related knowledge, attitudes and behaviour.

Diffusion of Innovation Theory

Overview of Theory

Diffusion of Innovation Theory (Rogers, 1995) describes the communication of innovations throughout social networks over time (Larkey et al., 1999; Rogers, 2002). An innovation is a new idea, practice or object (Rogers, 2002). The time taken for innovations to diffuse through a social network depends on how members of the network perceive the relative advantage, compatibility, complexity, trialability and observability of the innovation (Rogers, 1995).

Diffusion of Innovation Theory suggests that new information and behaviours diffuse throughout a group as more and more group members discuss the information and subsequently change their behaviour. Those who first practice and explore a new behaviour (early adopters), are generally well integrated in the group and can often be described as opinion leaders (Rogers, 1995; Rogers, 2002). Early adopters are able to provide information in a context specific and culturally appropriate manner (Larkey et al., 1999). Other group members learn by observing and modelling behaviour of early adopters. Introducing innovations through opinion leaders has been found to result in more rapid diffusion of innovations of health interventions than providing factual information and feedback (Rogers, 2002).

Of particular interest in drug education is the idea of preventive innovations, ie new ideas aimed at preventing drug-related harm. These are ideas that require action to avoid future unwanted consequences (Rogers, 1995). Preventive innovations may be relatively low in perceived relative advantage and less likely to be adopted. Strategies that may successfully enhance diffusion of preventive innovations include those that use opinion leaders as champions to promote preventive innovations, use peer support to change norms within the social network, use entertainment to present educational ideas, and activate peer networks to diffuse preventive innovations (Rogers, 2002).

Implications for Peer Education

Diffusion of Innovation Theory supports the use of informal approaches to peer education that rely on ongoing contact and cultural change. Peer educators can be conceptualised as early adopters. Peer education initiatives may channel the influence of early adopters by providing AOD training to opinion leaders within the peer group. Following training, the peer educators disseminate the newly learned information and enact newly formed behaviours, which increases the observability of desired behaviours.

It is possible that the failure of some preventive drug education initiatives is at least in part the result of the perceived low relative advantage of preventive innovations (Rogers, 2002). However, peer education possesses many of the characteristics of strategies for enhancing diffusion of preventive innovations, for example, peer education may:

- train opinion leaders within peer groups as peer educators
- encourage peer educators to provide support to their peers
- draw on popular culture and entertainment mediums to deliver drug education messages
- encourage peer educators to communicate safe drug messages to those in their immediate and wider social network

(Rogers, 2002).

Social Comparison Theory

Overview of Theory

According to Social Comparison Theory, people form beliefs about their own abilities and opinions by comparing themselves with others who are similar in relation to relevant characteristics. The process of evaluating self against similar others has an informative and motivating effect. Originally, it was thought that social comparison was only used for self evaluation (Festinger, 1954), however recent research has suggested that social comparison is also used for self improvement and self enhancement. When an individual compares themself to others in the hope of self improvement, they tend to compare themself to others who they believe are superior in relation to relevant characteristics.

Implications for Peer Education

Adolescence is a time when young people feel a heightened sense of identification with their peers and realise that they share many characteristics with other young people (Ransom, 1992; Bond and McConkey, 2001). A young person is more likely to look to others of their own age for the purposes of social comparison rather than to adults, particularly in relation to aspects of youth culture including drug use. Social Comparison Theory is concordant with the rationale for peer education. Young people who are similar to the target group may positively influence drug-related norms within the target group and potentially motivate them to adopt safer attitudes and behaviours.

Cognitive Factors

Cognitive Dissonance Theory

Overview of Theory

According to Cognitive Dissonance Theory, developed by Festinger (1954), cognitive dissonance occurs when a person receives information inconsistent with their existing knowledge, attitudes and beliefs and which may produce feelings of conflict or guilt, depression, lowered self-esteem and decreased self-efficacy (Marlatt and Gordon, 1985). When dissonance occurs, a person may reduce unwanted feelings by either accepting or avoiding the new information (Festinger, 1964 and Steele, Southwick and Critchlow, 1981 cited in Marlatt and Gordon, 1985). Acceptance means changing beliefs or attitudes to match the new information. A common avoidance response is to dismiss the new information as lacking credibility. Individuals may also engage in more subtle forms of avoidance, for instance accepting that the information is true to some extent, but not, or usually not, true for them. This is referred to as applying self exemption. Responses to cognitive dissonance are represented graphically in Figure 4.2.

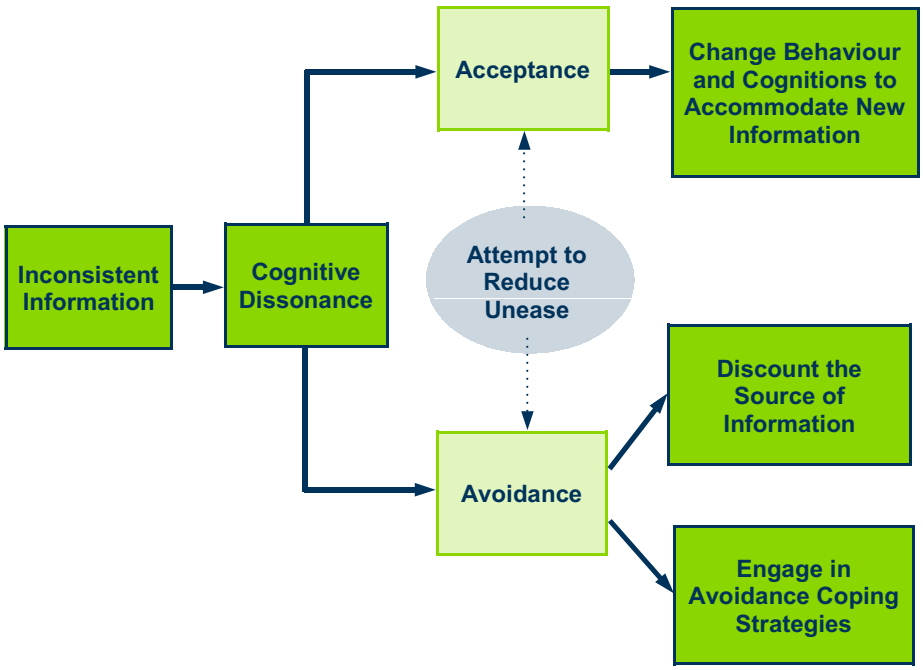

Figure 4.2: Cognitive Dissonance and Potential Responses

Cognitive dissonance can also occur when an individual behaves in a manner inconsistent with their existing self image or belief system. To avoid the cognitive dissonance that arises in this situation, the individual may blame their behaviour on external forces in order to avoid changing their self image. For example, if a person becomes intoxicated they may believe they had no control over their behaviour. This is referred to as "self serving bias". Alternatively, the individual may accept the new behaviour and modify their self image. For example, if an ex-drug user returns to drug use, the validity of their self image as an ex-user is challenged, which may decrease their perceived self efficacy, reinforcing the belief that they cannot exert control over their use (Donovan and Chaney, 1985).

Implications for Peer Education

Cognitive Dissonance Theory highlights the importance of tailoring peer education initiatives according to the expectations and experiences of the target group. It also provides some insight into strategies for enhancing the acceptability of peer education content. It may include strategies, for example, to reduce the:

- likelihood of dissonance occurring it may be useful to:
  - deliver information that is relevant and consistent with the person's experience
  - provide a balanced view (eg include information about why some young people may see drug use as a positive experience as well as providing information about potentially negative consequences of drug use) so that if participants or their friends have experienced drug use as fun the overall message from peer education may be more consistent with their own experience

- likelihood that dissonant information will be dismissed as not credible. It may therefore be useful to:
  - ensure both the message and messenger (ie peer educator) are highly credible, which may be achieved if:
    - the peer educator is similar to the target group in relation to key characteristics (eg age, socioeconomic background, drug-related experience, gender)
    - the content of peer education does not contradict participants' experience

- likelihood that participants will apply a self exemption (ie dismiss information as not true for them). It may therefore be useful to:
  - provide information and examples that closely resemble participants' context and experience

- consequences of dissonance, such as guilt or reduced self efficacy. It may therefore be useful to:

- provide achievable strategies to address problems so that participants' self efficacy is maintained
- provide information in a non-judgemental manner in an effort to reduce feelings of guilt.

Health Belief Model

Overview of Theory

The Health Belief Model (HBM) was developed to explain health-related behaviour in response to a disease condition (originally to explain uptake of tuberculosis screening). According to the HBM, the probability of engaging in a given behaviour is determined by four main beliefs concerning the perceived threat of a negative health outcome and perceptions of recommended health action in response to the threat (Kaplan et al., 1993) (see Figure 4.3 McDonald, 1996, p18).

Overall perceived threat is determined by perceived susceptibility (perception of personal risk for a health condition) and perceived severity (perceived magnitude of medical, clinical or social consequences of a health condition) (Rosenstock, 1990; Grodner, 1991). Although high perceived severity and susceptibility increase the likelihood of taking the recommended health action, perceived susceptibility has been demonstrated to have greatest impact (Rosenstock, 1990; McDonald, 1996).

Perceptions about health actions in response to perceived threat comprise perceived benefits and perceived barriers. Perceived benefits refer to judgements about the likely effectiveness of an action in reducing the threat of disease. Perceived barriers are the potential negative consequences of engaging in the behaviour (Rosenstock, 1990). Perceived barriers relating to drug use may include rejection by peers, and fear of short- or long-term consequences, such as overdose or chronic disease. The process of evaluating costs and benefits is thought to be unconscious. The Health Belief Model predicts that the motivation for action occurs only when benefits are perceived to outweigh costs (Rosenstock, 1990; Kaplan et al., 1993). Perceptions of threat and response combine to influence the final likelihood of health preventive behaviour. Specifically, the health action is most likely to be taken if the perceived threat of disease (or other negative consequence) is high and the benefits of the health behaviour outweigh the barriers (Rosenstock, 1990; Kaplan et al., 1993).

The concept of self efficacy was added to this model in later work. In essence, an individual is more likely to engage in the health behaviour if they believe they are capable of carrying it out successfully (Rosenstock, 1990). Other variables added to subsequent versions of the HBM include demographic, sociopsychological and structural variables which may impact on the individual's perceptions, thereby indirectly affecting health behaviour.

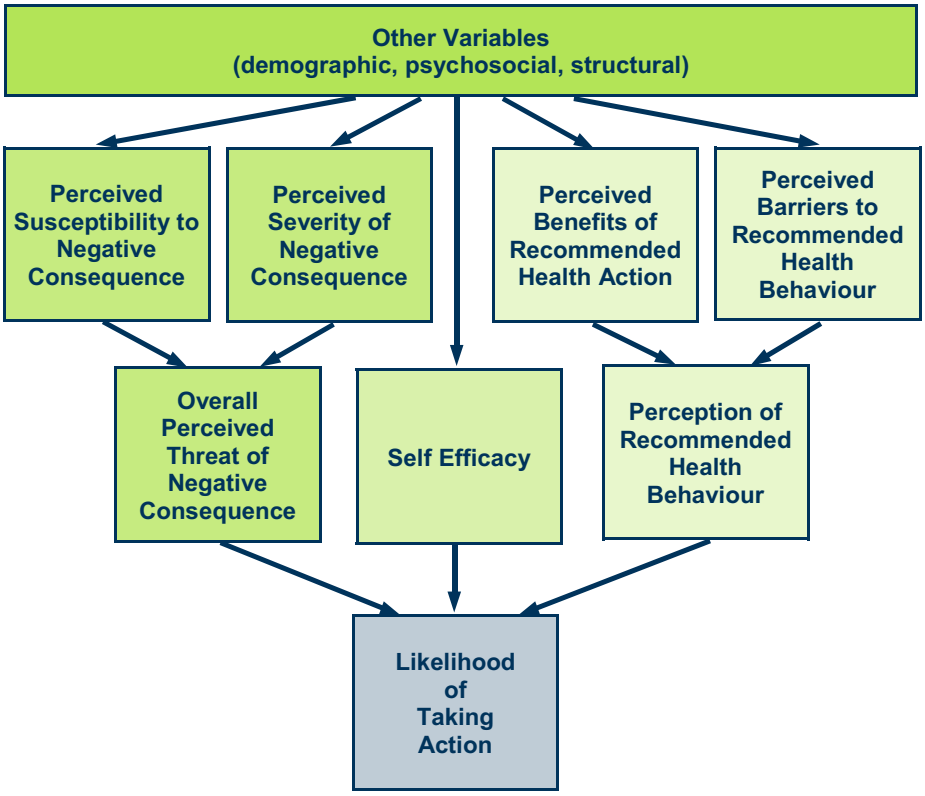

Figure 4.3: The Health Belief Model Revisited
(McDonald, 1996)

Implications for Peer Education

Reduced consumption, altering risky use, or abstinence are all health related behaviours relevant to drug use. The HBM suggests that the content of peer education initiatives should focus on young people's perceptions of susceptibility to and severity of AOD-related harms (eg overdose, chronic disease, infections, tiredness, rejection by peers, in trouble with school or parents). The HBM suggests that peer education should focus not only on identifying effective behaviours to reduce AOD-related risks and harms, but should also provide young people with information, skills and support needed to overcome potential barriers to performing such behaviours (eg peer pressure, existing dependency, difficulty in accessing clean needles, poor coping skills).

Finally, the finding that perceived susceptibility has a greater impact on behaviour than perceived severity indicates that the effectiveness of peer education may be enhanced if less severe, but more widespread, consequences are also addressed. Examples of less severe consequences to which young people may feel susceptible include feeling sick or embarrassed if they drink to intoxication, the high cost of cigarettes or the negative impact of smoking on skin tone.

Socio Cognitive Models

Theory of Planned Behaviour

Overview of Theory

Outlined above are a number of individual cognitive and social explanatory models of behaviour relevant to young people and drug taking behaviour. The Theory of Planned Behaviour provides an integrated account of the antecedents of behaviour that takes into consideration many of the issues discussed previously.

The Theory of Planned Behaviour describes the mechanisms that influence an individual's behavioural intention, which in turn influences actual behaviour (Ajzen and Madden, 1986; Ajzen, 1991). The Theory of Planned Behaviour has been applied to a wide range of health related behaviours, including alcohol and other drug use (Grube, 1986; Grube and Voas, 1996). It is a useful theoretical framework for peer education because it incorporates a variety of social and individual factors that influence drug-related behaviour.

According to this theory, behavioural intentions and subsequent behaviours are determined by an individual's attitudes, normative beliefs and perceived behavioural control (see Figure 4.4). According to this model, attitudes are determined by the interaction between beliefs about consequences of a given behaviour and the value placed on those consequences. For example, the perceived consequences of drinking alcohol may be both acceptance by peers and feeling sick. However, if the individual values peer acceptance over avoiding feeling sick, they are likely to drink alcohol.

Normative beliefs are an individual's beliefs about whether relevant individuals or groups (eg parents or peers) approve or disapprove of a particular behaviour and whether they engage in that behaviour themselves (Grube and Voas, 1996). The impact of normative beliefs on behavioural intentions depends on the individual's motivation to comply with the expectations of these individuals or groups.

Finally, perceived behavioural control refers to the level of self control an individual feels over their own behaviour. This concept takes into account the perceived impact of internal (eg skill, motivation, knowledge) and external (eg luck, chance, the control of powerful others) influences on behaviour.

Implications for Peer Education

The Theory of Planned Behaviour highlights the importance of the normative influence of peers and other relevant individuals (eg parents). Peers are perceived as significant in the lives of the individual, particularly in adolescence, and as such play a key role

in determining normative behaviour. The Theory of Planned Behaviour also highlights the importance of beliefs about outcomes and the evaluation of these outcomes and suggests that young people are likely to evaluate potential outcomes by observing their peers. Given the influence of peers, information that peer educators provide to young people about social consequences and norms related to drug use may influence young people's behavioural intentions and actual behaviour.

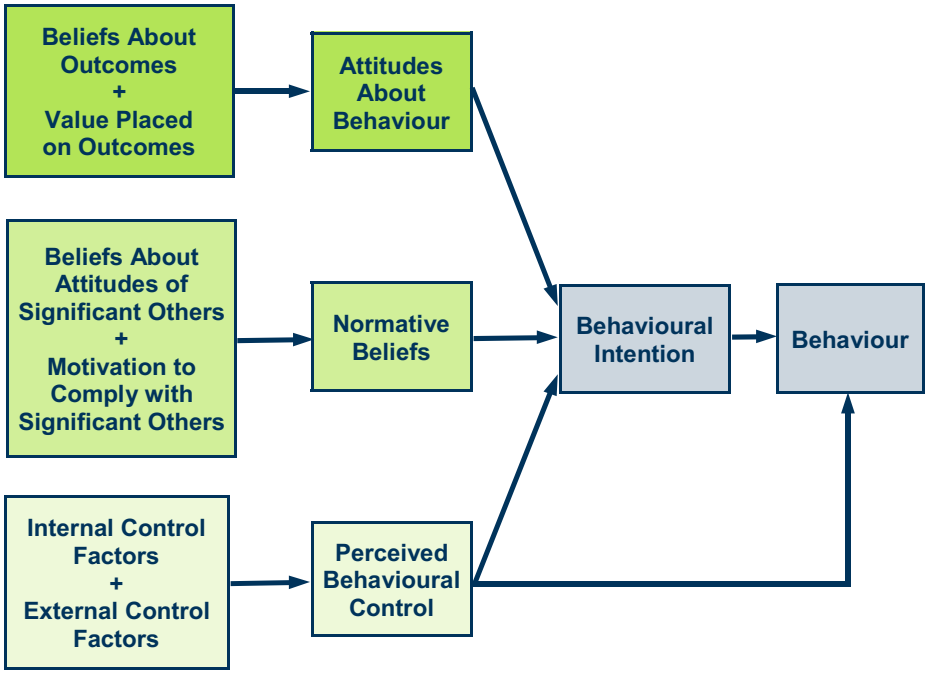

Figure 4.4: Model of the Theory of Planned Behaviour
(as proposed by Ajzen and Madden, 1986)

Changing Behaviour

A common goal of peer education initiatives is to change or modify risky, undesirable or inappropriate behaviours. The theories described above identify some of the major factors likely to influence an individual's behaviour. It is also important to acknowledge that initiating a change in established patterns of behaviour is a complex process that extends beyond many of the theories discussed above. Below is an overview of a popular model of behaviour change – the Trans-Theoretical Model of Change.

Trans-Theoretical Model of Change

Overview of Theory

The Trans-Theoretical Model of Change, also commonly referred to as the Stages of Change Model, was developed to explain how problematic behaviour is modified (Prochaska and DiClemente, 1982; Prochaska et al., 1992). It has been applied to a wide range of health-related problems, for example smoking cessation (Brannon and Feist, 2000). According to this model, an individual progresses through five stages when attempting to alter a particular behaviour: precontemplation, contemplation, preparation, action and maintenance (as shown in Box 4.1).

Smooth progression through each stage is rare. It is more likely that a person will progress sequentially and slowly through each stage with occasional relapses back to earlier stages (Prochaska et al., 1992). It is important to recognise that successful efforts to change behaviour are frequently followed by periods of relapse.

Box 4.1: Stages of Change

1. Precontemplation

The individual does not intend to change behaviour and often does not acknowledge the behaviour as problematic.

2. Contemplation

The individual is aware of the problem and is thinking about changing the behaviour in future.

3. Preparation

The individual is making plans and taking positive steps towards changing the behaviour.

4. Action

The individual is implementing planned changes.

5. Maintenance

The individual is making efforts to sustain change and resist relapse.

The model explains why knowledge change may have little impact on behaviour change and offers insight into the complex nature of behavioural change for problematic health related behaviours. It is argued here that knowledge change may move an individual from precontemplation to contemplation. Attitude change may shift the individual into the preparation stage. Ongoing support and reinforcement may facilitate entry into the action and maintenance stages and hence result in behaviour change (see Figure 4.5).

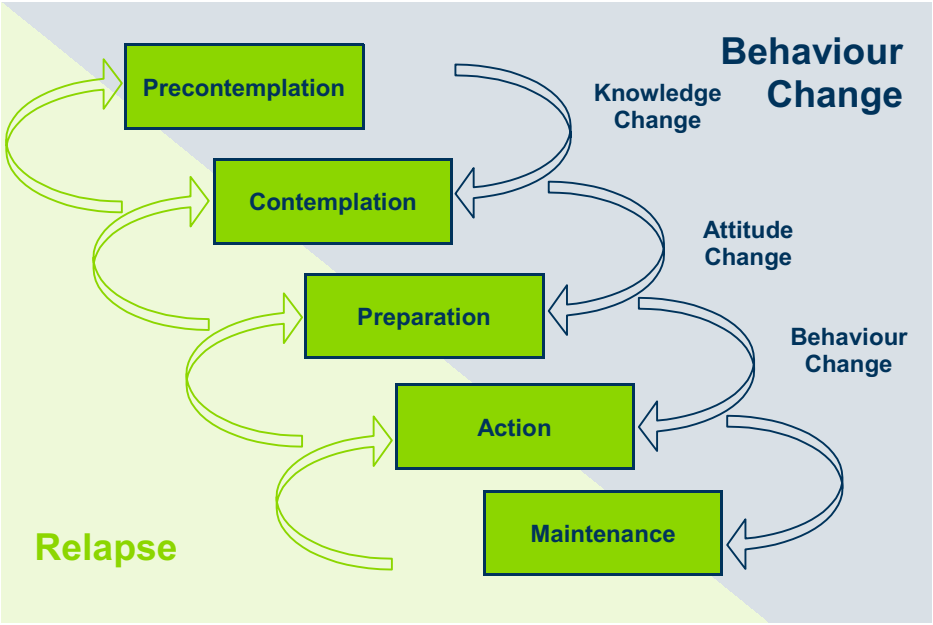

Figure 4.5: Stages of Change and Impact of Knowledge, Attitudes and Behaviour

Implications for Peer Education

The Stages of Change Model highlights the need to move beyond simply providing information to young people on drug-related issues, which is unlikely to exert a significant impact on behaviour. Rather, the model identifies several important strategies to be incorporated into peer education initiatives:

- provide practical strategies for implementing change
- use credible peer educators and information compatible with the experience of the target group to influence attitudes
- provide ongoing reinforcement and support to encourage long-term behavioural change.

The Stages of Change Model indicates the importance of assessing the current stage of target group members, in relation to change, in order to tailor peer education

strategies to the capacity and willingness of the target group to change. For example, a key issue for non-users and ex-users will be maintenance of existing behaviour, whereas a focus on motivation to change is more appropriate for interventions with problematic users. In addition, appropriate behaviour change will depend on existing drug use and willingness to modify particular aspects of drug using behaviour.

Summary

This review has illustrated the ways in which peer education is consistent with a number of well established social psychological theories concerning the antecedents and mechanisms of change associated with drug-related attitudes and behaviours. This literature also serves as an important reminder that a person's behaviour results from a complex mix of social and individual factors. As highlighted above, carefully designed peer education initiatives are well placed to address the range of factors likely to impact on a young person's response to drug-related issues.

Theories of social influence (Social Learning, Social Identity, Diffusion of Innovation, Social Comparison) provide important insights into the mechanisms underlying the potential influence of a peer educator on young people. Social Identity and Social Comparison theories indicate the importance of carefully selecting peer educators perceived to be a member of young people's in-group from the perspective of the young people themselves. Establishing in-group membership will allow a peer educator to tap into the powerful sources of social influence associated with group membership, and is also likely to increase their effectiveness as a role model and as a disseminator of information and knowledge. Theories of social influence suggest that peer educators should actively model the attitudes and behaviours desired of the target group. Diffusion of Innovation Theory suggests that a peer educator should take a leadership role as an "early adopter" of new or modified behaviours within the group.

The second section of this chapter described three major theories of attitudes and behaviour from the perspective of cognitive processes operating within the individual. Cognitive Dissonance Theory provides an important reminder that information challenging young people's attitudes, beliefs or views of their own behaviour is likely to pose a significant threat to self esteem. In order to alleviate self-protective responses such as denial and avoidance, the Health Belief Model highlights the importance of providing an appropriate balance of information focused on the negative consequences of harmful AOD behaviours and methods of avoiding such outcomes. The Health Belief Model emphasises the importance of increasing young people's confidence in their ability to perform the behaviours needed to reduce AOD-related harms. As noted, a peer educator accepted into a young people's in-group has the potential to be a powerful leader, role model and information disseminator for AOD-related information. A consistent theme across the social influence theories, Health Belief Model and Theory of Planned Behaviour is the importance of considering young

people's perceptions of the benefits and harms associated with AOD-related behaviours. These theories indicate that peer education focused on AOD-related harms and benefits should target those outcomes that are of greatest importance and value to the young people themselves.

Finally, the Stages of Change Model highlights the importance of understanding behaviour as a dynamic process rather than a static response. Similar to the theories of individual cognition, the emphasis is again on understanding responses to AOD issues from the perspective of young people themselves. The Stages of Change Model indicates that the goals of peer education should be adjusted according to a young person's readiness and openness to change.

An underlying theme linking each theoretical perspective – social, cognitive and stages of change – concerns the importance of establishing a clear understanding of young people's perspectives in relation to:

- membership of their peer group
- the importance of peer group influence in determining their behaviour
- the harms and benefits associated with AOD use of greatest importance or significance
- their susceptibility to important harms from AOD use
- their capacity to engage in behaviours that reduce AOD-related harms (ie, self efficacy)
- their openness and willingness to modify or change their AOD-related behaviours and attitudes.

This was the final chapter in Part B: Understanding Peer Education. You might like to stop here and briefly review the concepts above and take the opportunity to reflect on what research has indicated as the most appropriate way forward in relation to peer education. Part C changes gear and moves away from the background and theoretical issues to provide practical guidelines for planning, implementing and evaluating a peer education initiative.

Part C

Guidelines

The first half of this monograph focused on the conceptual and theoretical underpinnings of peer education. The following chapters focus on practical, hands-on strategies for implementing peer education initiatives.

This section addresses four core stages of the peer education process and provides guidelines to assist you. The four chapters in this section are:

Chapter 5: Planning Peer Education Initiatives
Chapter 6: Evaluation
Chapter 7: Selecting, Training and Supporting Peer Educators
Chapter 8: Implementation of Peer Education Activities

Chapter 5

Planning Peer Education Initiatives

Planning is a critical component of successful peer education initiatives (Walker and Avis, 1999). Central tasks of planning are to:

- identify the target group
- develop appropriate aims
- address administrative issues
- plan an evaluation strategy (planning and implementation of evaluation are both covered in the next chapter).

Identifying the Target Group

Development of a peer education initiative is informed by the parameters, characteristics and needs of the target group. Identification of the target group will contribute to decisions about content, delivery and the setting of peer education activities, as well as the required characteristics and training of peer educators.

It is important to understand the difference between parameters and characteristics. Parameters are the boundaries that define the target group, while characteristics refer to a description of those who fall within these boundaries. Age, for example, may be a parameter in some cases, in others, it may be a characteristic.

Parameters of the Target Group

Parameters are the boundaries that define the target group. For instance, the target group may be defined by:

- age
- residence within a given geographical area
- attendance at a particular school
- enrolment in a given grade / year level
- participation in a given extra curricular activity
- attendance at certain events
- utilisation of particular services.

Once the parameters have been defined, the characteristics and needs of those within the target group can be ascertained.

Target Group Characteristics

Important target group characteristics that may need to be assessed include age, drug-related experience, gender, ethnicity, lifestyle and education level. Some of these are discussed in greater detail below.

Age

The age range of the target group has important implications for the appropriate age of peer educators, as well as selection of suitable settings and content. It is advisable to keep the age range of the recipients of peer education within narrow boundaries if possible (eg 11-13, 15-17). This will allow more targeted and appropriate programs and strategies to be developed. The evidence is very clear that as a young person develops, matures and changes rapidly throughout adolescence, so too does their need for appropriately tailored education.

Age of Peer Educators

Ideally, peer educators should be the same age or slightly older than the target group. There is evidence to suggest that recipients of peer education will find peer educators who are slightly older more credible (Cripps, 1997).

Setting

The age of the target group may indicate the most appropriate setting for peer education. School may be appropriate for children who are legally required to attend school. Work or tertiary education settings may be more suitable for those aged over the legal school age. In social settings, adolescents aged under 18 may be found at all-ages events or community social gatherings, such as youth groups. Licensed premises and events may be more appropriate settings for those aged over 18.

Content

The average age of first use for most illicit drugs is the late teens (Australian Institute of Health and Welfare, 2002). As such, unless indicated by other characteristics and interests of the target group, high prevalence drugs (namely alcohol, tobacco and cannabis) may be the most relevant drugs to be addressed for younger adolescents, whereas a wider range of illicit drugs may need to be addressed for older groups, including young adults.

Drug-related Experience

The target group's experience of drugs and related issues may vary from little or none, to indirect experience (ie through the experiences of others) to intense personal experience. Age may indicate drug-related experience. There may also be variation within the target group.

Experience of Peer Educators

Young people are more likely to respond to a peer educator who has experiences of drugs and related issues that are similar to their own (Douthwaite, 1997), including the type of drug and context of use (experimental, recreational or problematic) (Cripps, 1997). Groups with little or no drug-related experience may be responsive to trained and well informed peer educators, regardless of their level of personal experience with drug use (Douthwaite, 1997).

Content

The content of peer education needs to be credible, relevant and appropriate to the experience of the target group. Selection of content material is a crucial component of peer education. It needs to be undertaken with care and close consideration of the group's needs. For example, information about the location of needle exchanges or routes of administration may be relevant to injecting drug users, but very inappropriate for non-injecting youth.

Gender

The literature suggests that young women respond to both male and female peer educators, whereas young men are more responsive to male peer educators (Baklien, 1993; Bloor et al., 1999). One explanation is that young men see young women as less credible sources of drug information. This is reflected in the gender dynamics of illicit drug users. Anecdotal evidence suggests that males may introduce females to illicit drug use, often actually injecting their female partners and that it is less common for females to introduce young men to illicit drug use. The implication for planning peer education is that the gender balance of the target group will indicate the proportion of male and female peer educators to be recruited.

Level of Education

The most appropriate delivery of peer education will depend in part on experience of formal education among the target group, such as whether their experience has been positive or negative and the number of years they have spent in formal education (including secondary and tertiary study). Early school leavers, marginalised youth, or Indigenous youth may not respond as well to formal peer education as young people who are familiar and comfortable with school or other types of formal education

(Prendergast and Miller, 1996). Level of education and the literacy level of the group also need to be considered in relation to the type of material and resources used. The literacy level of the group needs to be established to ensure that both the content of material and resources are appropriate.

Target Group Needs: Needs Assessment

Before commencing the development of the initiative, it is essential to undertake a needs assessment. In general, need refers here to the difference between the way things currently are and the desired situation (Owen and Rogers, 1999). In this context, need refers to the difference between the target group's current drug-related knowledge, skills, attitudes, beliefs, values or behaviour and that which is desired. Four types of need may be relevant (Hawe et al., 2000):

- normative need (defined by expert opinion)
- expressed need (inferred by observing use of services)
- comparative need (derived by examining services provided in one area to one population and using this as the basis to determine the sort of services needed in another area with a similar population)
- felt need (what members of the target group say they want or the problems they think need to be addressed).

Needs assessment is the process of identifying needs, setting priorities and making decisions about how to address needs (Witkin and Altschuld, 1995 cited in Owen and Rogers, 1999). There are five objectives of needs assessment. They:

- identify the desired situation
- identify the current situation
- identify the difference between current and desired situations
- identify reasons for the difference
- prioritise needs

(Owen and Rogers, 1999).

Needs assessment may be conducted in three stages:

1. Planning

   The tasks of planning a needs assessment are to identify the purpose of the needs assessment, outline methods to be adopted and identify potential uses of findings (Owen and Rogers, 1999).

2. Data Collection and Management

Tasks during this stage are to collect information about the current and desired situation from a range of sources to identify the nature and magnitude of needs among the target group (Owen and Rogers, 1999). It is important to:

- consult members of the target group and other key people who are likely to have an understanding of the target group needs
- refer to existing sources of information
- present findings to all who have contributed to data collection so they can confirm or provide feedback about the findings so far.

3. Prioritisation

During this stage, decisions are made about the relative importance of addressing each need according to the priority of different needs within the target group, availability of time and resources, including peer educators' skills and knowledge.

Aims and Objectives

Following identification of the target group, clear and realistic aims and objectives have to be established. Aims are the broad purpose or intent of the initiative. Objectives are statements that describe the specific steps required to achieve the aim (Health Services Division, 2001). Close consultation with the target group during this (and subsequent) stages may increase their sense of ownership and more accurately identify their needs and interests, thereby enhancing the likelihood of success (Prendergast and Miller, 1996; Mudaly, 1997; Ryan et al., 1999; Crompton, 2003). Outlined below are examples of peer education aims and the process of goal setting.

Aims
are the broad purpose or intent of the initiative.

Objectives
are statements that describe the specific steps required to achieve the aim.

Peer Education Aims

The aims of a peer education initiative need to be clearly articulated during planning. The aim may be to influence the target group's knowledge, attitudes, skills, behaviours and/or cultural norms or to empower them to make their own decisions (see Box 5.1 for examples). The stated aims inform the strategies and content and are used to gauge the success of the initiative.

Box 5.1: Potential Aims of Peer Education

Knowledge change:

- physical effects
- social and psychological effects
- prevalence of use
- aetiology of use
- political and legal issues
- harm reduction strategies
- safe practices
- responses to consequences (eg overdose of friend)
- support services
- further information

Attitude change:

- attitudes towards drug users

Skill enhancement:

- decision making
- communication
- accessing and assessing information

Behaviour change:

- abstinence
- avoiding risky consumption
- adopting safe practices

Change cultural norms:

- support for harm reduction strategies
- reducing environmental pressure to use

Empowerment:

- enhancing knowledge of drug-related issues
- learning communication and decision making skills
- building confidence to pass information on to others

For example, if the aim is to:

- enhance participants' knowledge:
  - activities focused on information transfer may be sufficient
  - success may be measured by completion of a knowledge questionnaire before and after peer education by participants
- influence behaviour:

- opportunities for interaction, observation, modelling and practice will be required
- success may be measured by actual behaviour, either observed or self reported behaviour.

The feasibility of implementing and evaluating a program or initiative with a given aim will depend on available funding, resources and time. For example, implementation and evaluation of peer education aimed at knowledge change may require fewer resources and time than peer education aimed at behaviour change.

Effective Goal Setting

In setting goals, it may be useful to use the SMART goals concept. SMART goals have five key characteristics – they are **S**pecific, **M**easurable, **A**chievable, **R**elevant and **T**ime bound (these are described in Box 5.2).

Administration

Before a peer education initiative begins, a number of central administrative issues need to be considered, such as:

- budget
- support from government, sponsors and other partners
- advisory group and coordinator
- staff retention
- retention of peer educators.

Budget

Often peer education initiatives have a limited funding base, particularly when conducted by schools or community based organisations. Detailed cost estimates may help prevent over expenditure and will also help support applications for funding and sponsorship. To minimise the impact of unexpected costs, it is advisable to build in an additional 5% buffer or contingency fund into the budget. Costs to incorporate into the budget include:

- recruitment and payment of staff (such as a coordinator and trainers) and peer educators
- administrative costs for purchase or hire and running of equipment such as telephones, photocopiers, computers etc
- costs for purchase or hire of resource materials (such as pamphlets, video tapes, overhead transparenciess) and equipment (such as projectors, television and video players)

Box 5.2: SMART Goals

Specific:

- The goal is stated explicitly (eg specific behaviours to be achieved, knowledge obtained), not in general or vague terms.
- Peer education example: Increased knowledge of physical and social consequences of illicit drug use.

Measurable:

- The goal can be quantified to assess pre and post-initiative change.
- Peer education example: knowledge of physical and social consequences of illicit drug use assessed using pre and post-initiative questionnaires.

Achievable:

- The most effective types of goals represent an appropriate balance between challenge and realistic expectations. Setting unrealistic or unachievable goals is likely to decrease the peer educator's motivation.
- Peer education example: providing information can result in increased knowledge, but is unlikely to result in behaviour change.

Relevant:

- The goal needs to be consistent with existing beliefs, ideology, schedule, resources or project brief, consistent with the general direction of the initiative, not frivolous or unnecessary.
- Peer education example: participants drinking within NHMRC guidelines at two-month follow-up is a relevant goal for a harm reduction initiative that has funding that extends to two months after completion of peer education activities.

Time Specific:

- Specific dates are set for achievement of milestones and achievement of final goal. This process helps to maintain motivation and enables separate evaluation for aspects leading to each milestone.

(Nelson and Economy, 1996)

- incentives for peer educators (such as reimbursement for travel, meals and possibly payment for involvement)
- venue hire for training of peer educators and peer education activities
- evaluation.

Support from Government, Sponsors and Other Partners

The costs of conducting peer education initiatives may be met or supplemented by seeking government funding or corporate sponsorship and building partnerships and collaborating with relevant community and government agencies.

Government Funding

At the national level, primary responsibility for AOD rests within the Drug Strategy Unit, Department of Health and Ageing. The website of the Prime Minister's advisory body, the Australian National Council on Drugs (ANCD) also provides information about funding opportunities. For further information about funding through these bodies, visit the following websites:

- Commonwealth Department of Health and Ageing <http://www.health.gov.au/>
- National Drug Strategy <http://www.nationaldrugstrategy.gov.au>
- Australian National Council on Drugs (ANCD) <http://www.ancd.org.au/>

At the state level, responsibility for AOD often rests with the Health Department. A number of other departments may be responsible for or have an interest in AOD, including Human Services, Education, Youth and Child Services, Housing, and the Premier's Department. To establish which department is most appropriate:

1. Determine whether there is a statewide coordinating body
2. Determine which department has the principal responsibility for AOD
3. Identify state government departments with some interest in AOD.

Funding at the local government level differs between jurisdictions. For specific local government funding initiatives, contact the council directly. In addition, all capital city councils belong to the Council of Capital Cities Lord Mayors (CCCLM) Drugs Action Team. Some councils outside the capital city may also have a similar group.

Corporate Sponsorship

A range of private corporations also offer sponsorship for initiatives aimed at youth, particularly initiatives coordinated by charitable or community organisations. Most of these organisations have guidelines for sponsorship activities on their website. Organisations offering sponsorship for youth activities at the time of writing included

Telstra, Lions Club, Alcohol Education and Research Foundation (AERF), General Motors Holden and the Macquarie Bank.

It is also appropriate to develop a sponsorship package to offer various organisations. The types of organisations to be approached for sponsorship may be those with which you have an existing association or whose product or service is used by the broad target group of the initiative. Sponsorship may be sought for financial assistance or in-kind support, for example, provision of equipment, staff or the training venue. Guidelines for seeking sponsorship are given in Box 5.3.

Box 5.3: Guidelines for Seeking Sponsorship

Outline benefits for the sponsor:

- clarify the benefits to the potential sponsor, rather than approaching them only with the needs of the initiative
- identify the type of benefits likely to appeal to the sponsor by reading their website, annual report or other publications
- clearly outline real value and tangible benefits in any initial correspondence with the sponsor (benefits may include mailing the sponsor's literature to participants, acknowledgement of involvement in any publications resulting from the initiative, or direct face-to-face access to participants)
- detail the individual elements of the sponsorship package, including the number of people in the target group, and the estimated real value for each item for which sponsorship is sought.

Timeline:

- allow a reasonable lead time when approaching potential sponsors because many organisations set their budgets, including allowances for sponsorship, up to a year in advance.

Follow-up if successful:

- ensure you deliver what has been agreed upon – this will enhance your chance of obtaining sponsorship from the organisation for any future endeavours
- ask the sponsor for a post-sponsorship evaluation so you can target areas for improvement if you plan to seek further sponsorship in the future, for an ongoing peer education initiative or a new one.

(Fioravanti, 1995)

Building Partnerships

It is important to build partnerships with key stakeholders to facilitate feedback and input from these groups. Key stakeholders include young people, parents, teachers, and community and government agencies. Strong working relationships with key stakeholders may also meet some administrative requirements, potentially easing budget constraints through in-kind support. Stakeholders may help by providing:

- venues and resources for training peer educators and implementing peer education activities
- support for peer educators, such as advice and referral
- incentives or benefits for participation in peer educator training.

Advisory Group and Coordinator

Advisory Group

An advisory group can guide development of aims, goals and processes, and provide support by contributing information, resources, contacts and advocacy. Terms of reference developed at the outset will clarify the advisory group's role (see Appendix 1 for an example). The group will probably be most active at the beginning of the initiative.

It is important to include representatives from key stakeholders, such as the target group, special interest groups and peer educators. A diverse and balanced advisory group will have members with various levels and types of experience in areas such as peer education, project management, drugs and alcohol, education and training, youth and related issues.

Coordinator

A peer education initiative may have one or more coordinators or various support staff, depending on the scale of the initiative. The coordinator is the key point of contact for all those involved in the initiative, including the advisory group, peer educator trainers, peer educators, funders and sponsors, community groups and providers (of resources such as venue, equipment and catering). The coordinator undertakes most of the work (such as organising venue hire, promoting, recruiting peer educators, evaluation and meeting reporting requirements), refers to the advisory group for advice and support, and reports to them about progress.

Staff Retention

Many peer education initiatives are grant funded, with staff employed on fixed term contracts for the period of the initiative. Staff may begin to seek their next employment

contract towards the end of the initiative and might accept a position offered during this period. This is particularly problematic if a staff member leaves at a crucial time, such as when peer educators are engaging in peer education activities and require additional support and guidance from staff.

Strategies to minimise the risk of early resignation of staff include:

- extending the contract period slightly beyond the expected length of the initiative
- providing an incentive for completing the contract, for example a financial bonus
- employing staff who are already permanently employed by the organisation running the initiative
- seconding staff from other positions or agencies
- providing appropriate support, training and career development opportunities.

Strategies also need to be developed to minimise disruption if a staff member, particularly the coordinator, leaves before completion of the initiative, such as:

- employ additional staff members who can adopt the coordinator role if necessary
- systematically document plans and progress for the project
- arrange alternative sources of support for peer educators
- divide the project into discrete stages.

Retention of Peer Educators

Support and incentives are both important for retaining peer educators. The coordinator and other key staff are important sources of support for peer educators. The strategies described above for retaining staff may also contribute to retention of peer educators.

It is generally accepted that some incentives should be provided to peer educators, such as:

- financial reimbursement for expenses, such as travel
- non financial incentives, such as meals, phone cards and access to resources and training

(Miller, 1996).

However, payment of peer educators is controversial (Power et al., 1996) (the case for and against payment for peer educators is outlined in Box 5.4). The decision to pay peer educators may be determined by factors such as:

- age of peer educators
- time commitment required from peer educators
- number of available peer educators
- availability of funds.

Box 5.4: The Case For and Against Financial Payment For Peer Educators

Case For Payment

- enhanced retention of peer educators (participation in peer education without financial compensation limits peer educators' ability to gain paid employment elsewhere. This is a particular problem for experienced peer educators, who may be able to utilise the skills gained in peer education in a paid position)
- enhanced commitment by and motivation of peer educators
- greater perceived credibility of peer educators because payment may be seen as a reflection of their value and expertise.

Case Against Payment

- there may be a shift in the power dynamics between the peer educators and the target group
- peer educators may be motivated by financial gain rather than a desire to help educate their peers
- the target group may be sceptical about the peer educators' motives.

Summary

Comprehensive planning may increase the likelihood of success of a peer education initiative. Planning also facilitates implementation and evaluation of peer education. The first stage of planning is to identify the parameters and characteristics of the target group. Aims can then be determined based in part on the identified needs of the target group. The aims of peer education may be to influence the target group's knowledge, attitude, skills, behaviours and/or cultural norms or to empower them to make their own decisions.

Planning will be facilitated by development of a sound administrative system, which addresses issues such as:

- budget and financial or in-kind support from government, corporate sponsors or community and stakeholder partnerships
- formation of an advisory group including members with expertise in a range of relevant areas and representatives from key stakeholders
- appointment of a coordinator to undertake most of the work required to implement the initiative
- development of strategies to enhance retention of staff and peer educators.

The next chapter covers the evaluation of peer education initiatives, including:

- what is evaluation?
- why evaluate?
- stages of evaluation
- designing the evaluation strategy
- evaluation methodology: process, impact and outcome
- measurement
- interpreting findings
- reporting findings.

Chapter 6
Evaluation

It is essential that peer education initiatives are evaluated. This should also include assessment of planning and organisation, peer educator training and the impact on the target group. For the novice evaluator, this may seem a daunting task. Many valid forms of evaluation can be readily and easily implemented, often at low cost. This chapter outlines the process of evaluation and provides:

- an outline of the fundamentals of evaluation
- guidelines to plan and implement an evaluation strategy
- references for further reading (listed at the end of this chapter).

There are various avenues for advice and support when planning and implementing evaluation. It may be helpful to include someone with evaluation expertise on the advisory group, to employ someone to conduct the evaluation or to engage a consultant. Seeking informal input and advice on evaluation at the outset of the initiative may also be helpful.

Topics covered in this chapter include:

- what is evaluation?
- why do evaluation?
- stages of evaluation
- designing the evaluation strategy
- evaluation methodology: process, impact and outcome
- measurement
  - measuring aims and objectives
  - data collection and analysis
- interpreting findings
  - timing of data collection
  - the influence of external factors
  - cost effectiveness
- reporting findings.

What is Evaluation?

Evaluation is gathering information to assess the impact of something (Hawe et al., 2000). Information collected is analysed to determine causality, ie whether the intervention initiated or permitted a sequence of events that resulted in the identified outcomes (Rothman, 1976, 1986 cited in English et al., 1995) and whether aims and objectives have been achieved (Premier's Drug Prevention Council, 2002). Effective evaluation is not a one-off activity (McDermott, 1991). It begins during the planning phase and continues for the duration of the initiative and beyond (Health Services Division, 2001).

Why Evaluate?

The primary reasons for evaluating peer education initiatives are to check that the initiative has been implemented as intended and to identify what outcomes have been achieved. The results of evaluation serve several purposes (shown in Box 6.1). The first is to assess the efficiency and effectiveness of the initiative, including the impact on the target group, and to identify what the initiative has achieved, particularly whether aims and objectives have been met.

At a minimum, evaluation is necessary to make sure the initiative is not having a negative effect.

Box 6.1: Purposes of Evaluation

- to assess efficiency and effectiveness
- to refine and improve the initiative
- to decide whether to continue or replicate the initiative
- to inform future initiatives and contribute to the peer education evidence-base
- to justify the initiative, decide whether to continue or replicate the initiative and procure further funding or support

(Owen, 1991; Kirkpatrick, 1998).

Results of evaluation can also inform refinement and improvement of the initiative by:

- facilitating quality control efforts
- identifying strengths and weaknesses
- enhancing understanding of how processes contribute to outcomes

- improving planning and management of the initiative
- providing constructive feedback to the initiative team, including coordinator, advisory group, peer educator trainers and peer educators
- preventing repetition of mistakes.

Reporting conclusions from an evaluation of an initiative may inform future initiatives, providing guidance to increase efficiency and effectiveness and avoid pitfalls. Publishing findings from evaluation of a peer education initiative may also help build the evidence-base for peer education. The wide range of contexts and circumstances in which peer education occurs limits generalisability of findings. It is therefore important to contribute to the evidence-base that reflects this diversity.

Finally, evaluation is an important strategy for procuring new or continued funding and support for peer education. Positive findings justify continued use of resources, encourage new investment and support funding applications. Identification of areas for improvement can also demonstrate the importance and value of investing in peer education.

Evaluation needs to be designed to meet the needs of the range of people who are interested in the outcomes of evaluation, including the initiative organisers, target group, peer educators, funders, consumers, community, government and other people involved in peer education activities.

Stages of Evaluation

There are several discrete stages in an evaluation process. It is important to be aware of them at the outset and to ensure that each stage is carefully and systematically addressed. The stages of evaluation are shown in Figure 6.1.

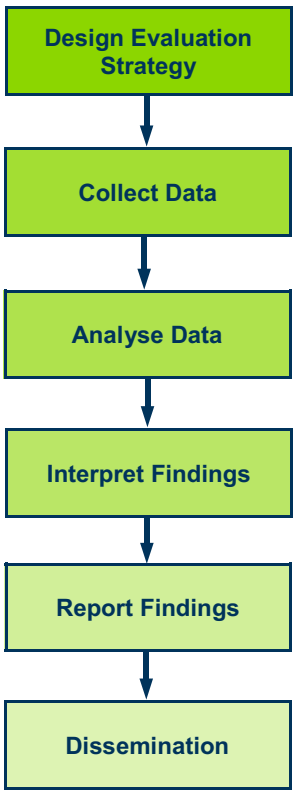

Figure 6.1: The Stages of Evaluation

Designing the Evaluation Strategy

Evaluation is an integral part of peer education that needs to be planned and managed from the outset. The evaluation strategy needs to take account of each stage of the initiative, including the impact of peer education activities on the target group, the success of peer educator training and administrative and organisational issues. Further development and refinement of the evaluation strategy will continue for the duration of the project, taking into account any modifications to the initiative, unexpected events and resource availability.

The planning stage includes clarification of:

- the reasons for undertaking evaluation
- initiative aims, objectives, strategies and indicators (described in Box 6.2)
- cost, time and resource constraints
- proportion of time and budget to be committed to evaluation (5% to 10% may be appropriate)
- how and why results will be used
- recipients of evaluation findings
- the timing and form of evaluation reporting

(Health Services Division, 2001).

Box 6.2: Aims, Objectives, Strategies and Indicators

Aims are the broad purpose or intent of the initiative.

Objectives are statements that describe the specific steps required to achieve the aim. Objectives reflect expected outcomes and provide a concrete basis for measuring effectiveness.

Strategies describe what the initiative will do and how you plan to achieve objectives.

Indicators guide the information that needs to be collected to assess and interpret the progress of the initiative, comprised of:

- performance indicators: measurable changes that indicate progress towards aims and objectives
- performance measures: how changes will be measured.

(Health Services Division, 2001)

Decisions need to be made regarding the extent of evaluation and what is realistically achievable. This will depend on how well the initiative is designed, availability of resources, how well the objectives are defined and consistency between objectives and strategies.

A final consideration while planning the evaluation is to decide whether an internal or external party will manage the evaluation. Both have benefits and risks, which are outlined in Table 6.1. The costs of engaging an external party to conduct the evaluation may be managed if you avoid requesting a broad evaluation brief and instead request specific, defined evaluation tasks (eg design a survey to assess changes in self-reported drug using behaviour before and after peer education) (Zipparo, 2001).

Table 6.1: Benefits and Risks of Internal vs External Evaluation of Peer Education Initiatives

	Benefits	Risks
Internal	The evaluator is already familiar with the initiative and those involved The evaluator poses little threat or anxiety to those being evaluated	The evaluator may find it difficult to be objective The evaluator is part of the initiative hierarchy and power structure The evaluator may be motivated by personal gain The evaluator may lack training
External	The evaluator has a fresh perspective The evaluator is not personally involved and therefore more likely to be objective The evaluator is not part of the formal hierarchy or power structure The evaluator has nothing to gain from the outcomes of the evaluation	The evaluator may not understand the initiative and those involved The evaluator may cause anxiety among participants and organisers because their motives are unknown

Adapted from a presentation by Richard Cooke, Drug and Alcohol Services Council (DASC) of South Australia during the Youth for Youth Peer Educator Training Initiative (McDonald et al., 2000).

Evaluation Methodology: Process, Impact and Outcome

The three key types of evaluation are process, impact and outcome evaluation. Each assesses different aspects of the initiative (examples of each are shown in Box 6.3). Each type of evaluation corresponds to a different aspect of evaluation, namely the aims, objectives or strategies (as shown in Figure 6.2).

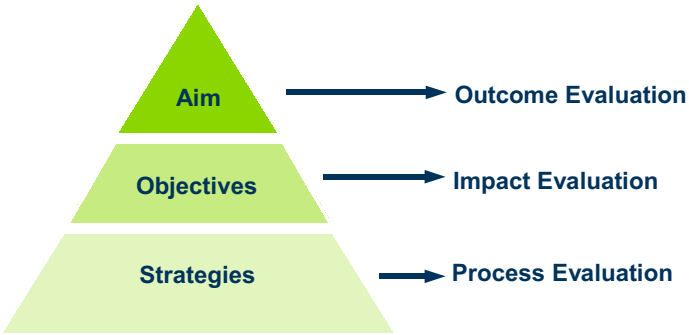

Figure 6.2: Key Types of Evaluation

Box 6.3: Examples of Process, Impact and Outcome Evaluation

Process:

- monitoring by project coordinator and regular liaison interviews
- observation and evaluation of peer education training sessions and the work carried out by the peer educators
- participant observation at steering group meetings

Impact:

- feedback from peer educators about training, organisation of the initiative, and their experiences conducting peer education activities
- surveys of knowledge and attitudes of peer educators and participants of peer education activities

Outcome:

- decrease in prevalence rates of drug use among target group
- decrease in risky behaviours in relation to drug use
- increased adoption of safe practices

Process evaluation, also referred to as formative evaluation, is a type of quality control. This type of evaluation is intended to assess strategies and improve and refine the initiative. Process evaluation measures the activities of the project, its quality and whether the target group was reached. While this type of evaluation does not assess the impact on the target group, it can tell us whether the initiative was implemented as designed. If the initiative was not implemented as designed, it is not possible to make sound conclusions about effectiveness (Black et al., 1998). Given this, process evaluation should be undertaken before impact and outcome evaluation (Hawe et al., 2000). Process evaluation considers issues such as:

- planning, development, organisation and administration of the initiative
- what actually happened
- who was involved
- whether the target group was reached
- how and why the peer educators or target group changed as a result of the initiative
- how participants felt and thought about the initiative, including the target group, the peer educators, initiative organisers, key stakeholders, funders etc.

Impact evaluation is aimed at assessing achievement of stated objectives. This type of evaluation is concerned with the immediate effects of the initiative, such as changes in knowledge, awareness, beliefs, attitudes, skills and behaviour in both the peer educators and the target group (Hawe et al., 2000).

The focus of outcome evaluation is achievement of the overall, longer term aim or goal of the initiative (Hawe et al., 2000), such as reduction in risky behaviours in the target group. Both impact and outcome evaluation are intended to make a judgement about the success of the initiative and establish a causal link between the initiative and the observed outcomes (Hawe et al., 2000) However, it can be difficult to assess whether the aim of the initiative is achieved and maintained in the long-term. Impact evaluation may therefore be more appropriate or achievable for peer education initiatives.

Many evaluations of peer education initiatives focus on process or impact rather than outcome evaluation (Gray, 1996). Given that changes in attitudes, norms and culture can take some time to occur (Rollin et al., 1994; Bloor et al., 1999; Zipparo, 2001), the most accurate indicator of success may be assessed by long-term follow-up, (ie to assess the outcomes of the peer education initiative over time). However, such evaluation strategies may be difficult because of resource limitations (Miller, 1996) or difficulty in tracking the target group (Fors and Jarvis, 1995). It is important that these limitations are acknowledged when initiative aims are developed.

Measurement

Measuring Aims and Objectives

The aim of reducing risk taking behaviours may be assessed by measuring the frequency with which specific risky behaviours occur such as sharing needles, drinking with strangers or drinking in unfamiliar surroundings.

Data Collection and Analysis

Data collection and analysis may be quantitative, qualitative or a mix of both. Table 6.2 provides a comparison of quantitative and qualitative approaches. Box 6.4 lists examples of quantitative and qualitative evaluation options for peer education.

Quantitative Evaluation

Quantitative evaluation may be thought of as providing information about "how much", or an analysis with numbers (Hawe et al., 2000). This type of evaluation is suited to testing the extent of change caused by the initiative (Hawe et al., 2000). Data should be collected through standardised procedures so it can easily be counted and compared with other data, as well as subjected to more complex statistical analysis (McDermott et al., 1991). Measures may be frequencies or ratings of intensity, duration or severity (Health Services Division, 2001). Data can be compared across different studies and populations and over time (Health Services Division, 2001). Some quantitative measures may be relatively brief and easy to administer, score and interpret while others may require expertise or training for effective use (Health Services Division, 2001). The Statistical Package for Social Sciences (SPSS) is a common software application used to facilitate quantitative data analysis.

The strengths of quantitative evaluation are that data can be collected from a large number of participants, comparisons are possible, effect size can be measured and findings may be generalised to other people and situations (Hawe et al., 2000). The main limitation of quantitative evaluation is lack of depth and detail about experiences (Hawe et al., 2000).

Qualitative Evaluation

Qualitative evaluation may be understood as providing information about "why", or an analysis of words and meaning (Hawe et al., 2000). This type of evaluation collects detailed and in-depth information from a relatively small number of participants (Hawe et al., 2000). Techniques used in qualitative evaluation are largely used to explore (ie identify new issues) and consolidate (ie add detail or depth to data) (Health Services

Table 6.2: Comparison of Quantitative and Qualitative Evaluation

	Quantitative	Qualitative
Detail and amount of information	Gain less detailed information from a larger number of people	Gain in-depth information from a smaller number of people
Type of analysis	Analysis of numbers	Analysis of words and meaning
Key concern	Concerned with "how much"	Concerned with "why"
Data collection	Data collected in terms of frequency, intensity, duration, severity	Data collected using in-depth interviews, focus groups, observation, and analysis or stories and scripts
Time requirements	May be brief and easy to administer, score and interpret	More time intensive in terms of administration and analysis
Useful software	Statistical Package for the Social Sciences (SPSS)	NVivo and NUD*IST
Strengths	Reaches more subjects Allows more comparisons Enables measurements of effect size Findings are generalisable to other people or situations	May reveal why things happened May reveal unexpected information
Limitations	Lack of depth	Difficult to generalise findings

Division, 2001). As such, qualitative evaluation may highlight issues that are not identified through quantitative means (Health Services Division, 2001).

Data may be collected using in-depth interviews (either semi-structured or unstructured), focus groups (usually less than 10 people), open-ended questions, community or stakeholder consultation, observation of actual behaviour, diaries or analysis of stories and scripts (Health Services Division, 2001). Data collection, while not standardised, is collected and analysed systematically (McDermott et al.,

Box 6.4: Examples of Quantitative and Qualitative Evaluation

Qualitative:

- interviews with stakeholders and interested parties
- interviews with those who train the peer educators
- individual interviews with peer educators
- focus groups with peer educators
- focus groups with participants of peer education activities
- observation of peer educators conducting peer educator activities
- personal observations of the coordinator
- focus groups with the advisory group

Quantitative:

- surveys of peer educators' knowledge, confidence and attitudes administered before and after training, and before and after they conduct peer education activities
- retention / dropout of peer educators
- surveys of key stakeholders, advisory group and peer educator trainers about development and implementation of the initiative
- knowledge, attitude and behaviour surveys of peer education participants before and after they participate in peer education activities
- survey of a sample of the target group before, immediately after peer education activities are implemented and again at follow-up (eg six months, one year)
- rates of proxy measures, such as distribution of free needles, number of ambulance calls for overdose, frequency of drug-related crime, frequency of admission to outreach services, frequency of telephone calls to drug information hotlines
- measurement of other relevant variables

1991). Results are reported in general terms and findings reveal detailed information that is not easily generalised to the larger population. Useful software used to store and analyse qualitative data include NVivo and NUD*IST (Richards and Richards, 1988; Bazeley and Richards, 2000).

The major strengths of qualitative evaluation are the ability to find out why certain things happened and the revelation of unexpected information, both of which can provide greater insight into the effect of the initiative. However, while qualitative evaluation may result in large amounts of in-depth information, it is gathered from

relatively few people, making it difficult to generalise findings to other people and situations (Hawe et al., 2000).

A number of considerations will determine the most appropriate method of data collection and analysis, including:

- availability of resources and funding
- time availability
- availability of existing measures
- number of potential respondents (sample size)
- characteristics of respondents
- context
- nature of the variables
- intended use of findings.

Triangulation

Methods of data collection are not mutually exclusive and a combination of strategies is commonly used (DePoy and Gitlin, 1998). Combining methodologies is referred to as "triangulation" (Wilde and Sockey, 1995). Triangulation enables the weaknesses of one methodology to offset the strengths of another and provides greater support for conclusions if the findings of independent methodologies are consistent.

It is therefore recommended that evaluation of a peer education initiative considers including a combination of both quantitative and qualitative evaluation methods. For example, changes in knowledge, confidence and attitudes may be assessed through quantitative means (such as knowledge or confidence surveys) which may be enhanced by exploring further detail about participants' experiences through qualitative approaches (such as interviews). Appendix 2 contains samples of surveys and semi-structured interviews for assessing a peer education training initiative.

Facilitating Interpretation of Findings

Impact Over Time

To interpret findings adequately, it is necessary to understand the various ways peer education outcomes may manifest over time. While the desired impacts of peer education are those that are immediate and sustained (as shown in Figure 6.3) this rarely occurs. Instead, the impact of peer education may become apparent over a different timeframe.

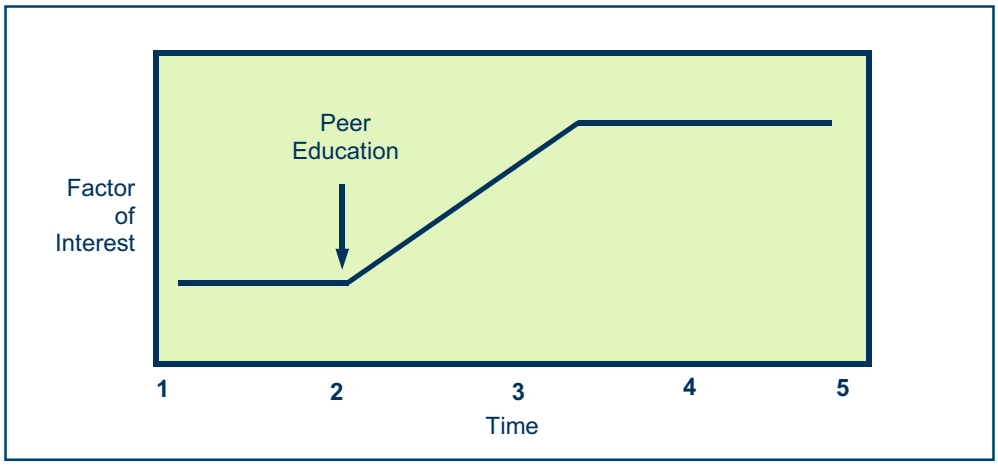

Figure 6.3: Ideal Impact of an Intervention
(Hawe et al., 2000)

Lawrence Green (1977 cited in Hawe et al., 2000) has suggested that the real effects of an intervention may fall into one of five categories (shown graphically in Figures 6.4), described as:

- sleeper effect: effect becomes apparent some time after peer education
- backsliding effect: effect is immediate but short lasting
- trigger effect: effect is to bring forward behaviour that would have occurred anyway
- historical effect: observed outcome may have been gradually occurring over time and is unrelated to peer education
- backlash effect: effect is opposite to planned, for example, if peer education is inconsistent with participants' experience or if the initiative is ceased prematurely.

The variety of possible effects described above indicates that findings may be more accurately interpreted if data is collected throughout the peer education initiative. However, it may not be feasible to collect data often enough to detect all the effects described in Figure 6.4. For example, numerous measures may become a burden for respondents. Available resources and time may also limit the frequency and scope of measurement. To manage the possible time effects it is important to:

- be strategic about when to collect data – key periods are before, during and after both peer educator training and implementation of peer education activities, and again some time after (eg two months, six months or one year) to assess sustained or delayed effects
- be aware of the possible effects over time and incorporate these into interpretation of findings.

In addition to repeated measures at key intervals, it is important to be aware of any external factors that may impact on the target group, potentially magnifying or

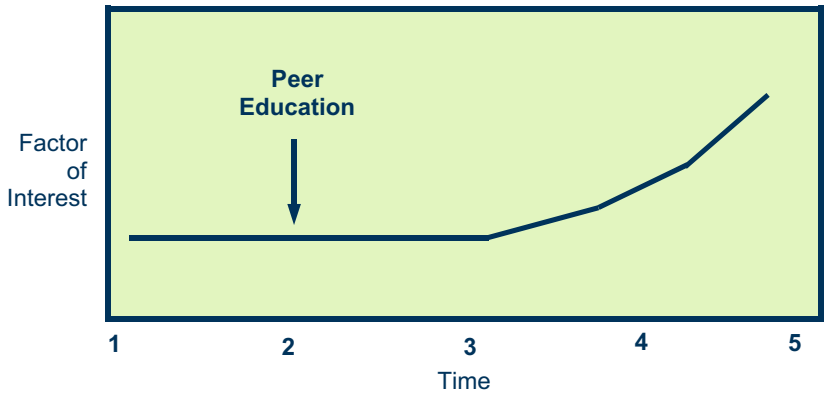

Figure 6.4a: Sleeper Effect

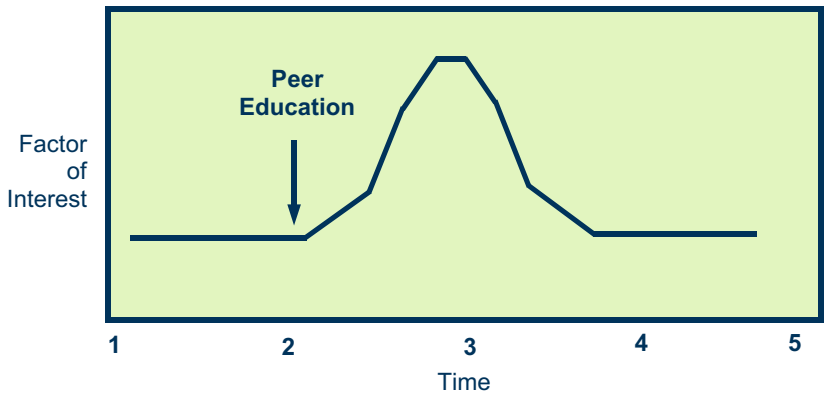

Figure 6.4b: Backsliding Effect

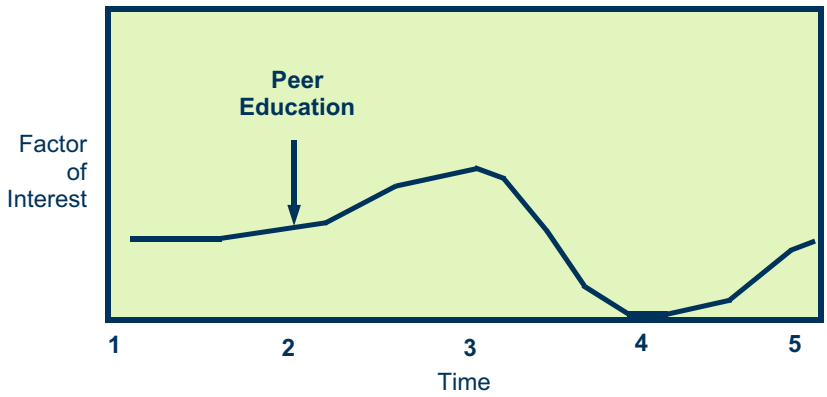

Figure 6.4c: Trigger Effect

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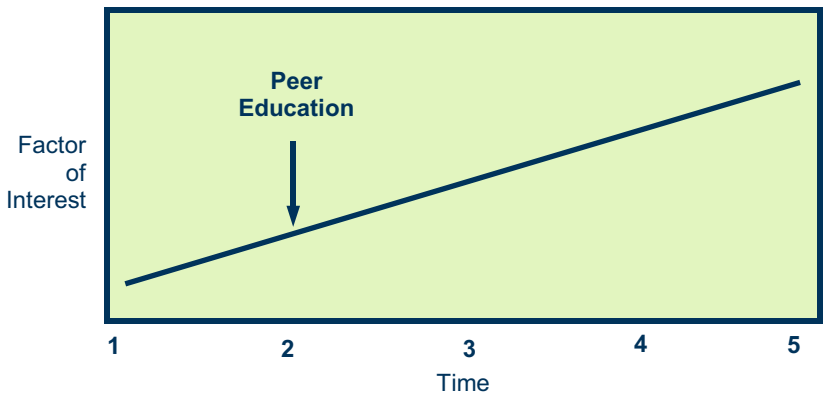

Figure 6.4d: Historical Effect

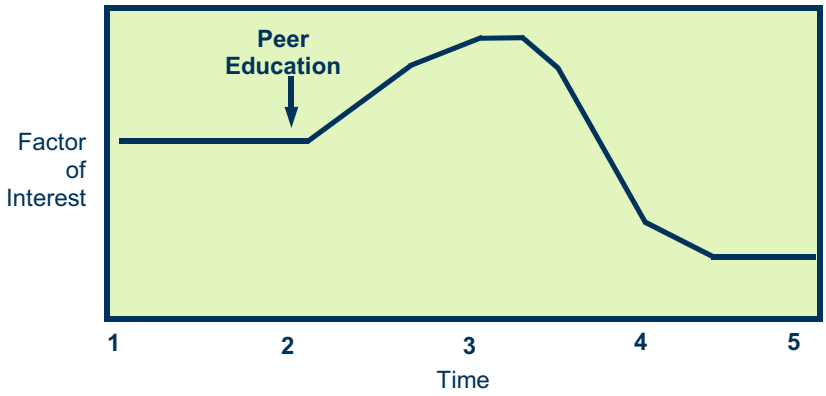

Figure 6.4e: Backlash Effect

Figure 6.4: Possible Effects Over Time
(Lawrence Green, 1977 cited in Hawe et al., 2000)

counteracting the impact of the initiative. Such external factors are referred to as "confounders". Examples of confounders include a media campaign or incident within the target group (eg overdose of a friend).

Matching Aims and Evaluation

The method of evaluating peer education initiatives can impact significantly on assessments of effectiveness. Appropriate evaluation methods are identified according to the aims and objectives of the project. For example, initiatives based on information delivery need to be measured in terms of knowledge and understanding, whereas initiatives aimed at developing life skills should be measured in terms of social competency (Coggans, 1997). A mismatch between the initiative and evaluation

content is likely to produce a poor assessment of effectiveness. An initiative based on information delivery that is evaluated in terms of behaviour change is more likely to be interpreted as unsuccessful than if measured in terms of knowledge change.

Reporting Findings

Reporting findings fulfils a number of evaluation purposes, particularly refining and improving existing initiatives, informing future initiatives, contributing to the peer education evidence-base and obtaining ongoing or further funding or support. Many funders will require interim and final reports. Others may also be interested in the reported outcomes, including the key stakeholders, peer educators, target group, advisory group and others interested in implementing or researching peer education. All of these groups are likely to be interested in information about:

- the target group
- context and setting
- aims, objectives and strategies
- implementation of the initiative, including planning, administration, peer educator training, peer educator activities
- evaluation strategy and methodology
- outcomes
- interpretation of findings
- initiative strengths and areas for improvement
- future directions.

Outcomes may be reported in various formats to suit a broad audience and wider dissemination. Initiative funders often require a detailed and formal report. The advisory group's input to the final report will be valuable. An adapted version of the detailed report (removing sensitive or confidential information) may also be sought by others intending to implement peer education as this type of report will include fine detail about what was done, how it was done and the outcomes. A summary report, written in plain English will probably suit communities, peer educators and the target group. The initiative and findings may be more widely disseminated by presenting results at conferences and publishing in journals and on the internet. Publication in peer-reviewed journals is important for building the peer education evidence-base and to ensure the findings are included in indexed and peer reviewed literature, which is a common source of information for those developing other peer education initiatives.

Summary

Evaluation is essentially gathering information about the effects of the peer education initiative. It is a necessary component of any peer education initiative and needs to be planned at the outset and conducted throughout the initiative.

Evaluation consists of a number of stages, including designing the evaluation strategy, collecting and analysing data, interpreting findings, and reporting conclusions. During the planning/design stage a number of issues are clarified, including the initiative's aims, objectives, strategies and indicators and the way these will be measured. There are three key types of evaluation – process, impact and outcome evaluation. Data may be collected and analysed through quantitative or qualitative methodologies. Each approach has strengths and disadvantages. It may be beneficial to use a mix of both. Interpretation of findings will be facilitated if:

- data is collected at appropriate intervals throughout an initiative
- the influence of external factors (confounders) is observed, managed and/or accounted for
- evaluation is consistent with the aims of the initiative
- a cost effectiveness analysis is conducted to determine whether the benefits of the initiative outweigh the costs involved.

The final stage of evaluation is reporting findings. Different versions of the report may be produced to suit various audiences, including the funders, target group, stakeholders and community.

The next chapter addresses recruitment, training and support of peer educators. Key recruitment tasks are to identify the key characteristics of effective peer educators and determine the most appropriate method for selecting peer educators. Important training tasks are to:

- select an appropriate setting
- establish training aims and objectives
- clarify expectations and obligations
- establish the appropriate length of training
- recruit and support trainers
- determine appropriate content and delivery of peer educator training.

Following training, peer educators require support before, during and after they engage in peer education activities.

Further Reading

What Is Evaluation / Evaluation Fundamentals

Goff, S. (2001). *Participatory Evaluation Manual*, Professional Development Network for the NSW Department of Education: Ryde, NSW.

Hawe, P., Degeling, D., Hall, J. (2000). *Evaluating Health Promotion: A Health Worker's Guide*, MacLennan and Petty: Sydney.

Health Services Division (2001). *Evaluation: A Guide for Good Practice*, Commonwealth Department of Health and Aged Care.

Owen, J.M., Rogers, P.J. (1999). *Program Evaluation: Forms and Approaches*, Second Edition, Allen and Unwin: St Leonards.

Shadish, W.R., Cook, T.D., Leviton, L.C. (1991). *Foundations of Program Evaluation*, Newbury Park: Sage.

Reasons for Evaluating

Health Services Division (2001). *Evaluation: A Guide for Good Practice*, Commonwealth Department of Health and Aged Care.

Kirkpatrick, D.L. (1998). *Evaluating Training Programs: The Four Levels,* Second Edition, Berrett-Koehler Publishers Inc: San Francisco.

Planning Evaluation

Hawe, P., Degeling, D., Hall, J. (2000). *Evaluating Health Promotion: A Health Worker's Guide*, MacLennan and Petty: Sydney.

Health Services Division (2001). *Evaluation: A Guide for Good Practice*, Commonwealth Department of Health and Aged Care.

McDermott, F., Pyett, P., Hamilton, M. (1991). *Evaluate Yourself: A Handbook for Alcohol and Other Drug Treatment Agencies,* Commonwealth Department of Health and Aged Care.

Wilde, J., Sockey, S. (1995). *Evaluation Handbook*. Evaluation Assistance Center, Western Region, New Mexico Highlands University, Albuquerque, Internet. Accessed 11 April 2003. Available from: <http://www.ncela.gwu.edu/miscpubs/eacwest/evalhbk.htm>.

Negotiating an Evaluation Plan

Owen, J.M., Rogers, P.J. (1999). *Program Evaluation: Forms and Approaches*, Second Edition, Allen and Unwin: St Leonards.

Evaluation by Insiders or Outsiders

Owen, J.M. (1990). Encouraging Small Scale Evaluation: Roles for an External Evaluator, *Evaluation Journal of Australasia*, 2(3):41-50.

Owen, J.M., Rogers, P.J. (1999). *Program Evaluation: Forms and Approaches*, Second Edition, Allen and Unwin: St Leonards.

Evaluation Methodology

Hawe, P., Degeling, D., Hall, J. (2000). *Evaluating Health Promotion: A Health Worker's Guide*, MacLennan and Petty: Sydney.

Health Services Division (2001). *Evaluation: A Guide for Good Practice*, Commonwealth Department of Health and Aged Care.

Process Evaluation

Hawe, P., Degeling, D., Hall, J. (2000). *Evaluating Health Promotion: A Health Worker's Guide*, MacLennan and Petty: Sydney.

Windsor, R.A., Baranowski, T., Clark, N., Cutter, G. (1984). *Evaluating Health Promotion and Health Education Programmes,* Mayfield Publishing Company: Palo Alto, California.

Impact and Outcome Evaluation

Braverman, M.T. (Ed) (1989). *Evaluating Promotion Programs: New Direction for Program Evaluation,* No 43, Jossey Bass: San Francisco.

Hawe, P., Degeling, D., Hall, J. (2000). *Evaluating Health Promotion: A Health Worker's Guide*, MacLennan and Petty: Sydney.

Owen, J.M., Rogers, P.J. (1999). *Program Evaluation: Forms and Approaches*, Second Edition, Allen and Unwin: St Leonards.

Speer, D.C. (1998). *Mental Health Outcome Evaluation*, Department of Aging and Mental Health, University of South Florida, Academic Press: Tampa.

Measurement

Hawe, P., Degeling, D., Hall, J. (2000). *Evaluating Health Promotion: A Health Worker's Guide*, MacLennan and Petty: Sydney.

Wilde, J., Sockey, S. (1995). *Evaluation Handbook*. Evaluation Assistance Center, Western Region, New Mexico Highlands University, Albuquerque, Internet. Accessed 11 April 2003. Available from: <http://www.ncela.gwu.edu/miscpubs/eacwest/evalhbk.htm>.

Qualitative Research

McDermott, F., Pyett, P., Hamilton, M. (1991). *Evaluate Yourself: A Handbook for Alcohol and Other Drug Treatment Agencies*, Commonwealth Department of Health and Aged Care.

Patton, M.Q. (1986). *How to Use Qualitative Methods in Evaluation*, Sage Publications: New York.

Silverman, D. (1985). *Qualitative Research Methods*, Gower Publishing Company: Aldershot.

Taylor, S.J., Bogdan, R. (1984). *Introduction to Qualitative Research Methods,* Second Edition, Wiley and Sons: New York.

Survey Methods and Questionnaire Design

Abramson, H.J. (1979). *Survey Methods in Community Medicine*, Churchill Livingston: Edinburgh.

Fink, A., Kosecoff, J. (1998). *How to Conduct Surveys – A Step By Step Guide*, Second Edition, Sage Publications: Beverley Hills, CA.

Hawe, P., Degeling, D., Hall, J. (2000). *Evaluating Health Promotion: A Health Worker's Guide*, MacLennan and Petty: Sydney.

Health Services Division (2001). *Evaluation: A Guide for Good Practice,* Commonwealth Department of Health and Aged Care.

McDermott, F., Pyett, P., Hamilton, M. (1991). *Evaluate Yourself: A Handbook for Alcohol and Other Drug Treatment Agencies*, Commonwealth Department of Health and Aged Care.

Miles, M.B., Huberman, A.M. (1982). *Qualitative Data Analysis: A Sourcebook of New Methods,* Sage Publications: Beverly Hills.

Sudman, D., Bradburn, N.M. (1986). *Asking Questions: A Practical Guide to Questionnaire Design*, Jossey Bass: San Francisco.

Running a Focus Group

Basch, C.E. (1987). Focus Group Interview: An Underutilised Research Technique for Improving Theory and Practice in Health Education, *Health Education Quarterly*, 14(4):411-48.

Hawe, P., Degeling, D., Hall, J. (2000). *Evaluating Health Promotion: A Health Worker's Guide*, MacLennan and Petty: Sydney.

Miles, M.B., Huberman, A.M. (1984). *Qualitative Data Analysis*, Sage Publications: Beverly Hills.

Patton, M.Q. (1980). *Qualitative Evaluation Methods,* Sage Publications: Beverly Hills.

Choosing Measuring Instruments

Hawe, P., Degeling, D., Hall, J. (2000). *Evaluating Health Promotion: A Health Worker's Guide*, MacLennan and Petty: Sydney.

Data Analysis

McDermott, F., Pyett, P., Hamilton, M. (1991). *Evaluate Yourself: A Handbook for Alcohol and Other Drug Treatment Agencies,* Commonwealth Department of Health and Aged Care.

Reporting

Health Services Division (2001). *Evaluation: A Guide for Good Practice*, Commonwealth Department of Health and Aged Care.

McDermott, F., Pyett, P., Hamilton, M. (1991). *Evaluate Yourself: A Handbook for Alcohol and Other Drug Treatment Agencies*, Commonwealth Department of Health and Aged Care.

Wilde, J., Sockey, S. (1995). *Evaluation Handbook*. Evaluation Assistance Center, Western Region, New Mexico Highlands University, Albuquerque, Internet. Accessed 11 April 2003. Available from: <http://www.ncela.gwu.edu/miscpubs/eacwest/evalhbk.htm>.

Getting Help: Finding and Working with Consultants

Hawe, P., Degeling, D., Hall, J. (2000). *Evaluating Health Promotion: A Health Worker's Guide*, MacLennan and Petty: Sydney.

Chapter 7
Selecting, Training and Supporting Peer Educators

This chapter is concerned with the processes of selecting, training and supporting peer educators. Emphasis is placed on strategies to ensure an appropriate mix of personal characteristics, experience, skills, knowledge and confidence.

Selecting Peer Educators

Two important issues to consider when selecting peer educators are the selection criteria and the selection process.

Selection Criteria

Appropriate selection criteria may include a number of characteristics associated with successful peer educators, such as credibility, trustworthiness, confidence and personableness. It is also useful to select peer educators who possess, or have the potential to develop, a range of necessary peer educator skills, such as communication, interpersonal, planning and organisational skills.

Particular attention needs to be given to credibility. The type of peer educator that will be perceived as credible by members of the target group depends on the characteristics of that group. Peer educator credibility refers to messenger-based credibility (Shiner and Newburn, 1996), which is comprised of person and experience-based credibility. The issue of credibility is addressed in Chapter 3, but is briefly revisited below in the context of selecting peer educators.

Person-based Credibility

Peer educators are more likely to be perceived as credible by the target group if they are matched on relevant personal characteristics, such as language, dress style, age, gender and style of interaction (Perry et al., 1989; Miller, 1995; Miller, 1996; Cripps, 1997; Gore, 1997).

To identify personal characteristics relevant to the selection criteria it is useful to:

- consult the target group
- seek input from other relevant parties, such as teachers, AOD workers or parents
- examine previous research with similar groups.

Experience-based Credibility

Peer educators' experience-based credibility depends on their experience of drug-related issues as well as their social experience, and how well these match the experience and expectations of the target group.

Drug-related Experience

It is important to match the type of drug-related experience of the peer educator and target group. Factors to be considered include:

- nature of drug use (experimental, recreational, problematic, dependent)
- experience of drug use (personal use, use by friends or family)
- type of drugs used (tobacco, alcohol, cannabis, amphetamines, hallucinogens, opioids, pharmaceuticals etc)
- cultural norms (acceptability of drug use and extent of drug use within the social group).

The issue of peer educators and personal drug use experience is contentious. A peer educator who has drug using experience may have enhanced credibility with a target group who also have experience, particularly direct experience, of illicit drug-related issues. However, some argue that drug users are not positive role models. For this reason, ex-users may be more acceptable and appropriate in some contexts. Their experience gives them credibility and it is believed they can be positive role models for problematic users among the target group. The drug-related experience of young people who are active and well connected in the local drug scene, but who are not actually users may also be perceived as credible drug educators (Preston and Sheaves, 2001).

Social Experience

In this context, social experience refers to participation in particular social activities, membership of particular social groups, or cultural background. If the peer educator is seen to have relevant social experience, the target group are likely to see them as a credible source of drug-related social information, such as norms relating to use, prevalence of use, socially acceptable drug using behaviour, and the social consequences of drug use (positive and negative) (Cripps, 1997).

Selection Process

The process of selecting credible and acceptable peer educators is crucial. Methods of selection include self nomination, target group nomination and selection by initiative organisers or other adults such as teachers (Klepp et al., 1986; Wiist and Snider, 1991). The advantages and disadvantages of each of these methods are presented below, together with strategies to minimise disadvantages.

Self Nomination

Self nomination means young people nominate themselves as potential peer educators. Self nominators may be sought from the target group or other similar social groups. For example, peer education aimed at a local youth group may seek peer educators from former members or members of another similar youth group. The main advantage of this method is that those who self nominate are likely to be interested in the subject, motivated and committed to making the initiative work.

Guidelines for Self Nomination

- *specify desired characteristics of peer educators*
- *provide selection criteria*
- *clearly outline selection process*
- *clearly state philosophy and aim of program*
- *provide incentives*
- *promote widely.*

Two disadvantages of this method are that some self nominators may be inappropriate, while other potentially suitable peer educators may not nominate themselves. Self nominators may be inappropriate because they:

- are unlikely to be seen as a peer by the target group
- are unlikely to be seen as credible by the target group, based on either their personal characteristics or experience
- may not possess necessary peer educator skills and abilities (eg they may not be competent communicators or have insufficient understanding of key concepts)
- may hold a philosophy that is inconsistent with that of the initiative, for example they may advocate abstinence while the initiative philosophy is harm reduction (changing attitudes is difficult, therefore volunteers with conflicting attitudes to the initiative's philosophy should be accepted with caution).

Given these considerations, it is inevitable that some volunteers will be considered inappropriate and rejected. This may be minimised by providing guidelines for required peer educator characteristics, skills and experience and by ensuring in advance that the selection criteria and process are clearly understood.

There may be many reasons why potentially effective peer educators do not volunteer, including:

- limited self confidence about ability to be a peer educator
- perception that the peer education initiative is "uncool"
- reluctance to commit time and energy
- poor understanding of requirements.

Strategies to tackle reluctance to volunteer include:

- ensuring requirements are clearly understood
- widely promoting the initiative in a manner likely to appeal to desired peer educators
- explicitly stating desired peer educator characteristics
- providing incentives for participation, for example:
  - material incentives (such as payment, reimbursement for expenses, travel allowance, food, free giveaways, eg t-shirts, movie passes or vouchers)
  - formal recognition of participation (eg through certificates or a graduation ceremony) (Mudaly, 1997)
  - promoting peer educator skills as transferable, adaptable to other aspects of life and a valuable inclusion in records of achievement, portfolios and CVs (Bailey and Elvin, 1999).

Nomination by the Target Group

An alternative approach is to ask the target group to nominate potential peer educators, and then vote from the list of nominees. Providing guidelines may encourage nomination of people that are seen as:

- trustworthy
- motivated and committed to the role
- influential
- good communicators
- organised
- reliable
- experienced in issues valued by the target group.

Guidelines for Target Group Nomination

- *provide guidelines for nomination*
- *check availability and willingness of nominated peer educators*
- *ask target group to vote from shortlist of nominated peer educators.*

The main advantage of target group nomination is that peer educators are more likely to be seen as credible, acceptable and appropriate by the target group. A potential disadvantage may be reluctance from those nominated. Peers may also nominate candidates considered inappropriate by program organisers for other reasons.

Selection by Organisers of the Initiative or Others

Organisers (eg advisory group or coordinator) or other adults (eg teachers, health workers) may also nominate and select peer educators. An advantage of this approach is that those selected are likely to possess necessary peer educator skills. However, there may be a tendency to select model students (ie highly motivated, academically successful etc) who may not necessarily be credible, appropriate or acceptable to the target group.

Combining Selection Methods

A combination of some or all the above nomination and selection methods may help minimise the potential disadvantages of each. The methods may be combined in a number of ways (two examples are shown in Figure 7.1).

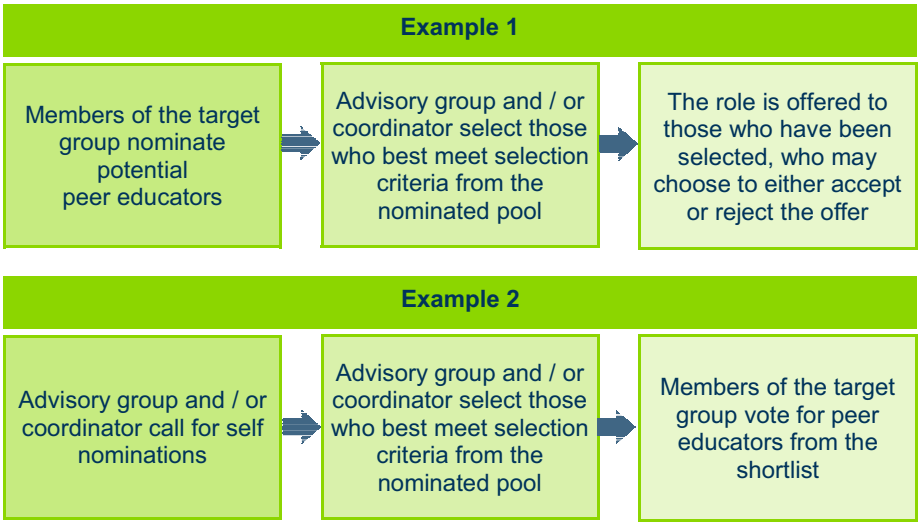

Figure 7.1: Examples of Combined Selection Methods

Training Peer Educators

Training is designed to build knowledge and a range of peer educator skills, including skills in initiating and facilitating discussion, presenting information and managing difficult people (Cripps, 1997). In addition, training can enhance the credibility of peer educators in the eyes of the target group. In particular, training may enhance peer educators' credibility as reliable sources of factual information, such as physical, social and legal consequences of drug use (Klepp et al., 1986; Perry et al., 1989).

A range of factors need to be considered in training peer educators, including:

- the setting in which training occurs
- length of training
- trainers
- pre-training preparation
- content
- delivery of training.

Setting

Issues to be addressed in relation to the training setting include location, layout, and ambience. Training is often conducted in a school or community centre (eg local hall, church, clubrooms or even in a local park). The characteristics of the peer educators (such as level of education, socioeconomic status and previous experience of school) may guide the choice of training location. For example, young people from socially excluded groups or those with negative experiences of school will probably respond better in a non-school setting. If the peer educators are drawn from the same location, for example, attend the same school or belong to the same club, it may be useful to conduct peer education in a venue with which they are already familiar.

Training room layout is important. A traditional classroom setting is quite common, where the trainer speaks from the front of the room with trainees in rows or desks. However, trainees are more likely to engage with the trainer if they are seated in a less formal manner, for example, in a circle, with the trainer as part of the circle. This layout is less hierarchical and affords the trainer and trainees similar status, which facilitates two-way interaction. It also models a style of interaction that the peer educator can emulate.

Room ambience may seem trivial, however, an appropriate temperature, comfortable seating and an inviting and relaxed atmosphere contribute to concentration and impact positively on learning. In addition, the size of the training venue compared to the training group will impact on ambience. A large room for a small group of people may seem uninviting and cold, whereas a small room for a large group may be crowded and uncomfortable.

The actual setting in which the peer educators will be conducting peer education is a key consideration. It is important that the peer educators are able to transfer the skills they have learned in training to the setting in which the peer education will take place. If the peer education will eventually be conducted in an informal setting it is appropriate for peer educator training to occur in an informal setting.

Length of Training Program

> *Insufficient practice opportunities for peer educators has been cited as a major contributor to unsuccessful peer education.*

The length of the training program will be largely determined by the aims and objectives of the peer education initiative, characteristics of the peer educators (particularly prior knowledge, skills and experience) and resources. Sufficient time is required to cover essential content and to include interaction, discussion and practice. While interaction, discussion and practice absorb considerable time, their importance cannot be overstated in relation to facilitating learning and helping trainees to maintain concentration and enthusiasm. (Baklien, 1993).

The training program may be conducted over a short, intensive period (for example, two or three whole day sessions) or broken down into a number of shorter sessions conducted over a longer period (eg 10 two-hour sessions over 10 weeks). This will depend on:

- availability of participants
- their ability to absorb information and maintain concentration
- availability of opportunities for trainees to absorb and practice newly acquired knowledge and skills.

If training is conducted over an intensive period, participants are more likely to remain focused and motivated if they are given practical activities and regular breaks.

Energy levels and trainee availability are important considerations in determining the time of day, week or year when training is conducted. People tend to have more energy in the morning and early afternoon. However, trainees may be unable to attend during the day, so evening sessions may be necessary. Shorter, intensive programs may need to be conducted on weekends or during school holidays (if the peer educators attend school).

The Trainers

Who are the Trainers?

A range of people may contribute to training of peer educators, including youth leaders, project officers, teachers, academics, drug and alcohol workers, community workers or other health professionals. Peer educators who have previously been trained for other initiatives have also been found to be useful trainers (Mathie and Ford, 1998). Some peer educators may feel that training is more "youth friendly" if it is conducted

by a younger person (McDonald et al., 2000). A single person may conduct the entire training program or there may be a number of trainers involved, each covering a different topic or running a different session.

Recruitment and Selection of Trainers

Various methods may be used to recruit and select trainers. Recruitment may be quite informal. For example, the initiative organisers or peer educators may recommend a person for the position. Alternatively, a formal recruitment process may be used in which the position is advertised and candidates are required to submit a formal application. Regardless of the recruitment method, it is important that clear criteria are established before trainers are appointed. Just as peer educators need to be credible and communicate well, so do the people who train them. It is important that trainers are knowledgeable about their topic, are able to relate to the trainees and can communicate information in a clear and engaging manner. The values and philosophy of the trainers need to be consistent with those of the initiative. It is also important that trainers have sufficient and relevant past AOD training and experience, and qualifications.

Trainer Preparation and Support

Before preparing their training material, trainers need to be informed about the aim and purpose of the initiative, its learning objectives, participant profiles, the length and format of training sessions and their role in the program. It may be useful to provide a written program overview and training session template. If more than one trainer is involved, a meeting of all trainers and shared contact details may facilitate communication and minimise the likelihood of unnecessary overlap. To avoid disruption resulting from a cancelled training session, it is important to ensure there is a backup plan in the event that a trainer is unexpectedly unavailable, for example, through illness.

Pre-training Preparation

Establishing Aims and Objectives

A peer education initiative requires specific and explicit aims. This will clarify the specific purpose and content of the initiative for trainers, trainees, initiative organisers and funders. The aims of the training program need to be established either before training or during the first training session. Peer educator training is an important milestone in the peer education initiative, not an endpoint. As such, the aims of training will be distinct from, but contribute to the aims of the initiative overall. It is important that all participants, including initiative organisers, trainers and peer educator trainees, have a clear understanding of aims and objectives. To ensure that this clear

understanding is retained, it is essential to provide a written version of aims and objectives and to revisit these frequently throughout training (McDonald et al., 2000). Example objectives are shown in Box 7.1. These examples are general guidelines to help organisers develop objectives.

Box 7.1: Example Objectives of Peer Educator Training

By the end of the training program, trainees will be able to:

- communicate effectively through discussion and leadership
- work effectively within a team
- be a good listener
- respond effectively to groups and individuals
- have knowledge of support systems for peers with problems
- reproduce exercises from the training program in a variety of settings
- attain respect from their peers
- have a good and correct knowledge of the facts surrounding the topic

Adapted from Bailey and Elvin (1999).

Clarifying Expectations and Obligations

The expectations and obligations of all participants (including trainers, trainee peer educators, coordinator and advisory group) need to be clear to all involved. As with the aims and objectives, it is useful to discuss expectations and obligations before or during the first session, provide a written record and revisit it at regular intervals throughout training. The types of issues that may be addressed include:

- duration of the training program
- content to be covered
- incentives, such as reimbursement for travel, providing a meal or nominal payment for participation
- background and experience of trainers and trainee peer educators
- level of commitment required by trainee peer educators, such as amount of time each week and participation in subsequent peer education activities
- evaluation requirements, such as questionnaire completion, participation in evaluation interviews and design and implementation of evaluation of their own peer education activities
- establishment of group norms and expectations.

Content

A core objective of peer educator training is to equip peer educators with the skills, knowledge and confidence to carry out peer education activities in a variety of settings (Brew, 1996), taking into account any anticipated obstacles in those environments (Baklien, 1993).

The topics to be covered will depend on the:

- aims of the initiative
- role of the peer educator (eg teacher, counsellor, helper, information source)
- specific needs of the target group
- philosophical orientation of the initiative.

It is important to understand that not *all* of the topics listed below will be included in *all* peer educator training. A number of topics that may be useful include:

- drug information
- accessing and assessing information
- psychological and social processes involved in drug use
- development of a range of skills, such as communication, interpersonal, organisational and presentation skills and the ability to initiate and facilitate discussion
- ethical and legal considerations (relating to conducting peer education, not AOD).

Drug Information

Peer educators require a broad (Gooding, 1996; Lixenberg, 1997), comprehensive (Ward et al., 1997), factual and non-judgemental (Prendergast and Miller, 1996) presentation of drug-related information. This may include:

- general drug information, eg:
  - models of addiction
  - pharmacological properties of various drugs
  - legal status of various drugs and other related legislation
- effects of various drugs, eg:
  - physical, social and psychological effects
  - positive and negative consequences
  - impact of age, gender and previous experience on a drug's effect
- harm reduction strategies, particularly if peer educators will be working with current drug users (Fors and Jarvis, 1995; Lixenberg, 1997; Weiss and Nicholson, 1998)
- information about appropriate actions:
  - responses to problematic or dependent drug use
  - strategies to avoid drug problems

- healthy ways to manage stress
- how to make responsible decisions

(Fors and Jarvis, 1995; Lixenberg, 1997; Weiss and Nicholson, 1998).

However, as the AOD area is vast and increasingly complex it is important to have modest and realistic expectations of what a young, inexperienced peer educator can be expected to learn. The training provided to peer educators will only ever be of a general, non-specific nature. It is important the knowledge base be kept to a minimum focusing on accuracy and balance.

Accessing and Assessing Information

It is important to achieve a balance between providing too much information and ensuring peer educators are confident about their knowledge. Novice peer educators may be concerned that they do not know enough about drugs, particularly about a wide range of drugs, and will be unable to answer questions. In reality, many young people are primarily concerned with alcohol, tobacco and cannabis, and peer educators may seldom be asked about other drugs (McDonald et al., 2000). Peer educators need to know how to access information and assess its quality. In response to a question they cannot answer, they will then be able to either direct the inquirer to an appropriate information source or agree to locate this information themselves and forward the answer when available. Peer educators also need to know that it is okay to admit that they do not know the answer to a given question. Box 7.2 describes a number of websites that act as key information access points for AOD information.

Psychological Factors

Peer educators will benefit from some insight into the psychological processes involved in drug use. However, given the complexity of these processes, only a limited exposure to this issue may be possible. It is important, however, that peer educators are aware of these processes and understand their complex nature. Inclusion of the theories presented in Chapter 4 of this monograph, particularly the Trans-Theoretical Stages of Change model, will help peer educators to understand the psychological processes involved in changing an established behaviour. Developing an understanding of the range of common attitudes of young people towards drug use (Bloor et al., 1999) and how attitudes are formed will also be useful (Baklien, 1993). Discussion about the factors that motivate decisions about drug use can include peer pressure and peer selection, desire for peer acceptance and belongingness, media pressure and situational factors (Baklien, 1993; Weiss and Nicholson, 1998).

Development of Skills

The skills that peer educators need to develop depend on the type of activities they will engage in following training. The skills required for spontaneous and opportunistic

Box 7.2: Some Key Information Access Points on the Internet

Australian Drug Information Network (ADIN)

<http://adin.com.au/>

ADIN is a portal for internet-based alcohol and drug information. It includes a large collection of quality assessed Australian and international websites and databases.

Drug Information Network (DrugInfo)

<http://druginfo.adf.org.au/index.asp>

DrugInfo is a clearinghouse. It collects, interprets and disseminates information on drug prevention. DrugInfo comprises a resource centre, website, publications and prevention research evaluation reports and register.

DrugNet

<http://drugnet.bizland.com/index.html>
DrugNet is a website containing alcohol and drug information to support professionals who work with drug users, including non-drug specialists. It contains information about various drug-related issues, including advice, models of addiction, assessment, intervention and links to other relevant sites.

National Clearinghouse for Alcohol and Drug Information (NCADI)

<http://www.health.org/>

NCADI is the information service of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP) in the United States. It is a one-stop resource for current and comprehensive information about substance abuse prevention and treatment. The clearinghouse distributes the latest studies and surveys, guides, videocassettes and other types of information and materials from various agencies, including the US Department of Education and Labor, the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment, the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse.

activities (such as initiating conversations about drug-related issues with their peers) will be quite different to those required for preparing and conducting structured information presentations and interactive group sessions. It is unrealistic to expect peer educators to master all the skills referred to below, but instead to develop those that are relevant to the type of peer education they are expected to conduct.

General skills that may be useful for most peer education activities include:

- communication
- active listening
- self reflection
- giving information to people who are not receptive because they think they already have the answers or are not in the right frame of mind
- addressing gender dynamics, particularly power issues
- selecting an appropriate moment
- adopting an appropriate manner with different people.

Skills relevant to more structured peer education activities include:

- writing aims and objectives
- developing and using teaching aids
- planning and presentation
- structuring a presentation
- small group teaching methods
- evaluation

(Prendergast and Miller, 1996; Bloor et al., 1999; Backett-Milburn and Wilson, 2000).

Skills required for more interactive sessions include the ability to:

- focus and direct a group
- encourage interaction
- create a non-judgemental climate
- accept a variety of attitudes and opinions.

A peer educator's ability to convey information and communicate effectively will be enhanced if they are taught informal and fun teaching methods, including use of humour, games (see Appendix 3 for examples) and dramatic skills (Ming, 1995; Brew, 1996).

Delivery of Peer Educator Training

Adult Learning Principles

The application of adult learning principles may be valuable in peer educator training (Gray, 1996; Gore, 1999). This involves inclusion of content that is largely determined by the participants, and that is relevant and applicable to their beliefs and experience. Problem- and outcome-focused learning where the participants can draw on their own knowledge and experience and control their own learning is also important, as is mutual respect and minimising the power differential between trainers and trainees (McDonald et al., 2000).

Mix of Interactive and Didactic Strategies

It is advisable to use a range of methods for training peer educators. The appropriate mix will be determined by the type of information to be presented, the background of the trainees and the peer education activities to be conducted. Using a variety of teaching methods will provide peer educators with a range of learning opportunities and options to use when conducting their own peer education activities. It is advisable to avoid didactic, lecture style methods where possible. When this is unavoidable, for example when conveying large volumes of information, it is important to facilitate concentration by using visual aids and humour (Rollin et al., 1994; McDonald et al., 2000).

Interactive and enjoyable activities may enhance trainees' motivation and enthusiasm (Baklien, 1993; Lixenberg, 1997; Mudaly, 1997) and demonstrate to trainees that their input is valued (Klepp et al., 1986; Baklien, 1993). Interactive methods include brainstorming, role plays, games and videos (Rollin et al., 1994; Weiss and Nicholson, 1998) (a number of interactive exercises are described in Appendix 3). Role plays are particularly valuable because they provide the opportunity for trainees to practice newly learnt skills.

Modelling

It is important that trainers model educational styles and techniques that the trainees can emulate, particularly the use of enjoyable, interactive and practical methods (see Appendix 3 for examples). Using these techniques in peer educator training serves a dual purpose – it facilitates learning by trainees and demonstrates techniques that trainees can use when conducting peer education activities.

Visual Learning Aids

Visual aids can considerably enhance learning by helping maintain trainees' concentration, highlighting key concepts and providing a permanent record of

information covered. Useful visual aids include Powerpoint presentations, overheads, videos, handouts and pamphlets. These aids also act as a guide for the type of materials peer educators can use when conducting their own sessions. Consolidation of the information provided may be facilitated if trainees are encouraged to compile their own reference folder. Time may be allocated for the reference folder during each session (McDonald et al., 2000). Appendix 3 describes some visual aids that may be appealing to young people.

Practice

Practice is an essential part of peer educator training. It can enhance peer educator confidence (Lixenberg, 1997; Mudaly, 1997), lead to a sense of accomplishment (McDonald et al., 2000) and increase the likelihood of information retention and skill acquisition (Goodstadt and Caleekal-John, 1984 cited in Gonzalez, 1990).

Practice may occur during training (eg after learning a particular technique) and during post-training pilot peer education activities. For example, during training, trainees may:

- prepare and present a mock information session
- engage in role playing activities, such as initiating a conversation with a friend who has been experience drug-related problems.

Reward

In addition to providing material incentives such as payment, reimbursement, travel allowance or food, it is useful to give peer educators more intangible rewards. Participation in a graduation ceremony and receiving an official certificate upon completion can be immensely rewarding for peer educators (see Appendix 4 for sample certificates). Graduation ceremonies not only give peer educators a sense of accomplishment, but may also provide an opportunity to involve families and friends and to promote the peer educator training program to other interested young people (Mudaly, 1997). Certificates can be a valuable record for peer educators to demonstrate their skills to future employers or others, particularly if the certificates list competencies achieved by the peer educators (Bailey and Elvin, 1999).

Support for Peer Educators

After completing training, peer educators need access to adequate levels of support, particularly in the early stages when they may lack confidence (McDonald et al., 2000). It is the role of the coordinator, advisory group and/or trainers to support peer educators before, during and after their engagement in peer educator activities. The extent of support required may vary, depending on the skills and confidence of the peer educators and the nature of their activities.

Support Before Peer Education: Planning and Organising

The type of support peer educators may need while planning and organising their activities include:

- guidelines (eg a planning template)
- advice
- access to resources
- other peer educators.

Guidelines (Planning Template)

A planning template may be used to guide peer educators through planning and organising their endeavours and may help them identify potential pitfalls (an example is provided in Appendix 5). The template may require peer educators to clearly articulate, in writing, key aspects of planning and organising, such as:

- aims, goals, objectives
- strategies
- timeline
- broad target group
- participant details (if known)
- content
- delivery
- resources
- evaluation strategy.

Advice

Peer educators may require advice about a range of planning and organisational issues, such as:

- addressing the issues raised in the proforma
- identifying and overcoming potential obstacles
- feedback on their planning and organisational progress
- contacting key people
- locating resources.

The latter two points are addressed in more detail below. To ensure peer educators have sufficient access to advice, it may be useful to schedule regular meetings where peer educators can provide updates and receive feedback about their progress, raise concerns and ask questions about any difficulties they are experiencing. It is also important to provide peer educators with contact details and available times for key support people (eg coordinator, trainers, advisory group members) in case they need advice between scheduled meetings.

Access to Resources

Peer educators may need help to access resources, including:

- visual learning aids, such as postcards, wallet cards, handouts, overhead transparencies or video tapes
- resources needed to organise and implement their activities including transport, telephone, email and postage facilities (or reimbursement for such expenses)
- equipment needed to implement activities, such as venue, projector, television, video player.

The coordinator (or other initiative staff) may obtain these on behalf of the peer educator, or refer them to another source to obtain required resources. If the latter, it is useful to introduce or refer the peer educator to those they need to contact, rather than expecting the peer educator to "cold call".

Other Peer Educators

Other peer educators can be another valuable source of support, either as a source of advice or by collaborating to plan and deliver peer education. Working with others may enhance confidence and make the experience more enjoyable. In addition, pairs or small groups of peer educators may have a wider variety of personal characteristics and experience, which may increase the likelihood that the participants will identify with them and find them credible.

Support During Peer Education Activities

For some formats (eg group sessions or at events) peer educators may feel supported by the presence of adults, such as the coordinator, trainers, a teacher or other health professional. However, this is a contentious issue. On the one hand, a peer educator may feel more confident because the adult can provide assistance such as responding to questions the peer educator cannot answer or helping to manage unruly and difficult participants. There are, however, a number of arguments against the presence of adults:

- the credibility of the peer educator may be undermined, perhaps giving the impression that the peer educator cannot handle a group of young people on their own
- the adult may intervene and take control away from the peer educator
- the peer educator may over rely on the adult, frequently turning to them for support, rather than learning how to manage difficult issues themselves, resulting in limited development of the peer educator's confidence and ability
- presence of an adult may impede the responsiveness of participants.

An alternative source of support during peer education may be another young person. Perhaps someone a few years older with more peer education experience. However, this can also result in over-reliance on this individual by the peer educator with subsequent failure to develop confidence and ability. It may be appropriate for another person to be present only for fledgling peer educators.

Conducting peer education in pairs or small groups is another way of providing peer educators with support during peer education. This approach is less threatening to credibility, and less likely to result in dependence by the peer educator.

Support After Peer Education

It is advisable to plan at the outset for a debriefing session to occur soon after completion of initial peer education activities. If the peer educators are conducting multiple sessions, it is useful to debrief between sessions, as well as following completion of all sessions. The aims of debriefing are to:

- integrate, consolidate and generalise learning
- provide the opportunity to share experiences
- encourage in-depth reflection
- facilitate further bonding between peer educators
- identify support needs for future peer education endeavours.

Issues to be discussed during debriefing may include:

- what the peer educator thought worked well
- what the peer educator thought worked less well
- any problems that arose
- how the peer educator dealt with those problems
- additional strategies for addressing these problems
- what they would do again in future activities
- what they would change in future activities.

The debrief facilitator asks questions to elicit feedback and stimulate discussion. Once the group has explored the issues, the facilitator summarises key themes. It is also useful to write up the summary of the session and distribute this to peer educators.

Summary

This chapter provided guidelines for selecting, training and supporting peer educators. It is useful to develop criteria for selecting peer educators that the target group will find credible, trustworthy, confident and personable. Peer educators may be selected through self or target group nomination, selection by the coordinator and/or advisory group or a combination of the three.

Issues to consider in training peer educators are the setting for training, length of training, the trainers, pre-training preparation, content and delivery of training. Following training, peer educators will continue to require support while planning and organising, during and after their activities. Planning and organising support may be provided through guidelines, advice, access to resources and collaboration with other peer educators. Peer educators may feel more supported during peer education if they have an adult, other young person or other peer educator present. A key support mechanism following implementation of peer education activities is debriefing.

The next chapter provides guidelines for implementing peer education activities. The chapter includes descriptions of four examples of peer education formats – planned group sessions, dissemination of resources, opportunistic interactions and creative approaches and popular culture. Guidelines are also provided for peer educators to plan and organise activities, addressing issues such as:

- negotiating with relevant people
- identifying characteristics, expectations and needs of participants
- planning content and delivery
- organising resources
- planning evaluation.

Guidelines for style and techniques for delivering peer education are contained in Appendix 3, rather than the body of Chapter 8 as the content of Appendix 3 is also relevant to training peer educators, as described in this chapter.

Chapter 8

Implementation of Peer Education

While the peer education literature is vast, there is surprisingly little published on the activities of peer educators. Many papers are concerned with peer educator training, theoretical underpinnings of peer education or the efficacy of peer education. A number of published papers report on peer education initiatives, describing the method of training and evaluation in detail, but with little mention of the activities undertaken by peer educators post-training. In some papers, it is even difficult to determine whether the topic of discussion is peer educator training or peer educator activities.

The lack of detailed description in the published literature does not mean peer education initiatives are not written up in detail. It is probable that coordinators of many initiatives do write up detailed reports, particularly for funding bodies, but these reports frequently do not enter the published literature and are therefore not easily accessed. The Internet has the potential to overcome this limitation, providing a widely accessible medium for dissemination of project outcomes. Access to such reports would provide a wealth of information about the vast array of peer education activities. This would be valuable as peer education activities do not constitute a "one size fits all" approach.

This chapter was informed by the few papers in the peer education literature that describe the activities of peer educators and by drawing on the experience of the authors. The chapter begins with brief descriptions of some common peer education formats:

- planned group sessions
- dissemination of resources
- opportunistic interactions
- creative approaches that utilise popular culture.

While these activities differ significantly, it is possible to provide peer educators with guidelines for planning, organising and implementing their activities. Guidelines for preparation of peer education form the second part of this chapter.

Specific guidelines and tools for implementing peer education activities are described in detail in Appendix 3[1] and include:

- establishing group norms
- style of delivery
- techniques for delivery
- visual learning resources.

Format Options

Described below are four examples of how peer education is frequently implemented. However, peer education is not limited to these formats. Peer educators may engage in a range of other types of activities.

Planned Group Sessions

A traditional understanding of peer education is group sessions prepared and presented by peer educators instead of teachers, health professionals or other adults (Gore, 1997, 1999). The delivery of such group sessions may differ vastly in terms of formality, structure and flexibility. They may be didactic, or interactive and practical. The content, activities and timetable may have been set in the planning phase, or be more flexible and driven by the interests of participants on the day, for example in a forum or question and answer session.

Dissemination of Resources

An alternative format for peer education is dissemination of resources, such as information leaflets or practical guidelines for reducing harm. This format does not require a significant time commitment from the target group and can also be an effective strategy for young people who are difficult to access through more traditional peer education activities.

Resources may be disseminated at events likely to be attended by young people, such as music festivals. At these events, peer educators may distribute leaflets and other resources by setting up a stall, or simply by mingling with the crowd. Both strategies have advantages. A stall may be equipped with colourful resources, such as posters, banners and balloons to attract people. However, if running a stall, peer educators may have to wait for young people to approach them. In contrast, mingling with the crowd enables peer educators to be more proactive (McDonald et al., 2000). It is probably advantageous to mix the two – with peer educators operating in pairs or small groups, where some of them mingle with the crowd and others remain at the stall.

While handing out resources, peer educators may also have the opportunity to engage in one-to-one conversations with other young people (McDonald et al., 2000). They can then provide additional information, such as advice about safe practices and referral to other sources of information or support. Such spontaneous conversations have the potential to result in more in-depth engagement with young people, particularly those at risk of drug-related harm.

In addition to providing information, peer educators may also take the opportunity to disseminate other resources to minimise harm, such as clean injecting equipment or condoms (Power et al., 1996). Giving out other products, such as soft drinks, healthy snacks, or toys, keyrings etc, may also act as an incentive to attract young people to the peer educators, increasing opportunities for interaction.

Opportunistic Interactions

Opportunistic interactions, such as everyday conversations with friends and acquaintances, is one of the most informal methods of peer education, yet perhaps one of the most powerful. This form of peer education may impact on individual and group behaviour. The process is often referred to as "cultural diffusion" (Bloor et al., 1999) or "social contagion" (Skog, 1980) because knowledge, attitudes and behaviours gradually diffuse throughout social networks of young people as peer educators pass on the information they learnt in their training and model certain behaviours to their friends, who in turn pass it on to others. This approach to peer education has potential to reach at-risk and marginalised youth and to access hidden populations of drug users. It is also less resource intensive than more formal approaches, although it is useful for peer educators to have a supply of supplementary information resources, such as wallet cards, postcards, fridge magnets, and contact details for referral to further information.

Peer educators may adopt a slightly more structured approach by working with youth organisations, participating in community events, concentrating on a particular location or environment, attending clubs and raves or contributing to media events (Power et al., 1996).

An added advantage of the opportunistic approach is that peer educators can tailor interactions specifically to the other person's experience, while the recipient has the opportunity to contribute to the direction of the interaction in a way that may not be possible in more structured or formal sessions (Backett-Milburn and Wilson, 2000).

Creative Approaches that Utilise Popular Culture

During adolescence and early adulthood, youth culture and popular culture exert considerable influence (Spooner et al., 2001). For this reason, peer education activities

that adopt a creative approach, or utilise popular culture, may be effective in reducing drug-related harm. Examples of such approaches include the use of websites, theatre productions, music, photography, visual art and journalism. Rather than simply providing information, these media can represent youth culture and provide realistic and practical information about drug use consequences and prevention strategies in a manner that is appealing and acceptable to young people. Examples of creative approaches to peer education that have been adopted in previous peer education initiatives are outlined in Boxes 8.1a - 8.1e. The reader is encouraged to study these examples and explore options for similarly creative and flexible approaches to peer education that could be adopted in their own locality.

Box 8.1: Examples of Creative Approaches and Popular Culture used in Previous Peer Education Initiatives

Box 8.1a:
Website: Somazone<http://www.somazone.com.au>

The Somazone website was developed by young people to provide information about a range of youth issues, including drugs, for other young people. The key target group is 14-18 year olds. The site is operated by the Australian Drug Foundation (ADF) and supported by a range of other agencies.

The philosophy of the site is to empower young people to manage their physical, emotional and social health needs by providing appropriate, unbiased, relevant and non-judgemental information. Young people are able to anonymously access information about drugs, health, relationships and legal issues. Information is "youth friendly", direct and easy to understand.

The site was launched in November 1999. There were seven young people aged 17-21 involved in development of the site. They were supported by a project coordinator and steering committee, but it was the young people who determined the content and design of the site.

The website is interactive, with a question and answer (Q&A) section, personal stories and interactive games. It also provides a support network. The Q&A and personal stories sections consist of content submitted by young people and visitors are able to access this information. This gives young people visiting the site the opportunity to see the kinds of issues that confront other young people.

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Question and Answer Section

Questions are submitted anonymously and forwarded to relevant health professionals. Answers are published on the site along with the questions. Questions relating to drugs are listed according to type of drug. The types of questions asked, however, are similar across different drug types, for example:

- effects and consequences
- risks and strategies for minimising risks
- street information
- communication strategies
- checking myths and facts.

Personal Stories

The website publishes personal stories submitted anonymously. The aim of the stories is to give the reader an opportunity to vicariously experience the lives of others and to understand the writers' motivation, feelings and consequences.

Interactive Games

The interactive games offered on the website are fun and informative. The website games could also be adapted for use in more traditional peer education activities. Similarly, many games used in peer education activities (see Appendix 3) may also be adapted for online use. Two games included on the site at the time of writing this monograph are:

- The Counselling Game

  The game provides the opportunity to role play being a counsellor for young people. The player is shown a question and asked to select an appropriate response. The player's answer is then evaluated and they receive a report.

- The Decisions Game

  The Decisions Game is played on a checkerboard. The player presses a button to roll the dice. When they land on an active square, they are asked a question. If the answer is correct, they are awarded points, if incorrect, points are taken.

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The player is also provided with feedback about the answer in youth friendly language, for example:

- Question
  At your part-time job as a checkout operator a customer asks for cigarettes. He looks about 18, should you ask for photo ID?

- Answer
  - Yes (correct answer): "You betcha baby. It's better to be safe than sorry."
  - No (incorrect answer): "Wrong. Looks can be deceiving – legally you should check his ID."

Support Network

The support network page provides information about:

- a range of services which can be accessed by state
- links to relevant websites
- advice, services and links for accessing help.

Preparation for Peer Education Activities

Peer education initiatives will differ in terms of the extent of responsibility given to peer educators for planning and implementation. In some cases, such as the Youth for Youth Project (McDonald et al., 2000), the peer educators may be responsible for identifying, planning, implementing and evaluating peer education activities, with support from the initiative coordinator, advisory group and other staff. The peer educators involved in other initiatives may not be expected to do anything beyond delivering the peer education. Other initiatives may have expectations of their peer educators that fall somewhere between these two extremes. The guidelines provided below address many issues peer educators may encounter when preparing to conduct peer education activities, although some of these tasks may be undertaken by the coordinator or others for some initiatives.

The amount of planning required by peer educators will depend on the nature of their intended activities, for example a structured group session will require more planning

Box 8.1b:
Theatre Production: Hunting in Packs, Southern Youth Theatre Ensemble (SYTE)

In 1999 and 2000, the Southern Youth Theatre Ensemble, located in the outer southern suburbs of Adelaide, produced two plays, both entitled Hunting in Packs. One of the authors of this monograph (JMcD) was a member of the steering committee for the 2000 production.

The Hunting in Packs theatre productions addressed issues of alcohol and other drug use by young people. The cast were teenagers from the Southern Youth Theatre Ensemble. The productions were performed at South Australian metropolitan high schools and other locations. Professional videos were made of each production and made available as a resource for organisations and groups promoting the prevention of problematic drug use.

A forum was conducted after each performance where members of the audience could discuss issues raised in the play, ask questions of the cast and provide feedback about the play. A cartoon booklet, or "zine", version of each production was also produced. The zines contained a cartoon strip version of the play and non-judgemental, factual advice, such as consequences of risky practices, legal rights of young people and contact details of relevant organisations and websites for further information, support or advice.

The play and the zine were developed by the young actors involved based on their own real life experience. They used language that realistically represented the way young people communicated and expressed themselves, and did not avoid confronting situations that were common to young people. The artistic director of the play was keen to "push the envelope", represent realistic scenarios instead of resorting to scare tactics and to be non-judgemental, avoiding "moralising". She wanted to let the audience learn from watching scenes they could relate to their own lives and make their own conclusions, rather than being "sent a message". In this way, the play in some ways emulated the impact of movies, television and other popular culture on the opinions and behaviours of young people.

The cast also helped develop the evaluation strategy, which consisted of self completion questionnaires by audience members about their experience of the play, how relevant it was to their life and the usefulness of the forum.

Box 8.1c:
Music: Intox Out Of Tune (Ryan et al., 1999)

The Intox project involved year 10 and 11 students from New South Wales high schools. The purpose of the project was to encourage students to develop a culturally appropriate product in a performance medium, in this instance popular music, aimed at entertaining and enhancing knowledge about alcohol consumption among listeners. It was expected that the influence and credibility of the message would be enhanced by using a medium that would be compelling to young people.

The peer educators attended educational sessions about alcohol and were then encouraged to write an original song based on their knowledge gained from the training sessions and submit it to the project song competition. The intention was to "harness the competitive spirit" (Ryan et al., 1999, p 27) common in secondary school cultures. The challenge of incorporating information about alcohol into song lyrics complemented and facilitated learning from the education sessions.

One song from each of the participating schools was selected to represent the school in the final event. Eight songs were performed from eight schools. The concert was attended by students from the participating schools, as well as local news media. The performances were videotaped and the winning song professionally recorded and distributed to schools to be used as a learning resource.

The project was evaluated using pre and post test knowledge questionnaires of participants which indicated some improvements in knowledge. Feedback from participants indicated reduction in risky drinking behaviour.

than opportunistic interactions. Despite the difference in the extent of planning, in general, peer educators need to:

- identify characteristics, expectations and needs of participants
- organise resources
- negotiate with relevant people
- plan content, delivery and evaluation.

Box 8.1d:
Visual Art: Photography Course (Porteous, 1999)

This British project involved unemployed young people, aged 16-25, in an eleven week art project to design, produce and disseminate photographs conveying images of problematic drug use. The aim of the photographs was to raise awareness and inform young people about choices of drug use. The project did not aim to reduce drug use. The photographs were made into posters that were used as drug awareness resources in the media and at community events. The posters aimed to counter scare tactics, hysteria and more extreme depiction often encountered in the media. The photographs and posters were included in magazines, at youth and community events, conferences, and youth centres.

Process evaluation indicated that the project was delivered as planned. Participants enjoyed their involvement, gained confidence and developed skills. Some of the posters developed were used as resources for drug awareness and the project was reported in the media.

Box 8.1e:
Magazine: New Youth Connections (Blustain and McCarthy, 1999)

New Youth Connections is a New York magazine aimed at teenagers, produced by teenagers. It is published by Youth Communication and has a readership of about 200,000. The view of the magazine is that young people will be most open to learning about life from other young people. It consists of personal stories written by young people about their own experience or knowledge. The stories are expected to act as a self help tool by assisting young people to analyse their situations and make informed decisions about drug use. The stories are insightful and aimed at informing the reader about the consequences of risky drug use. The stories go beyond promoting simplistic solutions to complicated problems and avoid venting or blaming. Instead, they explore complexity and confusion, question motivations, place concerns in a broad framework and examine choices and consequences. The stories help the reader understand that other people have similar experiences. The reader is also able to vicariously experience events, decision making and consequences.

The magazine does not have an evaluation strategy to assess its impact on its readers, and relies instead on unsolicited feedback.

Negotiate with Relevant People

Peer educators may need to negotiate with relevant people who are not a part of the peer education initiative. "Relevant" people include the key contact person for the organisation, event or location where peer education activities will occur. This may include an event organiser, the coordinator of a community group, or the teacher of a school class, among others. Liaison with these people may involve:

- exchanging information about aims and objectives of activities (ie of peer educators, contact person and participants)
- negotiating rules or norms, and expectations of both the peer educator and the other relevant person
- arranging venue and equipment
- determining characteristics and needs of expected participants
- making preliminary contact with participants if appropriate (eg to determine participant expectations and interests etc)
- checking whether anyone else will be present, particularly adults such as teachers, parents, coordinators and negotiating the role and boundaries of these people
- arranging to be introduced to participants so the peer educators do not need to go in "cold".

Identify Characteristics, Expectations and Needs of Participants

A key planning task is to identify the characteristics, expectations and needs of the participants. The initiative organisers will probably have identified the characteristics and needs of the target group before recruiting and selecting peer educators (as discussed in Chapter 5). However, when the peer educators plan their activities, they are more likely to know which members of the target group will participate in their activities. Their specific characteristics, expectations and needs may differ from those of the broader target group. For example, the target group for the initiative may be homeless young people, but the peer educators may be planning to conduct peer education at a particular homeless shelter. Therefore, "homeless young people" are the target group and homeless young people at the particular shelter are the participants.

Collecting further information about participants may enable peer educators to tailor their activities in terms of content, resources and collaborators. Collaborators may include other peer educators or other adults, such as teachers, health professionals or others. The type of information to be collected about the participants includes:

- the extent of their experience in drug-related issues
- key drugs of interest
- existing knowledge
- expectations of peer education activities

- demographic characteristics (age, gender, educational background, socioeconomic status, cultural background)
- anticipated number of participants.

The participants' experience of drug-related issues, key drugs of interest and existing knowledge may indicate the most appropriate drugs and related topics to address. Demographic characteristics of the participants may influence the type of language and dress style of the peer educators. Demographic information will also provide insight into which peer educator will have more credibility with the group. For example, in the Youth for Youth project (described in McDonald et al., 2000), three peer educators conducted group sessions with a group of boys aged 13-15 who had previously been expelled from school. Two of the peer educators were reasonably well educated, middle class young women. The third was a young man who appeared more "streetwise". The peer educators in this group reported that the participants identified with the young man in relation to some issues, particularly street information. The trio worked well because the young man was seen as more credible in relation to street information, and the young women had more experience in peer education, and were able to support the young man in areas in which he felt less confident.

The anticipated number of participants is also an important issue, because the approach used for larger groups will differ from that of smaller groups, for example, interaction and practical activities may be easier to run for smaller groups. Group size also has implications for venue, number of resources and number of peer educators needed to facilitate activities.

The method of collecting information about participants will depend on the type of peer education activity. For example, peer educators may run a group session for a particular group, such as a community organisation or school class. The peer educators can contact the coordinator of the group and ask them about the characteristics of those expected to attend. Alternatively, peer educators can ask the participants themselves, through methods such as a survey or focus group conducted before the sessions, perhaps a week before.

If peer education is based on opportunistic interactions at a particular event, peer educators can contact the event organisers to find out about the demographics of the event's target audience. In most cases, event organisers will have a clear definition of their target audience which they would have used to promote and market the event. In addition, the type of event will probably provide important information about issues such as expected age range, gender balance, types of drugs commonly used and relevant popular culture. For example:

- drugs of interest will probably differ between a rock music festival and a rave
- male peer educators may be more successful than female peer educators at a car show

- peer educators who appear well educated may be appropriate for a conference attended by young people
- the appropriate age of peer educators will differ between licensed and unlicensed events.

Plan Content and Delivery

Depending on the activity, peer educators may need to plan the content of their activity and the style and techniques they will use to deliver the content. Planning of content and delivery is most relevant for more planned activities, such as group sessions. Many of the issues related to content and delivery are similar for peer educator training and implementation. They are described in more detail in Appendix 3.

Organise Resources

A comprehensive training program will have provided peer educators with strategies for obtaining resources, but initiative organisers need to make it clear that they will help peer educators to locate any additional resources required. It may be necessary to make this offer more than once, as peer educators may be reluctant to approach initiative organisers.

The types of resources peer educators need to locate will depend on the type of activities they are conducting, but may include items such as:

- learning resources (eg leaflets, postcards, wallet cards, magnets – described in more detail in Appendix 3)
- audiovisual equipment (eg overhead transparencies and projector, television, video player, whiteboard, flip chart)
- resources to facilitate organisation and implementation of peer education activities (eg transport, computer and telephone access, useful contact people).

Plan Evaluation

Planning the evaluation of peer education activities follows the same process as planning the evaluation of the entire peer education initiative. The key elements are shown below. Refer to Chapter 6: Evaluation for further details.

During planning:

- the reasons for the evaluation are clarified
- aims, objectives, strategies and indicators are developed (see Box 6.2 in Chapter 6 for description)
- cost, time and resource needs (and limitations) are assessed
- timing and type of evaluation are determined.

Summary

There is very little published about the details of peer education activities. This chapter is based on the few published papers available and the experiences of the authors. The chapter began by describing four formats for peer education – planned group sessions, dissemination of resources, opportunistic interactions and creative approaches and popular culture.

It is not possible to provide comprehensive "one size fits all" guidelines for peer education activities. This chapter provided general guidelines for peer educators to plan and organise their activities, including negotiating with relevant people; identifying characteristics, needs and expectations of participants; planning content and delivery; organising resources and planning evaluation. More specific guidelines and tools for implementing peer education activities are provided in Appendix 3 and include establishing group norms, style of delivery, techniques for delivery and visual learning aids. The content of Appendix 3 is relevant to both the training of peer educators and the implementation of activities by peer educators.

The final chapter of this monograph considers future directions for peer education.

Notes

[1] Many of the issues covered in Appendix 3 are applicable when training peer educators and when peer educators engage in peer education activities, particularly planned and structured activities, such as group sessions.

Part D

Conclusion

Chapter 9

Where To From Here?

The closing chapter outlines future directions for peer education, including:

- summary recommendations for future peer education initiatives
- suggestions for further research into peer education
- ideas for development of resources to support the AOD field to implement peer education.

Recommendations for Future Peer Education Initiatives

Peer education is not a stand alone, one-off strategy. It should be seen as part of a comprehensive, holistic approach to addressing problematic drug use among young people.

During development of a peer education initiative it is important to seek information from a variety of sources, such as:

- the peer reviewed literature regarding best practice for peer education and approaches that have been shown to be effective
- reported implementation and outcomes for peer education initiatives that are not published in the peer reviewed literature, including those that have been published on the internet and unpublished reports
- others who have been involved in peer education initiatives, including those who have organised initiatives, peer educators and young people who have received peer education
- the guidelines provided in this monograph.

Sufficient attention needs to be given to the planning and development stage of peer education. At the outset:

- ensure all involved have a clear understanding of the aims of the initiative
- consult widely during planning, including stakeholders such as the target group and community members
- plan the evaluation strategy at the outset and ensure it is implemented as planned
- ensure the evaluation strategy is consistent with aims of the initiative
- select peer educators based on whether they will be credible, appropriate and acceptable to the target group
- ensure peer educators are appropriately trained and sufficiently supported to undertake peer education activities.

Suggestions for Peer Education Research

There is a need for more rigorous research about peer education that is undertaken in variety of settings and formats (particularly informal and opportunistic peer education) and with various target groups. There is also a need for more long-term follow-up. A substantial proportion of the peer education literature reports on findings from process evaluations of peer education initiatives, rather than outcome evaluation. Much of it is also descriptive in nature, rather than experimental. Future research needs to:

- identify the characteristics of effective peer education
- examine the differential impact of peer education on young people with various characteristics, eg age, gender, cultural background, educational background, experience with drug-related issues
- ensure transparent reporting of research and initiatives in the literature, eg:
  - clarify the way peer education has been defined
  - describe characteristics of both peer educators and target group
  - state ideology of the initiative, ie where on abstinence / harm reduction continuum
  - indicate when information pertains to peer educators and when it refers to the target group.

Development of Resources to Support the AOD Field

Feedback received by the National Centre for Education and Training on Addiction (NCETA) from the alcohol and other drugs field has indicated significant interest in peer education, and a need for information and resources to support the field in implementing peer education initiatives. In addition to this monograph on peer education, NCETA plans to develop a number of other resources to support the field, including:

1. Development of a series of resource kits for various aspects of peer education, including kits for:

   a) Trainers to use in training peer educators, including:

      - subject modules, such as drug information, psychosocial factors that contribute to drug use, accessing and assessing resources, ethical and legal issues, skills in disseminating information and facilitating discussion
      - guidelines for using practical, interactive and experiential learning approaches
      - visual learning aids, such as video tapes, overhead transparencies, Powerpoint slides, handouts

   b) Peer educators to use in their peer education activities, such as templates for planning peer education activities, "youth friendly" information resources (eg postcards, wallet cards), reading lists, and contact details of people or organisations who can provide information, support or referral

   c) Evaluating peer education, such as guidelines for developing an evaluation strategy, tools (questionnaires, interview questions), reading lists

2. Establishment of Peer Education Networks, including development of a website to facilitate interaction and communication between:

   - organisations implementing peer educator training
   - organisations implementing peer education activities
   - trained peer educators
   - young people interested in becoming peer educators
   - groups seeking peer educators.

3. Consultation on development of peer education initiatives by other agencies and organisations within the AOD field.

Problems associated with youth drug use are an area of growing concern. Careful consideration needs to be given to strategies that can be appropriately and effectively applied in this area. Peer education is one strategy that has been shown to be effective when applied with care and thought. It is hoped that this volume will assist those interested in undertaking initiatives to address youth drug use. It is also hoped that any initiatives, whether they be peer education or one of a range of other initiatives, are applied in a way that is consistent with the best available evidence, best practice and with relevance to the intended targe group. In this way, we optimise chances of successful outcomes.

References

References

Ajzen, I. (1991). The Theory of Planned Behavior, *Organizational Behavior and Human Decision Processes*, 50:179-211.

Ajzen, I., Madden, T.J. (1986). Prediction of goal-directed behavior: Attitudes, intentions, and perceived behavioral control, *Journal of Experimental Social Psychology*, 22(5):453-474.

Allott, R., Paxton, R., Leonard, R. (1999). Drug Education: A Review of British Government Policy and Evidence of Effectiveness, *Health Education Research*, 14(4):491-505.

Armitage, C.J., Conner, M., Loach, J., Willietts, D. (1999). Different Perceptions of Control: Applying an Extended Theory of Planned Behaviour to Legal and Illegal Drug Use, *Basic and Applied Social Psychology*, 21(4):301-316.

Australian Institute of Health and Welfare (1999). *1998 National Drug Strategy Household Survey*. Australian Institute of Health and Welfare: Canberra.

Australian Institute of Health and Welfare (2002). *2001 National Drug Strategy Household Survey*, Australian Institute of Health and Welfare: Canberra.

Backett-Milburn, K., Wilson, S. (2000). Understanding peer education: insights from a process evaluation, *Health Education Research: Theory and Practice*, 15(1):85-96.

Badura, A.S., Millard, M., Peluso, E.A., Ortman, N. (2000). Effects of peer education training on peer educators: Leadership, self-esteem, health knowledge, and health behaviors, *Journal of College Student Development*, 41(5):471-478.

Bailey, J., Elvin, A. (1999). Drugs and Peer Education. In A. Marlow, G. Pearson (Eds) *Young People, Drugs and Community Safety*. Russell House Publishing, Dorset.

Baklien, B. (1993). Two-step drug education in Norway, *Journal of Drug Education*, 23(2):171-182.

Bament, D. (2001). *Peer Education Literature Review*. South Australian Community Health Research Unit: Adelaide.

Bandura, A. (1977). *Social learning theory*, Prentice Hall: Englewood Cliffs, NJ.

Bangert-Drowns, R.L. (1988). The effects of school-based substance abuse education – a meta analysis, *Journal of Drug Education*, 18(3):243-264.

Battjes, R.J. (1985). Prevention of adolescent drug abuse, *International Journal of Addiction*, 12:1113-1135. Cited in Wragg, J. (1991). A review of successful and unsuccessful models of drug education, *Drug Education Journal of Australia,* 5(1):15-26.

Bauman, A., Phongsavan, P. (1999). Epidemiology of substance use in adolescence: Prevalence, Trends and Policy Implications, *Drug and Alcohol Dependence*, 55(3):187-207.

Bazeley, P., Richards, L. (2000). *The Nvivo Qualitative Project Book*, Sage Publications: London.

Black, D.R., Tobler, N.S., Sciacca, J.P. (1998). Peer helping/involvement: an efficacious way to meet the challenge of reducing alcohol, tobacco, and other drug use among youth?, *Journal of School Health*, 68(3):87-93.

Blackman, S.J. (1996). Has Drug Culture become an inevitable part of youth culture? A critical assessment of drug education, *Educational Review*, 48(2):131-142. Cited in Crompton, L. (2003). Young People Shouting in Hallowed Halls: Young People's Participation in Policy Development. Presented at the *International Research Symposium Preventing Substance Use, Risky Use and Harm: What is Evidence-Based Policy?* Perth, Western Australia, February 2003.

Bleeker, A. (2001). Drug Use and Young People – Rationale for the DSP. Presented at the *2nd International Conference on Drugs and Young People: Exploring the Bigger Picture*, Melbourne.

Bloor, M., Frankland, J., Parry Langdon, N., Robinson, M., Allerston, S., Catherine, A., Cooper, L., Gibbs, L., Gibbs, N., Hamilton-Kirkwood, L., Jones, E., Smith, R.W., Spragg, B. (1999). A controlled evaluation of an intensive, peer-led, schools-based anti-smoking programme, *Health Education Journal*, 58:17-25.

Blum, R., Garfield, E., Johnstone, J., Magistad, J. (1978). Drug education: further results and recommendations, *Journal of Drug Issues*, 8:379-426. Cited in Wragg, J. (1991). A review of successful and unsuccessful models of drug education, *Drug Education Journal of Australia,* 5(1):15-26.

Blustain, R., McCarthy, N. (1999). Peer support through teen journalism, *Social Policy*, Fall:7-12.

Bond, N.W., McConkey, K.M. (2001). *Psychological Science: An Introduction*, McGraw Hill Book Company: Sydney.

Botvin, G. (1990). Substance abuse prevention: theory, practice and effectiveness. In M. Tonry, J. Wilson (Eds) *Drugs and Crime (Crime and Justice)*, 11:461-520. University of Chicago Press: Chicago, Illinois. Cited in Black, D.R., Tobler, N.S., Sciacca, J.P. (1998). Peer Helping/Involvement: An Efficacious Way to Meet the Challenge of Reducing Alcohol, Tobacco, and Other Drug Use Among Youth?, *Journal of School Health,* 68(3):87-93. Cited in Mellanby, A.R., Rees, J., Tripp, J.H. (2000). Peer-led and adult-led school health education: A critical review of available comparative research, *Health Education Research,* 15(5):533-545.

Botvin, G.J., Baker, E., Renick, N.L., Filazzola, A.D., Botvin, E.M. (1984). A cognitive-behavioural approach to substance abuse prevention, *Addictive Behaviors*, 9:137-147. Cited in Mellanby, A.R., Rees, J., Tripp, J.H. (2000). Peer-led and adult-led school health education: A critical review of available comparative research, *Health Education Research,* 15(5):533-545.

Botvin, G.J., Wills, T.A. (1985). Personal and social skills training: Cognitive-behavioural approaches to substance abuse prevention. In C.S. Bell, R. Battjes (Eds), *Prevention research: Deterring drug abuse among children and adolescents*, NIDA Research Monograph 63. Cited in Wragg, J. (1991). A review of successful and unsuccessful models of drug education, *Drug Education Journal of Australia,* 5(1):15-26.

Brannon, L., Feist, J. (2000). *Health Psychology: An Introduction to Behavior and Health*, Wadsworth: Australia.

Breen, C., Degenhardt, L., Roxburgh, A., Bruno, R., Duquemin, A., Fetherston, J., Fischer, J., Jenkinson, R., Kinner, S., Longo, M., Rushforth, C. (2002). Australian Drug Trends 2002: Findings from the Illicit Drug Reporting System (IDRS). *NDARC Monograph No 50*, National Drug and Alcohol Research Centre (NDARC): Sydney.

Brew, R. (1996). *Word is out! A resource booklet on peer education for workers with young people and funding providers*, Family Planning South Australia: Adelaide.

Broadbent, R. (1994). Young people's perceptions of their use and abuse of alcohol. *Youth Studies Australia*, Spring, 32-35.

Carpenter, D. (1996). Alcohol on the agenda,. *Health Education*, 5:21-24. Cited in Parkin, S., McKeganey, N. (2000). The rise and rise of peer education approaches, *Drugs, Education, Prevention and Policy,* 7(3):293-310.

Chassin, L., DeLucia, C. (1996). Drinking during adolescence, *Alcohol Health and Research World*, 20(3):175-180.

Child and Youth Health (n.d.). *About Us*. Government of South Australia. Internet. Accessed 4 February 2003. Available from: <http://www.cyh.com/cyh/about/about_index.stm?section=about&page_id=2>.

Clarke, J.H., MacPherson, B., Homes, D.R., Jones, R. (1986). Reducing adolescent smoking: a comparison of peer-led, teacher-led and expert interventions, *Journal of School Health*, 56:102-106. Cited in Mellanby, A.R., Rees, J., Tripp, J.H. (2000). Peer-led and adult-led school health education: A critical review of available comparative research, *Health Education Research,* 15(5):533-545.

Coggans, N. (1997). What have we learned from drug education? In *Proceedings of the 8th International Conference on the Reduction of Drug Related Harm*, Paris, 23-27 March 1997.

Coggans, N., Watson, J. (1995). Drug education: approaches, effectiveness and delivery, *Drugs: Education, Prevention and Policy*, 2(3):211-224.

Coleman, J., Hendry, L. (1990). *The Nature of Adolescence*. Routledge: London. Cited in Shiner, M. (1999). Defining Peer Education, *Journal of Adolescence,* 22:555-566.

Collins, D.J., Lapsley, H.M. (2002). Counting the Cost: Estimates of the Social Costs of Drug Abuse in Australia in 1998-9. *National Drug Strategy Monograph Series*, No 49. Canberra.

Commonwealth Department of Health and Family Services (1996). *National Drug Strategy, Household Survey*. Survey Report 1995. Australian Government Publishing Service: Canberra.

Commonwealth Department of Human Services and Health (1994). *National Drug Strategy Household Survey: Urban Aboriginal and Torres Strait Islander Peoples Supplement*, Australian Government Publishing Service: Canberra.

Cripps, C. (1997). Workers with attitude, *Druglink*, 12(3):15-17.

Crompton, L. (2003). Young People Shouting in Hallowed Halls: Young Peoples Participation in Policy Development. Presented at *International Research Symposium Preventing Substance Use, Risky Use and Harm: What is Evidence-Based Policy?* Perth, Western Australia, February 2003.

Cuijpers, P. (2002a). Effective ingredients of school-based drug prevention programs. A systematic review, *Addictive Behaviors*, 27:1009-1023.

Cuijpers, P. (2002b). Peer-led and adult-led school drug prevention: a meta-analytic comparison, *Journal of Drug Education*, 32(2):107-119.

Degenhardt, L., Lynskey, M., Hall, W. (2000). Cohort trends in the age of initiation of drug use in Australia, *Australian and New Zealand Journal of Public Health*, 24(4):421-426.

DePoy, E., Gitlin, L.N. (1998). *Introduction to Research: Understanding and Applying Multiple Strategies*, Mosby: St Louis.

Donovan, D.M., Chaney, E.F. (1985). Alcohol Relapse Prevention and Intervention: Models and Methods. In G.A. Marlatt, J.R. Gordon (Eds) *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors*, The Guilford Press: New York, London, p351-416.

Douthwaite, J. (1997). Peering into the future of alcohol education, *Alcohol Concern*, 19-20.

Dusenbury, L., Falco, M. (1995). Eleven components of effective drug abuse prevention curricular,. *Journal of School Health*, 65:420-425. Cited in Midford, R. (2000). Does drug education work?, *Drug and Alcohol Review,* 19:441-446.

Ellickson, P.L., Bell, R.M., Thomas, M.A., Robyn, A.E., Zellman, G.L. (1988). *Designing and implementing Project ALERT: A smoking and drug prevention experiment*, The Rand Corporation. Cited in Wragg, J. (1991). A review of successful and unsuccessful models of drug education, *Drug Education Journal of Australia,* 5(1):15-26.

Elliott, K.J., Lambourn, A.J. (1999). Sex, drugs and alcohol: two peer-led approaches in Tamaki Makaurau/Auckland, Aotearoa/New Zealand, *Journal of Adolescence*, 22:503-513.

English, D.R., Holman, C.D.J., Milne, E., Winter, M.G., Hulse, G.K., Codde, J.P., Bower, C.I., Corti, B., de Klerk, N., Knuiman, M.W., Kurinczuk, J.J., Lewin, G.F., Ryan, G.A. (1995). *The quantification of drug caused morbidity and mortality in Australia*, 1995 edition, Commonwealth Department of Human Services and Health: Canberra.

Fabiano, P.M. (1994). From personal health into community action: Another step forward in peer health education, *Journal of American College Health*, 43:115.

Fast Forward (1997). The Crunch. *Negotiating the agenda with young people. A peer education training manual*. Health Education Board for Scotland: Edinburgh. Cited in Parkin, S., McKeganey, N. (2000). The rise and rise of peer education approaches, *Drugs, Education, Prevention and Policy,* 7(3):293-310.

Festinger, L. (1954). A theory of social comparison processes, *Human Relations*, 7:117-140.

Festinger, L. (1964). *Conflict, decision and dissonance*, Stanford University Press: Stanford. Cited in Marlatt, G.A., Gordon, J.R. (Eds) (1985). *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors,* The Guilford Press: New York, London.

Finn, P. (1981). Teaching Students to be lifelong peer educators, *Health Education*, 12:13-16.

Fioravanti, M. (1995). *Meet Adelaide*, Adelaide Convention and Tourism Authority: Adelaide.

Flay, B.R. (1985). What we know about the social influences approach to smoking prevention: review and recommendation. *NIDA Monograph Series 63*. Cited in Wragg, J. (1991) A review of successful and unsuccessful models of drug education, *Drug Education Journal of Australia,* 5(1):15-26.

Fors, S.W., Jarvis, S. (1995). Evaluation of a peer-led drug abuse risk reduction project for runaway/homeless youths, *Journal of Drug Education*, 25(4):321-333.

Foxcroft, D.R., Ireland, D., Lister-Sharp, D.J., Lowe, G., Breen, R. (2003). Longer-term primary prevention for alcohol misuse in young people: a systematic review, *Addiction*, 98(4):397-411.

FPEP (1997). The Peer Education Project in Fife. Summary report. Fife Healthcare NHS Trust Health Promotion Department. Cited in Parkin, S. and McKeganey, N. (2000) The rise and rise of peer education approaches, *Drugs: Education, Prevention and Policy,* 7(3):293-310.

Glyn, T. (Ed) (1983). *Drug Abuse: prevention research*, NIDA: Rockville MD.

Goldsmith, M., Reynolds, S. (1997). *Step by Step to Peer Health Education Programs: A Planning Guide*. ETR Associated. Cited in Lezin, N. (n.d.). *With a Little Help From My Friends: Peer Education in Teen Pregnancy Prevention*, Resource Centre for Adolescent Pregnancy Prevention. Internet. Accessed 30 January 2003. Available from: <http://www.etr.org/recapp/theories/peereducation/index.htm>.

Gonzalez, G.M. (1990). Effects of a theory-based, peer-focused drug education course, *Journal of Counseling and Development*, 68(4):446-449.

Gooding, D.A. (1996). ASAP: Attitudes of Students to Alcohol. A Peer Educator Program. In *Conference proceedings: 7th International Conference on the Reducton of Drug Related Harm: from Science to Policy to Practice, Hobart, Australia, 3-7 March 1996*. Australian Drug Foundation: Melbourne, p495-504.

Goodstadt, M.S. (1980). Drug education – A turn on or a turn off? *Journal of Drug Education*, 10:89-99. Cited in Wragg, J. (1991) A review of successful and unsuccessful models of drug education, *Drug Education Journal of Australia,* 5(1):15-26.

Goodstadt, M.S., Caleekal-John, A. (1984). Alcohol education programs for university students: A review of their effectiveness. *International Journal of the Addictions*, 19:721-741. Cited in Gonzalez, G.M. (1990). Effects of a theory-based, peer-focused drug education course, *Journal of Counseling and Development,* 68(4):446-449.

Gore, C. (1997). Development and delivery of peer education approaches. In *Proceedings of a national workshop organised jointly by the National Centre for the Prevention of Drug Abuse and the Drug and Alcohol Services Council, Sydney, 15 August, 1997*, Curtin University of Technology: Bentley, p27-31.

Gore, C. (1999). Peer education among injecting drug users. In *Strategies for intervention in opioid overdose: a resource for community workers. Report of the Workshop, "Heroin Overdose: National forum on Strategy Development", Adelaide, February 1997.* National Centre for Education and Training on Addiction (NCETA): Adelaide.

Gorman, D.M. (1998). The irrelevance of evidence in the development of school-based drug prevention policy, *Evaluation Review*, 22:118-146. Cited in Webster, R.A., Hunter, M., Keats, J.A. (2002). Evaluating the effects of a peer support program on adolescents' knowledge, attitudes and use of alcohol and tobacco, *Drug and Alcohol Review*, 21:7-16.

Gray, J. (1996). Peer education: looking for a home, *Forum on Child and Youth Health*, 4(3):3-8.

Green, J. (2001). Peer education, *Health Education Research*, 8(2):65-68.

Green, J., Tones, K. (1999). Towards a secure evidence base for health promotion, *Journal of Public Health Medicine*, 21(2):133-139.

Green, L.W. (1977). Evaluation and measurement: some dilemmas for health education. *American Journal of Public Health*, 67:155-161. Cited in Hawe, P., Degeling, D., Hall, J. (2000). *Evaluating Health Promotion,* MacLennan and Petty Pty Limited: Sydney.

Grodner, M. (1991). Using the health belief model for bulimia prevention, *Journal of American College Health*, 40(3):107-112.

Grossman, S., Canterbury, R.J., Lloyd, E., McDowell, M. (1994). A model approach to peer-based alcohol and other drug prevention in a college population, *Journal of Alcohol and Drug Education*, 39(2):50-61.

Grube, J.W. (1986). Attitudes and normative beliefs as predictors of smoking intentions and behaviours: A test of three models, *British Journal of Social Psychology*, 25:81-93.

Grube, J.W., Voas, R.B. (1996). Predicting underage drinking and driving behaviors, *Addiction*, 91(12):1843-1857.

Haines, M.P. (n.d.) *A Social Norms Approach to Preventing Binge Drinking at Colleges and Universities*. Northern Illinois University. Internet. Accessed 12 December 2002. Available from: <http://www.edc.org/hec/pubs/socnorms.html>.

Hansen, W.B. (1993). School-based alcohol prevention programs, *Alcohol Health Research World*, 17:54-60. Cited in Midford, R. (2000). Does drug education work?, *Drug and Alcohol Review,* 19:441-446.

Harrison, C. (1996). *Wimmera Regional Alcohol Schools Peer Education Program: evaluation report*. Palm Lodge Centre: Horsham.

Hawe, P., Degeling, D., Hall, J. (2000). *Evaluating Health Promotion: A Health Worker's Guide*, MacLennan and Petty Pty Limited: Sydney.

Hawkins, J.D., Lishner, D., Catalano, R. (1985). Childhood predictors and the prevention of adolescent substance abuse, in C. Jones and R. Battjes (Eds) *Etiology of Drug Abuse: implications for prevention*, NIDA Research Monograph 56: Rockville, MD. Cited in Coggans, N., Watson, J. (1995). Drug education approaches, effectiveness and delivery, *Drugs: Education, Prevention and Policy*, 2(3):211-224.

Hawthorne, G. (1992). Unreal expectations: Drug education in schools, *Australian Health Review*, 15(2):200-212. Cited in Ryan, J., Conway, R., Fairbrother, G. (1999). Intox: an innovative school-based drug education intervention, *Youth Studies Australia,* 18(1):23-28.

Hawthorne, G., Garrand, J., Dunt, D. (1992). Primary school drug education: an evaluation of life education. Victoria research report 2, National Centre for Health Programme Evaluation: Melbourne. Cited in Webster, R.A., Hunter, M., Keats, J.A. (2002). Evaluating the effects of a peer support program on adolescents' knowledge, attitudes and use of alcohol and tobacco, *Drug and Alcohol Review*, 21:7-16.

Health Services Division (2001). *Evaluation: A guide for good practice*. Commonwealth Department of Health and Aged Care. Internet. Accessed 8 January 2003. Available from: <http://www.mentalhealth.gov.au/resources/evaluation.htm>.

Higgins, K., Cooper-Stanbury, M., Williams, P. (2000). *Statistics on drug use in Australia 1998*. Australian Institute of Health and Welfare: Canberra.

Holly, C. (2001). *Review of Literature on Injecting Drug Use Within Urban Indigenous Communities*, Aboriginal Drug and Alcohol Council (SA) Inc. Portable Document Format (pdf). Accessed 30 April 2003. Available from: <http://www.adac.org.au/resources/r_idu_lit_review.pdf>.

Hunter, G., Ward, J., Power, R. (1997). Research and development focusing on peer intervention for drug users, *Drugs: Education, Prevention and Policy*, 4(3):259-270.

Jay, M.S., DuRant, R.H., Shoffitt, T., Linder, C.W., Litt, I.F. (1984). Effect of peer counsellors on adolescent compliance in use of oral contraceptives, *Paediatrics*, 73:126-131. Cited in Turner, G., Shepherd, J. (1999). A method in search of a theory: Peer education and health promotion, *Health Education Research,* 14(2):235-247.

Jernigan, D.H. (2001). *Global Status Report: Alcohol and Young People*, World Health Organization: Genva. Cited in Foxcroft, D.R., Ireland, D., Lister-Sharp, D.J., Lowe, G., Breen, R. (2002). Longer-term primary prevention for alcohol misuse in young people: a systematic review, *Addiction*, 98(4):397-411.

Jessor, R. (1982). Problem Behavior and Developmental Transition in Adolescence, *Journal of School Health*, 52(5):295-300. Cited in Fors, S.W., Jarvis, S. (1995). Evaluation of a peer-led drug abuse risk reduction project for runaway/ homeless youths, *Journal of Drug Education,* 25(4):321-333.

Jones, S.P., Heaven, P.C.L. (1998). Psychosocial correlates of adolescent drug-taking behaviour, *Journal of Adolescence*, 21:127-134.

Jordheim, A., (1976). A comparison study of peer teaching and traditional instruction in venereal disease education, *Journal of the American College Health Association*, 24:286-289. Cited in Mellanby, A.R., Rees, J., Tripp, J.H. (2000). Peer-led and adult-led school health education: A critical review of available comparative research, *Health Education Research,* 15(5):533-545.

Kaplan, R.M., Sallis, J.F., Patterson, T.L. (1993). *Health and Human Behavior*, McGraw Hill Inc: New York.

Kelly, J.A., St Lawrence, J.S., Diaz-Yolanda, E., Stevenson, L.Y., Hauth, A.C. Brasfield, T.L., Kalichman, S.C., Smith, J.E., Andrew, M.E. (1991). HIV risk behaviour reduction following intervention with key opinion leaders of population: an experimental analysis, *American Journal of Public Health*, 81:186-171. Cited in Turner, G., Shepherd, J. (1999). A method in search of a theory: Peer education and health promotion, *Health Education Research,* 14(2):235-247.

Kim, S., McLeod, J.H., Rader, D., Johnston, G.. (1992). An evaluation of a prototype school-based peer counseling program, *Journal of Drug Education*, 22(1):37-53.

Kinder, B., Pape, N., Walfish, S. (1980). Drug and alcohol education. A review of outcome studies, *International Journal of Addiction*, 15:1035-1054. Cited in Midford, R. (2000). Does drug education work?, *Drug and Alcohol Review,* 19:441-446.

Kirkpatrick, D.L. (1998). *Evaluating Training Programs: The Four Levels*, Second Edition, Berrett-Koehler Publishers Inc: San Francisco.

Klepp, K., Halper, A., Perry, C. (1986). The efficacy of peer leaders in drug abuse prevention, *Journal of School Health*, 56(9):407-411.

Komro, K.A., Perry, C.L., Murray, D.M., Veblen-Mortenson, S., Williams, C.L., Anstine, P.S. (1996). Peer-Planned Social Activities for Preventing Alcohol Use Among Young Adoelscents, *Journal of School Health*, 66(9):328-334.

Kraus, J. (1979). An abrogation of professional responsibility? *Australian Journal of Social Issues*, 14:11. Cited in Wragg, J. (1991). A review of successful and unsuccessful models of drug education, *Drug Education Journal of Australia,* 5(1):15-26.

Laiho, M., Honkala, E., Nyyssonen, V., Milen, A. (1993). Three methods of oral health education in secondary schools, *Scandinavian Journal of Dental Research*, 1010:422-427. Cited in Mellanby, A.R., Rees, J., Tripp, J.H. (2000). Peer-led and adult-led school health education: A critical review of available comparative research, *Health Education Research,* 15(5):533-545.

Larkey, L.K., Alatorre, C., Buller, D.B., Morrill, C., Buller, M.K., Taren, D., Sennott-Miller, L. (1999). Communication strategies for dietary change in a worksite peer educator intervention, *Health Education Research*, 14(6):777-790.

Larson, A. (1996). *What Injectors Say About Drug Use: Preliminary Findings from a Survey of Indigenous Injecting Drug Users* – IDU Working Paper #2, University of Queensland. Cited in Holly, C. (2001). Review of Literature on Injecting Drug Use Within Urban Indigenous Communities, Aboriginal Drug and Alcohol Council (SA) Inc. Portable Document Format (pdf). Accessed 30 April 2003. Available from: <http://www.adac.org.au/resources/r_idu_lit_review.pdf>.

Leigh, B. (1999). The risks of drinking among young adults. Peril, chance, adventure: concepts of risk, alcohol use and risky behaviour in young adults, *Addiction*, 94(3):371-383.

Letcher, T., White, V. (1999). Australian Secondary Students' Use of Over-The-Counter and Illicit Substances in 1996. *National Drug Strategy Monograph Series No 33*, Canberra.

Lezin, N. (n.d.). *With a Little Help From My Friends: Peer Education in Teen Pregnancy Prevention*, Resource Centre for Adolescent Pregnancy Prevention. Internet. Accessed 30 January 2003. Available from: <http://www.etr.org/recapp/theories/peereducation/index.htm>.

Lindsey, B.J. (1997). Peer Education: A Viewpoint and Critique, *Journal of American College Health*, 45(4):187-196.

Lixenberg, L. (1997). Learning the lessons of peer education, *Alcohol Concern*, 12(3):20-22.

Lowe, G. (1999). Drinking behaviour and pleasure across the life span. In S. Peele, M. Grant (Eds) *Alcohol and Pleasure: A health perspective*, Brunner/Mazel: Philadelphia, p249-277.

Lynskey, M., Hall, W. (1998). Cohort trends in age of initiation to heroin use, *Drug and Alcohol Review*, 17:289-297.

McDermott, F., Pyett, P., Hamilton, M. (1991). *Evaluate Yourself: A Handbook for Alcohol and Other Drug Treatment Agencies*. Commonwealth Department of Health and Aged Care.

McDonald, J. (1996). *The Influence of Puberty and Health Beliefs of Eating and Weight Concerns in Adolescent Girls*. Unpublished honours thesis in Psychology Department, University of Adelaide, Adelaide.

McDonald, J., Ashenden, R., Grove, J., Bodein, H., Cormack, S., Allsop, S. (2000). Youth for Youth: A Project to Develop Skills and Resources for Peer Education: Final Report. National Centre for Education and Training on Addiction (NCETA): Adelaide. Available from: <http://www.nceta.flinders.edu.au/ >.

McDonald, J., Grove, J., Youth Advisory Forum (2001). Youth for Youth: Piecing Together the Peer Education Jigsaw. Presented at the *2nd International Conference on Drugs and Young People: Exploring the Bigger Picture*. Melbourne, Available from: <http://www.nceta.flinders.edu.au/ >.

Mackie, D.M., Worth, L.T., Asuncion, A.G. (1990). Processing of persuasive in-group messages, *Journal of Personality and Social Psychology*, 58(5):812-822.

Makela, K., Room, R., Single, E., Sulkunen, P., Walsh, B. (1981). *Alcohol, society and the State: A Comparative Study on Alcohol Control*, Vol 1, Toronto: Addiction Research Foundation. Cited in Perry, C.L., Grant, M., Ernberg, G., Florenzano, R.U., Langdon, M.C., Myeni, A.D., Waahlberg, R., Berg, S., Andersson, K., Fisher, K.J., Blaze-Temple, D., Cross, D., Saunders, B., Jacobs, D.R., Schmid, T. (1989). WHO Collaborative Study on Alcohol Education and Young People: outcomes of a four-country pilot study, *International Journal of the Addictions,* 24(12):1145-1171.

Marlatt, G.A., Gordon, J.R. (Eds) (1985). *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors*, The Guilford Press: New York, London.

Mathie, E., Ford, N. (1998). Peer Education for Health. In K. Topping, S. Ehly (Eds) *Peer-Assisted Learning*, Lawrence Erlbaum Publishers: New Jersey.

Mellanby, A.R., Newcombe, R.G., Rees, J., Tripp, J.H. (2001). A comparative study of peer-led and adult-led school sex education, *Health Education Research*, 16(4):481-492.

Mellanby, A.R., Rees, J., Tripp, J.H. (2000). Peer-led and adult-led school health education: A critical review of available comparative research, *Health Education Research*, 15(5):533-545.

Midford, R. (2000). Does drug education work? *Drug and Alcohol Review*, 19:441-446.

Milburn, K. (1995). A critical review of peer education with young people with special reference to sexual health, *Health and Education Research*, 10:407-420.

Milburn, K. (1996). *Peer Education: young people and sexual health. A critical review*. Working Paper No 2. Health Education Board for Scotland: Edinburgh.

Miller, S. (1995). *Evaluation of the Juvenile Justice Specialist Support Services Adolescent Peer Education Program*. Victorian Government Department of Human Services: Melbourne.

Miller, S. (1996). The power of the peer oriented approach for adolescents. In *Conference proceedings: 7th International Conference on the Reducton of Drug Related Harm: from Science to Policy to Practice, Hobart, Australia, 3-7 March 1996*. Australian Drug Foundation: Melbourne, p653-663.

Ming, C.R. (1995). *Youth to Youth: a comprehensive prevention program for youth*.

Mudaly, B. (1997). A strategic alliance in Springvale: an innovative drug education strategy for young people and parents of diverse cultural backgrounds, *Youth Studies Australia*, 16(2):20-25.

Mundy, J. (1997). Drug Education in Schools: What Young People Say. In *Connexions*, Dec96/Jan 97:22-24.

Murray, C., Lopez, A.D. (1997). *The Global Burden of Disease*, Harvard University Press: Cambridge. Cited in Foxcroft, D.R., Ireland, D., Lister-Sharp, D.J., Lowe, G., Breen, R. (2002). Longer-term primary prevention for alcohol misuse in young people: a systematic review, *Addiction*, 98(4):397-411.

Nelson, B., Economy, P. (1996). *Managing for Dummies*, IDG Books.

Office for Youth (n.d.). Government of South Australia. Internet. Accessed 4 February 2003. Available from: <http://www.dete.sa.gov.au/youth/>.

Owen, J.M. (1991). An Evaluation Approach to Training Using the Notion of Form: An Australian Example, *Evaluation Practice,* 12(2):131-137.

Owen, J.M., Rogers, P.J. (1999). *Program Evaluation: Forms and Approaches*, Second Edition, Allen and Unwin: St Leonards.

Paglia, A., Room, R. (1998). Preventing substance-use problems among youth: a literature review and recommendations, ARF research document series No 142, Addiction Research Foundation: Toronto.

Parkin, H., Haynes, B. (1998). Colour by numbers: peer education from scratch, *Druglink*, 13(3):22-23.

Parkin, S., McKeganey, N. (2000). The rise and rise of peer education approaches, *Drugs: Education, Prevention and Policy*, 7(3):293-310.

Perkins, H.W. (1999). *College student misperceptions of alcohol and other drug norms among peers: exploring causes, consequences, and implications for prevention programs*. Higher Education Centre. Internet. Accessed 12 December 2002. Available from: <http://www.edc.org.hec/pubs/theorybok/perkins.html>.

Perry, C., Grant, M. (1988). Comparing peer-led to teacher-led youth alcohol education in four countries, *Alcohol, Health and Research World,* 12(4).

Perry, C.L., Grant, M., Ernberg, G., Florenzano, R.U., Langdon, M.C., Myeni, A.D., Waahlberg, R., Berg, S., Andersson, K., Fisher, K.J., Blaze-Temple, D., Cross, D., Saunders, B., Jacobs, D.R., Schmid, T. (1989). WHO Collaborative Study on Alcohol Education and Young People: outcomes of a four-country pilot study, *International Journal of the Addictions*, 24(12):1145-1171.

Population Council (n.d.). *Peer Education and HIV/AIDS: Past Experience, Future Directions*. Portable Document Format (pdf). Accessed 30 January 2003. Available from: <http://www.popcouncil.org/pdfs/peer_ed.pdf>.

Porteous, D. (1999). Casing the Joint: An Evaluation of Two Drug Education Projects. In A. Marlow, G. Pearson (Eds) *Young people, drugs and community safety*, Russell House Publishing: Dorset.

Power, R. (1994). Peer education: make the most of it, *Druglink*, 9(3):15.

Power, R., Hunter, G., Ward, J. (1996). Guidelines for peer education, *Druglink*, 11(4):18-19.

Premier's Drug Prevention Council (2002). Guide to evaluating drug prevention projects in Victoria. Portable Document Format (pdf). Accessed 13 Feburary 2003. Available from: <http://druginfo.adf.org.au/article.asp?id=4796>.

Prendergast, N., Miller, S. (1996). Reducing the risk: the Juvenile Justice peer oriented approach. In *Conference Proceedings: Re-shaping the Future: Drugs and Young People*, Australian Drug Foundation: Melbourne, p277-286.

Preston, P., Sheaves, F. (2001). That's SIC: Mobilising peer networks for hepatitis C prevention. Presented at *2nd International Conference on Drug and Young People*, Melbourne, Australia.

Prochaska, J.O., DiClemente, C.C. (1982). Transtheoretical therapy: Toward a more integrative model of change, *Psychotherapy: Theory, Research and Practice*, 20:161-173.

Prochaska, J.O., DiClemente, C.C., Norcross, J.C. (1992). In search of how people change: applications to addictive behaviours, *American Psychologist*, 47:1102-1114.

Ransom, M.V. (1992). Peer perceptions of adolescent health behaviors, *Journal of School Health*, 62(6):238-242.

Richards, T., Richards, L. (1988). NUDIST: a system for qualitative data analysis, *Australian Computer Society, Victorian Bulletin*, 5-9.

Robins, A. (1994). *Sharing Our Experiences and Learning from Others Like Us: peer education for drugs prevention*. Home Office Prevention Initiative: London. Cited in Shiner, M. (1999). Defining Peer Education, *Journal of Adolescence,* 22:555-566.

Roche, A.M. (2001). Drinking Behavior: A Multifaceted and Multiphasic Phenomenon. In E. Houghton, A.M. Roche (Eds) *Learning About Drinking*, Brunner-Routledge, p1-34.

Roche, A.M., Watt, K. (1999). Drinking and university students: from celebration to inebriation, *Drug and Alcohol Review*, 18:625-632.

Rogers, E.M. (1995). *Diffusion of Innovations*, Free Press: New York.

Rogers, E.M. (2002). Diffusion of preventive innovations, *Addictive Behaviors*, 27:989-993.

Rollin, S.A., Rubin, R., Hardy-Blake, B. et al. (1994). Project K.I.C.K. school-based drug education research project – peers, parents and kids, *Journal of Alcohol and Drug Education*, 39(3):75-86.

Rooney, B.L., Murray, D.M. (1996). A meta-analysis of smoking prevention programs after adjustment for errors in the unit of analysis, *Health Education Quarterly*, 23:48-64. Cited in Cuijpers, P. (2002a). Effective ingredients of school-based drug prevention programs. A systematic review, *Addictive Behaviors,* 27:1009-1023.

Rosenstock, I.M. (1990). The Health Belief Model: Explaining Health Behavior Through Expectancies. In K. Glanz, F.M. Lewis, B.K. Rimer (Eds) *Health Behavior and Health Education: Theory, Research and Practice*, Jossey-Bass: San Francisco, p405-419.

Rothman, K.J. (1976). Causes. *American Jounral of Epidemiology*, 104:587-592. Cited in English, D.R., Holman, C.D.J., Milne, E., Winter, M.G., Hulse, G.K., Codde, J.P., Bower, C.I., Corti, B., de Klerk, N., Knuiman, M.W., Kurinczuk, J.J., Lewin, G.F., Ryan, G.A. (1995). *The quantification of drug caused morbidity and mortality in Australia*, 1995 edition, Commonwealth Department of Human Services and Health: Canberra.

Rothman, K.J. (1986). *Modern Epidemiology*, p10-16, 311-326. Little Brown: Boston. Cited in English, D.R., Holman, C.D.J., Milne, E., Winter, M.G., Hulse, G.K., Codde, J.P., Bower, C.I., Corti, B., de Klerk, N., Knuiman, M.W., Kurinczuk, J.J., Lewin, G.F., Ryan, G.A. (1995). *The quantification of drug caused morbidity and mortality in Australia*, 1995 edition, Commonwealth Department of Human Services and Health: Canberra.

Ryan, J., Conway, R., Fairbrother, G. (1999). Intox: an innovative school-based drug education intervention, *Youth Studies Australia*, 18(1):23-28.

Sangster, D. (2002). *Peer Education and Young Black People*. Internet. Accessed 13 June 2002. Available from: <http://www.drugtext.org/articles/b101.htm>.

Schaps, E., Di Bartolo, R., Moskowitz, J., Palley, C.S., Churgin, S. (1981). A review of 127 drug abuse prevention program evaluations, *Journal of Drug Issues*, 11:17-43. Cited in Wragg, J. (1991). A review of successful and unsuccessful models of drug education, *Drug Education Journal of Australia,* 5(1):15-26.

Schippers, G., van Aken, M., Lammers, S., de Fuentes Merillas, L. (2001). Acquiring the competence to drink responsibility. In E. Houghton, A.M. Roche (Eds) *Learning About Drinking*, Brunner-Routledge: Philadelphia, p35-55.

Shanahan, P., Hewitt, N. (1999). *Developmental Research for a National Alcohol Campaign*. Summary Report prepared for the Commonwealth Department of Health and Aged Care. Commonwealth Department of Health and Aged Care: Canberra.

Shiner, M. (1999). Defining Peer Education, *Journal of Adolescence*, 22:555-566.

Shiner, M. (2000*). Doing it for themselves: an evaluation of peer approaches to drug prevention*. Public Policy Research Unit, Goldsmiths College, University of London, London.

Shiner, M., Newburn, T. (1996). *Young people, drugs and peer education: an evaluation of the Youth Awareness Programme (YAP)*, Home Office Drugs Prevention Initiative: London.

Silverman, M. (1990). Prevention research: impediments, barriers and inadequacies, in: K. Rey et al. (Eds) *Prevention Research Finding: 1988*, OSAP: Rockville MD. Cited in Coggans, N., Watson, J. (1995). Drug education approaches, effectiveness and delivery, *Drugs: Education Prevention and Policy*, 2(3):211-224.

Skog, O-J. (1980). Social interaction and the distribution of alcohol consumption, *Journal of Drug Issues*, 10:79-92.

Smith, M.U., DiClemente, R.J. (2000). STAND: A peer educator training curriculum for sexual risk reduction in the rural south, *Preventative Medicine*, 30:441-449.

Sparam, E., Roy, J., Stratton, P. (1996). Youth: The Voices of a Lost Generation, *Human Systems: The Journal of Systemic Consultation and Management*, 6:295-398. Cited in Crompton, L. (2003). Young People Shouting in Hallowed Halls: Young People's Participation in Policy Development. Presented at the *International Research Symposium Preventing Substance Use, Risky Use and Harm: What is Evidence-Based Policy?* Perth, Western Australia, February 2003.

Spooner, C., Hall, W., Lynskey, M. (2001). Structural Determinants of Youth Drug Use. Australian National Council on Drugs (ANCD): Woden.

Steele, C.M. Southwick, L.L., Critchlow, B. (1981). Dissonance and alcohol: Drinking your troubles away, *Journal of Personality and Social Psychology*, 41:831-846. Cited in Marlatt, G.A., Gordon, J.R. (Eds) (1985). *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors,* The Guilford Press: New York, London.

Stockwell, T., Heale, P., Dietze, P., Chikritzhs, T., Catalano, P. (2001). Patterns of alcohol consumption in Australia. National Drug Research Institute: Perth.

Svenson, G.R. et al. (1998). *European Guidelines for Youth AIDS Peer Education*, Department of Community Medicine, Lund University: Lund. Cited in Parkin, S., McKeganey, N. (2000). The rise and rise of peer education approaches, *Drugs, Education, Prevention and Policy,* 7(3):293-310.

Tobler, N. (1986). Meta-analysis of 143 adolescent drug prevention programs: Quantitative outcome results of program participants compared to a control or comparison group, *Journal of Drug Issues*, 16(4):537-567.

Tobler, N.S. (1992). Drug prevention programs can work: research findings, *Journal of Addictive Diseases*, 11(3):1-28.

Tobler, N.S., Roona, M.R., Ochshorn, P., Marhsall, D.G., Streke, A.V., Stackpole, K.M. (2000). School-based adolescent drug prevention programs: 1998 meta-analysis, *Journal of Primary Prevention*, 20:275-336. Cited in Cuijpers, P. (2002a). Effective ingredients of school-based drug prevention programs. A systematic review, *Addictive Behaviors,* 27:1009-1023.

Todts, S. (1996). Peer education at the free clinic of Antwerp, *International Journal of Drug Policy*, 7(1):23-26.

Trautmann, F. (1995). Peer support as a method of risk reduction in injecting drug-user communities, *Journal of Drug Issues*, 25:617-628. Cited in Parkin, S., McKeganey, N. (2000). The rise and rise of peer education approaches, *Drugs, Education, Prevention and Policy*, 7(3):293-310.

Turner, G., Shepherd, J. (1999). A method in search of a theory: Peer education and health promotion, *Health Education Research*, 14(2):235-247.

United Nations Office for Drug Control and Crime Prevention (2000). *Demand Reduction: A Glossary of Terms*, ODCCP Studies on Drugs and Crime: Guidelines, United Nations: New York.

Vander Zanden, J.W. (1980). *Educational Psychology: In Theory and Practice*, Random House: New York.

Victorian Department of Human Services (1999). *The Victorian Burden of Disease Study: Mortality*, Health Intelligence Series, Volume 3, Victorian Department of Human Services: Melbourne.

Walker, S.A., Avis, M. (1999). Common reasons why peer education fails, *Journal of Adolescence*, 22:573-577.

Ward, J., Hunter, G., Power, R. (1997). Peer education as a means of drug prevention and education among young people: an evaluation, *Health Education Journal*, 56(3):251-263.

Webster, R.A., Hunter, M., Keats, J.A. (2002). Evaluating the effects of a peer support program on adolescents' knowledge, attitudes and use of alcohol and tobacco, *Drug and Alcohol Review*, 21:7-16.

Weiss, F.L., Nicholson, H.J. (1998). Friendly PEERsuasion against substance use: the Girls Incorporated Model and Evaluation, *Drugs and Society*, 12(1/2):7-22.

White, D., Pitts, M. (1997*). Health promotion with young people for the prevention of substance misuse*, Health Education Authority: London.

White, D., Pitts, M. (1998). Education young people about drugs: a systematic review. *Addiction*, 93:1475-1487. Cited in Midford, R. (2000). Does drug education work?, *Drug and Alcohol Review,* 19:441-446.

Wiist, W.H., Snider, G. (1991). Peer education in friendship cliques: prevention of adolescent smoking, *Health Education Research: Theory and Practice*, 6(10):101-108.

Wilde, J., Sockey, S. (1995). *Evaluation Handbook*. Evaluation Assistance Center, Western Region, New Mexico Highlands University, Albuquerque, Internet. Accessed 11 April 2003. Available from: <http://www.ncela.gwu.edu/miscpubs/eacwest/evalhbk.htm>.

Wilder, D.A. (1990). Some Determinants of the Persuasive Power of In-Groups and Out-Groups: Organization of Information and Attribution of Independence, *Journal of Personality and Social Psychology*, 59(6):1202-1213.

Williams, M., Roche, A.M. (1999). Young People's Initiation into Injecting Drug Use: The Role of Peer Interviewers in Risk Reduction Research, *Health Promotion Journal of Australia*, 9(8):213-218.

Witkin, B.R., Altschuld, J.W. (1995). *Planning and Conducting Needs Assessments*, Sage: Thousand Oaks, CA. Cited in Owen, J.M., Rogers, P.J. (1999). *Program Evaluation: Forms and Approaches,* Allen and Unwin: St Leonards.

Wragg, J. (1991). A review of successful and unsuccessful models of drug education, *Drug Education Journal of Australia*, 5(1):15-26.

Youth Substance Abuse Service (YSAS) (n.d.). *About YSAS*. Youth Substance Abuse Service (YSAS). Internet. Accessed 4 February 2003. Available from: <http://www.ysas.org.au/about_ysas.html>.

Zickler, P. (2002). *Few Middle Schools Use Proven Prevention Programs*. Internet. Accessed 14 April 2003. Available from: <http://www.nida.nih.gov/NIDA_notes/NNVol17N6/MiddleSchool.html>.

Zipparo, L. (2001). *A brief guide to evaluation for NSW drug summit programs*, New South Wales Office of Drug Policy.

Zubrick, S., Silburn, S., Burton, P., Blair, E. (2000). Mental health disorders in children and young people: scope, cause and prevention, *Australian and New Zealand Journal of Psychiatry*, 34(4):570-578.

Appendices

Appendix 1

Sample Terms of Reference for a Peer Education Project Advisory Group

Adapted from the Youth for Youth Project (McDonald et al., 2000)

The role of the Project Advisory Group will be to provide advice, support and facilitation to assist the project investigators to achieve the project's objectives. Members of the Project Advisory Group have been identified on the basis that they bring particular expertise considered valuable to the conduct of the project. The project investigators may co-opt other individuals to join the group as the need for additional expertise and advice arises.

The Project Advisory Group will provide advice to help the project investigators to:

- develop a train-the-trainer program for those wishing to be trained as peer educators
- identify the needs of the groups receiving peer education services through the pilot programs conducted as part of the project
- develop a process to identify appropriate responses to these needs
- develop appropriate methodologies to evaluate the training provided to the peer educators and the training provided as part of the pilot programs.

Appendix 2

Sample Surveys and Interview Questions for Evaluation of Peer Educator Training

Adapted from the Youth for Youth Project (McDonald et al., 2000)

Sample Only

Appendix 2.1: Usefulness Survey

Appendix 2.2: Perceived Knowledge Survey

Appendix 2.3: Structured Interview Questions for Peer Educators

Appendix 2.4: Structured Interview Questions for Trainers

The questions contained in this appendix reflect the aims, ideology and format of the Youth for Youth Project. The questions may therefore need modification if used to evaluate another peer educator training program.

Appendix 2.1: Usefulness Survey

Please indicate your answer to the questions below by ticking the response that most accurately reflects your opinion.

Question 1

Please rate the usefulness of each topic covered by this session.

	Not at all useful	Fairly useful	Moderately useful	Very useful	Extremely useful
Drug Information	☐	☐	☐	☐	☐
Accessing and Assessing Resources	☐	☐	☐	☐	☐
Psychological Factors Associated with Drug Use	☐	☐	☐	☐	☐
Skill Development	☐	☐	☐	☐	☐

Other Comments _____

_____

Question 2

A number of different teaching methods were used in this session. Please rate the usefulness of each method.

	Not at all useful	Fairly useful	Moderately useful	Very useful	Extremely useful
Lectures	☐	☐	☐	☐	☐
Small Group Activities	☐	☐	☐	☐	☐
Individual Exercises	☐	☐	☐	☐	☐
Role Plays	☐	☐	☐	☐	☐
Handouts	☐	☐	☐	☐	☐

Other Comments _____

_____

Sample Only

Question 3

What things do you think should have been added to the session?

Question 4

What things do you think should not have been included in the session?

Question 5

What aspect(s) of the session do you think should have been covered in a different way?

Question 6

Did the session meet your expections? If not, why not?

Sample Only

Any other comments

Thank you for completing this questionnaire.

Sample Only

Appendix 2.2: Perceived Knowledge Survey

To be administered before and after training.

Please indicate your answer to the questions below by ticking the response that most accurately reflects your opinion.

---

1. I understand models of addiction behaviour and how they relate to responding to the needs of young people

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

2. I understand and can describe the implications for young people of the effects of drugs

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

3. I am able to identify and describe the harms that can arise from drug use, especially in relation to young people

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

4. I can describe the risks that young people may be exposed to in relation to drug use

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

5. I can communicate strategies to avoid drug-related harms

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Sample Only

6. I can communicate strategies to respond to drug-related risk

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

7. I can describe strategies that could be used to assess the information and education needs of a group of young people

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

8. I can design an education or information strategy to respond to the needs of young people

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

9. I am aware of the basic principles and strategies of evaluation

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

10. I know how to find resources to assist me in developing an educational or information strategy for young people

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

11. I am able to identify the legal issues that relate to organising and running an education or information program for young people

Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Thank you for completing this questionnaire.

Sample Only

Appendix 2.3: Structured Interview Questions for Peer Educators

Feedback about Pilot Projects[1]

1. Describe your pilot, including the aims and objectives and how it was implemented.
2. What do you think was most successful about your pilot? What do you think was least successful about your pilot?
3. If you were to conduct your pilot again, what changes would you make and what would you do the same?
4. How useful were the resources you used during your pilot? Would you change them if you were to run it again?
5. How responsive were participants in your pilot? Do you think they enjoyed it?
6. How successful were your methods of information delivery/teaching methods? Which worked best, and which were least successful?
7. How do you feel about your evaluation of the pilot?
8. Did you encounter any difficulties when organising or implementing your pilot?
9. Were there any unexpected events (either positive or negative) when you conducted your pilot?
10. What aspects of the pilot did you enjoy the most, and which the least?
11. What aspects of the pilot did you find easiest, and which did you find most difficult?
12. How confident did you feel before conducting your pilot?
13. How confident did you feel after conducting your pilot?
14. Are you more or less confident now about your ability to undertake this kind of activity?

Sample Only

15. Do you think the participants saw you as a peer?

16. Do you think you met the aims and objectives of your pilot?

Feedback about Training and Support

17. Do you think the training program adequately prepared you to conduct your pilot?

18. What skills and knowledge covered by the training program do you think were most useful?

19. Is there anything you think should have been added, omitted or covered differently in the training program?

20. What were your expectations about the pilots following the training program? Did these match your experience of the pilots?

21. Is there anything else relating to the training program that impacted on your pilot?

22. Have you spoken to anyone (including friends, family, acquaintances etc) about the things you learnt in the training program? This includes any kind of informal conversation.

23. Were you satisfied with the level of support you received in relation to conducting your pilot?

24. Do you have any other comments about either the training program or your pilot project?

Sample Only

Notes

[1] As part of the peer educator training in the Youth for Youth Project, trainees planned, implemented and evaluated a pilot peer education project.

Appendix 2.4: Structured Interview Questions for Trainers

Organisation of Program

1. Would you change any of the following? If so, why and how?

   a) Individual Session
   - length of each session
   - time at which sessions were run
   - preparation time available for sessions
   - size of group

   b) Overall Program
   - overall length of training program, ie time available
   - organisation of sessions, ie length, number and distribution of sessions

2. Were you satisfied with the following:

	Very Satisfied	Satisfied	Undecided	Dissatisfied	Very Dissatisfied
a) Venue					
• space available	☐	☐	☐	☐	☐
• lighting	☐	☐	☐	☐	☐
• equipment	☐	☐	☐	☐	☐
b) Organisation of Program	☐	☐	☐	☐	☐

If not, why and what changes would you make?

3. Did you encounter any difficulties when organising your session(s)? If so, what?

Sample Only

Content

4. What do you know about the content of the program as a whole?

5. Is there anything that you think should be added, omitted or modified for a similar program in future? If so, why?

6. Is there anything you would add, omit or modify if you were to present your session as part of a similar program in the future? If so, why?

7. What parts of the session do you think the participants enjoyed the most? Why?

8. What parts of the session do you think participants benefited from most? Why do you think this?

Teaching Methods

9. How successful were the teaching methods (eg lectures, small group work etc) used? What method changes would you make to a similar program in future?

10. What methods did you think worked best? Why?

11. What methods did you think were least successful? Why?

12. How useful were the resources (eg overheads, handouts etc) used? Would you change this in a future program? Why? How?

13. How did the participants respond to the resources used?

Outcomes

14. Do you think the participants enjoyed your session? What in particular did they enjoy?

15. How responsive were the participants?

16. Did you encounter any specific problems? What were they and why were they problematic?

Sample Only

Appendix 3

Tools for Peer Educator Training and Peer Educator Activities

Below are a number of issues related to peer educator training and peer educator activities, particularly planned group sessions. In both of these cases, the recipients are young people and the aims may be to enhance knowledge, develop skills, influence attitudes and/or influence behaviour. Peer educators can learn appropriate delivery techniques by modelling the behaviour of their own trainers.

Issues addressed in this appendix include:

- establishing group norms
- style of delivery
- interactive and practice techniques
- visual learning aids

Establishing Group Norms

At the outset it is important to establish group norms. Group norms are agreements about how members will behave. Norms outline appropriate attitudes, behaviours and rights of group members. Housekeeping issues can also be addressed in-group norms. Box A lists common group norms. The primary reason for establishing norms is to create a safe environment where all group members feel comfortable and confident participating without fear of negative responses from other members.

Style

There are a number of relevant principles for delivery which are probably best referred to as "style". A friendly and interactive manner that demonstrates that participants' opinions are valued facilitates communication. Communication may also be facilitated by reassuring participants that everything they disclose is confidential. Matching language and behaviour to that of the participants helps to engage them, contributes to rapport, and enhances credibility of the trainer or peer educator. Behaviour and language also need to be appropriate to participants' culture, age and gender. Information is best delivered in an objective and non-judgemental manner. Humour,

where appropriate and relevant, may be used to maintain interest and energy among participants.

Box A: Common Group Norms

Attitudes:

- respect confidentiality
- respect others and different opinions
- be non-judgemental
- have fun and keep positive and motivated

Behaviours:

- only one person talks at a time
- be encouraging and do not put people down

Rights:

- group members have the right to pass or not participate

Housekeeping:

- sessions start and finish on time
- mobile phones only left on after prior arrangement

Interactive and Practical Techniques

A variety of interactive and practical techniques can be used to engage participants and help maintain energy and interest, such as:

- role play exercises
- games (see Box B for descriptions of some useful games)
- debates
- brain storming exercises
- quizzes
- question and answer sessions.

Box C contains a list of user-friendly resources where the reader can learn more about these techniques.

These activities can facilitate learning through repetition, positive reinforcement, association and involvement of multiple senses. They encourage people to think about their own beliefs and provide insight into the attitudes, beliefs and norms within the peer group. Interactive activities address knowledge, feelings and attitudes and provide an opportunity to discuss consequences.

Box B: Descriptions of Useful Games

Information collated by Jill Grove, Drug and Alcohol Services Council (DASC) of South Australia, from various sources over many years of AOD teaching

Myths and Facts Cards

Aim

This game is helpful for dispelling common myths.

Description

This game works well in small groups. The group facilitator shows cards containing a drug-related statement. Participants are asked to identify whether it is a myth (false) or a fact (true). The correct answer is then revealed and followed by group discussion about the statement.

Values Walk

Aim

This game prompts participants to examine their beliefs, and to understand the role of feelings, as well as knowledge, in their opinions about drug-related issues.

Description

The facilitator makes a statement containing a value judgement. It is important that this is not a factual statement with a right or wrong answer, but an opinion or judgement.

eg alcohol advertising should be banned

Participants are asked to indicate their level of agreement with the statement. Answers may be based along a continuum, or in triads (ie agree, undecided, disagree). A useful way for responses to be indicated is for participants to move around the room to show their level of agreement, eg agree to the left, undecided stay in the middle and those that disagree move to the right. A representative of each class of response is nominated to debate for each position. One representative states the reason for their opinion. The other teams listen without interrupting. The representative of the next team then responds, first

(continued over page)

by responding to the point made by the previous person and then presenting a new point. Group members can move around the room to indicate whether they have changed their opinion based on the points raised by team representatives. An interesting way to modify the game is to ask people to argue the case for the opposite opinion.

Given the potential for conflict, it is important that this game has clear rules, such as not speaking while someone else is arguing their case and not engaging in personal insults.

Variation

A variation on this game is to make a statement and then ask participants to indicate whether this concerns them (eg very concerned – not concerned).

eg A 25 year old man has a beer when he gets home from work and a couple of glasses of wine with his evening meal.

The statement is then gradually modified, for example, in terms of frequency of use (every day), drug type (cannabis, heroin), consequences (violence, driving). Between each modification, participants move around the room to indicate their level of concern and the reasons for concern are discussed.

Identify the Drug

Aim

This game provides participants with the opportunity to test their knowledge.

Description

This game is based on the "Who am I?" game. A card with the name of a drug is placed on participants' heads. They are not shown the card. They then attempt to identify the drug by asking questions, to which the group replies "yes", "no" or "don't know". If they receive an answer of "yes", they can ask another question. If the answer is "no" it becomes someone else's turn to try to identify their drug.

In addition to facilitating learning, these techniques serve various other purposes, ranging from helping participants to get to know each other to maintaining and raising group energy levels. Interactive activities can inspire and involve participants, facilitate cooperation among participants, help create a sense of unity, break down barriers and energise participants intellectually and physically.

Box C: Further Reading for Interactive and Practical Techniques

Ashton, M., Varga, L. (n.d.). *101 Games for Groups,* Hyde Park Press: Adelaide.

Benson, J.F. (1997). *Working More Creatively With Groups*, Second Edition, Routledge: London.

Callister, E., Davis, N., Pope, B. (1988*). Me, You and Others: Class and Group Activities for Personal Development,* Brooks Waterloo: Albion.

Clarke, J.E. (1984). *Who, Me Lead a Group?* Harper and Row: San Francisco.

Jarvis, T.J., Tebbutt, J., Mattick, R.P. (1995*). Treatment Approaches for Alcohol and Drug Dependence: An Introductory Guide*, John Wiley and Sons.

Kroehnert, G. (1990*). Basic Training for Trainers: An Australian Handbook for New Trainers*, McGraw Hill: Sydney.

Lambert, C. (1986). *Secrets of a Successful Trainer: A Simplified Guide for Survival*, John Wiley and Sons: New York.

Silberman, M. (1990). *Active Training: A Handbook of Techniques, Designs, Case Examples and Tips*, Jossey-Bass Inc: San Francisco.

These exercises will be better able to maintain attention and interest of participants if they are fun, brief, fast moving with plenty of variety of content and stimulate discussion among the group. A number of these techniques may be used to aid evaluation of peer education efforts, providing informal and practical methods of gauging participants' knowledge.

It is also useful to encourage participants to get up and move around or to talk among themselves. This may prevent boredom and fatigue and uses up excess energy that might otherwise be channelled into disruptive behaviour. Providing the opportunity for participants to talk among themselves enhances the impact of an informal, conversational approach. They are more likely to feel that their opinions are valued. It provides an opportunity for everyone to talk, including those who are not comfortable speaking up in a larger group. It also provides an opportunity to talk about more personal experiences, including what happened on the weekend, such as going to a party, which is likely to be particularly relevant to the topic at hand.

Visual Learning Aids

Visual aids may enhance learning by helping maintain participants' concentration, highlighting key concepts and providing a permanent record of information covered. Useful visual aids include Powerpoint presentations, overheads, video tapes, handouts and pamphlets. Resources that are likely to be interesting and relevant for young people include those that are colourful and appealing and contain concise and relevant information, such as magnets, postcards or wallet cards. Small things such as these are attractive, simple to use and can be kept somewhere that is easy to refer to (for example, wallet cards kept in wallet, magnets placed on fridge). They are also subtle and inconspicuous, which may facilitate confidentiality because young people can pick them up or carry them without the knowledge of others. Those that display key information, such as summary points, on the front are particularly useful so the reader does not have to look through lots of less relevant information. Fridge magnets are popular and can potentially access a larger group of people because parents and others may see them if the participant puts them on their fridge. Colourful postcards seem to attract attention and more detailed, but practical information can be contained on the reverse side, such as strategies to deal with given situations.

Figures A to D show examples of colourful and appealing information resources (originals are printed in full colour), supplied courtesy of the Drug

Box D: ADIS Telephone Numbers for Each State

Australian Capital Territory

02 6205 4505 (24 hours)

New South Wales

02 9361 8000 (24 hours)
1800 422 599 (country callers)

Northern Territory

Amity Community Services
08 8981 8030 (8.00 am to 4.30 pm)
1800 629 683 (country callers)

Queensland

07 3236 2414 (24 hours)
1800 177 833 (country callers)

South Australia

1300 13 1340 (24 hours)

Tasmania

03 6222 7511 (9.00 am to 5.30 pm)
1800 811 994 (24 hours and country callers)

Victoria

03 9416 1818 (24 hours)
1800 136 385 (country callers)

Western Australia

08 9442 5000 (24 hours)
1800 198 024 (country callers)

and Alcohol Services Council (DASC) of South Australia. A considerable array of user-friendly resources is now available from various sources. It is important to obtain current resources, as new resources are developed and old ones may become obsolete and even incorrect. Select resources that are most relevant for your target group. Some may be designed to provide information to young adolescents and those with limited drug experience. Others are designed to provide harm reduction information to existing users, for example, the wallet cards in Figure 3.2 are targeted specifically at existing drug users and contain information that is inappropriate for non-users and younger adolescents.

Copies of the resources in Figures A to D can be ordered by contacting the Alcohol and Drug Information Service (ADIS) in South Australia. If you are outside South Australia, these particular resources may be inappropriate or unavailable for your state. Contact ADIS in your state (telephone numbers are provided in Box D) to obtain similar resources relevant to your local context.

Figure A: Standard Drink Fridge Magnets
(Provided courtesy of the
Drug and Alcohol Services Council (DASC) of South Australia)

Figure B: Illicit Drug Fold Out Wallet Cards Containing Harm Reduction Information For Users
(Provided courtesy of the
Drug and Alcohol Services Council (DASC) of South Australia)

Figure C: Alcohol Postcards
(Provided courtesy of the
Drug and Alcohol Services Council (DASC) of South Australia)

Figure D: Heroin Postcards
(Provided courtesy of the
Drug and Alcohol Services Council (DASC) of South Australia)

Appendix 4
Sample Certificates

Adapted from the Youth for Youth Project (McDonald et al., 2000)

Sample Only

Appendix 4.1: Participation in Peer Educator Training

Appendix 4.2: Participation in Peer Educator Training and Peer Educator Activities

The certificates shown in this appendix were used in the Youth for Youth Project. The certificates may therefore need modification if used for another peer education initiative.

Youth for Youth Project

in collaboration with

National Centre for Education and Training on Addiction (NCETA)

and the

Youth Advisory Forum (YAF)

hereby grants this

Certificate of Completion

to

_____

in recognition of participation in the

Peer Education Training Program

for the

Youth for Youth Project

Signed for and on behalf of NCETA

_____

Director

_____

Dated

Sample Only

Youth for Youth Project

in collaboration with

National Centre for Education and Training on Addiction (NCETA)

and the

Youth Advisory Forum (YAF)

hereby grants this

Certificate of Completion

to

_____

in recognition of participation in the

Peer Education Training Program

and the planning, implementation and/or evaluation of

Pilot Peer Education Project

for the

Youth for Youth Project

Signed for and on behalf of NCETA

Director _____

Dated _____

Sample Only

Appendix 5

Planning Template for Peer Educators

Adapted from the Youth for Youth Project (McDonald et al., 2000)

Sample Only

Section 1: Aims and Objectives

What is your Aim or Goal?

ie broad purpose or intent, long-term target, for example to reduce risk-related behaviours among ecstasy users.

What are your Objectives?

ie statements that describe specific steps that will contribute to achievement of goal and are measurable and observable, for example:

- decrease incidence of dehydration at dance parties
- increase knowledge among cannabis users regarding physical and social effects of long-term cannabis use
- increase availability of information related to ecstasy.

Section 2: Implementation

How will you Set Up and Implement your project?

ie the steps required to organise and implement your project, for example:

- contact expertise
- arrange venue
- recruit participants.

The planning template shown in this appendix was used in the Youth for Youth Project. The template may therefore need modification if used for another peer education initiative.

What is the Timeline for set up and implementation of your project?

ie time required to carry out steps above, for example:

- commencement and completion dates
- time required to recruit participants
- time required to book venue
- time required for preparing content and teaching methods.

Section 3: Method

What is your overall *Strategy*?

ie what the project will do, how you will achieve aims and objectives, for example:

- conduct information sessions on risky behaviours relating to amphetamine use
- hand out information leaflets on ecstasy at dance parties
- design posters outlining safe use of alcohol to be displayed around universities.

Who is your Target Group?

ie in broad terms, the group your project is directed at, for example:

- young people aged between 15 and 20 attending dance parties on a regular basis
- young people aged between 15 and 25 who smoke cannabis regularly.

Who will you involve in your project?

ie the specific group you will recruit to participate in your project, for example:

- students attending the year 12 camp at high school *X* (to attend a drug information session)
- young women at university *X* (via posters placed around the university).

How many Participants do you hope to involve in your project?

This may include:

- specific number at an information session
- target figure to whom you will distribute information leaflets
- "guess-timate" of the number of people who will view a poster.

Sample Only

Who will you Contact/Recruit from your intended target group?

What will the Content of your project be?

ie what you would you like the people you are working with to learn, for example:

- dangers of mixing certain drugs
- possible short-term consequences of binge drinking
- legal issues relating to cannabis use.

How will you Deliver peer education to the people you are working with?

ie teaching techniques, practical exercises or method of interacting, for example:

- lectures and small group work
- handing out information leaflets at a stall during university orientation week.

What Resources will you use to conduct your project?

for example:

- teaching aids – overheads, handouts, workbooks, videos
- teaching facilities – overhead projector, screen, whiteboard
- supplies – butcher paper, markers, blank overhead transparencies, pens
- other facilities – coffee and tea making facilities, tables, chairs.

Where will you conduct your project?

ie the location (city, metropolitan, country) and the venue.

When will you conduct your project?

ie date(s) and time(s).

Give an outline of the Structure of your project

ie organisation of content, activities and time required.

Sample Only

What legal issues do you need to consider in relation to your project?

for example:

- occupational health and safety
- contract
- copyright
- confidentiality/mandatory reporting
- equal opportunity and discrimination.

Section 4: Evaluation

How will you conduct your Process Evaluation?

ie assessment of how well the activities were implemented, for example:

- feedback sheet including questions about structure and content of the activities and teaching methods used.

Issues for consideration include:

- how the activities were implemented
- what happened when activities were implemented
- who was involved, did you reach your target group
- how the group or activities developed
- why things changed, how things changed
- what the participants thought of it.

How will you conduct your Impact Evaluation?

ie assessment of objectives – immediate effects of the program, for example:

- compared to before your activities, participants' demonstrated increased knowledge of physical and social effects of long-term cannabis use.

Program effectiveness is often assessed in terms of:

- knowledge and awareness
- beliefs and attitudes
- skills
- behaviour.

Sample Only

How, if possible, will you conduct your Outcome Evaluation?

ie assessment of overall goal/aim of project, for example:

- reduction in risk-related behaviours among ecstasy users.

Sample Only

Peer education for young people about alcohol and other drugs is popular, widely used and intuitively appealing. However, there are variable definitions of the term peer education and often conflicting research findings on its effectiveness. Peer education initiatives often have different aims, target groups and implementation strategies. This makes it very difficult for practitioners to know what to do, or not to do.

This monograph represents a synthesis of the information about peer education derived from a variety of sources, including the published and unpublished literature and the authors' first hand experience. It provides a comprehensive, evidence-based overview of peer education for young people about alcohol and other drugs. It clarifies the meaning of peer education, reasons for using peer education, theories of behaviour change applicable to peer education, and presents guidelines for the development of peer education initiatives.

It is a user-friendly, practical guide that is based on the best evidence currently available on peer education. Its aim is to help practitioners use peer education appropriately. This book will be a useful resource for advocates and those contemplating funding or undertaking peer education initiatives.

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