ALCOHOL PREVENTION PROGRAMS: AN EXPLORATION OF GRADE 11 STUDENTS' PERCEPTIONS

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ABSTRACT

The purpose of this study was to explore Grade 11 students' perceptions of programs related to the prevention of alcohol use in four Saskatchewan high schools through an analysis of data elicited from student questionnaires and focus groups. Utilizing a case study design, information regarding current prevention policies in the schools was obtained by interviewing school principals. Interviews were then conducted with teachers and counsellors to determine the context in which the students were learning and included collecting data about the programs that were being delivered. In the final phase, 452 student questionnaires were administered and four focus groups were undertaken to explore students' perceptions of alcohol prevention programs.

It was found that formal and informal school programs to prevent alcohol use were influenced by a number of factors. Time was an essential factor in allowing information to be conveyed to students. Although the topic of alcohol prevention was included within the health curriculum, there was limited time allotted to present this information in an effective manner. In fact, senior high school students did not receive any formal health education. With regard to alcohol prevention, the students identified that practicing resistance skills, the delivery of developmentally appropriate accurate information, and personal stories would contribute to their engagement in prevention programs and improve program efficacy. Methods of program delivery including peer interaction should be considered at all levels including the Grade 9 level when a large proportion of students reported that they started using alcohol. For the students in this study, the location and methods for student referrals to support services should be more transparent and accessible.

The findings of this study generated several implications for practice, policy, and research. First, systematic monitoring of students' alcohol use would be useful in informing policy and program development. In adjunct to programs, teacher professional development should be implemented and informed by evidence-based practice to ensure

consistency in the program goals and objectives. To support a comprehensive program with clear and consistent messages, policy needs to include the educative approach, professional development, strategies for student infractions, referral processes, parental information and guidelines, and evaluative measures. Implications for research underline the need for further exploration of students' perceptions of zero tolerance policy, the nature of engaging prevention-related content, and efficacy of methods of information delivery to students on the risk continuum. Questions concerning how to actively involve parents at the school level need to be pursued.

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DEDICATION

I dedicate this dissertation to my family who made this pursuit possible:

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CHAPTER ONE

Background

Students' experiences, role models and the environment form many of the ideas, attitudes and expectations of youth regarding the use of alcohol (The National Alcohol Strategy Working Group, 2007). The Canadian and Saskatchewan Governments have identified health promotion, prevention, and education programs for youth as priorities to reduce the harms associated with youth alcohol use (Health Canada, 2005; The National Alcohol Strategy Working Group, 2007; Wall, 2008). Moreover, these frameworks advocate a coordinated approach among agencies to meet the challenges associated with youth alcohol use. The Saskatchewan Ministry of Education (2008) is also committed to a comprehensive approach to health education that recognizes the shared responsibility of the school, the home, the community to "…extend their knowledge base and decision making skills related to drug use and abuse" (Government of Saskatchewan, ¶1) and "coordinate education campaigns about the dangers of drugs and alcohol" (Wall, 2008, p. 3).

Three Canadian provinces/territories lack data regarding the use of alcohol among youth (i.e., prevalence rates) and do not have a process for systematic collection and recording of data on a regular basis [Saskatchewan, Quebec and Nunavut] (Clark, 2008; Government of Canada, 2008). In 2005, former premier, Lorne Calvert announced a plan to strengthen services for substance abuse prevention and treatment in Saskatchewan. In 2006, some progress had taken place in the area of: (a) treatment by improving accessibility, flexibility, and effectiveness; (b) supply reduction by increasing the number of enforcement officers and by work on strengthening penalties for drug possession; (c) movement towards a directorate, including a community

development framework, creating a new research chair, and improving evaluation of substance abuse programs; and (d) enhancing efforts in prevention and education which began with the development of campaigns for public awareness (Saskatchewan Health, 2005).

Mass-media campaigns and school-based curricula are the main vehicles in use for conveying health and safety information regarding alcohol use to youth. Health Canada (2008) reported that despite preventative efforts, youth was using alcohol at hazardous rates and "had higher rates than the general population of reported lifetime harms in the past year as a result of their own drinking" (p. 5). Alcohol use tends to start in adolescence and is the most frequently used substance by Canadian Youth (Health Canada, 2005) and motor vehicular accidents continue to be the number one cause of death in youth (Saskatchewan Government Insurance, 2008). The early use of alcohol is associated with development of dependence and of various types of harm related with its use (DeWit, Adlaf, Offord, & Ogborne, 2000; Poulin & Elliot, 2007).

Trends and consequences of alcohol use can change quickly and dramatically during the teenage years because of the developmental significance of the pivotal adolescent years and because they are the targets of continuous marketing of psychoactive substances including alcohol. Tracking patterns of use is essential to keep the public and educators informed regarding use of alcohol and of its consequences. Knowledge related to "… the extent of alcohol use and the consequent harms can help greatly in determining the aims, timing and key messages for a school district" (Roberts, 2007, p. 10). The national treatment strategy working group (2008) stated, "system planning must be based on current, accurate prevalence data" focusing on

substances causing the greatest harm (p. 10). Information derived from students is central in providing useful information on prevalence rates.

Purpose of this Research and Guiding Questions

The purpose of this study was to explore the perceptions of alcohol prevention programming of Grade 11 students in selected high school settings and to ascertain the rates of alcohol use amongst these students. The following questions guided my research:

1. What were the self-ascribed perceptions of Grade 11 students in relation to alcohol prevention programs?
2. What was the knowledge base of these students with respect to alcohol use and the effects of alcohol?
3. What formal and perceivable informal programs/activities on prevention of alcohol use were delivered in selected high schools?
4. What were the rates of alcohol use among students in selected Saskatchewan high schools?

These research questions were directed by an effort to identify what the intentions of the policies were, the processes of implementation, and the students' experiences of the programs. Guba's (1985) *Domains Model* stated, "there are at least three levels at which the term policy has meaning …" (p. 11): policy-in-intention, policy-in-implementation and policy-in-experience. Guba (1985) stated, "It is never policy that is tested but only some treatment or program undertaken in the name of the policy, together with the experience of that treatment or program by the target group and other affected stakeholders" (p. 11). This model provided a framework for examining programs for alcohol prevention in which "the experience is heavily mediated by

context (e.g., by the local culture; by the reactions and expectations of peers; by the motivation of the implementers and the size of their workload) and the actual availability of authorized resources" (p. 11). The students, themselves, should be the main source of data collection when exploring programs for alcohol prevention since they are the target group and "… it is the young that are most knowledgeable about their own behavior" (World Health Organization, 1993, p. 1).

To understand the context in which the students were experiencing the program, teachers, counsellors and vice-principals were interviewed. In order to understand the policy-in-intention, vice-principals were interviewed. Teachers and counsellors were interviewed to represent policy-in-implementation. Through the use of surveys and focus groups with Grade 11 students' policy-in-experience was brought to description.

These data are also instrumental in identifying which of the educational measures have been used, which are working and how these measures can be improved. Students' perceptions based on Bandura's (2006) four components (information, social and self management skills, sense of efficacy and social supports) necessary for effective prevention programs will be examined in light of Guba's (1985) three level model for viewing policy.

Significance of the Study

The Canadian Addiction Survey (CAS) (2004) indicated that for individuals between 15 and 25 years of age there had been significant increases in alcohol use since 1994 (Adlaf, Begin, & Sawka, 2005). As a result of youth substance use and harms associated with that use, the Saskatchewan and Canadian Frameworks identified, "health promotion, prevention, and education programs for youth are important components of the strategy, and significant efforts

need to be put into the design, implementation and evaluation of future initiatives" (The National Alcohol Strategy Working Group, 2007, p. 9).

This research was timely because there was limited documentation of students' views regarding alcohol prevention programming in Canada. In fact, "there is strong consensus among reviews and recent primary studies, that for school drug education programmes to be effective, they should be based on the needs and be relevant to the young people who are likely to participate in the programme" (McBride, 2003, p. 734). White and Pitts (1998) suggested few programs are based on young people's experiences.

Through this research I sought to understand students' perceptions of alcohol prevention programs in schools. It was my hope to share my findings with parents, teachers, administrators, health professionals and policy-makers in order to affirm and enhance current preventative approaches and to provide insight for future decisions related to policy, strategies, and practice. In particular, students provided insight into present school programs related to preventing alcohol use in youth. Moreover, students provided suggestions on methods of delivery and key messages that might improve student engagement and improve program effectiveness.

This research informs the local communities in the area of evaluation of prevention of alcohol programs. Particularly in relation to school programs, a formal system to engage students to provide feedback or input into formal curricular or supportive programs (counselling and referrals) is necessary and little has been addressed in this area. In addition, practices worthy of re-evaluation include the punitive approaches used when dealing with school alcohol-related infractions.

As Saskatchewan has not yet developed a systematic and ongoing approach for monitoring youth alcohol use, this research informs the community about youth alcohol usage in selected school communities. The findings support programming utilizing students' perceptions of their behaviour related to their alcohol use to evaluate current strategies being used and to develop future strategies. This research will aid in examining changes in students' use of alcohol, the monitoring of patterns and the identification and projection of trends of current, and future student alcohol use. More specifically, the findings from this research can inform policy makers and practitioners of local student alcohol use along with insights provided by students to tailor their strategies.

In summary, this research contributes to the literature by providing understanding from the students' perspectives: students offer their perceptions of present programs and provide practical strategies for improving their efficacy. The knowledge gained from this research will provide information for future comparisons, insight for policy, programming and monitoring based on students' perceptions of school programs and policy, and their experience with alcohol use. As the national treatment strategy working group stated, improved understanding is one of "the key ingredients to start improving substance use services and supports" (National Treatment Strategy Working Group, 2008, p. 2).

Assumptions

The following assumptions have influenced this study. I assumed that:

1. Students' perceptions and experiences of alcohol prevention programs in the school system represented the policy-in-experience.

2. Teachers were responsible for program implementation and information they provided represented the policy-in-implementation.
3. The vice-principals were responsible for the policies related to alcohol prevention programs in the schools and their perceptions of how the policy was implemented represented the policy-in-intention.
4. That a qualitative case study research design was appropriate for the intentions of this research.
5. All participants interviewed and in focus groups were capable informants as they entered into dialogue with the researcher.
6. Participants responded honestly to interview and survey questions.

Delimitations

Research questions, sources, analyses and syntheses of the data were delimited as follows:

1. This study involved four Saskatchewan urban school cohorts of Grade 11 students and the vice-principals, teachers, and counsellors involved with alcohol prevention programs.
2. This study focused exclusively on youth alcohol use since alcohol is regarded as the student drug of choice (Adlaf et al., 2005).
3. Data collection for this study was delimited to a four-month period from February to June 2009.
4. The student populations in this study were an estimate based on the most current enrollment data. All statistical descriptions were calculated using these data.

5. Responses were not amenable to means and comparisons between schools because this intent was not included in the design of the study and due to ethical considerations this was not pursued.

Limitations

The following limitations apply to the research:

1. The information gained was limited by the information sought by researcher's ability to gather perceptions and the specific methods and instruments of surveys, focus groups and interviews.
2. The transferability or generalizability of findings is limited by the case study research design.
3. General questions in relation to alcohol were asked on the student questionnaire to answer research question number two because the curriculum guide did not contain specific information in relation to alcohol.

Definitions of Terms

The terms below will have the meaning there assigned to them:

1. **Teacher:** anyone in the schools who "hold(s) a valid certificate of qualification to teach in schools in Saskatchewan" pursuant to Section 2 of the Saskatchewan *Education Act* (1995).
2. **Principal:** an individual who has been appointed by a board of education and carried out the duties of a principal (Education Act, 1995).
3. **Vice-Principal:** an individual who assists the principal in all matters pertaining to the operation of the school (Administrative Manual Policy, 2004, p. 1).

4. **High School:** a school which offers Grade 9 to 12 courses of study as prescribed by the Province of Saskatchewan (Education Act, 1995).
5. **Urban School:** operates within an urban area or city where urban is defined as an "area with a population of at least 1,000 and no fewer than 400 persons per square kilometer" (Statistics Canada, 2001, ¶2).
6. **Comprehensive School Health:** a broad spectrum of programs, policies, services and activities that take place in schools and their surrounding communities (Saskatchewan Learning, 1998). Comprehensive School Health encourages active partnership and collaborative planning among all persons who can contribute to enhancing the well-being of students.
7. **Alcohol-related harms:** include immediate physical and social harms associated with alcohol intoxication, such as, physical injury, property damage, unplanned sexual behaviour, impaired driving, illegal behaviour, and disagreements with family and friends. Chronic heavy alcohol exposure can interfere with brain and cognitive development. Alcohol can cause death due to overdose (Paglia-Boak & Adlaf, 2007). Those who initiate alcohol use by 14 are four times higher than those who start by age 20 (Grant & Dawson, 1997).

Researcher's Background

My interest in the topic of alcohol prevention has developed over the years. As a teenager I was curious as to the patterns of drinking among my peers and the harms that they suffered as a result of their drinking. When at university, the same questions came to mind, only in a different setting. As a registered nurse working in Saskatchewan, in pediatrics wards, emergency, and in

schools, many of the patients had issues of alcohol use, and many youths were affected by their own use of alcohol, that of their friends or their parents. The effects of alcohol use that I was seeing caused irreversible harms (e.g., fetal alcohol spectrum disorder) yet they were preventable.

As I entered into a new phase of my career, teaching new nurses, what became apparent was, as an experienced health professional I was able to teach about the results of the harms related to alcohol use and how to care for them physically but I was ill-equipped to offer support to aspiring professionals on what and how to teach effectively to prevent reoccurrence. The lack of information in the clinical setting relating to how to support and what to teach patients and their families about the effects of alcohol became a stark reality.

I started researching this topic during my Masters in Nursing, where my perceptions were validated; the prevention of alcohol use by youth was not only an area of need but also an area that I could contribute to from a unique background. As a nurse, seeking insight from youth related to their health was routine for me and therefore, it seemed only natural for me to seek out from youth what they were thinking, what they were seeing and what their experiences meant to them and their peers related to their alcohol use. I was interested in what information they were receiving and what information they felt they needed to make healthy lifestyle choices. Today, this need has become even more relevant and essential to me because I teach nursing students in clinical settings in the hospital and schools where this information is needed. It is through this journey that I have come to this present study and desire to understand students' perceptions of the prevention of alcohol use. Within my own professional practice I plan to share the knowledge that I have attained from this research with nursing students that I teach within community and

acute care settings. Nursing students will be presented with unique opportunities to teach and provide information, related to alcohol use, to youth and their families. These teachable moments often appear during critical times of a person's life. This research will better equip nursing students to identify the need for knowledge dissemination as well as insight into methods of delivery and information necessary to engage youth in issues related to alcohol use.

Structure of the Dissertation

The dissertation is organized into five chapters. This first chapter provides the personal background and beliefs of the researcher. Furthermore, this chapter outlines the overview of the study, the problem addressed and the significance of the research. As well key definitions are included along with the assumptions, delimitations and limitations of the study were discussed.

Chapter two provides a summary of prevention programs, more specifically of programs related to evidence-based practice. Next, concepts that guided my conceptual framework such as comprehensive school health is defined, Bandura's (2006) theory of efficacious prevention programs, student engagement and a diagram of my conceptual framework. Finally, I concluded this chapter with a look at the rates of alcohol use in Saskatchewan youth.

Chapter three describes the research design, the methods of data collection and the procedures used in providing direction during this research.

Chapter four describes the findings obtained, including the perceptions of students' alcohol use and summarizes the themes that emerged from data.

Chapter five is a discussion of the findings, analyzes the students' responses and the policies and prevention programs in use in these schools, interprets the results and presents the implications of this study for further research.

CHAPTER TWO

A Review of Relevant Literature

Health education is provided in a variety of settings. These settings deliver programs to specific populations; have systems for diffusion of programs, facilitation of policy development and support positive health practices (Mullen et al., 1995). Traditionally, schools have been and continue to be settings in which health teaching occurs and are locations where the majority of youth are reached by health education.

Health education is rapidly evolving to include approaches, methods, and strategies, and is dependent on ever changing epidemiology and statistics. Further, health education is "strengthened by the close collaboration among professionals of different disciplines" such as psychology, medicine, nursing, social work, education and other human service professionals (Glanz, Rimer, & Viswanath, 2008, p. 7). Alcohol is the most frequently used substance amongst Canadian and Saskatchewan youth (Adlaf, Begin, & Sawka, 2005; Health Canada, 2005) and driving while under the influence of alcohol continues to be the main cause of injury and death of Canadian youth. Health education focusing on the behaviour of alcohol use is included in elementary, middle and high school health curriculums.

In order to address the purpose of my research, students' perceptions of programs on the prevention of alcohol, I begin this chapter by looking at the history of approaches in the prevention of alcohol use by youth, followed by a summary of literature pertaining to evidence-based practice in this area. I then briefly discuss the main components of my conceptual framework that guided my research, which included comprehensive school health, Bandura's (2004) theory of effective prevention programs and student engagement. Following the

presentation of my conceptual framework, I provide a review of Canadian and Saskatchewan surveys that have already been published. An overview of local youth prevalence rates provides a perspective of the youth culture in relation to alcohol use, the lack of current local data for tracking trends and for informing present programs.

Approaches to School Health Programs

I begin by focusing on different models and theories used in health prevention and promotion and on those used specifically for alcohol prevention programs. Of course, health education covers the continuum of disease prevention to the early detection of illness and rehabilitation.

Healthy behaviour is the primary concern of health education. Programs that influence health behaviour, "including health promotion and education programs and interventions are most likely to benefit participants and communities when the program or intervention is guided by a theory of health behaviour" (Glanz et al., 2008, p. xxi). Theories used in health promotion have evolved with the approaches to health education. Health education for changing individual behaviour occurs through instructional activities and through strategies such as organizational efforts, policy directives, economic supports, mass media, and community-level programs. No single theory or conceptual framework dominates research or practice in health prevention and education (Glanz et al., 2008). However, some theories are more commonly used in alcohol prevention programs and those "theories that gain recognition in a discipline shape the field, help define the scope of practice, and influence the training and socialization of its professionals" (Glanz et al., 2008, p. 31).

Alcohol Prevention Programs

Like health education, alcohol education has evolved over the years. The early drug and alcohol prevention programs focused on dissemination of information and were based on the principle that young people need factual information to make healthy decisions (Roberts, 2007). Such knowledge-based programs were substituted by affective education programs, which introduced attitudes and values; and the latter also failed to produce desired results (Paglia & Room, 1999). Current drug education programs draw primarily from the *social learning theory* and the *health belief model* (Skara & Sussman, 2003). The *social learning theory* is based on three parts, that people learn through observing others, imitating others and reinforcement and the *health belief model* is used to predict health behaviour change by attempting to explain factors that influence compliance (Shah, 2003). Two major models currently used in programs in prevention of alcohol use are the *social influences model* and the *life skills model,* which are derived from the above theories and are typically aimed at the promotion of abstinence from alcohol use rather than harm reduction (Skara & Sussman, 2003).

The first model views adolescent substance use as a result from influences such as substance use or messages by family, peers and the media (Flay & Petraitis, 1994). This model aims to create awareness and to develop skills for analysis and minimizing these influences. Training focuses on identifying when these influences for skills are apparent and on teaching students tactics for dealing with the messages. This approach has not been found to contribute to program effectiveness (Cuijpers, 2002). Normative education whereby young people overestimate the prevalence of alcohol use by their peers and adults is better supported by scientific evidence. Normative approaches are intended to correct misconceptions and thus shift

norms. This approach has shown mixed results, it is suggested that students that do not use alcohol might view themselves apart from the norm and thus encourage more alcohol use (Schultz, Nolan, Cialdini, Goldstein, & Griskevicius, 2007). As such, this approach is most effective when students overestimate the use of others and care should be taken when using this approach with all students (Granfield, 2004).

The second model emphasizes teaching of personal and social skills (Botvin, 2000). The skills are necessary for decision-making, problem-solving, resisting peer and media influences (cognitive), increasing personal control and enhancing self-esteem, coping, and improved assertiveness. This approach is common and is claimed to be effective when used specifically with drug related situations.

It has been concluded that, the best of universal curriculum-based programs are modestly successful, with effects eroding after a year or two, and benefiting those least at risk (Gottfredson & Wilson, 2003; McBride, 2003). Five distinct views have been isolated on how to strengthen school substance use prevention. These views represent the basis and "hopes for advancing the prevention of student substance use problems" (Roberts, 2007, p. 22):

1. Universal programs are worthwhile continuing even if they *delay use* for a year or two for a few students given the range of harms linked to early substance use (McBride, 2003);
2. Abstinence for all students is unrealistic; *other positive substance use outcomes* need to be considered (McBride, Farringdon, Midford, Meuleners, & Phillips, 2004);
3. In addition to the general (universal) student population, efforts need to be focused on *higher risk students* (Stewart et al., 2005);
4. Curriculum is necessary but insufficient and is necessary to be embedded in a *whole-school, comprehensive approach* (Stewart-Brown, 2006).

5. "Many of the factors affecting young people's use and abuse of substances lie outside the purview of schools, so *linking to community programs* is important" (Roberts, 2007, p. 22).

Single and Kellner (2005) agree with the above statement, that approaches to the prevention of alcohol vary, and:

> There is much research to support decisions about the appropriate balance between population-based and harm reduction strategies for alcohol problems. It is important to remember that we are not talking about evidence that would lead to the adoption of one approach over the other, but rather evidence that indicates where the balance of effort should be placed (p. 7).

It is important to understand the different types of prevention programs in use. The following is a synopsis of the different types of programs involved in alcohol prevention.

School-Based Health Programs and the Prevention of Alcohol Use

The most widely evaluated and used school programs for drug prevention are universal curriculum-based programs (Roberts, 2007). Mrazek and Haggerty (1994) distinguished three types of prevention universal, selective and indicated. These groups differ with respect to the intervention and target group.

1. Universal – targets a whole population group and each member of this group is considered to benefit from the program. The aim is to prevent young people from starting to drink alcohol.
2. Selective – "targets subsets of the population whose risk of developing use is above average …" and "…identified by the presence of biological, psychological, social or environmental risk factors" (Mrazek & Haggerty, pp. 24-25).
3. Indicated – targets high-risk individuals who seem to be at risk of developing a

disorder but who do not meet the criteria for diagnosis at this time.

Universal programs are unable to deliver a program that is effective for all. Roberts (2007) suggested that the intensity, dosage, content and method of delivery of such programs might not meet the needs of all students. However, modest, short-term effects for universal classroom substance education programs have been evident. Many factors that influence substance use lie outside the school. Since teachers are in a position to influence some of these factors through curriculum and instruction (Flay, 2000), it is important to understand the workings of these factors. According to Cuijpers (2002), educational opportunities are positioned in the area of encouraging an understanding and coping effectively with social influences that promote substance use, as well as supporting the development of relevant personal and social skills.

The *social influences model* and the *skills training model* have been used in universal prevention programs with various results based on the following factors.

1. Methods of delivery: Student interactivity has the most support from research (Tobler & Stratton, 1997; Tobler, Lessard, Marshall, Ochshorn & Roona, 1999, McBride, 2003). More specifically, interaction of student-to-student rather than student-to-teacher interaction showed better effects on prevention of student substance abuse (Tobler & Stratton, 1997). Tobler (2000) considered that practice and feedback on skills practice is superior to specific content for producing change. The teacher becomes a facilitator who sets an appropriate atmosphere rather than a presenter, and maximizes opportunities for peer interaction and for correction of misconceptions (McBride, 2003).
2. Qualities of teacher/leader: Programs led by peers are more effective than those that are teacher-led or co-led (Gottfredson & Wilson, 2003). However, because of challenges in sustaining peer-led programs, drug education has been concluded best

3. Timing: Most program evaluations have been directed to middle/junior high school students, the most effective method at this level being the *Social Influence Model* (Roona, Streke, Ochshorn, Marshall, & Palmer, 2000). Hawks et al. (2002) suggested that timing could be tailored best by using local prevalence data. McBride (2003) went on to suggest that using information that is relevant to students might encourage student engagement of the programs. For example, the students may not take programs that focus on abstinence from alcohol seriously when many in the student population are using.
4. Length of program: There is limited research to clearly outline the time necessary except that occasional presentations have no measurable effects on behaviour. More specifically, confusion seems to be around the terms intensity, duration and the risk level of the population (Hawks et al., 2002). At present it is recommended that the aims of the program be best used to determine the time spent (Roberts, 2007).
5. Program delivery: It is neither unknown to what extent Canadian schools use evidence-based drug education curriculum nor how fully teachers implement the programs that they do use (Roberts, 2007). Several drug education-related studies from the U.S.A. found that less than 20% used "interactive teaching methods more often than non-interactive methods, and only 14 % implemented both content and process as designed" (Ennett et al., 2003, p. 1).

Universal programs seem to be more effective with lower-risk students because they are unable to tailor their content to youth with different needs or higher risk (Gottfredson & Wilson, 2003). Nonetheless, the literature identifies short-term effects of interactive programs directed at middle/junior high school students more than other levels. More specifically the effects include "delaying or preventing onset of use, hazardous use and harmful consequences among some of

the students exposed to the programming" (Roberts, 2007, p. 28). Use of evidence-based school drug education programs is not common in the U.S.A, and those that are used are frequently "not being delivered as intended" (Roberts, 2007, p. 29). The situation in Canada on this matter is unknown.

Norms and Policies on High School Substance Use

A school's norms are the product of influences from the broader community and the informal and formal messages in the school and the home. School norms are formed by what students, teachers, and administrators actually "say and do" (Roberts, 2007, p. 43). Policy on student alcohol use is one element of a strategy that can facilitate the creation of a healthy school environment (Nova Scotia Department of Health, 2002, p. 13). In relation to alcohol prevention, "…an environment of tolerance for substance use in school" has been found to increase the risk of substance use by students (Kumar, O'Malley, Johnston, Schulenberg, & Bachman, 2002, p. 122).

School policies on alcohol use are an important vehicle for influencing a school's norms and culture. How policies are developed, communicated and enforced is also important (Toumbourou, Rowland, Jefferies, Butler, & Bond, 2004). It is necessary to keep in mind that "most current knowledge on school drug policies is from the United States" (Roberts, 2007, p. 43), where the tendency is towards punishment rather than remediation when a school violation related to alcohol use in school occurs. Higher-risk students who are helped maintain links with school and with non-deviant peers are more likely to promote their well-being rather than a more punitive approach which increases the likelihood of antisocial behaviour (McAndrews, 2001; Roberts, 2007).

Universal Curriculum: Reducing Harms with Aims Including Abstinence

Because significant numbers of students use alcohol in risky ways some programs include material that focus on aims other than abstinence of alcohol use. U.S.A. drug policy does not support outcomes to interventions that have effects other than abstinence (Roberts, 2007). Instruction aimed at delay in onset of use, or reduction of the frequency of use, amount used or hazardous use is usually referred to as harm-reduction however, has been argued that this term is not accurate (Stockwell, 2006). Furthermore that a program with the above goals would be referred to as demand reduction and harm reduction would include strategies to reduce harm without change in the level of consumption. However, “there is limited information on when to introduce these types of aims and messages, but the decision is best made on the basis of the consumption patterns in a region” (Roberts, 2007, p. 29) (i.e., the prevalence of hazardous patterns). This means that each school or school board has to make decisions whether to use this approach based on consumptions rates of the school population.

There is controversy about this approach based on the age to implement this message because of concern regarding the students’ abilities to make decisions about the context of substance use (Poulin & Nicholson, 2005) and on the accuracy of the term harm reduction. Stockwell (2006) included programs that may not necessarily call for reduction or change in the user under the term harm reduction. Instruction that is aimed at delay in onset of use, or to decrease frequency or amount used by students would be considered *demand reduction* on which there is no research evidence for their effectiveness. Such prevention programs have the following characteristics:

1. Hazardous use prevention – this includes not combining two drugs, not using drugs in risky situations, education on street drugs, and teaching of responsible use.

2. Harm reduction – this refers to teaching the signs and symptoms of alcohol overdose and of effective response and how to monitor over use so as to ensure the safety of the user and of others. Furthermore, to be aware and provide resources if someone is being harmed by their own use or that of others (Roberts, 2007).

Most drug education research originates in the U.S.A. and emphasizes delaying alcohol use until at least age 21 years. Under-reporting or failing to detect some of the effects of drug education programs may exist because program evaluation has focused on the extent to which youth abstain or delay alcohol use rather than the measurement of the prevention of harm associated with alcohol use (Paglia & Room, 1999).

Studies from Nova Scotia and Australia reported encouraging results and elicit more investigation into the effectiveness of school-based programming aimed at reducing hazardous use and possible harms among students using a harm reduction-oriented program (McBride et al., 2004; Poulin & Nicholson, 2005). Schools and communities need to search for "acceptable responses to widespread hazardous use of alcohol by young people" (Roberts, 2007, p. 32) and may need to investigate appropriate instruction based on harm reduction models for all student populations.

Targeted Curriculum for Higher Risk Students

Higher risk students are based on the number of risks in their life or on the basis of early or hazardous substance use. Universal programs on substance-using youth have shown "either no effect or an increase in use" (Gottfredson & Wilson, 2003, p. 36). It has been established that

“Early substance use is considered an important risk factor for ongoing problems … but the early use itself usually is an outgrowth of earlier factors” (Roberts, 2007, p. 32). Although universal programs have shown little promising effect on the experimenting of youth with substances, programming during adolescence is still considered necessary. However, with higher risk youth programming beginning at a younger age may be more likely to result in behavior change (Toumbourou et al., 2004).

Multiple-target programs focus at different student populations. These include:

1. Early childhood/elementary level multi-component programs: These programs focus on improving environments, decreasing social exclusion and disruptive behaviour rather than on substance use (Toumbourou et al, 2007) with a few some producing positive results on later substance use (Gottfredson & Wilson, 2003),
2. School-linked targeted family programs: to help children improve relationship skills,
3. Middle/high school programs,
4. Programs for Aboriginal students,
5. Brief interventions for student populations that use alcohol hazardously but which are not which necessarily dependent.

Since early alcohol use is an important risk factor for continuing health problems (i.e., alcohol dependence), target groups for selected programming may be identified based on identification of risk factors or the amount they are using. Targeted approaches along with comprehensive school approaches are recommended to reduce alcohol problems in youth (Roberts, 2007).

Comprehensive Whole-school Approaches

That universal classroom education on substance use has only produced small and short-term effects has catalyzed the search for a more comprehensive approach (Roberts, 2007). The more comprehensive approach may be more likely to "tap into the many spheres of influence or risk and protective factors at play in the lives of students in a way that's not possible with a strictly instructional approach" (Roberts, p. 39).

Comprehensive programs are characterized by multiple interventions (i.e., instruction, policy and services) and multiple settings (i.e., school, family, community, mass media) (Nation et al., 2003). A comprehensive policy includes clearly written rules, regulations and consequences along with a strategy to guide education, intervention and referral to appropriate agencies (Nova Scotia Department of Health, 2002). These dimensions concentrate on risk factors or building protective factors (Schaps & Solomon, 2003). The goal of building protective factors is to enhance students' relationships of students with the school so as to provide a protective force. It can be achieved through programs that build connections between teachers, learning and students. Such programs assume that by including attention on the school environment will increase effectiveness and be more enduring than single-issue education programs. There is growing evidence in favor of comprehensive approaches, but the contribution the different elements make is not clear (Flay, 2000).

Comprehensive programs may be implemented at three school levels. The elementary school level, they focus on improving parenting skills and on modifying teaching practices so as to increase school commitment and school achievement and to reduce misbehaviour including hazardous drinking (Roberts, 2007). At the junior high/middle school level they can be effective

in reducing substance abuse, mental health problems, early sexual activity and antisocial behaviour (Roberts, 2007).

Risk and protective factors associated with substance use of youth have characteristics in common with those related to social development and academic outcomes (Roberts, 2007). Those interested in preventing substance abuse and in improving academic outcomes need to focus on whole school approaches including alliances with those involved in the school community that focus on both risk and protective factors (Schaps & Solomon, 2003). Evaluation of these comprehensive models may need to shift away from experimental models that focus on rigorous controls and short distinct interventions to comprehensive initiatives, which are broad in nature with school-wide changes (Stewart-Brown, 2006). Nonetheless, regardless of the approach, efforts to improve environments, policies, and programs should ultimately be evaluated on the basis of their effects on health behaviour which are defined as:

> those personal attributes such as beliefs, expectations, motives, values, perceptions, and other cognitive elements; personality characteristics, including affective and emotional states and traits; and overt behavior patterns, actions and habits that relate to health maintenance, to health restoration, and to health improvement (Gochman, 1982, p. 12).

If changes in policy does not lead to measurable changes in behavior, it may be too weak, too short-lived, or only a limited determinant of behaviour" (Glanz et al., 2008, p. 12).

Components of Effective Prevention Programs

The social cognitive theory views developmental life-span changes from the perspective that lives are created by the reciprocal interaction between personal factors and various

influences in ever-changing societies where people are the agents (Bandura, 2006, p. 1). This perspective views people as "… contributors to their life circumstances not just products of them" (Bandura, p. 3). People influence their own functioning and circumstances intentionally as planners, self-regulators, and self-examiners.

According to Bandura (2004), effective prevention programs include four components. These four components include (a) informational, (b) social and self-management skills, (c) building self-efficacy, and (d) enlists and creates social supports (Bandura, 2004). The first component focuses on information on health benefits and risks of various life-style habits. The second component includes developing social and self-management skills for "effective preventive practices" (p. 158). The third component entails building a "resilient sense of efficacy to support the exercise of control in the face of difficulties and setbacks that inevitably arise" (p. 158). The final component "enlists and creates social supports for desired personal changes" (p. 158).

The first and second components have been discussed earlier in light of published literature in relation to the prevention of alcohol in use. The third component, self-efficacy will be discussed in more detail followed by a brief outline of what social supports encompasses. The component of self-efficacy is gradually being incorporated into health education (Shah, 2003).

Self-efficacy

Central to the idea of humans as agents is that of personal efficacy which "… is the foundation of human motivation, well-being, and accomplishments" (Bandura, 2006, p. 3). Unless people believe that they can achieve the results of their actions, they have little reason to

act or persevere. Other factors influence decisions made however, the core belief that the person has the power to effect change needs to be present.

Bandura (2006) stated, “the belief in one’s efficacy is a key personal resource in self-development, successful adaptation, and change” (p. 4). Self-efficacy affects cognitive, motivational, affective, and decisional processes and people with high self-efficacy view obstacles as surmountable through self-development and effort whereas those with low self-efficacy are easily convinced to give up. Efficacy beliefs affect the emotional life and “determine the choices people make at important decisional points … which can profoundly affect the courses lives take” (Bandura, 2006, p. 4). Self-efficacy involves one’s subjective judgments about one’s own capacities to organize and implement courses of action to accomplish selected goals.

Efficacy judgments are based on beliefs about individual capability but are not necessarily an accurate assessment of such capabilities (Goddard, Hoy, & Hoy, 2004). According to Bandura (2006), “slightly overestimating one’s actual capabilities has the most positive effect on performance” (p. 4). However, people regularly over or underestimate their abilities and so affect the amount of effort and course of action they choose when pursing their goal and may also affect how well they utilize their skills.

Self-efficacy differs from self concept, self worth, and self esteem because self efficacy refers to judgment about one’s ability to complete a task whereas self esteem is considered to be related to feelings self worth. Bandura (1986) suggested “one’s sense of self-efficacy mediates the effects of self-concept on task success” (in Goddard, Hoy, & Hoy, 2004, p. 4). Furthermore

the choices that individuals make (through their actions) are “influenced by the strength of their efficacy beliefs” (p. 4).

Three important characteristics of self-efficacy. The characteristics of self-efficacy are important because they affect how self-efficacy should be measured. First, self-efficacy focused on the perceptions of capabilities to perform tasks rather than the personality of the person. Second, self-efficacy is context and task specific. Measures of self-efficacy are multi-dimensional and vary with specific tasks in different domains. The multi-dimensional analysis is a hallmark feature of self-efficacy assessment (Bandura, 1997). Third, self-efficacy is dependent on mastery of performance rather than comparing oneself to peers (normative criterion).

Four sources in shaping efficacy. Bandura (1986) described four factors that shape efficacy: mastery experience, vicarious experience, social persuasion and affective state. Mastery experiences are the most powerful as they tend to enhance efficacy beliefs that then contribute to the expectation that future performances will also be successful. In like manner, being unsuccessful decreases efficacy beliefs. Efficacy beliefs also improve when success is directly related to ability or effort rather than to luck or other intervening factors. Vicarious experiences are acquired by observing a skill being modeled by someone else. When a skill is modeled well, the observer’s efficacy beliefs are most likely improved. Social persuasion may include encouragement or feedback about a performance from someone in a position of authority or from a colleague. Its strength depends on the trustworthiness, expertise and credibility of the persuader (Bandura, 1986). Affective state adds to the individual’s perceptions of competence and capability. It includes the level of arousal of anxiety or excitement. Information from these sources must be cognitively weighed before decisions are made.

Self-efficacy is affected by actual performance, vicarious experiences, verbal persuasion and emotional responses whereby actual performance is usually consistent. Adolescents receive information from these sources at home, in schools and in their social environments. The processes by which youth weigh and combine the source and information are not well understood.

Self-efficacy and Health Promotion in Schools

Adolescent development takes place in different social contexts but mainly in the home and the school and through peer networks. Schooling has many potential influences on self-efficacy of adolescents (Schunk & Meece, 2006). For example, how instruction is structured, affects the ease or difficulty of learning, competition, grading practices, amount and type of teacher attention are a few identified forces. Lifestyle habits influence the quality of our health so that by managing health habits individuals can become healthier. According to Bandura (2006), "many of the habits that build the foundation for a healthful life or jeopardize it are formed during childhood and adolescence" (p. 16). It is easier to prevent disadvantageous health practices than to change them later in life.

Efficacy beliefs influence whether we change our habits or not. Since there is little point in trying to change if one does not feel that one has what it takes to change. Adolescent development in the health realm includes a continuum, which includes the promotion of healthy lifestyles and risk management. The beliefs that people can change occur at every stage of personal change initiation, adoption and maintenance (Bandura, 1997). Once people adopt positive health habits, the maintenance of habit change relies on self-regulatory capabilities, which require instilling a sense of efficacy that is resilient as well as imparting skills (Bandura,

1997). While health habits are embedded in family practices the schools have important roles in promoting health, as they are the only setting in which the largest proportion of children can be reached. Promotion of health can include teaching on topics of healthy eating, discouraging substance use and teaching of self-management skills.

Management of High-Risk Activities

Adolescence is a timeframe characterized by experimentation with risky activities. Learning how to deal successfully with potentially dangerous situations successfully expands and strengthens an adolescent's sense of efficacy. However, strengthening self-efficacy is best accomplished through guided mastery experiences that involve acquisition of "cognitive, behavioral and self-regulatory tools" or knowledge and skills needed to manage ever-changing situations (Bandura, 1995, p.3). Successful management of problem situations instills strong belief in one's capability or self-efficacy.

Many adolescents who experiment with risky behaviours do not adopt them. Some adolescents adopt the risky behaviours but the behaviours rarely occur in isolation that leads to more complicated issues. Frequent engagement with these hazardous behaviours leads to a high-risk lifestyle that may jeopardize health and healthy development and lead to irretrievable loss of life opportunities (Bandura, 2006).

Self-regulatory efficacy development and practice stem from familial practices. As adolescents grow and move into the larger world parents must now rely on the personal standards, self-regulatory skills of the youth and on the information that students share with the parents. The adolescent becomes an agent in the guidance process.

The peer group becomes an important influence during adolescence. According to Bandura (1997), the amount of guidance, development of self-regulatory capabilities, supportive familial communication, intensity and depth of early involvement with habit-forming substances, contribute to the ease of disengagement from high-risk activities associated with peer groups. Thus, "by acting on beliefs that they can manage peer pressure, adolescents who feel efficacious to withstand peer pressure discuss with their parents the predicaments they face" (Bandura, 2006, p. 25). Such adolescents discuss the issues they face discuss them with their parents whereas those who have low efficacy to resist peer pressure do not. Peers are an influential force but do not take the place or role of family.

Adolescents' perceptions of peer involvement with substance use is a strong predictor in the adolescents' own substance use (Bandura, 2006). Adolescents vary in their perceptions of peer involvement in problem behaviours. The continuation of risky activities is affected by whether adolescents view of peers' risky behaviour as normal, or not.

Whether youth choose to abandon risky activities or "become chronically enmeshed in them is determined, in large part, by the interplay of personal competencies, self-regulatory capabilities, and the nature of the prevailing social influences in their lives" (Bandura, 2006, p. 26). In general, those who adopt hazardous lifestyles place little value on academic self-development and are deeply influenced by those of their peers who indulge in risky activities. Adolescents who lack confidence in their efficacy are less able to evade risky behaviour than those who have a confident sense of self-regulatory efficacy (Allen, Aber, & Leadbater, 1990).

Some researchers have suggested that self-efficacy must be tailored to stages of behaviour change. However, "Bandura (1997) suggested that self-efficacy assessments should be

particularized judgments that carefully correspond to the outcome with which they will be compared" (Pajares & Urdan, 2006, p. 151). Schwarzer and Luszczynska (2006) suggested that self-efficacy beliefs change according to particular stages of health behaviour such as: pre-action self-efficacy, maintenance self-efficacy and recovery self-efficacy. The first refers to the phase where one is developing a motivation to act. The second refers to beliefs that a person has to deal with barriers that will arise. The third relates to the beliefs that one has to resume the targeted behaviour after a failure.

Adolescent development takes place in different social contexts but mainly, the home, in school or through peer networks. Schooling includes many potential influences on adolescents' self-efficacy (Schunk & Meece, 2006). These influences include how instruction is structured. Instruction affects the ease or difficulty or learning. Competition in the classroom, grading practices, amount and type of teacher attention are a few identified forces that were seen to affect students' self-efficacy. These methods as well as interactive instruction have been identified as significant influences in the success of alcohol prevention programs. Glanville and Wildhagen (2007) suggested that school practices influence student engagement.

Social Supports

Social supports refer to the purpose and quality of social relationships in prevention programs (Bandura, 1995). Bandura (1995) states " a general sense that one is loved and cared for by others, and that these others would help if really needed, contributes to psychological and physical well-being (p.181). Perceived social supports can decrease stress and the support that is received may be different than the support that is expected. Supports can include those within a family, friends and larger social circles.

Student Engagement

School is central to the life of many youth who spend considerable amounts of their time there. When schooling is viewed as essential to the long-term well-being it is reflected in the student's academic and non-academic participation and pursuits (Willms, 2003). Canadian Institute Health Information (CIHI) (2005) stated, "the school context is a key element of the adolescent development process" (p. 42). When students are engaged in the learning process they tend to learn more. The school setting can provide opportunities or challenges to their developmental process in the engagement process.

School engagement is "… the extent to which students identify with and value schooling outcomes, and participate in academic and non academic school activities" (Willms, 2003, p. 8). It is the degree of importance that youth place on *doing well* in school academically, socially or in extracurricular activities (CIHI, 2005). Students aged 12-15 years, who report feeling highly engaged with their school are less likely to report using substances such as alcohol and marijuana (CIHI, 2005).

School engagement is frequently discussed in theories of educational achievement and attainment. The definition of engagement usually includes a psychological and a behavioural component (Glanville & Wildhagen, 2007; Willms, 2003). The psychological component refers to students' sense of belonging at school and of whether or not school success is important to them (Willms, 2003) with the sense of belonging referring to feelings of being accepted and valued by peers and others at school and of whether school success will benefit them personally and economically. The behavioural component pertains to participation in school activities.

When students do not feel that they belong at school they are often referred to as alienated or disaffected (Willms, 2003).

Much of the research on engagement relates to academic performance and has demonstrated that higher engagement is associated with higher academic achievement and with reduced likelihood of school drop-out and that engagement is amenable to influence through school or classroom practice (Glanville & Wildhagen, 2007). However, there is no standard measure of engagement.

In other research literature engagement, multifaceted in nature, is defined as behavioural, this concerns student conduct and on-task behaviour, emotional, this concerns student attitudes, interests and values or cognitive, this concerns motivational goals and self-regulated learning (Fredericks, Blumenfeld, & Paris, 2004). All three being dynamically interrelated processes. These components can be looked at separately or in concert.

For these authors commitment or investment are central to engagement and imply levels or degrees of engagement. The example they provide of behavioural engagement ranges from doing work and following rules to participating in students governance, that of emotional engagement ranges from liking something or deeply valuing or identification with an institution and that of cognitive engagement ranges from memorization to use of learning strategies that encourage deeper understanding. These qualitative differences indicate that engagement can vary in intensity and duration.

The three common definitions of behavioural engagement are: student follows rules and classroom norms and lacks behaviours that are disruptive (Finn & Rock, 1997). Another includes

students are involved in learning and academic tasks through listening, being attentive, and contributing in class; and students participate in school-related activities (Finn & Rock, 1997).

Emotional engagement refers to students' emotional reactions in the classroom including interest or boredom and happiness (Skinner & Belmont, 1993). For other researchers emotional engagement involves the reactions of students to the school and the teacher. Identification with the school included students feeling important to the school and valued as appreciating school-related outcomes. Emotional reactions may be the result of positive emotions of students in relation to academic content, to their friends or to the teacher. In relation to emotional reactions to academic content, there are four components of value: interest, attainment value, utility value and cost (Fredericks et al., 2004). Yet another factor to consider is between positive emotions and high investment.

Cognitive engagement in school stresses investment in learning and involves self-regulation or being strategic. The definitions draw from two different literatures. One group identifies a psychological investment whereas another emphasizes cognition and strategic learning (Fredericks et al., 2004).

Willms (2005) identified engagement as "…a disposition towards learning, working with others and functioning in a social institution, which is expressed in students' feelings that they belong at school, and their participation in school activities" (p. 8). In summary, engagement is not seen as an unalterable trait of students, existing from their genetic make-up or experiences at home. Engagement includes "attitudes and behaviors that can be affected by teachers and parents, and shaped by school policy and practice" (Willms, 2005, p. 9). By identifying the

different realms of engagement and how we may increase engagement the effectiveness of our programs may be improved.

Conceptual Framework

My conceptual framework was comprised of three main concepts: comprehensive school health, engagement, and efficacious prevention programs (Bandura, 2006). The comprehensive school health approach was,

> designed to influence positively the knowledge, attitudes, and behaviours of students through the involvement of home, school, and community…and relates to the emotional, intellectual, moral, physical, and social aspects of a student's life. The foundational pillars to comprehensive school health include instruction, support services, healthy school environment, and social support (peers, families, school and community) (Saskatchewan Learning, 1998)

and has been instrumental in guiding the conception of my framework and research. The extant programs were viewed as comprehensive in nature that included all programs and policies in the school that related to the prevention of alcohol use.

Another element of my framework was Bandura's (2006) four components of efficacious prevention programs; information, social and self-management skills, sense of efficacy, and social supports. I have chosen Bandura's theory for two reasons, first, the underlying principles of the Social Cognitive theory complement comprehensive school health and second, the theory explicitly identifies the components of efficacious health programs that guided my research.

The final component of my framework is student engagement. Student engagement includes "attitudes and behaviors that can be affected by teachers and parents, and shaped by school policy and practice" (Willms, 2005, p. 9) and is not seen as an unalterable trait of students, existing from their genetic make-up or experiences at home. Engagement has been

defined to include three dimensions, behavioural engagement, emotional engagement and cognitive engagement (Fredericks et al., 2004). Identifying the different realms of engagement and how we may increase engagement may improve the effectiveness of our programs.

Figure 2.10 depicts my conceptual framework and represents the theories and concepts that guided my research. The bottom row depicts Bandura's (2006) components that are necessary for efficacious prevention programs and in which I present the data: informational, social and self-management skills, sense of efficacy, and social supports. These components are joined with a line to the second row, which portrays the multi-faceted definition of engagement. Each of the three dimensions of engagement is of equal importance and are not static entities; the arrows signify the higher and lower ranges of engagement that can be achieved. The extant programs include all the programs and policies in the schools and data on this information was achieved by interviewing vice-principals, teachers and counsellors. The box around the extant programs and engagement portray that the programs can be engaging at different levels. The top row is reflective of Bandura's (2006) theory of efficacious programs from which I chose and developed questions for the student questionnaire to explore their perceptions related to the prevention of alcohol in schools. The questionnaire explored students' sense of efficacy, students' knowledge and beliefs with related to alcohol, engagement in alcohol prevention programs, and students' use of alcohol and harms associated with its use.

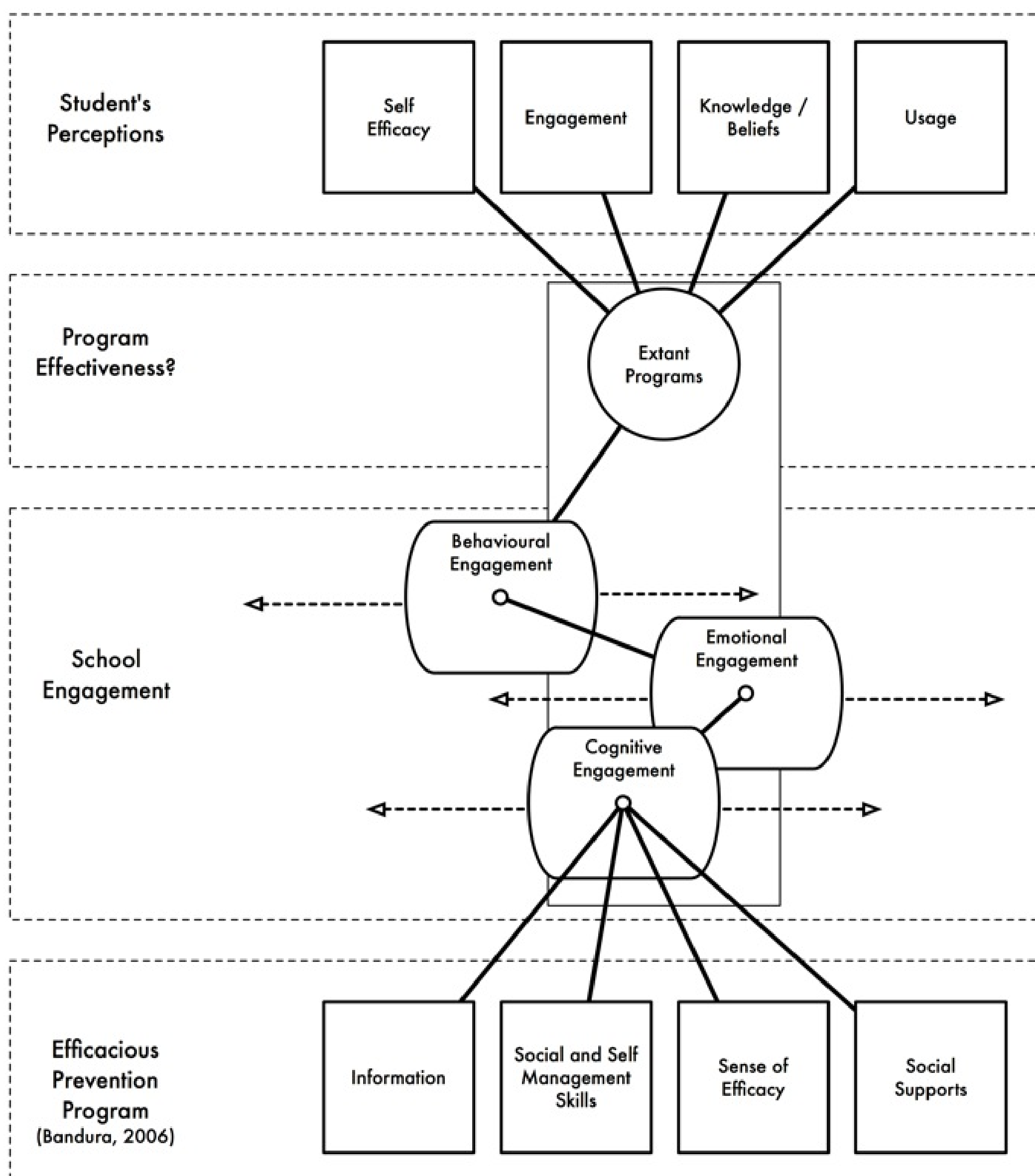

Figure 2.10 – Conceptual framework for exploring alcohol prevention programs.

National Overview on Youth Alcohol Use

There have been five national population surveys dedicated to alcohol and drug use in Canada since 1970 (Adlaf et al., 2005). A survey on drug use was conducted in 1970, followed by surveys specifically dedicated to alcohol and other drugs in 1989, 1994, and 2003. The most

recent survey was carried out in 2008. Other National health surveys (Canadian Community Health Survey and National Population Health Survey) (Statistics Canada, 2005) included some prevalence indicators useful for ongoing planning in the field of substance abuse and addictions. However, these surveys did not typically or consistently provide information on the harmful effects of substance use or on the personal life of users nor did they provide the knowledge base essential for ongoing planning (Clark, 2008).

In the section pertaining to the use of alcohol in youth, different indicators and questions were used for the various ages to determine the extent of alcohol usage in the National population health surveys (Statistics Canada, 2005). The behaviours were correlated with negative behaviours and outcomes, such as delinquent behaviours and poor school performance and varied by age. The questions regarding youth alcohol were adapted from the *Western Australia Child Health Survey* and from questions provided by Richard Tremblay from the University of Montreal. The questions on the use of drugs and addictive substances were adapted from the *Northwest Territories Health Attitudes, Knowledge and Behaviours Study.* Questions on risk taking behaviours including driving under the influence or being a passenger with drunk driver were adapted from the *North Carolina Evaluation of School-Based Health Centers* (Statistics Canada, 2005).

A select amount and type of information pertaining to youth alcohol use has been collected in various National Health surveys and are summarized in Table 2.10.

Table 2.10

Canadian Health Surveys that Included Questions on Alcohol

Year	Survey	Targeted Population
1978/79	Canada Health Survey	Information was collected for ages 15 and up in a lifestyle survey within ten provinces.
1981	Canadian Fitness Survey	Data collection occurred in ages 10 and up in ten provinces.
1984/85	Canada Health Attitudes and Behaviour Survey	All grade 4, 7, 10 classes in the ten provinces and three territories.
1985	Health Promotion Survey	All individuals aged 15 and up.
1986/87	Health and Activity Limitation Study	All individuals within the ten provinces, North West Territories and Yukon Territories including Indian reserves and institutions but excluding correctional facilities
1988	National Survey on Drinking and Driving	Impaired driving-attitudes, beliefs, behaviours, and actions towards prevention
1989	National Alcohol and Drugs Survey	All individuals aged 15 and up in ten provinces and the Northwest Territories.
1989/90/93/94	Health Behaviours of School-aged Children	All the grades 6, 8, and 10 students in ten provinces and the North West Territories and Yukon Territories.
1991	Aboriginal Peoples Survey	All individuals, aged 15-64, who indicated they were aboriginal on the 1991 census, in the ten provinces and two territories.
1993	General Social Survey-cycle 8	All individuals aged 15 and greater in ten provinces.
1994	Canada's Alcohol and Other Drugs Survey	All individuals aged 15 and greater in ten provinces.
1994	National Population Health Survey [NPHS]	All individuals aged 12 and greater in ten provinces and two territories.
1994	NPHS supplement to the main survey	All individuals aged 12 and greater in ten provinces.
1994/95	National Longitudinal Survey of Children and Youth [NLSCY]	All individuals aged 10 and greater in 10 Canadian provinces excluding children living on Indian reserves.
1996	Health Promotion Survey	All individuals aged 12 and greater in ten provinces.
1996/97/98/99	NLSCY	All individuals aged 10 and greater in 10 Canadian provinces excluding children living on Indian reserves.
1999	Canadian Profile (CCSA & CAMH)	A complete profile of drug use statistics in Canada.
2000/01/02/03	NLSCY	All individuals aged 10 and greater in 10 Canadian provinces excluding children living on Indian reserves
2001/03/05/07/09	Canadian Community Health Survey – Mental Health and Well-Being	All individuals aged 15 and greater in ten provinces. In 2009, the three territories were included along with the ten provinces and individuals aged 12 and over. Indian reserves were excluded.
2003	Canadian Addiction Survey (CAS)	All individuals aged 15 and greater in 10 Canadian provinces.
2004/05/06/07	NLSCY	All individuals aged 10 and greater in 10 Canadian provinces excluding children living on Indian reserves
2008	Canadian Alcohol and Drug Use Monitoring Survey (CADUMS)	All individuals 15 years and greater in 10 Canadian provinces.

Table 2.10 depicts national surveys that included questions on alcohol use. The most recent national survey *Canadian Alcohol and Drug Use Monitoring Survey* (CADUMS) (2008) was carried out in April 2008 (Health Canada). The CADUMS (2008) report was designed to provide national and provincial estimates of alcohol and drug-related behaviours; however, some prevalence rates were reported for youth (15 to 24). It was developed in collaboration with the CCSA, Centre of Addictions and Mental Health (CAMH), Centre for Addiction Research – British Columbia (CAR-BC), Alberta Health Services and Manitoba Health. The telephone survey was conducted with a total of 1008 participants from Saskatchewan and a total of 1443 participant from Canada were from 15 to 24 years of age.

The CAS (2005) was also a national focused survey (Adlaf et al.) and was followed by a more detailed report in CAS (2008), which focused on the use of alcohol and other drugs by youth and young adults (Health Canada). This report on youth and young adults included problems encountered as a result of their alcohol use and reasons for use. Both surveys utilized the data that was collected from telephone interviews made in December 2003, January and April 2004 for the CAS (2003) thus these two are not included in the chart. In general, telephone interviews “tend to over represent those with higher education” (Health Canada, p. 14). There were a total of 1,000 participants from each of the 10 provinces where 501 participants were in the 15 to 17 year group and 439 in the 18 to 19 year group (p. 19).

The Canadian Community Health Surveys (CCHS) collected data yearly rather than every two years, since 2007, however, the sample size was decreased to include 65,000 respondents, rather than 130,000 respondents (CIHI, 2009). The *Saskatchewan Education Indicators Report* (2009) included indicators that provided information on national and

provincial social trends in the Pre-K to twelve education system (Saskatchewan Ministry of Education). Student health indicators are used because health affects student learning and within this section the report includes information on students' use of alcohol that is provided by the CCHS (2007) and once again is therefore, not included in Table 2.10.

Continued monitoring of student drug use can aid in providing essential information regarding substance use trends, associated risks, socio-demographic correlates and identification of high-risk populations (Clark, 2008). This information can provide important information for policy and programming and aid in the evaluation of existing policies and programs. However, because of the wide variation of content, design and implementation, of the surveys, the ability to make comparisons and share knowledge across jurisdictions has been limited.

Most Recent Provincial Alcohol and Drug Use Reports in Canada

In Canada the five provinces that have established parameters in which to monitor youth alcohol and drug use includes: British Columbia, Manitoba, Newfoundland and Labrador, Nova Scotia and New Brunswick (Clark, 2008; Friesen, Lemaire, & Patton, 2008; Poulin & Elliot, 2007; Poulin & MacDonald, 2007). These most recently published surveys on alcohol and other drug use have utilized questionnaires in high schools to provide data regarding trends of student substance use. These reports have used various tools including the Atlantic Drug Risk Continuum to monitor "a number of specific harms and risky contexts of substance use, as well as the overall level or risk associated with substance use in the general population (Poulin & McDonald, 2007, p. 16). These reports provide the most recent comparison data available. These reports are significant because they provide other provinces with an essential source of information. This information includes trends, associated risks and identification of high-risk

groups in youth populations with similar sets of core indicators and standardized methodology for student surveys.

Provincial Overview on Youth Alcohol Use

In 1996 the Saskatchewan Youth Attitudes Survey (YAS) was undertaken to collect data on the attitudes and practices of Saskatchewan youth between the ages of 13 and 18 (Schissel & Eisler, 1999). Included in this data was information on patterns of drug and alcohol use, which was collected through the Saskatchewan education system. More recently, the Saskatchewan Institute on Preventions of Handicaps (2002), reported on the major causes of serious injuries among Saskatchewan children and youth for the years 1995-1999 in *Child and Youth Injury in Saskatchewan 1995-1999.* The report discussed leading causes of injury-related hospitalizations and deaths for Saskatchewan children and youth rather than the prevalence rates of alcohol use.

Students' Alcohol Use: A Summary of Research

The CAS (2005) reported that: 62% of Canadians aged 15 to 17 years and 91% of those aged 18 to 19 years consumed alcohol in the previous year (Adlaf et al.). In Saskatchewan, 19% of those over aged 15 years reported heavy drinking (5 or more drinks in a single sitting) monthly, 4% heavy drinking weekly, 2% heavy drinking daily, 44% light-infrequent (less often than once a week and usually fewer than 5 drinks), 20% light-frequent (drink once a week or more and usually fewer than 5 drinks), and 25% of 15-17 year olds exceeded low-risk drinking guidelines (more than 14 and 9 standard drinks per week for men and women respectively) (Adlaf et al.).

In the *Saskatchewan YAS* (1999) 13 to 18 year olds were asked to report how often they drank wine or other alcohol (Schissel & Eisler, 1999). Responses were presented by provincial area (North, Central and South) and gender as follows.

1. Overall more males than females consumed these forms of alcohol. The consumption of liquor was highest in the south and lowest in the northern region.
2. In the north 31% of males and 32% of females, and in the south 15% and 12% respectively never drink wine or hard liquor.
3. The percentage of youth in the Southern and Central areas drank wine or other alcohol more than once a week or every day by provincial area and gender.
4. Beer was drunk more than once a week by 8% of females and 19% of males.
5. Wine or hard liquor was drunk more than once a week by 6% of females and 12% of males.
6. Overall drinking increased with age for both males and females, the highest percentage of youth consumed up to once a week and occurred in the oldest category.
7. The highest percentage of female habitual users was in the youngest age group.

Youth who drank before age 15 were shown to be four times more likely to develop alcohol dependence than those who began drinking at age 21 (Grant, 1998). Drinking impedes judgment and is more likely to lead to engagement in unsafe practices (Canadian Centre on Substance Abuse, 2001; Shah, 2003). These health-risk behaviours contributed to motor vehicle accidents and self injury, which are the leading causes of mortality and morbidity among youth. These behaviours, established in youth, extend into adulthood, are interrelated and preventable (Dowdell & Santucci, 2004, Kann et al., 2000). Early initiation into alcohol use is associated with greater likelihood of dependence and alcohol-related injury later in life (DeWit et al., 2000). The risk of alcohol-related problems increased with heavy drinking where heavy drinking was

associated with having five or more drinks on a single occasion for men whereas for women, heavy drinking was associated with having four or more drinks on a single occasion (Adlaf et al., 2005).

Summary

In this chapter I began by briefly discussing the theoretical roots of alcohol prevention followed by the types of youth prevention programs targeting youth alcohol use. I outlined prevention approaches with available research of the programs. I then summarize Bandura's (2006) theory of efficacious health programs and the multi-faceted definition of engagement, which were the main constructs in my study. Finally, I summarized national and provincial surveys that included questions relating to youth alcohol use.

CHAPTER THREE

Research Methodology

Introduction

In this chapter I outline the specific methodological procedures used in this multi-site case study. The methods must fit both with the purpose as well as my philosophical orientation to my research. I begin by addressing the purpose of the study followed by my epistemological and ontological view. Next I provide a summary of Guba's (1985) Domains Model to provide a background to its use in framing my research findings. An overview of the methods used and data collection techniques are then outlined with concepts of my conceptual framework utilized as a guide for my data collection. Finally, the rules of quality depicted in my research are discussed, followed by ethical considerations necessary in my study. I begin with the purpose and my orientation to research.

Purpose and Researcher's Orientation

This research explored youth perceptions of school alcohol prevention programs. Lincoln and Guba (1985) pointed out "the policy which was intended…often turns out not to be the policy which is written…or the policy adapted in the process of devising the rules and regulations which accompany its promulgation" (p. 554). Identification of what the policies were, how they were interpreted and implemented was important to understand the context in which the students were learning. Vice-principals' descriptions of the policies on alcohol prevention provided information pertinent to *policy-in-intention*; teachers' and counsellors' descriptions of the content of alcohol prevention programs delivered were gathered and provided information pertinent to *policy-in-implementation* and the students' perceptions of the programs

were collected and provided information relevant to *policy-in-experience*. This study took place in the school, the natural setting, in attempting to understand phenomena and meanings as the students understood them. This study is situated within the naturalistic interpretive paradigm (Denzin & Lincoln, 2005).

The naturalistic paradigm adopts an inductive approach to thinking, seeking knowledge, understanding of phenomena and the meanings that people bring to them (Bogdan & Biklen, 2007). In the interpretive paradigm the researcher is the instrument tool and the task in this paradigm is to understand and interpret various perspectives (Glesne, 1999; Lincoln & Guba, 1985; Patton, 1990) and to focus the designs based on this. Working in the interpretive paradigm seeks explanation from "…within the frame of reference of the participant as opposed to the observer in action" (Burrell & Morgan, 1985, p. 28). The notion of multiple realities and social constructions of meaning or knowledge will be fundamental to this study and therefore, assuming relativist ontology. The constructivist paradigm assumes that the knower and the respondent co-create understandings and the researcher becomes the main research instrument, observing, asking questions, and interacting with research participants. Research paradigms determine the approach, research methods used, purpose of the research and the roles of the researcher (Glesne, 1999). Next I will discuss in general terms the researcher as the research instrument.

The Researcher

The researcher's task in the interpretive paradigm is to understand and interpret various perspectives (Glesne, 1999; Lincoln & Guba, 1985; Patton, 1990) and focus the designs based on this. The researcher becomes the main research instrument, observing, questioning, and

interacting with research participants. The researcher's values and beliefs influence every aspect of the research process. Therefore, my values influence my position in relation to the study.

Positioning ourselves in our research is like setting the stage and it is important to the "quality and rigor" (Lincoln, 1995, p. 280) of the text to address positionality. It is from positioning ourselves that others can understand the "grounds for knowing" (Lincoln, 1995, p. 280) and judge the quality of the research. Earlier in Chapter 1, I have positioned myself in my research by acknowledging my background and experiences as a teacher, a student, a nurse, and a mother that have all contributed to my role in this study. All of these experiences and beliefs have influenced my position in life and my ideas about this research and this topic in particular.

The researcher's role in the case study method is complex, "the researcher is the primary measuring instrument" (Gall, Gall, & Borg, 2003, p. 445) carrying out data collection, but even further becomes personally involved in the phenomenon being studied. In the following sections I will discuss my research methodology, approach and analysis.

Research Design

The research design "situates the researcher in the empirical work and connects them to specific sites, persons, groups, institutions, and bodies of relevant interpretive material, including documents and archives" (Denzin & Lincoln, 2005, p. 25). Having discussed my epistemological and ontological approach I will now go on to describing a set of guidelines that connected the theoretical paradigms to the strategies of inquiry and methods I used in collecting data for my research.

A *case study* may include a simple or complex functioning system (Stake, 2005) with one child or many, a specific happening or event. There are features within the system or boundaries

or each system that are considered to be one case study. There are also features outside the boundaries that may be significant as context. Patton (1990) stated that, “regardless of the unit of analysis, a qualitative case study seeks to describe that unit in depth and detail, in context, and holistically” (p. 54). A case study focuses on cases rather than samples and populations (Gall et al., 2003). Case studies can be used when policymakers are puzzled by particular cases of failures, success or dropouts (Stake, 2005).

Case studies are used for different purposes; an *instrumental* case study is used mainly to provide insight into an issue, “to illustrate the issue” (Creswell, 2002, p. 485), whereas *intrinsic* case studies are used to hear the voices of those “living the case” (Stake, 2005, p. 445). This research includes *multiple case studies,* “extended to several cases” and “are chosen to because it is believed that understanding them will lead to better understanding” (Stake, p. 446). The cases “… may be similar or dissimilar, with redundancy and variety each important” (Stake, p. 446). This study explored grade 11 students’ perceptions of school programs related to alcohol prevention – I approached this study as a multi-site case study that included four schools. The Grade 11 students’ perceptions were the main focus of this case study, the perceptions of vice-principals, teachers, and counsellors were used as contextual data.

Cases to be studied are complex entities located in a number of contexts and backgrounds; historical, physical, social, economic, political, ethical, to name a few (Stake, 2005). Stake suggested that, “qualitative case study calls for the examination of these complexities” (p. 449). Typically case studies involve fieldwork whereby studying a phenomenon is done in its natural setting (Denzin & Lincoln, 2005). The goal of my research was to study about the perspectives of those in the field, grade 11 students, their perspectives,

how they acted and reacted in their natural setting. The next portion will discuss the setting of the study.

Setting and Participant Selection

A distinguishing feature and key strengths of qualitative research is that data are collected through "contact with people in settings where subjects normally spend their time" (Bogdan & Biklen, 2007). This study took place in the natural setting, the school, and the main participants were grade 11 students. The administrative staff and teachers were also interviewed in the school setting.

Cases are usually required to be chosen in collective casework (Stake, 2005, p. 450). Purposeful sampling was used in that samples were chosen that were "rich in needed information" (Patton, 1990, p. 288). Creswell (2007) further explains that a purposeful sample "will intentionally sample a group of people that can best inform the researcher about the research problem under examination" (p. 118).

There were three criteria to enter in the study. These criteria included: (a) participants that were enrolled in at least one Grade 11 class (b) that participants were present during the time the study was conducted, and (c) that participants agreed to participate in the research.

Grade 11 level students were chosen versus because all curriculum content related to the prevention of alcohol youth was completed by the end of the Grade 10 year. I was confident that this group of students would be able to share their perceptions of programs related the prevention of alcohol use and contribute to the research. Schools from two cities and 2 school systems were used to capture multiple perspectives (Creswell, 2007). I used entire classrooms in four schools for the survey research (n=452), and students volunteered for four focus group interviews in

three of the four schools. Eight teachers and two vice-principals were interviewed from the participating schools. In the case study design a variety of methods can be used for gathering data, for a variety of purposes, (Stake, 2005); the methods for gathering data that I used are discussed in the next section.

Methods

Glesne (1999) stated that the research methods we choose say something about what qualifies as valuable knowledge and ontology. In the interpretive paradigm "qualitative methods are generally supported…" (Glesne, 1999, p. 5). However, Denzin and Lincoln (2005) go on to say that qualitative research does not have "… a distinct set of methods or practices that are entirely its own" (p. 7). Furthermore, "when researchers bring together both quantitative and qualitative research, the strengths of both approaches are combined, leading, it can be assumed, to a better understanding of research problems than either approach alone" (Creswell & Garrett, 2008, p. 322).

I chose to use mixed methods to depict the students' perceptions of the prevention of alcohol use. Creswell and Garrett (2008) define mixed methods as "an approach to inquiry in which the researcher links, in some way (e.g., merges, integrates, connects), both quantitative and qualitative data to provide a unified understanding of a research problem" (p. 322).

One form of data could become *less dominant* in a *dominant* design based on the other form of data (Creswell, 2002). Collecting quantitative and qualitative data can be done concurrently, in parallel or sequentially so that data from one source could enhance, elaborate, or complement data from the other source (Creswell, 2002). Bryman (2006)

identified many rationales for using mixed methods and in my research study, quantitative methods were initially used to help establish the context of the participants and the qualitative methods, through the use of focus groups, were used to gain in-depth understanding of the perceptions of the participants. In this study gathering both forms of data contributed to a more comprehensive understanding of the results. Bryman (2006) classified this rationale as *completeness,* which, "refers to the notion that the researcher can bring together a more comprehensive account of the area of enquiry in which he or she is interested if both quantitative and qualitative research are employed" (p. 106).

Quantitative data was collected first followed by the collection of qualitative data to elaborate and understand the data in more depth. Bryman (2006) goes on to say that using mixed methods in research "provides such a wealth of data that researchers discover uses of the ensuing findings that they had not anticipated" (p. 110). During the course of interpreting data I realized that I was also using mixed methods for triangulation. Creswell (2002) defines this method as the *triangulation mixed method design* suggests that the basic reasoning for this design was that, "one data collection form supplies strengths to offset the weaknesses of the other form" and furthermore in my research,

> the most important advantage presented by using multiple sources of evidence is the development of converging lines of inquiry….any finding or conclusion in a case study is likely to be much more convincing and accurate if it is based on several different sources of information (Yin, 1989, p. 97).

Triangulation was not the main reason for the research but an unanticipated consequence of using mixed methods.

In this study, questionnaires were used to gather quantitative data and multiple methods were used, including focus groups and interviews were used to collect qualitative data. The data collection was done in steps whereby the quantitative data (student questionnaires) were collected prior to the focus groups in each of the schools. The following discussion will focus on the importance of using these methods and how they contributed to the quality of the research.

Data Collection

After completion of the application to conduct research from the University of Saskatchewan Behavioural Research Ethics Board was obtained, permission to conduct the study from two of four school districts was sought and granted. As part of the process, e-mails were sent out to schools from the directors of the school divisions to inform them that permission to conduct the research was granted, and then I sent letters to the schools to generate interest. Four schools were chosen from two cities in Saskatchewan, which was based on their availability and willingness to conduct the research. This study was conducted in three phases. The first phase included interviews with vice-principals to establish the policies in place in the schools as well as an overview of formal program and to identify others that would be important to interview in the second stage of the study. The second phase included interviews with teachers and counsellors in establishing the process of implementation of the policy in the school and classrooms. The third phase included student questionnaires that collected data on student alcohol use and student perceptions on extant programs. In order to provide more depth I conducted four focus groups to identify the student's perceptions of programs related to the prevention of alcohol use in youth.

The main sources of data were the students. Using Guba's (1985) Domains Model as my framework, data was collected from the vice-principals, teachers and counsellors, and from

students to represent the three levels of policy. The next section provides an overview of this framework.

The Domains Model

Guba (1985) listed three levels at which policy can be applied, policy-in-intent, policy-in-implementation and policy-in-experience. My research focuses on the domain of policy-in-experience, exploring the perceptions of youth and at their behaviour. The following definition of policy is concerned with the effects of a policy and fits with the purpose of my study.

> Policy is the output of the policy-making system: the cumulative effect of all the actions, decisions, and behaviors of the millions of people who work in bureaucracies. It occurs, takes place, and is made at every point in the policy cycle from agenda setting to policy impact (Guba, 1984, pp. 64-65).

Discussion about the policy-of-intent and policy-in-implementation will take place to frame the contextual piece of the study.

Glanz (2002) wrote "theories help us interpret problem situations"… plan feasible and promising interventions, and identified steps that need to be assessed (p. 547). Theories or models can aid in identifying the targets for change and the methods for achieving the change. The Domains Model (Guba, 1985) provided the framework in which I approached my research. In the first phase I collected data from vice-principals (policy-in-intent), the second phase I collected data from counsellors and teachers (policy-in-implementation), and finally the thire phase, from the students (policy-in-experience). The following sections discuss the sources of data collection, the instruments that were used, data collection procedures and analysis.

Policy-in-intent

The purpose of this phase was to describe the policy-in-intent. According to Guba (1985), "… policy-in-intent is the domain of policy framers or legislators" (p. 11). Therefore, the appropriate subjects to collect data were from the administrators responsible with development and enforcement of alcohol prevention policy in the school systems. The vice-principals in the schools were responsible with enforcement of policies related to student infractions with alcohol use in the schools.

Sources of data collection. The sources of data collection were the vice-principals, who were responsible with developing the policy and enforcing the policies within the schools. I contacted them by telephone to arrange a time for the interview, and after consent forms were signed, I interviewed two vice-principals (See Appendix B & D). The school identities were held in strict confidence by assigning a pseudonym to each of the four schools.

Data collection instruments and procedures. Data collection, in this stage, included semi-structured personal interview. *Semi-structured interviews* are used when the researcher "knows something about the area of interest … but not the answers to the questions that are to be asked" (Mayan, 2001, p. 15). The questions were open-ended where the participants answered freely and were sent the questions in advance. The semi-structured interviews involved asking a series of structured questions followed by "probing more deeply using open-form questions to obtain additional information" (Gall et al., 2003, p. 240). This type of interview was ideal for this type of data collection where the respondents had time to prepare for the list of questions and I was allowed to probe deeper to understand and gather knowledge as needed. The interview with the vice-principals lasted about one half hour to one hour.

The interview questions were developed in order to answer the central question of the study and sub question four of the research. The interview questions were further refined through pilot testing (Creswell, 2007) to determine if the questions were relevant, could be clearly understood and could be answered in the allotted time by administering them to a vice-principal within the school systems under study but who was not a participant in the study. The individual was asked to respond to each question and add relevant questions. Once changes were made to clarify the questions and in some of the terms being used they were utilized for collecting data.

Document overview procedures. Written material and policy documents from the selected school districts that included policy on the prevention of alcohol use were collected and included as part of the data on policy-in-intent. Pertinent curriculum material in *Wellness 10* was included and student and parent handbooks.

The semi-structured interviews with the vice-principals were taped, transcribed and returned to each of the respondents for verification of accuracy. Once the respondents reviewed and revised the transcriptions, I included the revised data as content for this phase of the study, policy-in-intent.

Data analysis. Data analysis is a process of searching for meaning and organizing it in a way so that "what has been learned can be communicated to others" (Hatch, 2002, p. 148). These processes of collection, analysis and report writing "are not distinct steps … they are interrelated and often go on simultaneously" (Creswell, 2007, p. 150). At an informal level, "analysis is happening from the first moments of data collection" (Hatch, p. 150) by making decisions of what to ask, what to probe and what to ignore.

Transcriptions were typed professionally and I listened to each of the recordings of the interviews for accuracy and as an initial form of analysis (Creswell, 2007; Silverman, 2005). Formal analysis of the interview data was done using the data analysis spiral (Creswell, 2007). Specifically the following procedures employed were: (a) reading and memoing, (b) describing, classifying and interpreting, and (c) representing and coding using qualitative software (NVivo). I chose this approach because it is described as a "process of moving in analytic circles rather than using a fixed linear approach" (Creswell, 2007, p. 150).

Following organization of the data, it is suggested that researchers read the transcripts several times, "to the extent that you are familiar with the depth and breadth of the content" (Braun & Clarke, 2006, p. 87). I read the transcripts from the vice-principals at least three times, making notes and writing key concepts down (memoing) (Creswell, 2007). During this time, I started to interpret and arrange the data systematically into categories rather than themes, which emerged from my research questions. During the process of describing, classifying, and interpreting, "qualitative researchers develop codes or categories and to sort text …" into categories (Creswell, p. 152). Although I did not have prefigured codes, many categories emerged from the research and interview questions, which Creswell (2007) discusses as a popular procedure however, he cautions researchers "to be open to additional codes" (p. 152). Additional codes were added that emerged from the data and did not apply to the categories already formed.

Creswell (2007) stated that, "In the process of interpretation, researchers step back and form larger meanings of what is going on in the situation or sites" (p. 154). In the final phase of the process, the data is presented based on what was found in the text. In this phase I

reconsidered the content in each of the categories and began to interpret the data as a whole, synthesizing data from all sources. During this time I synthesized the data from both quantitative and qualitative findings to answer my research questions.

Policy-in-implementation

The purpose of this phase was to collect data about the policy-in-implementation; the programs that were being delivered on alcohol prevention. As Guba (1985) pointed out, "…policy-in-implementation is the domain of policy implementers, the agents who carry out the particular programs or treatments undertaken in the name of the policy…" (p. 11). The appropriate venue of data collection for this purpose was the teachers in the participating schools.

Sources of data collection. The sources of data collection were from those responsible in delivering the programs related to alcohol prevention within the schools. Interviews were done in two schools in two different cities. Three interviews were completed in one school and five from another school. Each of the schools had designated people organizing the research. These organizers with addition to input from the vice-principals identified appropriate teachers and counsellors to be interviewed.

Data collection instruments and procedures. Data collection, in this stage, included semi-structured interviews. Teachers and counsellors had received the list of questions formatted for teachers/counsellors in advance and were interviewed after consents were signed (See Appendixes B & E). The interview questions were pilot tested for clarity and relevance by administering them to a teacher outside of the participating school systems.

Data analysis procedures. The interviews were taped, transcribed, and returned to the respondents for verification of accuracy. Once they were reviewed and revised by the respondent, the transcriptions were included in the data as content for the second phase of the study, policy-in-implementation. The interview data were analyzed using the data analysis spiral as discussed in policy-in-intent phase (Creswell, 2007).

Policy-in-experience

The purpose of this phase was to explore students' experiences of alcohol prevention programs. This stage represents the policy-in-experience. Guba (1985) stated that "…policy-in-experience is the domain of putative policy beneficiaries" (p. 11). The appropriate groups for collection of data for this phase were the students; 452 grade eleven students who met the inclusion criteria in four schools completed the questionnaire. The overall response rate of students completing the questionnaire was 61%. Four student focus groups in three of the four schools based on student volunteers were conducted to further explore students' perceptions of alcohol prevention programs. Qualitative data were collected to create depth to the quantitative data collected in the student questionnaires.

Data collection procedures and instruments. Data collection consisted of administering questionnaires to entire classrooms of Grade 11 students in four schools in Saskatchewan (See Appendix F). Information was provided to the participating Grade 11 students regarding the research prior to them completing the questionnaires. Each student received written instructions, a questionnaire, and an envelope. To ensure anonymity, students were instructed to not put their names on the survey and to place the questionnaire in the envelope once completed. Students were given the choice of completing some or all of the questionnaire and through the process of

completing the questionnaire consent was implied. Each class had a designated time to complete the survey during the school day, to ensure that every student had equal opportunity to participate.

Survey research. In deciding what technique to use depends on what information we want to generate. *Questionnaires* are often used because a large amount of data can be collected in a relatively short amount of time and will contribute to understanding different perspectives (Patton, 1990). Questionnaires can provide data on generalizability, patterns and taps the surface of meaning. They can "… describe the attitudes, opinions, behaviours, or characteristics of the population" (Creswell, 2002, p. 396). They most often describe current and emerging trends in the data and learning about a population.

There are many advantages in administering questionnaires. One of the main advantages was that the participants could be canvassed anonymously without being influenced by the researcher or school. However, questionnaires do not provide participants the opportunity to respond to questions more fully. Another limitation identified in using questionnaires in schools is the underrepresentation of high-risk groups who may have dropped out of schools or were expelled, however, questionnaires can provide reliable information by capturing information from the majority of adolescents (Andersson, 2003).

The Youth Alcohol Prevention Questionnaire included questions on, demographical information, core indicators which focused on prevalence and patterns of alcohol use, and the harms experienced from alcohol use that have been identified by the CCSA (Clark, 2008). The questions that included demographic information were limited to factors such as age and gender which have been shown to be strongly related to substance use (Alberta Alcohol and Drug Abuse

Commission, 2003; Adlaf & Paglia-Boak, 2007). All of the questions related to prevalence of use and patterns of use, standardized measures, harms experienced from substance use and non-substance use indicators "have been tested for reliability and validity in one or more jurisdictions" (Clark, 2008, p. 7). My choice of questions were based on recommendations from the CCSA who was given a mandate under Canada's Drug Strategy to determine indicators to be included as minimum standard in student surveys. Nearly half of the questions in the survey were included from CAS Survey (2005); 1-4, 6, 34 -57, 69-71 (Adlaf et al.). These questions were subject to pre-survey analysis that included, "information from pre-test respondents, and expert evaluation from the Research Advisory Team" (Adlaf et al., p. 12). The following questions were used from the Primary Prevention Awareness, Attitude, and Use Survey (PPAUS) (2006): 19-23, 63-68 (Educational Council Foundation, 2006). Questions that were included from the Nova Scotia Drug Use (2007) survey were, 5-7, 34, 58–62 (Poulin & McDonald, 2007). Questions number 8 – 18 and 36 were questions that I added and the questions related to self-efficacy were adapted from Shwarzer and Renner (2000) and Annis (1987).

Questions on self-efficacy were developed keeping in mind that the foundation of self-efficacy assessment is that tasks and situations need to be clearly described (Bandura, 1997). Bong (2006) said that "research on adolescents' self-efficacy must start by asking the right question – "How confident are you that you can successfully perform these tasks" (p. 301)? Questions on self-efficacy were adapted from Shwarzer and Renner (2000), and Annis (1987).

Validity and reliability of questionnaire. Validity and reliability are two important characteristics in establishing the appropriateness and usefulness of instruments (Wiersma, 2000). Validity, "the extent to which an instrument measures what it is designed to measure" (p.

300), as this research was not measuring criterion, only content validation was considered. Content validity of the questionnaire was established through pilot testing (Borg et al., 2005). The questions were developed to be easily understood and straightforward. The reviewers comments were considered and changes made accordingly to add clarity to the questions. Face validity seemed apparent as comments were made such as “well constructed” and “great job”.

The research literature suggests that survey responses are valid, especially if respondents are confident: (a) their responses are confidential and anonymous, (b) the research is legitimate, and (c) there are no adverse consequences in reporting certain behaviours (Single, Kamdel, & Johnson, 1975). Confidentiality and anonymity was addressed through the anonymous nature of the questionnaire as well as by the procedures taken when administering the questionnaire as well as the presentation of the data.

It has been suggested that because student questionnaires ask students to report behaviours that are illegal and sensitive in nature they tend to underestimate true usage. However, despite this limitation they are regarded as the best method to estimate these behaviours (Single, Kandle & Johnson, 1975). “Although these biases influence alcohol use estimates at a single point of time, they should have less of an impact on estimating trends as long as under-reporting remains constant. If this is the case, estimates of change should remain unbiased and valid” (Adlaf et al., 2005, p. 15).

Reliability of an instrument depends on the “consistency in measuring whatever it measures” (Wiersma, 2000, p. 297) and one of the most commonly used *reliability* coefficients is Cronbach's Alpha. Alpha is a measure of the internal consistency of a scale and is based on the average correlation of items within the scale. Analyses of reliability were conducted on several

questions used within the questionnaire by PPAUS (2006) where scales with alphas above +0.7 were considered to be very reliable (Educational Council Foundation, 2006). Results of the analyses are shown below.

Table 3.10

Reliability Coefficients and Questionnaire Items

Survey	# of items	# on YAP	Related to	Cronbach Alpha
CAS (2005)	27	6, 34-57, 69-71		
Nova Scotia Drug Use (2007)	8	5-7, 34, 58-62		
PPAUS	4	19-23	Perceived Risks	.899
Annis (1987)	10	24-33	Self-efficacy	.85
Youth Alcohol Prevention (2008)	6	13-18	Information & Presentation	.87

Table 3.10 displays the questions from the questionnaire and the reliability coefficients. There were 71 questions in the questionnaire. When analyzing the data for reliability, I deleted the questions related to demographical data and sexual behavior from the analysis. The overall Cronbach Alpha Coefficient for 64 items was .82. The reliability for the CAS (2005) and Nova Scotia Drug Use (2007) survey was “inferred (loosely) by comparing the estimates over different years to the same question. Again, the CAS Detailed Report discusses similarities between the CAS data and the earlier CADS and other similar surveys” (C. Davis, personal communication, May 4, 2010).

The questionnaires were piloted by administration to a group of 30 grade 11 students within a school whose students were not participants in the study sample. These students made suggestions or commented by writing on the specific items on the questionnaire. The information obtained from the pilot test was used to modify the questionnaire for the study in the following manner. First, a number of students commented on question #37, that asked, "when did you first drink enough alcohol to feel drunk or get high?" Students reported that this question was "unclear - alcohol doesn't get you high" and, therefore, "get high" was removed from this question.

In addition to the above, the remainder of students' comments related to responses needing to be added to clarify the questions. In particular, the students suggested that optional responses be added to questions #42, #50 to #52 and #62 to #65 in order to clarify. The response that was suggested to clarify these questions included "don't drink alcohol". As a result of these comments I added the "don't drink alcohol" option to #42, #50-#52 and " not relevant to me was added to #62-#65. One student commented that question #36 was not relevant to her because the question asked, "If you *have never* used alcohol…" however, there was no response in the answers that indicated, not relevant, for those that have used alcohol. As a result of this I added a response to this question, "not applicable". Question # 35 asked students "when (if ever) did you first drink more than just a few sips of alcohol?" and the responses did not include grade11. Therefore, I added "grade 11" as one of the responses. Similarly in question # 37, the response was added, "never drank enough to feel drunk" and in question #50, the response, "Never, I got drunk but did not lose control" was added. Finally, a response was added to questions #13 to #18, "There were no classes on alcohol prevention".

In summary, responses were added to the questions to provide a clearer understanding for the students in the actual study. The pilot study was also done to give teachers and administrators a more accurate prediction of the time needed to complete the questionnaire.

Data analysis of questionnaire. Descriptive statistics were analyzed using Statistical Package for Social Science (SPSS). The data was organized by aggregating the data where frequencies and percentages were used to assess general trends.

Following the questionnaires, four focus groups were conducted, consisting of four to six participants, to further understand students' perceptions (See Appendix C & H). As Stake (2005) stated, "… activities are expected to be influenced by contexts, so contexts need to be described, even if evidence of influence is not found" (p. 452). Focus group questions were pilot tested for relevance and ease of understanding by administering them to a group of seven students within a participating school division however, these students did not participate in the study.

Focus groups. Data collected from focus groups added depth, detail and meaning at a more personal level (Patton, 1990). They were used to produce data that would be otherwise difficult to access through questionnaires. Focus groups "reduce the researcher's power and control of the interview process and heighten the relational aspects of interviewing" (Shope, 2006, p. 168). It was my hope that students would feel more comfortable in a group setting rather than in a one-on-one interview, furthermore that the group process would encourage discussion which might not take place otherwise. A focus group consists of six to ten participants that emphasize *interaction* among participants rather than between the moderator and the participants (Morgan, 1988). Four focus groups were conducted in three of the schools.

Data analysis. The focus groups were audio taped, transcribed into electronic format, and printed as hard copies. Once the tapes were transcribed, I sent e-mails to the people responsible for organizing the study in each of the schools, to communicate to the students that the transcripts were available for reviewing. The focus group data were analyzed using the data analysis spiral (Creswell, 2007) explained in policy-in-intent phase.

Table 3.12 summarizes the research questions and data collection methods.

Table 3.12

Research Questions, Data Collection Methods

Research Questions	Data Collection Methods
3.What formal and perceivable informal prevention of alcohol programs/activities were delivered to youth in these schools?	Program overview and vice-principal interviews
3. What formal and perceivable informal prevention of alcohol programs/activities were delivered to youth in these schools?	Teacher/Counsellor Interviews
1. What were the self-ascribed perceptions of Grade 11 students in relation to alcohol prevention programs? 2. What was the present knowledge base of these students with respect to alcohol use and the effects of alcohol? 4. What are the rates of alcohol use among Grade 11 students in 4 Saskatchewan schools?	Student questionnaires and focus groups

Table 3.12 depicts the data collection methods that were used for each of the research questions along with the sources for the collection. The student questionnaires and focus groups informed

research questions one, two, and four. Overview of the programs, vice-principal, and teacher and counsellor intervews were conducted to answer research question three.

Trustworthiness

Trustworthiness refers to the overall quality of the research (Guba & Lincoln, 1989). Lincoln and Guba (1985) argued that the basic issues of trustworthiness relate to the ability of the researcher to persuade the audience that the "findings of inquiry are worth paying attention to, worth making account of…" (p. 290). In new-paradigm inquiry, it is not only the method that promises truths but, "it is also the processes of interpretation" (Denzin & Lincoln, 2005, p. 205). Four components of trustworthiness demand attention: credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985, p. 296).

Credibility

Credibility relates to isomorphism of the realities of respondents and the reconstructions attributed to them (Guba & Lincoln, 1999). Credibility is an evaluation of whether or not the research findings represent a "credible" interpretation drawn from the participants' original data (Lincoln & Guba, 1985). Merriam (2009) goes on to say that, "it is important to understand the perspectives of those involved in the phenomenon of interest, to uncover the complexity of human behaviour in a contextual framework, and to present a holistic interpretation of what is happening" (p. 215). There are techniques that are used to increase the credibility of research findings. I used techniques such as member checking, triangulation, audit trail, peer debriefing, and reflexivity. *Debriefing by peers* includes "systematically talking through research experiences, findings, and decisions with noninvolved professional peers for a variety of

purposes – catharsis challenge, design of next steps, or legitimation (Lincoln & Guba, 1985). Creswell and Miller (2000) suggested someone who is familiar with the research to challenge the researchers' assumptions in written form or simply as sounding boards. I utilized four university colleagues when debriefing. I worked with two of the debriefers on an informal basis and two on a regular basis. The informal processes were carried out from proposal stage to the analysis of the process by having many discussions about the methods and procedures of data collections, and analysis. The two more formal processes included many hours from the stages of data collection to analysis. Another technique that I used was the reliance on mixed and multiple methods, which is called *triangulation*. Triangulation can be used for different purposes and achieved in different ways. The two purposes that I used triangulation were, to gather meaningful data and for validity purposes.

> The most important advantage presented by using multiple sources of evidence is the development of converging lines of inquiry…. any finding or conclusion in a case study is likely to be much more convincing and accurate if it is based on several different sources of information (Yin, 1989, p. 97).

Corroborating evidence was collected through the use of quantitative and qualitative methods and multiple methods including questionnaires, interviews, and focus groups. Denzin (1978) identified four types of triangulation: source, theoretical, method, and different investigators, I used triangulation of methods and sources.

An audit trail was used to establish clear documentation of all research decision and activities (Creswell & Miller, 2000). An external auditor was used to review the study but the audit trail itself was established through keeping a log of all activities, and recording data analysis clearly.

Member checks consisted of taking data and interpretations back to the participants in the study so that they can confirm that the narrative collected is accurate (Creswell & Miller, 2000). Transcriptions were sent back to the participants for accuracy and the transcriptions with changes made were included as data. Lincoln and Guba (1985) characterized member checks as “the most crucial technique for establishing credibility” (p. 314). The member checks can take place again as a focus group or on an individual basis any comments would then be included in the final narrative. After all transcriptions were complete, they were sent to the participants where they commented on the accuracy of the transcripts and changed them to make sense.

Reflexivity involves the researcher explaining their biases and dispositions so that the readers can better understand how the interpretation of data took place (Merriam, 2009). I presented my position in my research in chapter one and in chapter three where I outlined my epistemological and ontological approaches.

Transferability

Generalizability and transferability are used interchangeably (Guba & Lincoln, 1989). Transferability is the degree to which findings of the inquiry can transfer beyond the bounds of the research. Merriam (2009) suggested “every case, every situation is theoretically an example of something else … what we learn in a particular situation we can transfer or generalize to similar situations subsequently encountered” (p. 225). Several strategies can be used to enhance the possibility of the results of a study to be transferrable to another setting. Lincoln and Guba (1985) stated the best way to improve the opportunity for transferability is to create a “ thick description of the sending context so that someone in a potential receiving context may assess the similarity between then and … the study” (p. 125). Merriam (2009) stated, that today, rich

thick data refers to, “description of the setting, participants of the study, as well as a “detailed description of the findings with adequate evidence presented in the form of quotes from participants interviews” (p. 227). The use of providing rich, thick description of the time, place, context, and participant responses (Guba & Lincoln, 1989) so that readers can judge the applicability of the findings, formulate their own interpretations, and make personal judgments regarding transferability to their own or other contexts. The process that I took to allow for transferability was to provide the readers with enough description of the cases, which would allow them to make judgments to their own contexts.

Another strategy for enhancing transferability has been discussed earlier on in Chapter 1 where I presented my position as a researcher. As identified earlier reflexivity or positionality identify the researcher’s position in their research, which helps the reader understand how interpretations and inferences have been made. The use of multiple site case studies is another method that contributes to transferability and credibility of research (Merriam, 2009). The methods for establishing credibility in my study overlapped to meet criteria of transferability, dependability, and confirmability. These methods included using triangulation, member checks, audit trail, and reflexivity (positionality).

Dependability

Dependability is concerned with the change of data overtime (Guba & Lincoln, 1989). More specifically, dependability refers to the consistency of the research procedures used within the different settings in the research. Dependability can be achieved by stating the investigator’s position, using multiple methods of data collection, and by describing in detail any changes that

occurred in construction or methodological changes. I achieved dependability by stating my position as a researcher, use of an audit trail, and using multiple methods.

Confirmability

Confirmability is concerned with assuring that the data, interpretations, and outcomes are rooted in contexts of the participants (Lincoln & Guba, 1985). During data collection I ensured confirmability through the use of the audit trail, tape recording the interviews, and rereading the transcriptions for accuracy. After transcriptions were complete, participants were given the opportunity to review and confirm for accuracy.

Ethical Considerations

Research involving youth can present unique ethical issues. As the nature of this study involved human subjects and focused primarily with children, ethical considerations were carefully reflected and acted upon. Ethical guidelines were followed to ensure that all the participants of the study were treated with respect and consideration.

Following approval being granted by the University of Saskatchewan Behavioural Sciences Research Ethics Board (Appendix H) and reapproval in February, 2010, I received consent from the Directors of Education of the participating schools to conduct the research. Prior to conducting the interviews, all of the participants received a letter describing the study and how confidentiality would be maintained. Consents were signed prior to the vice-principals, teachers, and counsellor interviews. Each of these participants was also provided copies of their transcripts so that they could confirm accuracy.

Prior to student participation, participants were informed about the intent of the study, the procedures for data collection, reporting, and storage. Participants were informed about the rights

of confidentiality, and their right to withdraw from the study. Consent forms were obtained prior to focus groups, transcripts were also provided so that they were able to clarify, add to, or delete from their words to maintain the most accurate description of the information shared. Participants were reminded to respect confidentiality of the other members by not disclosing the contents of the discussion outside the group. Names of schools were replaced by pseudonyms. Through these measures that I discussed, I believe that ethical guidelines were followed to respect participants' safety and confidentiality.

Summary

In this chapter I presented my framework that guided my research, Guba's Domains Model (1985) followed by the methods and procedures for analysis that I used in this multi-site case study. This study, situated in the constructivist paradigm, took place in the school, to understand grade 11 students' perceptions of alcohol prevention programs. In summary, data collection techniques, such as semi-structured interviews, document overview, questionnaires and focus group interviews were utilized in this study and in order to establish trustworthiness of the study, naturalistic criteria such as credibility, transferability, dependability, and confirmability have been addressed. Triangulation through the use of mixed methods and multiple methods (data analysis, interviews, surveys, focus groups) were used to affirm the trustworthiness of data. The methods of peer debriefing, reflexivity, audit trail, and triangulation were used to establish quality in this study. Furthermore, ethical guidelines were outlined to ensure anonymity and confidentiality of the participants in this study.

CHAPTER FOUR

Presentation of Data

This multi-site case study was conducted in order to explore Grade 11 students' perceptions of alcohol prevention programming and alcohol prevention policy in the school setting. The sections in this chapter are organized under the broad areas of policy-in-intention, policy-in-implementation, and policy-in-experience. The data from my research are discussed, beginning with an overview of formal and informal programs; Saskatchewan Education Wellness Curriculum (2004), Students Against Destructive Decisions (SADD), Youth Action Circle (Student Handbook, 2008), and the P.A.R.T.Y Program, and followed by the themes of vice-principal interviews. The themes emerging from interviews with the teachers and counsellors will then be presented. When incorporating data from the transcripts I referenced quotations according to categories within the Nvivo coding system. Data obtained from the student questionnaires are presented along with the overall themes of the student interviews. Data presented from all sources of information are examined collectively rather than individually; however, differences, and commonalities among schools are signaled as the presentation of data progresses. Figure 4.10 depicts a diagrammatic representation of the presentation of data.

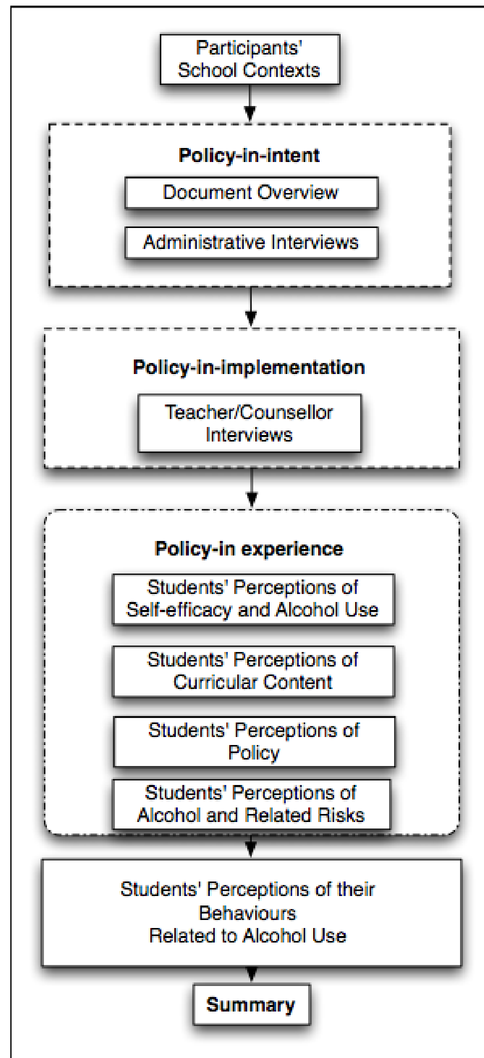

Figure 4.10. Diagrammatic representation of the presentation of data.

Figure 4.10 illustrates the presentation of data in chapter four. I begin with the participants' school contexts, followed by policy-in-intent, policy-in-implementation, and policy-in-experience. Policy-in-intent includes data from the vice-principals interviews, policy-in-implementation includes data from the teacher and counsellor interviews, and policy-in-implementation includes data from the students' questionnaires and focus groups. The chapter

concludes by presenting data on students' perceptions of their behaviour related to behaviour to alcohol use. I begin this chapter with a description of each school site to provide a point of reference for the context in which the students were learning but also provided an origin from which students' perceptions occurred.

The Participants' School Contexts

The number of enrolled students in the participating schools and observations of the school environment are included in the descriptions of each of the participating schools. The school names have been changed to pseudonyms to maintain confidentiality.

In 2006, Saskatchewan School Community Councils (SCC) were mandated and replaced Parent Teacher Associations, Home and School Associations or other related parental organizations. School Community Councils were to be advisory in nature, established at each school and focused on enhancing student learning and well-being (Endsin & Melvin, n.d.). Each of the participating schools had an SCC in place at the time of the study.

The Albert Collegiate

Enrollment in this grade 9-12 school situated in a city in Saskatchewan was 1500. Of the grade 11 population, 169 students participated in the questionnaire. The school population included youth from various cultures and the students that attended this school were from the community itself.

The Albert Collegiate was large, aesthetically pleasing and clean, and had a large parking lot. The school grounds and parking lot were clean without visible cans, bottles or litter. The students who smoked were in cars in the parking lot, or students smoked in the front of the school away from the main school entrance.

I met the counsellor who organized class lists and classroom locations needed for the research to be done in the school. Students were helpful in giving directions and the teaching staff was cooperative and appeared interested in the research. The teachers and students asked many questions about the questionnaire. The students had questions and opinions about the questionnaire and openly asked me questions including when they would be able to see the results of the survey.

Three counsellors and an addictions worker, who visited the school once a week, staffed the student resource office as well as a secretary at the front desk that directed people. Printed information was displayed on racks and tables and dealt with career choices, personal problems including student drinking, and other mental health issues.

The Battleford Collegiate

Enrollment of this grade 9 – 12 school situated in an affluent area of a city in Saskatchewan was 1200 and 172 of the 288 Grade 11 students participated in the questionnaire. Battleford Collegiate consisted mainly of students from middle to higher income families, but the school had experienced a recent influx of immigrant families. The school provided a variety of supports and special needs students formed an integral part of this school population. I noticed students smoking at the back of the school and across the street from the school. One of the two vice-principals organized the research to take place in this school. The vice-principal assigned to help me was extremely friendly and helpful as were most teachers.

The students did not ask me questions but were very quiet when completing the questionnaire. The teachers in general were more formal and business-like; however, the administrators were very open to answering any questions about the school. During my interview

with the school counsellor I had opportunity to observe the student services office. There was a secretary at the front desk, printed material on various topics of information and posters on the wall, with information on abusive behavior. Students walked freely in and out of the office while I waited for the school counsellor.

The Croswell Collegiate

The Croswell Collegiate, a brick school located in a core neighborhood of a city in Saskatchewan, had an enrollment of 250. Of the 70 grade 11 students, 44 participated in the questionnaire. The student population included ethnic backgrounds from Eastern European, Aboriginal Canadian, Asian, and African descent. There were two high schools located in this area. The student population included students from outside the neighborhood because this school offered special programs, as well as students from the neighborhood.

Students were smoking at the front doors where I entered the school. Vehicles were parked in the neighborhood, as there was no visible student parking lot. When I entered the auditorium I noticed the trophy case displayed with mostly sports-related student awards. On the wall was a poster that was advertising when blood donations would be taking place. The school principal was instrumental in organizing activities for the study and helpful in the administration of the survey. The students asked for clarification about some of the questions on the questionnaire and appeared concerned about answering them accurately. All of the students did the survey at the same time during a grade eleven assembly. The teachers in the assembly distributed pencils and kept the students focused and on task.

The Delta Collegiate

This school was located in an affluent neighborhood within a city in Saskatchewan and had an enrollment of 800. Many activities were taking place at the time the questionnaire was conducted so there were fewer participants at this school. Sixty-four of the 170 grade 11 students participated in the questionnaire. This school offered programs to mainstream, honors and advanced placement program, modified, alternative, French immersion, functional integrated, and English as a second language. It was the only school in this neighborhood.

When approaching this school I did not notice any students outside. The main desk was located at the office of the administrators where the secretaries contacted the teacher who was to assist with the administration of my research. The teacher was interested in the research topic and for that reason had volunteered to assist me. The questionnaires were administered in separate classrooms and students were polite and cooperative.

Policy-in-intent

Policy-in-intent was explored through an overview of programs, administrative interviews and provided data for the fourth guiding question of the research. In this question, I sought information on what formal and informal prevention of alcohol programs/activities were delivered to youth in these schools. Significant among these were the *Wellness 10* (2004) curriculum guide, student handbooks, and of two students groups that were present and functioning in two schools. These included, Students Against Destructive Decisions and the Youth Action Circle. I begin with the curriculum mandated by the province followed by the descriptions of the individual programs.

Saskatchewan Health Curriculum

In Saskatchewan, health education is introduced in the classroom in kindergarten and continues to grade 12. It is intended to enable students to apply daily life health knowledge to "increase health-enhancing behaviours and decrease health-risking behaviours" (Saskatchewan Learning, 2004, p. 1). Physical education focuses on the development of physically educated persons from kindergarten to grade 12. The *Wellness 10* (2004) *Curriculum Guide* presents a model that aims at integrating both health education and physical education at the grade 10 level.

Wellness 10 (2004) Curriculum Guide. Five circles of wellness guided the curriculum. These circles were labeled: the dimensions of wellness, spheres of wellness, strands of wellness, perspectives of wellness, and the decision-making process (Saskatchewan Learning). There were six goals that supported these circles of wellness:

(a) acquiring and evaluating health-related information,

(b) making knowledgeable decisions to improve health,

(c) applying decisions to improve own physical, mental, and social well-being and that of peers, families, and communities,

(d) developing positive attitudes toward physical activity

(e) promoting a lifestyle oriented to overall well-being, and

(f) developing concept-based skills (p. 3)

The curriculum included five units with a total instruction time of 100 hours. The units along with components began with the orientation that was five hours in length and required students to complete a wellness inventory. The second unit, Strands of Wellness, included physical activity and fitness, stress management, leisure, healthy eating and relationships. The

third unit was called, Challenges for Wellness, where five hours were provided to teach HIV/AIDS education. The forth unit allowed 15 hours to teach supports for Personal Wellness which included identification, prevention, and management of activity-related injuries. The final unit, Supports for Local and Global Wellness, allowed 15 hours for volunteering in the community.

The curriculum defined wellness as reaching beyond the traditional meaning of fitness and health. Wellness was defined as “a way of doing” (p. 3) that not only contributed to longevity but also improved the quality of life and was achieved through balance of the four dimensions. The program as identified in the document was, “designed to enable students to attain and maintain optimal wellness by providing opportunities for them to improve their ability to balance the physical, psychological, social, and spiritual dimensions of their well-being (Dimensions of Wellness)” (Saskatchewan Learning, 2004, p. 5). Each of the dimensions of wellness based on the current document is described next in conjunction with factors that can affect one’s level of wellness.

The *physical dimension* included the “functional operations of the body” (Saskatchewan Learning, 2004, p. 6), which was further expanded into the following four subtitles, physical activity and fitness, nutrition, medical self-care and the physical environment. Drug and alcohol education was one of nine topics that were listed under the subtitle physical environment. The *psychological* dimension included three categories: mental, emotional, and intellectual. The mental category incorporated items related to attitude and reacting to adversity. The emotional category integrated the understanding and management of feelings. The social dimension discussed relationships with humans and non-humans (cultural environment, natural

environment, and built environment). The *spiritual* dimension included personal values, beliefs, and commitments. Different meanings of spirituality were listed along with how to encourage spiritual development.

Strands of Wellness were described as the numerous factors that influenced one’s well-being. These strands were labeled as physical activity and fitness, stress management, healthy eating, relationships, and leisure. The curriculum also encouraged students to assume responsibility for personal, local, and global wellness (Spheres of Wellness) and practice wellness across the perspectives of active living, movement, and personal-social-cultural (Physical Education Perspectives). Significant objectives included in this program were for the student to be able to design, implement, and evaluate action plans for wellness to encourage responsibility for their own wellness (Health Education Decision-making Process).

Students Against Drunk Driving (SADD)

Founded as Students Against Driving Drunk in 1981, SADD is an organization that has “been committed to empowering young people to lead education and prevention initiatives in their schools and communities in relation to drugs and alcohol” (SADD, 2009). In 1997, SADD expanded its mission and name and now sponsors chapters called Students Against Destructive Decisions. Originally, the mission of the SADD chapter was to help young people say "No" to drinking and driving. SADD has become a peer-to-peer education, prevention, and activism organization dedicated to preventing destructive decisions, particularly underage drinking, other drug use, risky and impaired driving, teen violence, and teen suicide.

Youth Action Circle

The Youth Action Circle was a group of students from grades ten to twelve "who worked toward giving students' concerns a voice and to promote healthy living, lifestyles, and relationships" (School Handbook, 2008). They were trained facilitators who actively practiced their skills in the school and city. Within the school they presented forums to the grade nines on issues that concerned them such as peer pressure and healthy relationships. This group met weekly and presented at conferences within the city, at local elementary schools, and provincially.

Overview of Formal Programs/Policies

Saskatchewan's *Education Act* (1995) established how the education system including policy operates. Within the education system "powers and responsibilities flow from the Minister to boards of education in school divisions across the province".

School Policy Related to Drug and Alcohol Offenses

Each of the schools had a policy related to in-school drug and alcohol offenses that was included in the school student and parent handbooks. The policies were in congruence with the Saskatchewan Education Act (1995) where "every pupil is subject to the general discipline of the school" (S.152) and, the principal

> (a) may suspend a pupil from school for not more than three school days at a time for overt opposition to authority or serious misconduct and,
> (b) where he or she suspends a pupil pursuant to clause (a), shall immediately report the circumstances of the suspension and the actions taken to the parent or guardian of that pupil.
> (2) A principal may suspend the pupil for a period not exceeding 10 school days where the principal receives information alleging, and is satisfied, that the pupil has: (a) persistently displayed overt opposition to authority; (b) refused to conform to the rules of the school;

> (c) been irregular in attendance at school; (d) habitually neglected his or her duties; (e) willfully destroyed school property; (f) used profane or improper language; or (g) engaged in any other type of gross misconduct.

The policy within the student and parental handbook for the school stated that there is no tolerance for drug or alcohol use in the school or at school activities. Furthermore, “Misuse of alcohol or drugs during the school day or at school activities will result in one or more of the following consequences: parental involvement, referral to rehabilitative agencies, police involvement, and suspension and/or relocation to another school” (School Policy Handbook, 2007-2008, p. 27).

Administrative Interviews

Semi-structured interviews were conducted with vice-principals to elucidate their perceptions concerning policies related to the prevention of alcohol programs within their schools. The vice-principals had been in these roles for a number of years and dealt specifically with student issues related to drugs and alcohol in the school. These administrators played a central role in the schools related to alcohol use policy. Their perceptions are organized on their views of policy to six themes: typical event related to alcohol use policy, school policy on alcohol-related offenses, what was being done well and what could be improved in approaches to alcohol prevention, student input into policy or programming in relation to alcohol prevention, what indicators were used in relation to alcohol prevention, processes for student referral to a counsellor, and the prevention of alcohol use and other programs.

Typical Events Related to Alcohol Use in School

Purchase of alcohol by students and drinking at school or school sponsored events such as basketball games, dances, and football games were typical behaviours. An example given by one interviewee was,

> you'll get the binge drinker, they'll get a bottle of vodka or something like that and noon hour three or four of them will go some place and drink it and then come back and just be … out of it" (R2, S1VP, P).

The participant reported that they did not think that youth alcohol use had increased in recent years, in their 34 years as a teacher/administrator, the participant noted that the frequency of alcohol abuse remained the same, "…you have certain groups and certain individuals that will abuse alcohol" (R1&2, S1VP, U). Another interviewee measured the issue of alcohol use by comparing alcohol use to drug use, by directly relating the frequency of use of alcohol at events in school, he stated, "and it doesn't hold a candle to drug use" (R1, S2VP, U).

School Policy on Alcohol-Related Offenses

When I asked the participants about the school policy on alcohol prevention, they said that the policy for alcohol related offenses was in place in the school at the time. A participant stated that the policy is rather a practice and was outlined for the students in their day planner under the previous section (R1, S2VP, Py). From an administrative position, ramifications from the policy occur when students purchase alcohol during the school day or are under the influence of alcohol during the school day (R1, S2VP, Py). Another participant stated that policy is applied "the first time that a student is found to be under the influence of alcohol in school" (R1, S1VP, Py).

The vice-principals described their policy approaches to incidents around alcohol use in schools in both educative and disciplinary terms as one stated it as an "educable moment and we want to use that …there's a penalty that goes with it" (R1, S1VP, Py). Vice-principals commented that they attempted to lead administration into understanding the issues that resulted in the student being under the influence of alcohol in school. Furthermore, one of the administrators indicated that the policy was a 'punitive arrangement' that included an academic penalty and school-related penalties.

In another school the 'practice' outlined in the school planner was a "zero tolerance for alcohol consumption during the school day" (R1, S2VP, Py) that included zero tolerance for alcohol consumption occurring on school property or while attending any school functions. This 'practice' rather than policy was clearly outlined to students, in school two, at the beginning of the school year by the vice-principal making homeroom visits to orientate students to the practices and policies.

At the first offense, the vice-principals tried to understand the event, but suspension from school was automatic and a meeting with the parents was requested once the details of the alcohol-related event were reviewed (R1, S1VP, Py, R2, S2VP, Py). In accordance with the Education Act (1995), it was most common for one to three day suspensions however, suspensions could last up to ten days (R2, S2VP, Py). According to the policy, repetition of the offense resulted in the school attempting to get help for the student through resources that were available in or out of school. However, emphasis was placed on including parent support. Occasionally it was mandatory for the student to attend a treatment program for their alcohol use and the consequences depended on the age of the student and the student history. One school had

a compulsory three-day suspension with addictions counselling but repetition of the offense resulted in a ten-day suspension with counsellor involvement and referral to addiction services where the family could receive support as a group (R2, S2VP, Py). With further offenses there was a possibility that the student would no longer be allowed on school property and would have to go elsewhere for their education. If a third offense occurred, the parents would often opt to utilize the new Mental Health Act for a treatment program for the student.

In one school, breathalyzers were used prior to admission at school dances and attendance at such dances had decreased since this practice had been initiated (R3, S1VP, Py). Random checks with the breathalyzers replaced their use before admission when alcohol use decreased at dances. If a positive breathalyzer reading was found car keys were removed from the students, the parents were called and if the student was not cooperative, the police were called in.

Prevention of Alcohol Use: What was Done Well and What Could be Improved?

A vice-principal stated that an improvement in communication with students and in opportunities for one-on-one counselling through school student services had proved effective. Alcohol education was no longer referred to as 'behind the scenes, in a dark room' but it was offered openly (R1, S2VP, W&I). Although, for another participant working with individual students needed to be improved, through "school-parent-student education…having the parents as active participants … working with us to help their child is difficult for us at this particular point in time" (R2, S2VP, W&I). This participant noted that there was no clear mechanism in place, although there was policy. He added that there were no support groups for parents or student support groups in the school but that there were attempts to bring together parents to talk

about drug education. There was little education on alcohol education provided to the parents, despite the perception that a lot of students use alcohol.

Another participant reported that the way that information is dispersed might be improved; furthermore, he suggested that accessibility might be improved by reaching students over cell phones or blackberries. This information could be dispersed on an ongoing basis based upon reliable facts (R1, S1VP, W&I). Another vital piece that he shared was that the information that was being presented needed to come from people that the students trusted.

Student Input into Policy or Programming in Relation to Alcohol Prevention

According to one interviewee an organized system did not exist for receiving information or feedback from students where they could provide information that would be helpful on alcohol related issues (R1, S2VP, SI). Ad hoc responses came from informal in-house groups and from students' comments during home-room presentations in September. An interviewee stated that, "the students are very much in tune with voicing their opinions". Also, it was noted that the Student Representative Council reviewed any changes in policy and practice at the beginning of the school year and informed the students of the changes and why they were made. In one school, their SADD chapter contributed by choosing presentations brought in to the school (R1, S1VP, SI). Students did not generally have an effect on policy as the school board established this.

What Indicators Are Used in Relation to Alcohol Prevention?

The school administrative team gauged policies for effectiveness through an informal process. They listened to students and monitored school functions, as one participant observed: "we hear less and less from the kids … we have a bit of a handle of how good the situation is by

just putting the ear to the ground and listening to the kids … but basically we measure the size of the issue and relate it to the frequency of the events where they had alcohol in the school" (R1, S2VP, A&E). Another stated that they had fewer events of possession of alcohol or consumption during the school day within the last few years. An interviewee said that there had not been an instance in two years that needed to be dealt with at a school dance (R1, S1VP, I). Although, there was recourse to dry grads, half the people attended the dry grad and the other would be at a "liquor drink type of celebration" (R1, S1VP, I). However, now the greatest issues are alcohol at parties; a considerable amount of alcohol was being consumed by high school students outside of the school day (R2, S2VP, A&E). The vice-principals were not aware of any formal processes known to measure the amount of alcohol that was being consumed by the students. The vice-principal added that if there was an increase in incidents then the administrative team would assess the situation and look at what needed to be changed (R1, S2VP, A&E).

Process for Student Referrals to Counsellor

When presented with the question as to what process was in place for student referrals to counsellors, vice-principals indicated that a formal system for referral or for identifying students in need of support did not exist in the schools. It was suggested that most referrals occurred when a student told someone on staff that there was a problem with their friend or that someone needed help. One interviewee stated that occasionally a teacher noticed that a student smelled of alcohol or that a student's actions were not appropriate that day and the teacher would inform the administrators or counsellors.

Alcohol Prevention Curriculum and Other Programs

Administrators identified several arenas in which alcohol prevention was dealt with. It was being taught during physical education, home-room transition, and biology. Counsellors spent a significant amount of time counselling students and visiting classrooms to present information seminars (R1, S2VP, C). Data from the interviewees revealed that educational components on alcohol prevention were included through the physical education department in the health curriculum during grade nine and ten (R1, S1VP, C). It was not clear which teaching in grade 11 and 12 targeted addictions or alcohol prevention.

The interviewees spoke about the role of students groups. Youth Action Circle was a group for all grades in school, generally composed of grade nine, ten, eleven, and some twelve's. They were involved in putting on a number of presentations throughout the school year that focused primarily at the grade nine and ten level on topics of interest to students. These topics might have included addictions (R1, S2VP, Op). It was noted that another student led group, the SADD program, at least once every second year, invited speakers into the school to talk about addictions. This group was also active on a year-round basis and functioned through the use of posters and speakers in the school once every two years to provide advice about addictions (R1, S1VP, Op).

Policy-in-Intent: Key Findings

Through the Saskatchewan mandated curriculum, alcohol prevention was covered in the Wellness 10 curriculum. The wellness program focused on information and experiences that encouraged a balanced approach in four main dimensions of wellness. Alcohol prevention was included under the physical dimension of wellness. Other student led groups informally

presented information related to alcohol prevention. Overall the schools approached had in place a zero tolerance for alcohol use on school property or at school related events

The data revealed that the vice-principals did not perceive an increase in events related to alcohol use in the schools over the past few years; however, they did acknowledge that the students were consuming alcohol after school hours. The data revealed that the vice-principals had a general understanding of the curriculum including alcohol prevention covered within their schools. Areas that were identified as being done well in the schools included the presence of addictions counsellors in the schools and the general openness around the prevention of alcohol use in schools today. Areas that were identified as needing improvement included increasing active parental participation, school-parent-student information, and increasing communication in an ongoing manner. The vice-principal's main role in alcohol prevention was being involved when an issue arose around student alcohol use within the school or at school activities. A punitive approach was used once the students had been involved with alcohol; suspension was mandatory though both administrators stressed that understanding the situation was important. There was no system in place for tracking the level of student alcohol use, for measuring the effectiveness of the alcohol-related programs, or for identifying issues that students would like to be included concerning alcohol prevention.

Policy-In-Implementation

In order to gain perspective relating to policy-in-implementation I interviewed teachers and counsellors, and obtained detailed information on the formal and informal programs delivered to youth in the participating schools. The information from teachers and counsellors included data on the content that was delivered and the method of delivery. The vice-principals

identified teachers and staff important in delivering messages related to the prevention of alcohol use in youth. It was through their recommendations that I started the process of contacting interviewees for this next stage of research. In this section the following themes are explored:

- teacher experience in alcohol prevention programming,
- student alcohol use,
- teacher professional development relating to alcohol prevention,
- curriculum pertaining to alcohol prevention,
- skills training related to alcohol prevention,
- alcohol prevention programs other than curricular,
- school approaches to prevention of alcohol,
- challenges to prevention of alcohol use programming in schools,
- key components of alcohol prevention programs,
- what was being done well in regard to alcohol prevention in schools,
- teacher confidence in the approach in schools,
- what could be done better in relation to alcohol prevention,
- parental influences in prevention of alcohol use,
- student input in alcohol prevention programs, and
- community influences in alcohol prevention.

Teacher Experience in Alcohol Prevention Programming

All of the interviewees had at least eight years of experience in the school system teaching or counselling. One teacher identified that this was the first year in this school but has

taught the course for ten years in another location (R1, B30, E). Another teacher identified teaching the class for eight years, five being in the present course that included topics in relation to the prevention of alcohol use (R1, TCE, E). Yet another teacher stated that he had been teaching for fifteen years but had taught the course related to alcohol prevention for eight years (R1, W1, E). And another stated that they taught Grade 11 course for 12 years (R1, W2, E). The data revealed that the counsellors did not deal directly with presenting information on the prevention of alcohol in the classroom; however, they worked with students when alcohol had already become a problem.

Student Alcohol Use

The interviewees voiced their opinions about their perceptions of the prevalence of youth drinking. A school counsellor stated, "I think society is moving younger and younger in terms of what the kids are exposed to" (R1, C2, P). One of the teachers felt that "most students aren't doing it…90% are from families that are not involved in the event of unbalanced drinking or inappropriate behaviors with alcohol or drugs" and many abstain from using alcohol (R1, W1, P). In fact many students were viewed as exploring and experimenting with alcohol and not really drinking 'great volumes' (R2, W1, P). Parental involvement in the students' lives contributes and is important in the decisions by students as to whether to drink or not.

Teacher Professional Development Relating to Alcohol Prevention

There were no in-services that any of the interviewees attended related to the content on the prevention of alcohol in the curriculum in any of the participating schools. A teacher/counsellor said that she went to in-services in the beginning of her career but not since because of a lack of time as there were too many other issues to deal with (R1, C1, I). None of

the other seven participants received in-service or training on alcohol prevention in the schools in which they were teaching (R1, C2, I; R1, B30, I; R1, W2, I). However, one participant did seek out information on his own through the health district (R1, W1, I). Another participant noted that there were not any resources or specific information regarding alcohol prevention provided for the teacher to access, but information on resources for addictions was provided in the school (R1, TCE, I).

Curriculum Pertaining to Alcohol Prevention

All of the participants were aware that content on the prevention of alcohol use was included in Wellness 10. However, in one school the majority of content related to alcohol prevention was taught in grade 9 rather than grade 10. The teachers that were interviewed that did not teach Wellness 10 did include some information on alcohol use within their classes when opportunities arose. One participant suggested, “I think everybody in the school supports giving them information where it fits in…. it comes up incidentally” in stories and such (R1, C1, Q1) and another stated, “I try to incorporate both …a little bit about drugs and alcohol effect on the human body system, that it affects the liver, how it can impede your nervous system…but we don’t have a specific unit that deals directly with it” (R1, B30, I). Two of the counsellors’ noted that because of a lack of time, they themselves did not teach about alcohol prevention in the classroom (R1, C2, R; R1, C1, R). One teacher talked about alcohol use “fairly regularly in the grade eleven morality course, there were at least a few conversations on over-consumption which includes physical harm, harm in your relationships and harm at a spiritual level” (R1, TCE, I). He said that this discussion took place over a couple of class periods during the course of the year.

In one school, the prevention of alcohol was focused on at the grade 9 curricular level during "… a two day unit, one hour each day" (R3, W1, I) when students were taught at a "cognitive level" (R5). The two participants that taught this class had schedules that included the health unit that was dedicated to one classroom over one week time period (five days). Within this week, the content that was taught included: the harms of smoking, food and nutrition, relationships, and drugs and alcohol for 2 of the five days. (R3,W1, I). They elaborated that a theme of decision-making was taught which included how to make decisions around whether to smoke or use smokeless tobacco. Students were given information on where to seek help when needing support in one of those areas. Also one teacher felt that students needed to know how to get connected to get proper help. In this school, according to the counsellor and teacher, the curriculum was covered in Grade 9 and not Grade 10 (R8, C1, Q1).

Despite one schools' approach of providing the information at a grade 9 level others agreed that "there is not a whole lot at the grade 9 level, we deal with it at a grade 10 because that is when the drivers licenses start coming out, a little more alcohol is on the scene, you don't get such problems at grade nine" (R4, W2, I). The content related to alcohol prevention in the curriculum was dealt with in a "couple of hours to cover the whole thing over two days" (R6, W2, I). According to one participant, other than the formal school programs, "everyone is getting the 'casual' style of advertisement, like 'no drinking and driving' (R8, W2, I). The only educational support that the school received from agencies outside the school was a presentation by a police officer to the grade 9 students that lasted an hour and took place in small groups.

For several teachers, coverage and approach were a matter of professional discretion. One participant stated, "…obviously each instructor does his own thing uses the same materials but

… the focus is a little bit different" (R1, W2, I). His approach was from "the standpoint of giving them the information and show them basically the causes and different things that can occur… here's the information, you make the decision on whether or not this is right for you" (R2, W2, I). He called his stance the "realistic approach" and further explained that this meant to him, "I know they are using before they are of age".

Skills Training in Relation to Prevention of Alcohol Consumption

Overall, the participants reported that they provided examples to students regarding what to say when refusing to drink alcohol rather than actively practicing these skills. One participant used case studies and role-playing at the grade 9 level. This participant explained that it was only done once during one class because of time constraints and for it to be truly effective, "it takes hours to practice the skills in a really solid way" (R1, W1, S). Another participant said that they talk about what to say but they don't practice or role-play (R1, W2, S).

Alcohol Prevention Programs Other Than Curricular

Participants reported that within the school, student groups contributed to the prevention of alcohol use in youth. In one particular school, SADD was described as an extracurricular activity where a group of ten or twelve students attended conferences where the focus was to identify presentations to bring back to grade ten students and sometimes grade nine students. Also, the students in SADD sought out a major presentation for the entire school out.

In another school, the youth action circle was a program involved where students from grade ten through twelve presented to the grade 9 students on various topics that might include the prevention of alcohol use and abuse. Three of the four schools participated in the P.A.R.T.Y. program. One of the three schools allowed eighty or ninety of the 300 grade 10's to participate.

These students participated in the P.A.R.T.Y program which was offered on one half day during the course of the year.

School Approaches to Prevention of Alcohol

Participating schools varied in their approaches towards alcohol prevention. The approaches included zero-tolerance, use of alcohol in moderation only, and harm-reduction. A participant stated, “I think our approach is moderation. Now I could tell you why is because a lot of parents think that it’s okay” (R5, C1, Q1) and added “five years ago the parents were quite vocal because they had no alcohol for the grad party” (R5, C1, Q1). Other messages used in the school through posters and announcements included offering the students approaches to “… get around peer pressure, like it’s not okay to get in the car” (R6, CI, Q1).

Another stated that their “school is mostly abstinence” and that prevention of alcohol use in youth is the foundation for all activities, for example, being chem-free after-grad and school dances (R1, C2, Q1). Three of the four schools did not tolerate clothing with alcohol logos or other paraphernalia. This abstinence approach was felt to be successful as the student body accepted such activities “if they didn’t want to be part of that then perhaps I don’t think we would have as good a turnout …at our dances…and at all of our activities and chem-free after-grad” (R2, C2, Q1).

Challenges to Prevention of Alcohol Use Programs in Schools

Various challenges were presented in the data. The issue of time was common among participants. Time was providing a constraint and they were challenged to try new things because of this (R1, C2, C). Many of the issues around time were also included in the section of what can be improved.

In the participating school where the content was covered at the grade nine level the teacher felt that the content was not always appropriate because such students were not going to parties where they drove home drunk or had black outs. This information would be more appropriate at the Grade 11 or 12 level but because classes were subject based, there was a barrier to delivering them in the school (R2, W1, C) because no particular subject included this information. He said that teachable moments often occurred during tragedy.

Another challenge identified in one school was that the population was transient. The participant further clarified that there is “not a whole lot of comprehensiveness” and the teachers do not know what information the students have previously received (R2, W1, E). Yet another perceived challenge was “we have a very definite public school system and catholic school system” and I am sure the perspective is different in both systems (R2, W1, E).

Key Components of Alcohol Prevention Programs

The key component that was identified was the curricular content presented in the program. One participant went on to further distinguish that it wasn’t one key component but a combination of the information and topics covered in Christian ethics and Wellness around judgment and good decision-making (R1, C2, NB). Another interviewee felt that the accuracy of the information was key because the students received a large amount of information over the years and now it becomes relevant (R1, W1, NB). For another “understanding the effects of alcohol on the human body, biologically and emotionally that is what is important … in two days I am not going to say to them you shouldn’t do this…but with the information it may …reduce the amount of times that they do that?” (R2, W2, NB).

The method of presenting the information was also identified as important, "I believe in giving these kids the opportunity to be mature adults and try to make a decision because that will last a lot longer than me saying don't do this "…inform them and let them make their own decisions but inform them" (R3, W2, NB). Furthermore, "to hit kids with reality, technologies like the smart board and using the internet to be able to access information" would be effective (R1, W2, NB2).

What was Done Well In Regard to Alcohol Prevention in the Schools?

Overall the participants felt that they were doing a good job in the schools in a number of areas. Two of the participants felt that were doing well with the material that needed to be covered despite the lack time that was allotted for this topic and the time they had with the students overall. A participant stated, "I think we do a pretty good job here for a large school. But individually, some students are really hurting" (R2, W2, DW). Overall this teacher felt that they were reaching most of the students; however, there were still some individual students that needed more help. Another participant suggested that the moderation approach was effective because "the majority of the kids are okay…we do see a lot of kids who are in big trouble…but we're the school, we can't affect home life or the community…and the community tolerates it" (R1, C1, DW). It appeared that this participant felt that they were successful in reaching most of the students but that the community and home life needed to support the school approaches to be more successful.

Other participants felt that they were doing a good job in providing services in the schools to students that were higher risk or needing help with their use. A comment related to students in need of support and the services provided was, "I think that our school has made that

a priority, to catch these kids and find out what's going on"…through attendance, and marks and failure reports (R1, C2, W). One school counsellor identified that they had an addictions counsellor one morning a week. Many staff were concerned that the students would feel 'stigmatized' and concerned about confidentiality; however, she said, " I think students have no idea why people are coming down here" (R1, C2, W). In particular this teacher was saying that students were not only accessing services but also accessing the services while maintaining confidentially. Overall the participants felt they were doing well with the program given the resources that they had.

Teacher Confidence in the School Approaches

Once again there were varied responses to the participants' confidence in the approaches to alcohol prevention in the schools. One counsellor said,

> I am confident that what we are doing at this school is helpful to some…I don't think everyone is ready to hear the message. But I am confident that in my opinion if you get one person, you're …its successful. But it's a combination, its home, giving the same message, it the school giving the same message, its their peers … it has to come from more than one avenue. (R1, C2, C)

Another teacher said, "It's hard to say when you touch on it for two days ... so if the kid really wants to drink and his buddies are drinking, I'm not in two days going to be able to say to them, okay, this is wrong, you shouldn't do this" (R1&2, W2, C). Another teacher expressed, "We don't see them on the weekends … so there's no way in which we can measure how this is affecting them" (R3, W2, C). Another participant articulated that it is "part of a continuum in which I am able to give them information" (R2, W1, C). And when asked about the effectiveness of the approach they stated, "Very, but it is something you can't measure it at that

moment it is just something that as you work with them in a variety of other topics and health is unfortunately mixed in with many other subjects like some English teachers will be teaching alcohol in their units" (R1, W1, C).

Another perspective concerned the indirect impacts of alcohol prevention programs. As one participant noted, "I think that there would be an indirect impact; but in no way would I say it is extremely effective in regard to the student in promoting either prevention of alcohol use or delay. I think there would be an indirect impact…this is a life example of how the system works or can be impeded" (R1, B30, C).

What Could be Done Better In Relation to Alcohol Prevention

The participants identified various areas by which alcohol prevention programs could be improved. One teacher commented on technology and said that 'smart boards' were just being installed which would allow teachers to download material from the internet, he suggested that "…we need to hit kids with reality" (R1, W2, DB) "it is hard for us to cover as much as we would like to cover, it's hard to get these kids to actually believe…as long as we can get the information to them…I think we are doing well" (R2, W2, DB). Another teacher said, "I think that we can always improve and new ways of looking at things; …however, the protective nature of class time almost trumps these extra presentations" where some people promote it and some don't (R1, C2, DB). On the other hand he said that bringing in more presentations would help but that time is a challenge (R1, C2, DB).

One participant recognized that identification of students who are in need of assistance might be improved upon, "So the only thing we could do is to really try to identify kids and give them the information, and identify and get help for the kids who are in trouble" (R1, C1, DB).

Another participant was uncertain of whether the school could make their program or information more effective; she commented that when they had tried to organize parent groups, a great deal went into organizing an event and only one parent came (R1, C1, DB). Yet another participant agreed that the effectiveness would come if they could get the information to the parents (R2, W1, DB). Informing parents might be more effective through the use of websites, "if they were more user friendly, getting information to the parents…if they are ready for it; it might be useful rather than dealing with it during a crisis (R2, W2, DB).

Some participants were not sure of what teaching was actually going on in other classes in the school, for example "I am not aware of any formal program that they have for the prevention of alcohol use"(R1, B30, DB), and I can't say for certain…I would like to think that teachers take advantage of teachable moments" (R1, C2, DB).

Parental Influences in Prevention of Alcohol Use

Participants emphasized the importance of a family focus on prevention. One of the teachers felt that "it has to be family driven…we have them for 5 hours, whereas the other 19, it is where they live so that is what we have to do…prepare the family, workplaces…" (R1, W1, P). This participant also stated, "we see the behaviors at the later grades but the moral and values discussion is grade 4 to grade 8. That is where you hit them with the information" (R1, W1, P). Again the belief was,

> …I put it back on the families. They really need to be engaged … they really need to be involved. I really believe that schools just can't spend the time training parents at the level that what would really work" (R2, W1, P).

The teacher felt that it is a matter of readiness "…if they are ready for it, when are they usually ready for it? after the crisis". Another teacher agreed, "a lot of times it is more of a parental

thing because they are seeing them during the social times, they need to basically effectively tell them yes or no." (R1, W2, P).

Student Input in Alcohol Prevention Programs

The schools did not have any formal systems that provided students with a venue to offer suggestion to alcohol prevention programming. However, the participants responded that student input was sought informally through student led programs. In one school the student input comes through SADD that is student led (R2, C1, SI). With students being involved in SADD, going to conferences, and hearing speakers they are able to choose what they'd like to bring back to the school. "Normally we have one presentation during the year and we direct it to all grade tens". Students have control over fundraising for SADD, which includes red ribbons and lifesaver lollipops. These are all ways used to influence their peers (R1, C1, SI). In another school the students in the school would give their input to those on the SRC "or a group like the Youth Action Circle or they could mention it here to counselling services or administration". They clarified by saying, "…there isn't a …specific means right now though…" for student input (R1, C2, SI).

Community Influence in Alcohol Prevention

The participants viewed their role in alcohol prevention to be one of many sources that target youth. One participant viewed student use of alcohol as

> a societal issue, I think the media needs to really promote this. Unfortunately advertising makes drinking look like it's a lot of fun. Everyone's beautiful in those commercials and they're having fun, so I can see where young people are easily pulled in that direction because it looks like so much fun (R1, C2, CI).

Another comment referred to past events and views from parents, “There was a lot of criticism from the community about the dry grad about five years ago; the parents were livid because they said they’re going to be drinking anyway” (R1, C1, CI). This participant went on to say, “I think it is too difficult to be doing anything different or better…we’re the school, we can’t affect home life or you know the community…and the community tolerates it” (R1, C1, CI).

Another teacher felt “the power of peers is so important like where they are getting the alcohol and how are they connected to the older group to get the alcohol. They must be getting it from their parents. Some parents buy alcohol for their kids and that is those families where alcohol is just part of the food groups around the house … and that is where we can’t be involved” (R1, W1, AE). He went on to say that the parents that support abstinence during youth should support other parents that need to be stronger or group together.

Policy-In-Implementation: Key Findings

The minimum level of experience that the teachers and counsellors had in teaching content related to alcohol prevention was eight years. If the teachers felt that they needed in-service related to student alcohol prevention, it appeared that it was their responsibility to identify and locate information. Although resources were not made available to use in classroom instruction, information about resources related to addiction services was. Some of the participants were not aware of what material was covered in various subject areas in relation to alcohol prevention or in relation to what students had already been presented with. A general theme that presented from the data was that time was an issue. Specifically, there was not enough time delegated in the curriculum in alcohol prevention to try new things or to practice skills training. Overall, the practice of refusal skills was done once in one school and discussed in

others. Various messages were being conveyed through the prevention programs in schools that included a zero tolerance, use in moderation and harm reduction; teachers and counsellors emphasized importance of the family in prevention and felt that the message being presented to students needed to be consistent at home and in the community to be effective. The curricular content was viewed as a key component of alcohol prevention programs; however, the accuracy of the information and the method of presenting were also identified as important components.

Policy-in-experience

Policy-in-experience was explored through an examination of students' perceptions elicited through surveys and focus groups. Through these methods and keeping in mind, Bandura's (2005) components of effective prevention programs; informational, skills training, self-efficacy and social supports, I answer the following questions: (1) What are the self-ascribed perceptions of Grade 11 students in relation to alcohol prevention policies and programs? (2) What is the knowledge base of Grade 11 students in respect to elements of alcohol use? (3) What is the rate of alcohol use among Grade 11 students in four Saskatchewan schools?

Data in this section will be organized into four broad categories; students' perception of self-efficacy, students' perceptions of curriculum and school policy pertaining to the prevention of alcohol, students' perceptions of alcohol and risks, and students' perceptions of their behavior around alcohol use. First, I provide an overview of the student population.

The Student Population

There was equal distribution of students (N=452) surveyed between males and females. Of these students, the largest proportion (50%) were 17 years of age, 45% were 16 years of age, 4% were 18 years of age and 2% were 19 years of age. Finally, the proportion of students and

their overall academic averages were as follows: one percent of the 452 students reported their average to be below 50%, 7% from 50-59%, 19% from 60-69%, 27% from 70-79%, and 46% from 80-100%.

Students' Perceptions of Self-Efficacy

The following ten questions report the students' perceptions of self-efficacy in relation to their alcohol use. Summaries are presented on students' perceptions of self-efficacy in getting friends, parents, teachers, and professional support if they chose not to drink. Also included in this section are students' reported levels of confidence in resisting the urge to drink if they felt like celebrating, if in a situation where they had often drank, if after an argument with a close friend, if under pressure to be a good sport, or if at a party and wanting to celebrate.

Figure 4.11 presents a summary of students' confidence in getting friends support if they chose not to drink.

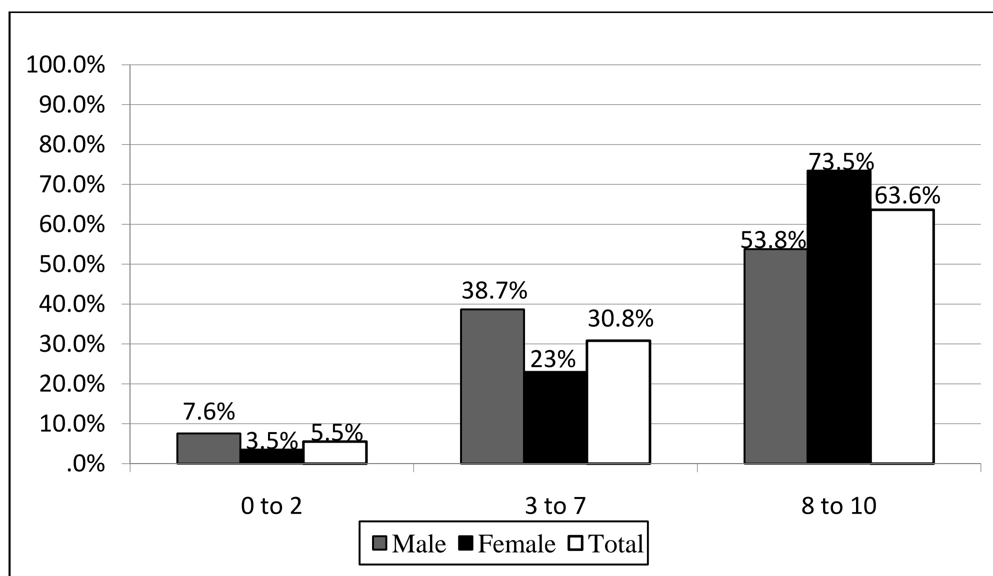

Figure 4.11. Confidence levels in getting friends support if they chose not to drink.

Figure 4.11 illustrates that 64% of all respondents reported that they were highly certain that they could get friends support if they chose not to drink and 5.5% reported that likely would not be able to get a friend to support them if they chose not to drink. A greater number of female students were highly confident in getting support than male students.

Participants were also asked how confident they were in getting teachers' help if they chose not to drink. Forty-seven percent reported being highly confident in getting teachers' help if they chose not to drink, and 19% of the students reported that they were not confident in getting teachers' help if they chose not to drink. When the students were asked about their confidence in getting parents support if they chose not to drink, 59% reported that they were highly confident in getting parents support, and 14% reported that they had no confidence in getting parents support.

A summary of students' confidence in getting professional help is shown in Figure 4.12.

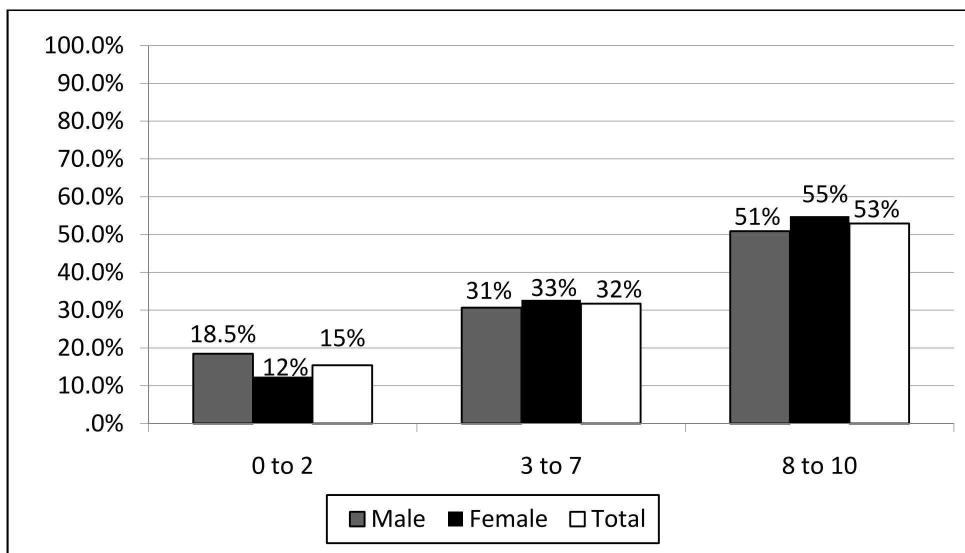

Figure 4.12. Confidence levels in getting professional help.

Illustrated in Figure 4.12 is that 53% of students reported that they were highly confident in getting professional help and 15% reported that they were not confident at all. More males than females reported that they were not confident that they could get professional help and more females were highly certain that they would be able to get professional help.

Figure 4.13 presents a summary of not drinking if I felt that things were going badly.

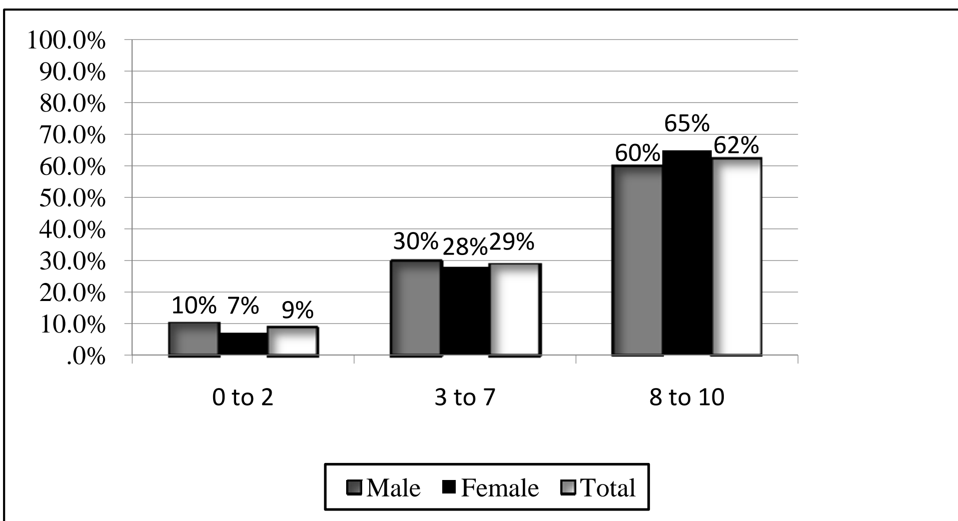

Figure 4.13. Confidence level in not drinking if I felt things were going badly.

As illustrated in Figure 4.13, 62% of the students reported that they were highly certain that they could resist the urge to drink if they felt that things were going badly and nine percent reported that they were could not resist the urge to drink if they felt things were going badly. More female students reported that they were certain that they could resist the urge to drink than male students and more male students reported they were not certain they could resist the urge to drink than female students if they felt things were going badly. Participants were also asked about their confidence level in resisting the urge to drink if they felt like celebrating. Forty-eight percent of the students were highly confident that they could resist the urge to drink if they were

celebrating and 17% were not confident. Fewer males were highly certain that they could resist the urge to drink if they felt like celebrating (46%, 50% respectively).

Students were asked and reported on their confidence in resisting the urge to drink if they were in a situation where they had often drank. Forty-two percent of the students reported that they were highly certain that they could resist the urge to drink if they were in a situation where they had often and drank, but 15% were not confident. Fewer male students than female students reported being highly confident in resisting the urge to drink (38.5%, 44.5% respectively), and more males than females reported not being confident at all (16%, 13% respectively).

The respondents were also asked how confident they were in resisting the urge to drink after an argument with a close friend. Seventy-two percent of the students reported that they were highly certain that they could resist the urge to drink if they had an argument with a close friend and 9% were certain that they could not resist the urge to drink if they had an argument with a close friend. Fewer males than females were confident in resisting the urge to drink if they had an argument with a close friend (68.5%, 75% respectively).

The students were also asked about their confidence in resisting the urge to drink if they were under pressure to be a good sport. Over half of the students (56%) reported that they were highly certain in being able to resist the urge to drink if they were being pressured to drink and 14% reported they were fairly certain that they could not resist the urge to drink if they were being pressured to drink. Fewer males than females were confident in resisting the urge to drink if they were under pressure to be a good sport (50%, 63% respectively).

Students were asked and reported on their confidence in resisting the urge to drink at a party. Forty-four percent reported that they were highly likely to be able to resist the urge to

drink if they were at a party enjoying themselves and 25% were fairly certain they could not resist the urge to drink if they were at a party. Fewer males than females were highly certain that they could resist the urge to drink if they were at a party (41%, 47% respectively).

Student Perceptions of Curricular Content on the Prevention of Alcohol Use

In the next section I present data from the questionnaire related to students' perceptions of curriculum that included content on the prevention of youth alcohol use and elaborated by data from student focus groups. Specifically information is reported on the students' perception on the number of classes that included content on alcohol, decision-making, peer-pressure, and refusal skills. Included in this section are students' perceptions of the degree to which material was informative, the relevance of material, how interesting the material was presented, and the amount of information presented.

The number of students and presentations they received on decision-making, peer pressure, assertiveness or refusal skills relating to student alcohol use is shown in Table 4.10.

Table 4.10

Presentations on Decision-Making, Peer-pressure, Refusal Skills, and Alcohol Use

Presentations	Male	Female	Frequency (N=452)
0	54 (24)*	48 (21.2)	102 (22.6)
1 or 2	135 (60)	143 (63.3)	278 (61.5)
3 or more	37 (16.4)	35 (15.5)	72 (15.9)
Total	226	226	452

*Percentages in parentheses.

Table 4.10 illustrates that 61.5% recalled taking one or two classes that included information on decision-making, peer pressure, assertiveness or refusal skills relating to the use of alcohol, 23% of the students reported that they did not have any presentations, and 16% had three or more presentations.

The participants were also asked how many presentations that they recalled on alcohol and 55% reported that they recalled one or two presentations while 32% reported that they did not recall any presentations on alcohol, and 13% recalled three or more classes. More female students than male students recalled having one or two classes (29%, 26% respectively).

Table 4.11 summarizes students' perceptions of the level of information provided on alcohol.

Table 4.11

Level of Information Provided on Alcohol

How Informative?	Frequency	Percent (N=452)
Not at all informative	24	5.3
Not very informative	41	9.1
Somewhat informative	244	54.0
Very informative	52	11.5
Nothing on prevention of alcohol use	87	19.2
Total	452	100.0

Table 4.11 illustrates that although 19% of the students reported that they did not recall any presentations on the prevention of alcohol use, 12% of the students recalled presentations that were very informative, and 55% recalled the presentations were somewhat informative.

Figure 4.14 summarizes students' perceptions of the relevance of presentation on the prevention of alcohol use.

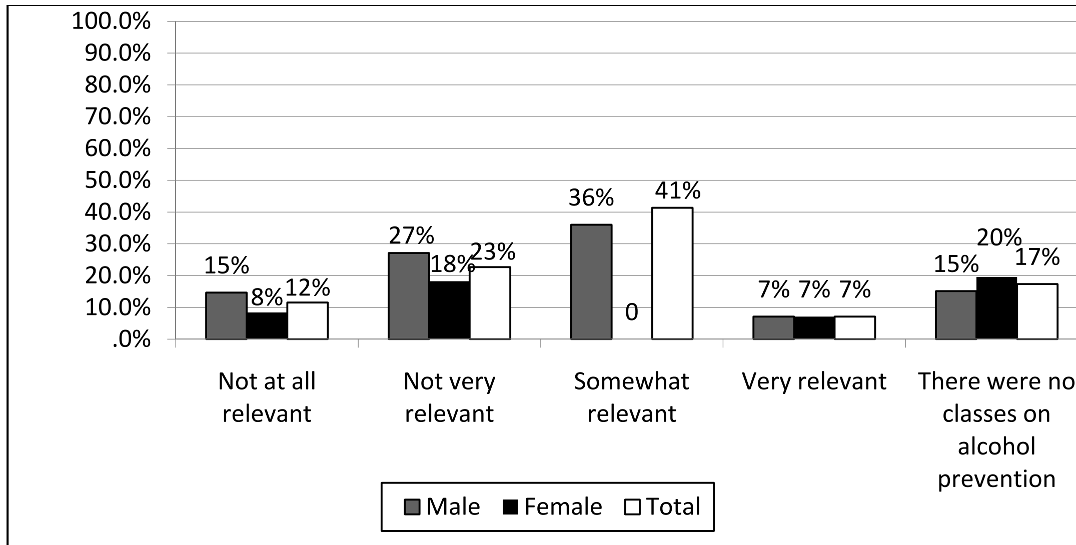

Figure 4.14. Relevance of presentations on prevention of alcohol use.

Figure 4.14 illustrates that 7% of the students recalled the presentations were very relevant, 41% of the students recalled the material to be somewhat relevant, 23% of the students recalled the material to be not very relevant, and 17% of the students did not recall presentations on alcohol prevention. More male students than female students recalled the material to be not at all or not very relevant (15%, 8% and 27%, 18% respectively).

Table 4.12 presents students' perceptions on how interesting the material was on alcohol prevention.

Table 4.12

Presentation of Material in an Interesting Manner

How Interesting	Male	Female	Total
Not at all	34 (15)*	16 (7.1)	50 (11.1)
Not very	49 (21.7)	46 (20.4)	95 (21)
Somewhat	85 (37.6)	92 (40.1)	177 (39.2)
Very	17 (7.5)	22 (9.7)	39 (8.6)
Recall no presentations on prevention of alcohol use	40 (17.7)	48 (21.2)	88 (19.5)
Total	226	226	452

*Percentages in parentheses.

Table 4.12 illustrates that 9% of the student recalled the presentations were very interesting and 39% of the students recalled the material somewhat interesting, 21% of the students recalled the presentations to be not very interesting, 11% of the students found it to be not at all interesting, and 19.5% of the students reported that they did not recall any presentations on alcohol prevention. Fewer male students than female students recalled that presentations were interesting.

The participants were also asked about their perceptions on the effectiveness of teacher presentations on alcohol use. Forty seven percent of the students reported that they agreed or somewhat agreed that the presentations were effective (13%, 34% respectively), 12% of the students reported that they did not view the presentations as being effective, and 23% of the students did not recall any presentations.

The students' perceptions of the appropriateness of amount of information on effects of alcohol are shown in Table 4.13.

Table 4.13

Appropriateness of Amount of Information on Effects of Alcohol

Amount of Information was Appropriate	Male	Female	Total N=452
Disagree	11 (4.9)*	11 (4.9)	22 (4.9)
Somewhat disagree	25 (11)	23 (10.2)	48 (10.6)
Somewhat agree	73 (32.3)	58 (25.7)	131 (29)
Agree	75 (33.2)	81 (35.8)	156 (34.5)
No presentations on prevention of alcohol use	41 (18)	51 (22.3)	92 (20.4)
No response	1 (.4)	2 (.9)	3 (.6)
Total	226	226	452

*Percentages in parentheses.

Table 4.13 illustrates that 63.5% of the respondents reported that they agreed or somewhat agreed on that their was an appropriate amount of information on effects of alcohol (34.5% and 29% respectively), 15.5% of the respondents disagreed or somewhat disagreed that there was an appropriate amount of information on effects of alcohol, and 20% of the respondents did not recall presentations on alcohol prevention.

Table 4.14 summarizes students' perceptions on the appropriateness of amounts of information on how to resist using alcohol use.

Table 4.14

Appropriateness of Amount of Information on How to Resist Alcohol Use

Appropriate amount of Information	Male	Female	Frequency
Disagree	18 (8)*	18 (8)	36 (8)
Somewhat disagree	35 (15.5)	33 (14.6)	68 (15)
Somewhat agree	74 (32.7)	72 (31.2)	146 (32.3)
Agree	49 (21.7)	50 (22.1)	99 (21.9)
There were no classes on alcohol prevention	48 (21.2)	50 (22.1)	98 (21.7)
No response	2 (.9)	3 (1.3)	5 (1.1)
Total	226	226	452

*Percentages in parentheses.

Table 4.14, illustrates that 54% of the respondents agreed or somewhat agreed that there was an appropriate amount of information on how to resist using alcohol (22% and 32% respectively) and a total of 23% of the respondents somewhat disagreed or disagreed that there was an appropriate amount of information on how to resist using alcohol while 22% did not recall any presentations on alcohol prevention.

Students elaborated on questions related to curricular content during focus groups. Data collected in the focus groups are presented in regards to curricular content, skills relating to resisting the urge to drink alcohol, student suggestions to improve programs on prevention of alcohol use and their confidence in the overall effectiveness of alcohol prevention in schools

Focus Group Reports: Curricular Content on Prevention of Alcohol Use

The presentations in which students reported learning about alcohol prevention included Wellness 9 and 10 (mostly in Wellness10), law, Christian ethics, psychology, and school clubs

like SADD (R1, S3, C). Some students recalled writing essays on the topic in English and presentations brought into the school by SADD (R2, S1, C).). Students specified that a unit or a week was focused on education on alcohol or drugs, “We had movies in grade 10 phys. ed. of what it actually does to our body” (R2, S2, CS; R1, S4, CS).

Students in four focus groups recalled learning about how alcohol affected the body (R3, S4, CS; R2, S1; R2, S2). One group recalled a Christian ethics presentation on how alcohol affects the body morally, “the body is the temple and it brings you further away from God” and information included “the effects on people around you if you are drinking more” (R3, S3, CS). Another group identified doing a project in grade 9 or 10 that included, “research on either a drug or alcohol and then you wrote about it and tell the effects of it (R1, S2, CS). This group recalled that the content within the school also included messages about “drinking and driving” where posters were put up and once in awhile speakers came in (R1, S1, CS). Specifically they recalled a presentation where someone in a wheelchair who likely spoke about drinking and driving, but students were unsure of the details. They were unclear about whether the presentation was attended by the entire school population or directed at particular classes, they did state that because this was a big school, not everyone was able to attend (R1, S1, CS). Yet another group recalled a specific presentation that they heard in elementary school, called Danae’s Song, which was about a young girl that was killed in a drunk driving collision. Another group heard a story in Grade 9 about a car accident, and another about a fight and felt that it would have been more appropriate in “Grade 11 or 12 because in grade 9 or 10 they are still not even driving” (R3, S1, CS). Finally, one group commented that sometimes teaching occurs if students start talking about it in class informally and this leads to a conversation (R1, S2, CS).

Skills Relating to Resisting the Urge to Drink Alcohol

Students recalled learning about skills in relation to resisting pressure to drinking alcohol, in elementary school, but not in grade 9 or 10 (R1, S1, SS). One student stated, "you usually learn to do that like…yourself" (R2, S2, SS) and "they have to find reasons in their self why they wouldn't drink" (R1, S4, SS). Two groups recalled learning about the decision making process but not specifically related to alcohol use (R1, S1, SS: R1, S4, SS). Yet another student reported that someone came to the classroom and listed 20 ways to say no, but much of the information was not specific to alcohol (R1, S4, SS). He added '…nothing is just alcohol specific, everything is piled in there…" (R1, S4, SS).

Approaches used in the Classroom Material

Some of the content was delivered through the use of video presentations; however, the students could not recall what they were about except that they were like commercials. The video that students could recall was on "really bad drug use where they went and talked to the addict and stuff… not so much on alcohol" (R1, S4, A). The videos included commercial style information based in Toronto or Vancouver where the addicts went to needle exchange.

One student talked about a class where he researched "either a drug or alcohol. Then he would write about it and tell the effects and what it does to you" (R1, S2, CS). Another student said "I personally don't see much in the school about alcohol, other than the odd football game ... its nothing" (R1, S4, CS). The data revealed that most information is presented to students by the teachers "they tell us" (S4).

Student Suggestions to Improve Programs on Prevention of Alcohol Use

Students made several suggestions to improving school programs on prevention of alcohol use. Overall suggestions were related to the content, presentation styles and at what age to present the information. In regard to content, three of the four focus groups indicated one way to improve the programs would be through teaching of skills through role-playing. (R1, S3, S). Furthermore, they commented that alcohol was viewed as more socially acceptable and not as much of a problem as hard drugs, "so in comparison to drugs its not as bad" (R1, S4, SS). Therefore, information and skills training need to be specific to alcohol. One group of students reported, "a person came into our class and there were 20 ways to say no to drugs" and if "you pile alcohol, drugs, heroine in one presentation and alcohol sort of gets lost in something like that, oh my God, of course you will listen to crystal meth, alcohol is overshadowed" (R3, S4, I).

Students noted that they need to have an opportunity to think of being in drinking situations and find reasons in themselves why they wouldn't drink, "they need to find something that means more to them than drinking and getting involved in that kind of thing" (R1, S4, SS). One student stated, "kids feel pressure", and although "I don't feel direct pressure to drink. There is no one who is specifically saying, hear drink this, the thing is you go to a party and like everyone around you is drinking. There are 14 people drinking, and you are the only one not drinking and indirectly it affects you and makes you want to drink" (R1, S4, SS). It would be helpful to hear information on the 'plus sides' of staying sober. Others thought it would be helpful to find some people that never drank and "how they did not give into peer pressure" and include "the bonuses that they got out of not drinking" (R3, S4, I). All of the groups identified that they would like to hear from some people that are alcoholics, how they got addicted and how

it changed their life and affected them as a person, and probably the most effective was "when the actual person comes to talk to you, about like how it affected their life, then it really like kind of hits home because they're like an everyday person … rather than reading about it" (R2, S1, I). Yet another student suggested providing, "information about if you have a father or mother that drank and how it affects you as a brother, etc, because there is recovery for the family too" (R2, S4, I).

When presenting information on alcohol, one student stated that instead of just saying "it's bad" (R3, S4, I; R2, S2, I) it is helpful to give information to "find out why and stuff" (R2, S2, I). In another group, students agreed, "like when people said oh you can't go to a party you'll just get hammered or whatever, and I'm just like this is kind of like … lame, yeah lame, I know myself, I just kind of tune out a little bit" (R3, S4, I). Another student suggested that information would be helpful, about "the effects on your friends and…more about the law and what could happen in if you're drinking and you could spend time in jail" (R1, S3, I). Two groups recommended focusing on the positives of being sober, such as, being the designated driver to make sure your friends get home safely (R3, S4, I) and "the fact that you can party without drinking" (R3, S4, I). Overall all focus groups identified that people sharing their personal stories was the highlights and they would like more of these presentations, which could be a movie or personally presented.

Of the four groups, one group recalled the presentation about Danae's Song and felt it was effective because they heard different perspectives on the effects of drinking and driving. Three of the groups talked about the PARTY program that was held in the hospital where they

recalled visiting the morgue in detail and felt this was effective because they were able to see "this is how my parents would react, if this happened to me" (R12, S1, I; R3, S4, I).

Other suggestions included "Have a whole separate thing" like teen aide (R4, S4, I) and another group suggested to make it mandatory (R6, S1, I). "I don't think it needs to go through the teachers, I think a separate section or a different group of people who come into the school needs to teach it" and it's so much better if it is separated from class stuff". They went on to say "It's easier to listen to someone that you don't listen to everyday" and "I think it would be good to get grade 12 students in and take groups of students like the Youth Action Circle, and the students could ask questions (R4, S4, I). Have someone their age, and explain what happens, which will make it personal (R2, S3, I; R1, S4, I). All of the groups suggested that youth talking to youth would be beneficial. One group agreed that, when you are in grade 9, you look up to the grade 12's. They should talk to grade 9's about alcohol stuff, and it's okay if you don't want to. That would have more influence than any of the teachers (R1, S4, ES). Furthermore, another group suggested that people in their twenties talk to the students in grade 11 and 12 (R1, S4, I).

All focus groups suggested that interactive activities would enhance and should be a part of classroom instruction rather than just disseminating information. Students agreed that "facts are important too, about how it happens to your body" (S1, p.9) however like them telling you like giving you how many thousand people in Saskatchewan die drunk driving per year, that doesn't really do anything." Another student went on to say, "You need to really get more, like I don't know, instead… make it a ratio, maybe like okay, two out of five people stand up and the guy says, you two people died, and you go, like just kind of make it more … realistic" (R3, S1, I). Another student said, "the teacher reading us a book, like we're supposed to read a handout

we’re not ... I mean we might but we’re not doing that …” (R8, S1, I). Within the focus groups, it was suggested, having an activity or interaction in class “involvement, not just, put your hand up” (R12, S1, I). When presenting, “give information without being bossy (R1, S1, I) and “don’t promote that partying is bad, because you can party still and have a good time without drinking” (R3, S4, I; R2, S2). And “Give accurate information don’t tell kids that if they drink they are going to become an alcoholic” (R4, S4, I) and “even if the school tells you that it is no good, the family and friends need to tell you the same thing in order to really make you feel confident” (R5, S3, I). This student went on to say that it is important to be able to talk to your parents about peer pressure because “you can’t talk to your teachers about it” (R6, S3, I).

Students identified that more information needs to be focused in the upper high school grade levels. All of the groups recommended giving more information at the grade 9 level because “in grades seven and eight no one really cares, oh it’s never gonna happen and then in grade nine, they say I’ll never do it, and bam, everyone who didn’t drink, drinks” (R3, S4, I). “What we got in elementary school I think would be more effective in high school…especially if you had it around nine” (R3, S3, I) and at the upper years in high school as well. Another student suggested that presentations related to drinking and driving need to be focused at the upper years because students in grade nine and ten are still not driving and learn it but, “don’t really apply it at all” (R1, S1, I).

In regards to information and programming to students that are already drinking, one of the students shared “I am not sure that we would change now because we have all had something to drink”. Another student agreed, that “if students are our age or maybe years younger, I’m not sure we’d be able to change now, like you know, because by now everyone’s had something to

drink" (R4, S2, I). However, in another group it was suggested that, "if they like saw how like people who are addicted, like, act and like, I don't know, how to change and stuff. I think that kids like kind of realize that, other than that I don't think they do because they're just having a couple of drinks, you know ... for fun and after it's too late or something" (R4, S1, I). Another suggestion included, "they should make you write an essay on what would happen if you got in an accident, and like make you really think about how it would change your life" and another agreed "because then you actually like brink it close to home…" (R2, S1, I).

Some final comments that one group wanted to have included were, that things that are fun to watch are good ways to get the information to students, "like police demonstration and gaming things and watching the effects to the body without being in the situation. Kids will learn a lot more through humor than to hard facts like telling kids they're gonna die" (R1, S4, AE).

Confidence in the Overall Effectiveness of Alcohol Prevention in Schools

Comments about the effectiveness of programs related to the prevention of alcohol use varied among students. Three of the four groups were able to recall information presented in elementary school (R1, S2, E; R2, S3, E), for example, "those were good. I remember all of those in grade seven or eight" (R1, S4, E). However, students recalled information at the elementary level about drinking and driving and said, "I guess you learn about it but you don't really apply it ... by the time you actually do it you're like, you forget it" (R3, S1, C).

Several students from different focus groups commented on the effectiveness of the programs in high school, "They are. Maybe for some people. It makes you think about it instead of it just being like … like drinking with your friends, it makes you kind of think of it differently like what it can actually do to you" (R1, S2, I) and went on to say, " instead of just saying it is

bad … and find out why and stuff. The information kind of gets through" (R1, S1, ES). Another student commented that the programs make "people more aware ... there's consequences that affect you, cause I don't really think …. people who drink very little, they're responsible and others might be more careful about options" (R1, S3, ES). However, went on to say, "I'm not sure we'd be able to change now because by now everyone's had something to drink" (R4, S2, I). In another group the most effective information was related to drinking and driving, a student reported, "I don't want to drink and drive, when I get in a car, or do much drinking" (R1, M1, ES; S1), but in this particular focus group not many students recalled curricular content in high school. Another student in this group reported that the most effective information that she recalled was when "the actual person comes to talk to you …about how it affected their life" (R1, S4, E).

In one focus group all students agreed that they were not confident in the program making a difference (R1, S4, ES; R3, S1, ES) "not at all, it's like nothing" (R5, S4, I) and two students clarified that they need to draw the line clearer between moderation and addiction (R6, S4, I). For example one student reported he was hearing, " it's like don't drink or you'll become an alcoholic" (Ref 1, S4, C). This group of students recalled information on alcohol prevention from grade nine and ten and present information was mostly from school rules.

In general, comments varied about effectiveness about the school programs. One comment was, "maybe for some people, it makes you think about what it can actually do to you instead of just saying it is bad" (R1, S2, ES). Yet another "Not at all, it's like don't drink or you'll become an alcoholic" (R1, S2, C). In one school hearing the message of not drinking and driving was seen to be effective (R1, S1, ES). In one focus group all students agreed that the

program was not at all effective. However, the most effective aspect was seen to occur when someone comes in and personally talks about their life (R1, S1, E; R2, S1, ES; R2, S3, I).

Students' Perceptions of School Policy on Prevention of Alcohol Use

Students' awareness and perceptions of policy were sought in the questionnaire and through the conducting of focus groups. In this section data is presented initially from the questionnaire and further elaborated by data from the student focus groups. I begin with students' perceptions of school rules on alcohol use and about their perceptions of messages about alcohol use from teachers, club coaches, parents, and the media.

The number of students who were aware of rules pertaining to alcohol use on school property or at school events is shown in Table 4.15.

Table 4.15

Awareness of School Rules on Alcohol Use

Aware	Male	Female	Total N=452
Yes	210 (46.5)*	215 (47.6)	425 (94)
No	1 (.2)	1 (.2)	2 (.4)
Don't know	15 (3.3)	10 (2.2)	25 (5.5)
Total	226	226	452

*Percentages in parentheses.

Table 4.15 illustrates that 94% of the students reported that they were aware of rules pertaining to alcohol use in schools and 5.5% of the students reported that they did not know if their school had rules about the use of alcohol on school property or at school events. The participants were also asked if the rules about alcohol use were followed consistently and 42% reported that the

rules were being followed consistently, and 41% somewhat agreed that the rules were being followed consistently. A total of 17% disagreed or somewhat disagreed that rules were being followed consistently.

Table 4.16 summarizes students' perceptions of the messages that they heard from teachers pertaining to alcohol use.

Table 4.16

Alcohol Use: Messages from Teachers

Messages	Male	Female	Total n=452
It is not okay to use	122 (54)*	115 (51)	237 (52.4)
Mixed message	64 (28.3)	69 (30.5)	133 (29.4)
It is okay to use	16 (7.1)	4 (1.8)	20 (4.4)
None	24 (10.6)	38 (16.8)	62 (13.7)
Total	226	226	452

*Percentage in parentheses.

Table 4.16 illustrates that 52% of students reported that they heard the message that it was not okay to use alcohol, 30% reported mixed messages, and 14% reported no message. More male students than female students heard that it was okay to use (3.5%, 1% respectively).

The participants were also asked about their perceptions of messages from athletic coaches, 49% reported that they heard it was not okay to use alcohol, 30% reported no messages, and 17% heard mixed messages. More male students reported that they heard mixed messages (11%, 6% respectively) and messages that it was okay to use (3%, 1% respectively). The participants were asked about their perceptions of messages about alcohol use from club advisors

and 46% reported that they heard that it was not okay to use, 13% reported mixed messages, 3.5% reported that it was okay to use, and 37% reported no message.

Focus Group Reports: Messages that the Students Heard about Alcohol Prevention

In the focus groups the messages that the students reported were: "no to do it" (R1, S2, M), "use in moderation" (R3, S4, M), "you shouldn't use it in school, or out of school until you're of age" (R1, S3, M), "be responsible about it, because they know we're going to … you're going to do it" (R1, S2, M) and "they kind of accept that we're going to do it, and they just say do it safely" (R2, S1, M), to "make good choices" (R2, S4, M). One student stated, "There's a lot on the actual drunk driving rather than prevention of alcohol" (R1, S1, M), and another clarified, "it's not really prevention, its just awareness". During one focus group the students reported, "it's not really a hot topic" and "personally I don't see much in the school about alcohol, anything other than the odd football game or in a school event like that I think it is mandatory on behalf of the school to tell the students that there is no drinking" (R1, S4, M). Other students had heard that if students were on sports teams they shouldn't drink alcohol but, "we still know that everybody is drinking" (R1, S3, M). Some students said, "they kind of accept that we're going to do it, and they just say do it safely" (R2, S1, M).

Students' Perception of Alcohol and Related Risks

In the questionnaire, the participants were asked about their perceptions of information about alcohol and perceived risks around use of alcohol. This section summarizes data from the questionnaire in regards to students' perceptions of: the term binge drinking, alcohol as a CNS depressant, whether males and females react to alcohol the same and the likelihood of alcohol dependence with earlier onset of drinking.

Table 4.17 summarizes students' perceptions of the nature of binge drinking.

Table 4.17

Perception of the Term Binge Drinking

Binge drinking is:	Male	Female	Total N=452
2 or more drinks	10 (4.4)*	7 (3.1)	17 (3.8)
3 or more drinks during an evening	14 (6.2)	20 (8.8)	34 (7.5)
4 or more drinks during an evening	17 (7.5)	23 (10.2)	40 (8.8)
5 or more drinks during an evening	118 (52)	124 (55)	242 (53.5)
I don't know	67 (29.6)	52 (23)	119 (26.3)
Total	226	226	452

*Percentages in parentheses.

Table 4.17 illustrates that 53.5% of the respondents perceived the term binge drinking as having 5 or more drinks on one occasion, while 26% did not know what the term meant.

Table 4.18 presents students' perceptions of whether alcohol is a CNS depressant.

Table 4.18

Alcohol as a CNS Depressant

CNS depressant	Male	Female	Total N=452
Yes	198 (87.6)*	190 (84)	388 (85.8)
No	4 (1.8)	4 (1.8)	8 (1.8)
I don't know	24 (10.6)	32 (14.2)	56 (12.4)
Total	226	226	452

*Percentages in parentheses.

As illustrated in Table 4.18, 86% of the students perceived alcohol as a CNS depressant. Twelve percent of the students reported that they didn't know that alcohol was a CNS depressant.

Table 4.19 summarizes students' perceptions of whether males and females react to alcohol in the same manner.

Table 4.19

Males and Females react to Alcohol the Same

Student Perceptions	Male	Female	Total N=452
Yes	36 (15.9)*	33 (14.6)	69 (15.3)
No	159 (70.4)	162 (71.7)	321 (71)
I don't know	30 (13.3)	31 (13.7)	61 (13.5)
No response	1 (.4)	0	0
Total	226	226	452

*Percentages in parentheses.

As illustrated in Table 4.19, 71% of the students responded that males and females react differently, and 15% reported that they react the same to alcohol.

Table 4.20 summarizes students' perceptions of the likelihood of alcohol dependence with earlier onset of drinking.

Table 4.20

Likelihood of Alcohol Dependence with Earlier Onset of Drinking

Student Perceptions	Male	Female	Total N=452
Yes	156 (69)*	183 (81)	339 (75)
No	43 (19)	19 (8.4)	62 (13.7)
I don't know	27 (11.9)	24 (10.6)	51 (11.3)
Total	226	226	452

*Percentages in parentheses.

As illustrated in Table 4.20, 75% of the total group of students perceived that the earlier one initiates drinking the more likely that they were to become alcohol dependent. Fewer males than females were aware that early onset of drinking contributed to alcohol dependence.

Students' Perceptions of Risks of Alcohol Use

In this section, summaries of data, from the questionnaire, related to students' perceptions of risks with trying alcohol are presented. Specifically students' perceptions will be reported on: trying one or two drinks of alcohol once, risk with drinking one or two drinks nearly every day, risk with drinking four or five drinks nearly every day, risk with drinking one or two dinks nearly each weekend, and risk with drinking five or more drinks nearly each weekend.

Table 4.21 summarizes students' perceived levels of inherent risk in trying one or two drinks once.

Table 4.21

Risk with Trying One or Two Drinks of Alcohol Once

Risk	Male	Female	Total (N=452)
No	126 (55.8)*	90 (39.8)	216 (47.8)
Slight	67 (29.6)	98 (43.4)	165 (36.5)
Medium	18 (8)	22 (9.7)	40 (8.8)
Great	10 (4.4)	9 (4)	19 (4.2)
Don't know	4 (1.8)	6 (2.7)	10 (2.2)
No response	1 (.4)	1 (.4)	2 (.4)
Total	226	226	452

*Percentages in parentheses.

Table 4.21 illustrates that 48% of students perceived there was no risk with trying one or two drinks once, 36.5% perceived a slight risk, and 9% of the students perceived a medium risk. More male than female students perceived trying one or two drinks of alcohol once as no risk (56%, 40% respectively).

Students were also asked about their perceptions of risk inherent in drinking one or two drinks nearly each weekend and risk with drinking one or two drinks nearly each day. Seventeen percent of the total respondents perceived no risk with drinking one or two drinks nearly each weekend, 40% of the student respondents perceived slight risk, and 32% perceived this to be of medium risk. More males than females viewed drinking one or two drinks nearly each weekend as no risk, (20%, 14% respectively), and slight risk (46%, 35% respectively).

Of all of the respondents, 44.5% perceived great risk of drinking one or two drinks nearly every day, 38% of students reported a medium risk, and 10% perceived a slight risk. Fewer male than female students perceived this as great risk (39%, 50% respectively) and more male than females perceived this as slight risk (14%, 6.7% respectively).

Table 4.22 summarizes students' perceptions of risk with drinking five or more drinks nearly each weekend.

Table 4.22

Risk with Drinking Five or More Drinks Nearly Each Weekend

Risk	Male	Female	Total (N=452)
No	20 (8.8)*	12 (5.3)	32 (7.1)
Slight	42 (18.6)	25 (11)	67 (14.8)
Medium	88 (38.9)	71 (31.4)	159 (35.2)
Great	67 (29.6)	111 (49.1)	178 (39.4)
Don't know	6 (2.7)	6 (2.7)	12 (2.7)
No response	3 (1.3)	1 (.4)	4 (.8)
Total	226	226	452

*Percentages in parentheses.

As illustrated in Table 4.22, 39% of student respondents perceived drinking 5 or more drinks of alcohol once or twice nearly each weekend as great risk while 35% of the students reported this to be of medium risk, 15% reported slight risk, and 7% reported no risk. A greater number of male than female students perceived no risk (8.8%, 5% respectively) and fewer male than female viewed this as great risk (30%, 49% respectively).

Students were also asked their perceptions of risk with drinking four or five drinks nearly every day. Eighty-six percent of the respondents, perceived great risk with drinking four or five drinks nearly every day, while 5% perceived medium risk, and 4% perceived a slight risk. Fewer male than female students perceived great risk (81%, 90% respectively).

Students' Perceptions of Their Behaviour in Relation to Alcohol

Results from the questionnaire on student behaviour and alcohol are described in this section. The perceptions of students concerning alcohol use are presented on items relating to time of first use, amount consumed in the previous year, and behaviors associated with drinking such as driving, seat belt use, and sexual activity. Data concerning students who have been hospitalized, seen by medical personnel or warned by police, family or friends in relation to their alcohol use will also appear in this section. Table 4.23 contains a summary of students' perceptions concerning the grade level of which they first used alcohol.

Table 4.23

Grade of First Alcohol Use

Grade	Male	Female	Total N=452
4 or before	10 (4.4)*	9 (4)	19 (4.2)
5	8 (3.5)	3 (1.3)	11 (2.4)
6	9 (4)	13 (5.8)	22 (4.9)
7	24 (10.6)	23 (10.2)	47 (10.4)
8	52 (23)	48 (21.2)	100 (22.1)
9	56 (24.8)	39 (17.3)	95 (21)
10	26 (11.5)	38 (16.8)	64 (14.2)
11	15 (6.6)	15 (6.6)	30 (6.6)
Never used alcohol in lifetime	22 (9.7)	38 (16.8)	60 (13.3)
No response	4 (1.8)	0	4 (.9)
Total	226	226	452 (100)

* Percentages in parentheses.

As illustrated in Table 4.23, 13% of the students reported never having used alcohol with 63% of these being female. Among those who had reported experiences with alcohol, the highest percentage had their first experience in Grade 8 and 9 (22% and 21% respectively) with more boys than girls reported having their first drink in grade 9. By grade 11, 86% of the students had already experienced drinking alcohol. Table 4.24 contains a summary of students' perceptions and their first time that they drank enough alcohol that they felt drunk.

Table 4.24

First Time Alcohol Use to Feel Drunk

Grade	Male	Female	Total (N=452)
4 or before	5 (2.2)*	2 (.9)	7 (1.5)
5	4 (1.8)	2 (.9)	6 (1.3)
6	4 (1.8)	6 (2.7)	10 (2.2
7	18 (8)	7 (3.1)	25 (5.5)
8	45 (20)	45 (19.9)	90 (19.9)
9	57 (25.2)	45 (19.9)	102 (22.6)
10	29 (12.8)	51 (22.6)	64 (14.2)
11	11 (4.9)	16 (7.1)	27 (6)
Never used alcohol in lifetime	24 (10.6)	37 (16.4)	61 (13.5)
Never drink until I feel drunk	28 (12.4)	29 (12.8)	57 (12.6)
No response	1 (.4)	2 (.9)	3 (.7)
Total	256	256	452 (100)

*Percentages in parentheses.

As illustrated in Table 4.24, 13% of the students reported that they had not consumed alcohol to the point of feeling drunk. Seventy-three percent of students reported having used alcohol to being drunk by grade 11. Most of the students reported that they had first consumed alcohol to feeling drunk in grades 8 and 9 (20% and 23% respectively) and more males had consumed alcohol to point of feeling drunk in grade 9 than females (25% and 20% respectively), and more females than males reported their first time of alcohol use to the point of feeling drunk in grade 10 (23% and 13% respectively).

Students were also asked if they had tried alcohol for the very first time during the previous 12 months. Sixteen percent of the students reported that they drank alcohol for the first time in the previous 12 months and 11.5 % of students indicated that they had never used alcohol. A greater number of female students reported never trying alcohol in their lifetime than male students (14%, 9% respectively).

Table 4.25 summarizes the students' perceived frequency of alcohol use in the previous 12 months.

Table 4.25

Occasions of Alcohol Use in Previous 12 Months

Frequency of Alcohol Use	Male	Female	Total N=452
Never used alcohol in my lifetime	20 (9)*	32 (14)	52 (11.5)
Drank only at special events (Christmas or wedding)	32 (14.2)	34 (15)	66 (14.6)
Had a sip of alcohol to see what its like	7 (3.1)	8 (3.5)	15 (3.3)
Once a month or less often	59 (26)	56 (24.8)	115 (25.4)
2 or 3 times a month	54 (23.9)	52 (23)	106 (23.5)
1 to 2 times a week	39 (17.3)	28 (12.4)	67 (14.8)
3 to 5 times a week	7 (3.1)	5 (2.2)	12 (2.7)
6 or more times a week	4 (1.8)	0	4 (.9)
Drank, but not in the last 12 months	2 (.9)	9 (4)	11 (2.4)
No response	2 (.9)	2 (.9)	4 (.9)
Total	226	226	452

* Percentages in parentheses.

As illustrated in Table 4.25, 15% just drank on special occasions and 3% had a sip of alcohol to see what it tastes like. Twenty-five percent of students reported drinking once a month or less, 23.5% reported drinking 2 or 3 times a month and 15% reported drinking 1 or 2 times a week in the previous 12 months. Males reported drinking at a higher frequency than females 1 to 2 times a week (17%, 12% respectively).

Table 4.26 summarizes students' perceptions of their alcohol use within the previous 4 weeks.

Table 4.26

Alcohol use within the Previous 4 Weeks

Response Category	Male	Female	Total n=452
Once or twice	76 (33.7)*	72 (31.9)	148 (32.7)
3 or 4 times	37 (16.4)	34 (15)	71 (15.7)
5 or 6 times	21 (9.3)	15 (6.6)	36 (8)
More than 6 times	14 (6.2)	9 (4)	23 (5.1)
Did not drink alcohol in the last 4 weeks	77 (34.1)	93 (41.2)	170 (37.6)
No response	1 (.4)	3 (1.3)	4 (.9)
Total	226	226	452

*Percentages in parentheses.

Table 4.26 illustrates that most students (62%) reported that they consumed alcohol within the previous 4 weeks and the largest proportion reported once or twice (33%) followed by 38% of the students who did not consume alcohol within the previous 4 weeks. In regard to gender, slightly more male students drank more frequently in the previous 4 weeks.

Table 4.27 summarizes students' perceptions of the number of times they were drunk within the previous four weeks.

Table 4.27

Number of Students and Number of Occasions Drunk Within the Previous 4 Weeks

Occasions drunk	Male	Female	Frequency N=452
1 or 2	56 (24.8)*	49 (21.7)	105 (23.2)
3 or 4	14 (6.2)	19 (8.4)	33 (7.3)
5 or 6	1 (.4)	1 (.4)	2 (.4)
More than 6	5 (2.2)	2 (.9)	7 (1.5)
None	117 (51.8)	130 (57.5)	247 (54.6)
Got drunk but not losing control	33 (14.6)	24 (10.6)	57 (12.6)
No response	0	1 (.4)	1 (.2)
Total	226	226	452

*Percentages in parentheses.

Table 4.27 illustrates that over half of the students (55%) reported not getting drunk within the previous 4 weeks whereas 23% had been drunk at least once or twice and 13% reported getting drunk but not losing control of their behavior. More male students than female students reported getting drunk but not losing control within the previous 4 weeks.

Table 4.28 summarizes students' perceptions and the number of drinks they consume on a typical day.

Table 4.28

Number of Drinks on a Typical Drinking Day

Drinks consumed	Male	Female	Frequency N=452
1	23 (10.2)*	25 (11.1)	48 (10.5)
2 to 3	21(9.3)	44 (19.5)	65 (14.4)
4	24 (10.6)	39 (17.3)	63 (13.9)
5 to 7	48 (21.2)	53 (23.5)	101 (22.3)
8 or more	68 (30.1)	11 (4.9)	79 (17.5)
Don't drink	40 (17.7)	52 (23)	92 (20.4)
No response	2 (.4)	2 (.4)	4 (.9)
Total	226	226	452

*Percentages in parentheses.

Table 4.28 illustrates that 22% of the participants reported drinking 5 to 7 drinks on a typical drinking day and 17.5% reported drinking 8 or more drinks on a typical drinking day. Twenty per cent reported not knowing how many drinks they had on a typical drinking day. More female students reported drinking more drinks than male students on a typical drinking day on all levels except at 8 or more level (30% and 5% respectively).

Table 4.29 summarizes students' perceptions of the amount of times that students reported consuming 5 or more drinks on one drinking occasion within the previous 4 weeks.

Table 4.29

Perceptions: Amount Consumed

Occasions in past 4 weeks	Males	Females	Total N=452
1	31 (13.7)*	32 (14.2)	63 (13.9)
2	27 (11.9)	28 (12.4)	55 (12.2)
3	19 (8.4)	14 (6.2)	33 (7.3)
4	17 (7.5)	9 (4)	26 (5.8)
5 or more	22 (9.7)	7 (3.1)	29 (6.4)
Did not drink in the last 4 weeks	67 (29.6)	90 (40)	157 (34.7)
Did not have five or more drinks on the same occasion in the last 4 weeks	41 (21.7)	42 (18.6)	83 (18.4)
No response	2 (.9)	4 (1.8)	1.3
Total	226	226	452(100)

*Percentages in parentheses.

As illustrated in Table 4.29, 46% of students reported binge drinking (5 or more drinks) on at least one occasion within the previous 4 weeks and 18% reported not drinking 5 or more drinks on one occasion; furthermore 35% of the students reported that they did not consume alcohol within the last 4 weeks. More female students than male students did not drink in the last 4 weeks and more male students than female students binge drank, 3 or more times (19%, 14% respectively) 4 or more times (17%, 9% respectively) and 5 or more times (10%, 3% respectively) in the previous 4 weeks.

Table 4.30 presents a summary of students' perceptions of number of times they were drunk at school within the previous 12 months.

Table 4.30

Times Drunk at School Within Previous 12 months

Occasion	Male	Female	Total N=452
0	185 (81.9)*	199 (88)	384 (85)
1	11 (4.9)	14 (6.2)	25 (5.5)
2 or 3	16 (7.1)	5 (2.2)	21 (4.6)
4 or 5	3 (1.3)	4 (1.8)	7 (1.5)
6 or 7	3 (1.3)	0	3 (.7)
8 or 9	0	2 (.9)	2 (.4)
12 or more	5 (2.2)	0	5 (1.1)
Not in the last 12 months	3 (1.3)	12 (5.3)	5 (1.1)
Total	226	226	452 (100)

*Percentages in parentheses.

An examination of the data in Table 4.30 shows that 5.5% reported being drunk once in the previous twelve months, and 5% reported two or three times within the previous twelve months. More males than female students reported being drunk at school 2 or 3 times in the previous 12 months (7%, 2% respectively).

Impacts of Alcohol

Student perceptions concerning specific impacts of drinking alcohol are presented in Table 4.31 including a summary of the number of students who reported that drinking alcohol caused tension or disagreement with family or friends. Also included are the number of students

that reported that they were seen by a doctor as a result of drinking alcohol and those being warned by police as a result of their drinking.

Table 4.31

Drinking Caused Concern Among Family/Friends/Doctor/Police

Questionnaire Item N=452	Yes	No	Don't drink alcohol
Drinking in last 12 months that caused tension or disagreement with family/friend	71 (16)*	298 (66)	83 (18)
Being Seen by a doctor or in a hospital as a result of drinking alcohol	18 (4)	359 (80)	74 (16)
Being warned by police related to their alcohol use	76 (17)	302 (67)	74 (16)

*Percentages in parentheses.

As illustrated in Table 4.31, 16% of the students reported disagreements or tension caused by their alcohol use and 18% reported that they didn't know, 4% reported that they had been in hospital or been seen by a doctor as a result of drinking and 16% did not know, while 17% reported being warned by police.

Table 4.32 summarizes students' perceptions on four impacts of drinking.

Table 4.32

Students' Perceptions on Four Impacts of Drinking

Questionnaire Item N=452	Never	<1/month	1/month	1/week	Daily or almost	Don't drink alcohol
Inability to stop drinking once started within the last 12 months.	283 (63)*	50 (11)	33 (7)	11 (2)	4 (.9)	70 (15.5)
Having not done things they were supposed to because of drinking within last 12 months.	243 (54)	84 (19)	39 (9)	11 (2)	4 (.9)	70 (15.5)
Need for a drink in the morning within the last 12 months	338 (75)	22 (5)	13 (3)	6 (1)	3 (1)	69 (15)
Unable to remember what happened the night before because they had been drinking within the last 12 months	186 (41)	112 (25)	57 (13)	22 (5)	6 (1)	69 (15)

* Percentages in parentheses.

As shown in Table 4.32, 11% reported inability to stop drinking once started less than once a month and 7% reported inability to stop drinking once started once per month. Nineteen per cent of students reported they failed to do things they were supposed to because of drinking once a month. Five per cent reported a need for a first drink in the morning within the last 12 months, 3% reported once per month and 15% did not know. Twenty-five per cent reported being unable to remember what happened the night before because of drinking less than once a month and 13% once a month.

Table 4.33 shows the number of students who reported that they had driven a motor vehicle within 1-2 hours of having two or more drinks.

Table 4.33

Times Driven within 1-2 hours of Drinking

Occasion	Male	Female	Total N=452
0	155 (68.6)*	189 (83.6)	344 (76.1)
1 or 2	49 (21.7)	23 (10.2)	72 (15.9
3 or 4	10 (4.4)	1 (.4)	11(2.4)
5 or 6	3 (1.3)	5 (2.2)	8 (1.8)
More than six times	8 (3.5)	7 (3.1)	15 (3.3)
No response	1 (.4)	1 (.4)	
Total	226	226	452

*Percentages in parentheses.

As shown in Table 4.33, 16% reported driving after drinking once or twice within 1-2 hours of drinking within the previous 12 months, and 3% reported driving more than six times within the previous 12 months.

Table 4.34 portrays the number of times students reported that they did not use a seatbelt as a passenger or when driving within two hours of drinking or where in an accident while driving after drinking.

Table 4.34

Behaviours While Drinking

Questionnaire Item N=452	Never	1-2 times	3-4 times	5-6 times	More than 6 times
Did not use a seatbelt as a passenger or driven within two hours of drinking within the last 12 months.	365 (80.8)*	45 (10)	13 (2.9)	8 (1.8)	17 (3.8)
Been in an accident within two hours of drinking within the last 12 months	442 (98)	6 (1.3)	1 (.2)	1 (.2)	2 (.4)
Been a passenger with a driver who had been drinking alcohol	256 (56.6)	118 (26)	37 (8.2)	15 (3.3)	24 (5.3)

*Percentages in parentheses.

As illustrated in Table 4.34, 10% reported that they did not use a seatbelt once or twice as a passenger or when driving within 2 hours of drinking within the last 12 months, and 4% reported more than 6 times within the last 12 months. One per cent of students reported being in an accident within two hours of drinking within the last 12 months and 26% had been a passenger at least once with a driver who had been drinking in the previous 12 months, and 8% reported at least 3-4 times in the previous 12 months.

In addition students reported on the number of times they or someone else was injured within the previous 12 months due to their alcohol use. Twenty-five percent of the students reported they or someone else had been injured due to their alcohol use, 12% of the students reported that they had not been injured in the previous 12 months and 46% reported neither they or someone else had ever been injured due to their alcohol use.

Table 4.35 summarizes the number of students who needed support, counselling, or advice about their alcohol use within the last 12 months.

Table 4.35

Need of Support/Counselling Because of Alcohol Use

Support Needed	Male	Female	Total N=452
Yes	5 (2.2)*	6 (2.7)	11 (2.4)
No	163 (72)	149 (66)	312 (69)
Not relevant to me	57 (25)	70 (31)	127 (28.1)
No response	1 (.4)	1 (.4)	2 (.4)
Total	226	226	452

*Percentages in parentheses.

As illustrated in Table 4.35, 2% of the students reported that they needed support pertaining to their alcohol use within the last 12 months. In addition to the information on the need for support, questions were asked about students' ability to find support/counselling that they were looking for from school resources. Twenty two per cent of the students reported that were unable to find the resources within the school and 16% did find support/counselling within the school and 61% found this not relevant to them.

Information on the number of students who accessed services to deal with their alcohol use was also collected. Four per cent of students reported that they accessed services for their alcohol use. In addition to this information students were asked if they attended drug or alcohol treatment in the previous 12 months. Three percent of students reported that they had been in treatment within the previous 12 months.

Other Issues

Additional aspects pertaining to youth alcohol use were included in the questionnaire including students' perceptions of how many of their friends use alcohol, most important reasons not to use alcohol and sexual activity, and alcohol use. Table 4.36 summarizes students' perceptions of their friends' alcohol use.

Table 4.36

Perceptions of Number of Friends That Use Alcohol

Friends	Male	Female	Total N=452
None	16 (7.1)*	15 (6.6)	31 (6.9)
¼	18 (8)	36 (16)	54 (11.9)
½	32 (14.2)	25 (11)	57 (12.6)
¾	69 (30.5)	77 (34.1)	146 (31.9)
All	89 (39.4)	73 (32)	162 (36.1)
No response	2 (.9)	0	2 (.4)
Total	226	226	452 (100)

*Percentages in parentheses.

Table 4.36 illustrates that 36% of the students reported that they perceived that all of their friends drank alcohol, 32% of the students reported that they perceived that three quarters of their friends drank alcohol, 13% of the students reported that they perceived that half of their friends drank alcohol, and 12% of the students reported that they perceived that one quarter of their friends drank alcohol. More male than female students perceived that all of their friends used alcohol (39%, 32% respectively) and more male than female students perceived that half of their friends used alcohol (32%, 25% respectively). Twice as many female students than male students

perceived that three-quarters of their friends used alcohol (34%, 31% respectively) and one quarter of their friends used alcohol (16%, 8%, respectively).

Table 4.37 summarizes students' perceptions of the most important reasons for not using alcohol.

Table 4.37

Most Important Reason For Not Using Alcohol

Reason	Male	Female	Total N=452
Friends do not drink	4 (1.8)*	3 (1.3)	7 (1.5)
Parents do not drink	2 (.9)	3 (1.3)	5 (1.1
Unhealthy	9 (4)	9 (4)	18 (4)
Fear of inability to stop	0	1 (.4)	1 (.2)
Parental disapproval	3 (1.3)	9 (4)	12 (2.7)
Cannot afford to	0	2 (.9)	2 (.4)
I enjoy other things	16 (7)	18 (8)	34 (7.5)
Many reasons	28 (12.4)	27 (11.9)	55 (12.2)
Not applicable	112 (50)	111 (49)	223 (49)
No response	52 (23)	43 (19)	95 (21)
Total	174	183	452

*Percentages in parentheses.

Table 4.37 illustrates that 12% of the students reported that there were many reasons that they did not use alcohol, 7.5% reported that the most important reason that they did not use alcohol was because they enjoyed other things, 4% reported that the most important reason was that it was unhealthy, and 3% reported that the most important reason that they did not use alcohol was

because of parent disapproval. Forty nine per cent reported this to be non-applicable and 21% did not respond.

Table 4.38 summarizes students' perceptions on their use of alcohol and sexual activity.

Table 4.38

Sexual Behavior and Alcohol Within the Previous 12 Months

Question	Gender	Yes	No	Not sexually active	Total N=150
The last time you had sex, did you drink	Male	22 (26.2)*	41 (48.8)	21 (25)	84
alcohol or use drugs?	Female	11 (16)	29 (42)	29 (42)	69
Missing					299
Total		33 (22)	70 (47)	50 (33)	452

*Percentages in parentheses.

Table 4.38 illustrates that 22% of the respondents drank alcohol when they had sex and 47% did not drink while having sex within the previous 12 months. More male students than female students reported that they drank alcohol or used drugs when they had sex (26%, 16% respectively). Additional questions regarding sexual behaviour were asked. When asked about whether they had unplanned sex in the previous 12 months, 37% of the respondents reported that they did have unplanned sex within the previous 12 months.

Finally a question asked if the students had unplanned sex after using alcohol or drugs within the previous 12 months and 28% of the students reported that they had unplanned sex after using alcohol or drugs in the last 12 months.

Summary: Student Perceptions of Programs and Policies Related to Alcohol Prevention and Perceptions of Behaviours Related to Alcohol Use

By Grade 11, 86% of the students reported drinking alcohol and 16% of students reported that they drank for the first time in the previous 12 months. Of students that reported that they abstained from drinking alcohol, 12% reported that they abstained for many reasons, and 8% reported because they enjoyed other things. Seventy four percent of the students reported being drunk in their lifetime and 43% reported being drunk for the first time in Grade 8 or 9. Thirty three percent reported being drunk once or twice in the previous four weeks where they lost control of their actions, and 13% reported being drunk but did not lose control of their actions within the previous four weeks.

Seventy percent of students reported that they used alcohol 4 or more times in the previous 12 months and 62% of students reported that they drank within the previous four weeks. Twenty two per cent of students reported drinking greater than 5 drinks on a typical day and 17.5% reported drinking 8 or more drinks on a typical day, and 46% reported drinking greater than 5 drinks at least once in the previous 4 weeks. Twenty-four percent of students reported driving within 2 hours of drinking at least once in the previous 12 months and 43% reported being passengers with a driver who had been drinking at least once in the last 12 months. Three percent of the students reported receiving treatment for their alcohol use within the previous 12 months, 4% reported accessing services within the school for their alcohol use, 22% did not find resources within the school, and 16% did find resources. Of 150 student respondents, 22% of the students reported that they drank alcohol when they had sex in the previous 12 months, 49% of

students reported that they did not drink alcohol when having sex in the previous 12 months, and 28% had unplanned sex after they drank alcohol.

Ninety four percent of students reported that they were aware of rules in the school pertaining to alcohol use and 83% reported that they agreed that they were followed somewhat consistently. Fifty two percent of students reported that they heard it was not okay to use alcohol from their teacher, 49% of students reported hearing from coaches that it was not okay to use alcohol, and 45% of students reported hearing from club advisors that it was not okay to use alcohol.

Twenty three percent of students did not recall any presentations on prevention of alcohol, 62% recalled one or two presentations, and 16% recalled 3 or more presentations on information on prevention of alcohol use. Thirty two percent did not recall any information on alcohol specifically, 55% recalled one or two classes. Twenty percent of students did not recall any information on skills to resist the use. However, 64% reported that there was an appropriate amount of information on alcohol, 48% recalled the information to be relevant, 66% reported the information to be informative, 48% recalled the presentations to be presented in an interesting manner, and 47% recalled the classes as effective.

Fifty four percent of the students reported that binge drinking included drinking five or more drinks in one sitting, 88% reported that alcohol was a CNS depressant; 86% of students reported that males and females reacted differently to alcohol, and 75% perceived an increased likelihood of alcohol dependence with early use of alcohol. Drinking fewer drinks less frequently was reported as less risky than drinking more drinks more frequently. Seventy four percent students reported that drinking five or more drinks nearly every weekend as medium or high risk

(39% and 35% respectively), 40% of students reported that they drank five drinks on a typical drinking day and 46% reported drinking greater than five drinks at least once in the previous four weeks.

More students reported that they were highly confident in being able to get a friends' support in their choice not to drink, than parents or teachers (64.5%, 59%, 47% respectively). Fifty two percent reported that they were highly confident that they would be able to get professional help if needed. Students' confidence levels of resisting the urge to drink appeared to change depending on situations, 71% of students reported that they were highly confident that they could resist the urge to drink if they were to have an argument with a close friend and 62 % reported that they were highly confident they could resist the urge to drink if things were going badly. Forty four percent of students reported that they were highly confident in resisting the urge to drink at a party, 48% of students reported that they were highly confident in resisting the urge to drink if they were celebrating, 41.5% of students were confident that they could resist the urge to drink if they were in a situation where they often drank, and 56% of students were confident that they could resist the urge to drink if they were under pressure.

Summary

In this chapter I presented the data representing the policy-in-implementation, which included an overview of formal and informal programs related to alcohol prevention, and themes from the vice-principal interviews. Themes from the interviews with the teachers and counsellors were then presented to represent policy-in-implementation. Data was then presented from the student questionnaire and focus group questions to represent the policy-in-experience. In the

final portion of chapter 5, data from the questionnaire on students' perception of their behaviours related to alcohol use were presented.

CHAPTER FIVE

Summary, Discussion, and Implications

I have collected data and reported on Grade 11 students' perceptions of alcohol prevention programs in four high schools in Saskatchewan. The data collection for this research took place from February to June 2008. Data were collected using semi-structured interviews, student questionnaires, and focus groups.

In this chapter, I first summarize the study by presenting an overview of the purpose and the methodology followed by a summary of the findings from the study along with the research questions. Second, I provide a discussion of the findings related to the *policy-in-intent*, *policy-in-implementation,* and *policy-in-experience*, along with recently published literature. Lastly, I reconsider the conceptual framework and address the implications of the study for future alcohol prevention programs through policy, practice, theory, and further research.

Purpose and Methodological Overview

I sought to explore Grade 11 students' perceptions of alcohol prevention programming in high school settings because there has been limited information on students' perceptions of the programs and there is a strong consensus among reviewers that for school drug education programs to be effective, they should be based on the needs and relevance of the young people who participate in them (McBride, 2003). In addition to the lack of students' perceptions of programs, there is limited information on the use of alcohol amongst Saskatchewan youth to inform practice. The focus of this research was on students' perceptions of programs; however, identification of what the policies were and how they were interpreted and implemented by professional educators was vital to understanding the context in which the students were

learning. In addition to this, rates of alcohol use by students were collected to provide contextual data about the students and their behaviours related to alcohol. Based on this background, the following questions guided my research:

1. What were the self-ascribed perceptions of Grade 11 students in relation to alcohol prevention programs?
2. What was the knowledge base of these students with respect to alcohol use and the effects of alcohol?
3. What formal and perceivable informal programs/activities on prevention of alcohol use were delivered in these schools?
4. What was the usage of alcohol among such students in 4 Saskatchewan high schools?

In my research, I used the case study research design (Stake, 2005) and purposive sampling (Patton, 1990). An overview of informal and formal programs were included as part of the data and semi-structured interviews were conducted with vice-principals, teachers, and counsellors. Students completed surveys and participated in focus groups. Once ethics approval was granted by the University of Saskatchewan Advisory Committee on Ethics in Behavioural Science Research I contacted the directors of education to elicit their participation. The criteria for student participants to enter into the study was that they were enrolled in at least one grade eleven class, were present on the day of data collection and were willing to participate in the research.

Three levels of policy outlined in Guba's *Domains Model* (1985) were used to frame this research. Semi-structured interviews were conducted with the principals to provide descriptions

of the policies on alcohol prevention and inform the *policy-in-intention*; teachers' and counsellors' descriptions of the content of alcohol prevention programs delivered were gathered and provided information pertinent to *policy-in-implementation* and the students' perceptions of the programs were collected through surveys and focus groups, and provided information relevant to *policy-in-experience*. SPSS was used to analyze quantitative data and was organized by aggregating the data where frequencies and percentages were used to assess general trends. After listening to the tapes and reading the transcripts from the qualitative data several times, formal analysis of the interview data was done using the data analysis spiral (Creswell, 2007). I identified themes and patterns from the interviews and focus groups. The procedures employed were: (a) reading and memoing, (b) describing, classifying, and interpreting, and (c) representing and coding using qualitative software (NVivo).

Summary of Findings: Responses to Research Questions

In this section I summarize findings to each of the four guiding research questions. I begin with the first research question: *what were the self-ascribed perceptions of Grade 11 students in relation to alcohol prevention programs?* Data elicited through the student questionnaire revealed that most students were aware of rules in the school pertaining to alcohol use and agreed that they were followed consistently. Many students recalled one or two classes on decision-making, peer pressure, and assertiveness relating to the use of alcohol. Just over half of the students reported that they recalled information on alcohol and some students reported that there was an appropriate amount of information presented on alcohol. However, many students did not recall any presentations on: the prevention of alcohol, information on alcohol or information on skills to resist the use of alcohol. Although a considerable number of students

reported that the information was informative, less than half of the students recalled the information to be relevant, or recalled the information to be presented in an interesting manner.

Students reported within the student focus groups that information with relation to alcohol prevention was mainly included in the wellness class. The method of delivery was done with the teacher presenting the content on alcohol prevention and the information on resistance skill in class. In addition to this, some students reported hearing information in Christian ethics, English, law, and Psychology. Students' suggestions to improve prevention efficacy included to ensure that content was accurate and age-specific. They recommended including information about alcohol and its effects to the body, legal aspects pertaining to the use of alcohol, and skill development. In addition to these components, participants recommended that information be incorporated at the older age groups as well as the grade nine level, and utilizing interactive methods of delivery. Along with these methods they suggested that personal stories from those who have chosen not to use alcohol, those who have suffered from addictions and family members of those addicted would be useful to improve prevention efforts. In more general terms, participants offered suggestions that increase behavioral, emotional and cognitive engagement through the use of relevant content, interactive methods in which students can practice new skills.

On the questionnaire and in the focus groups, students reported that they heard mixed messages in relation to alcohol use, which included: abstinence, drink in moderation, and harm-reduction messages. About half of the students reported that they heard it was not okay to use alcohol from their teacher, from coaches, and from club advisors.

Students also commented on the overall effectiveness of the programs in the school. These included: that they were somewhat effective and some said that they were not at all effective. In general, the program helped some to think about the consequences of their drinking or to be more aware; however, some students commented, most are drinking by now.

There were some differences in respect to gender differences in the questionnaire responses. More male students than female students recalled the information to be not at all or not very relevant and fewer male students than female students recalled that the presentations were interesting.

Next, I present a summary of the findings from the second research question: *what was the knowledge base of the students with respect to alcohol use and the effects of alcohol?* Findings from the student questionnaire revealed that just over half of the students reported that they knew what the term binge drinking meant, while most students reported that they knew that alcohol was a CNS depressant, that males and females reacted differently to alcohol, and many students perceived that there was an increased likelihood of alcohol dependence with early use of alcohol. More female students reported that they knew what binge drinking was and that there was an increase in likelihood of alcohol dependence with earlier onset of drinking.

Most students perceived there was no risk in trying one or two drinks on a single occasion. In addition to this most students perceived drinking one to two drinks nearly every weekend as slight or medium risk. Most students perceived that drinking five or more drinks nearly every weekend as medium or great risk. In general, more female students than male students reported drinking to be risky at all levels; trying one or two drinks and drinking five more drinks nearly each weekend.

In relation to their confidence level in resisting the urge to drink, more students reported that they were highly confident to be able to resist the urge to drink in situations when things were going badly, rather than if they were at a party, celebrating or at a place where they often drank. A greater number of female students than male students reported that they were confident in getting friends support if they chose not to drink or professional help. Fewer males than females were highly certain that they could resist the urge to drink if they felt like celebrating, in a situation where they had often drank, if they were under pressure to be a good sport or if they were at a party.

The third research question asked: *what formal and perceivable informal programs/activities on prevention of alcohol use were delivered in these schools?* Through the vice-principal, teacher and student interviews it was found that through the Saskatchewan mandated curriculum, alcohol prevention was covered in the Wellness 10 curriculum and in one school in the grade nine curriculums. Along with the curricular education some teachers included information in relation to alcohol in subjects such as: biology, Christian ethics and English when appropriate. Other student led groups informally presented information related to alcohol prevention. Overall the schools in this study a zero tolerance policies for alcohol use on school property or at school related events. All of the schools included the presence of addictions counsellors within the schools. A punitive approach was used once the students had been involved with alcohol; suspension was mandatory along with remedial approaches such as seeing a counsellor and involving parents.

Finally, a summary of the findings to the fourth research question*: what the usage of alcohol was among the grade 11 students in four Saskatchewan high schools?* Findings from the

student questionnaires revealed that by Grade 11, 86% of the students reported drinking alcohol and 73% of the students reported having used alcohol to point of being drunk in their lifetime. Many of the students reported that they had first consumed alcohol in grade eight and nine and first consumed alcohol to the point of feeling drunk in grades eight or nine.

Twenty-two percent of students reported drinking five to seven drinks on a typical drinking day and 17% of students reported that they drank eight or more drinks on a typical drinking day. Forty-six percent reported drinking greater than five drinks at least once in the previous four weeks. Forty-two percent of students reported that they used alcohol more than once a month in the previous 12 months and 62% of students reported that they drank alcohol within the previous four weeks.

Sixteen percent of students reported driving within two hours of drinking at least once in the previous 12 months and 43% of students reported being passengers with a driver who had been drinking at least once in the previous 12 months. In relation to sexual activity and alcohol use, 28% of the students reported that they had unplanned sex after using alcohol within the previous 12 months.

Three percent of students reported that they had been in treatment for their alcohol use within the previous 12 months, and 16% reported that they were able to find the support, counseling or advice about their alcohol use that they were looking for within the school. Twenty-two percent of students reported that they were unable to find support, counselling or advice about their alcohol use from the resources within the school when needed.

The findings revealed gender differences in a number of areas with relation to students' behaviour and alcohol. More males than females started drinking in grade 9 and more females

started drinking in grade 10 and more females reported never using alcohol in their lifetime. Likewise more male students reported their first time of alcohol use to feel drunk was in grade 9 and more females in grade 10. Within the previous 12 months and the previous 4 weeks, male students reported drinking alcohol more frequently than female students. Female students reported drinking more drinks on a typical drinking day than males except significantly more males reported drinking 8 or more drinks on a typical drinking day than females. Male students reported binge drinking with greater frequency in the previous 4 weeks than female students.

Discussion of Policy-in-intent

Policy-in-intent can include goals and intents, standing decisions, guide to discretionary action, and problem-solving strategy (Guba, 1985). This section includes data emerging from vice-principals interviews on policy on drug and alcohol prevention. Five main themes emerged from the document overview and vice-principal interviews: disconnected content on alcohol prevention in curriculum design, the place of zero tolerance in comprehensive strategies, open and transparent approach, and informal policy and ad-hoc practices. First, one observation of this section was that it was rather thin in comparison to the other two policy levels. When I reflected upon why this was, it became apparent that I was anticipating finding a document with written policies related to the area of alcohol prevention but this was not the case. Policy was written specifically related to student conduct in relation to alcohol use in the school and infractions related to this use. However, this did not mean that there was nothing else being done in the area, but rather that there were numerous unwritten policies and practices that took place which I attend to in this section. I will start by discussing the curriculum in which drug and alcohol

education is focused upon in tandem with policies and practices, all components of the comprehensive school health definition.

Disconnected Content on Alcohol Prevention in Curriculum Design

At the secondary education levels, health education is a compulsory subject taught at the grade nine and ten level; however, in grade ten it is included with physical education. The health curriculum foundation was based upon the term, *comprehensive school health* that included "a broad spectrum of programs, policies, services and activities that take place in schools, and their surrounding communities" (Saskatchewan Learning, 1998) but, was not defined in the *Wellness 10* (2004) curriculum guide.

Within the curriculum, drug and alcohol education was one topic that was covered under a broad spectrum of subject matter. Furthermore, there were multiple units to cover. After seeing the curriculum I was left wondering how the topic of alcohol prevention could be covered effectively given the range of topics to be addressed in 100 total hours of instruction. According to the curriculum, not only was the teacher expected to cover a large amount of material, but there was little content or direction provided for instruction. It appears that the intent was for the teachers to use their discretion to prioritize topics based on their insight and values on each of the topics. Last, this curriculum guide did not appear to be user-friendly. It was made up of five concepts, which were threaded throughout the document. As well there was no definition of comprehensive school health, which was identified as the foundation of the curriculum. A question arising from these observations is how can these core concepts be applied in a practical manner in the classroom?

The Place of Zero Tolerance in Comprehensive Strategies

In all of the schools, along with the curriculum, there was only one explicitly stated policy towards alcohol prevention, which outlined that the school did not tolerate the use of alcohol at school or related activities. The schools used a zero tolerance approach in regard to alcohol use in school wherein each of the schools automatically suspended students for their first infraction with alcohol. Immediate school suspensions for alcohol-related offenses are considered to be a zero-tolerance response and a punitive discipline approach that has been used extensively in the United States (Toumbourou et al., 2004) and in the schools in the current study. Punitive policies can have negative effects, such as increasing the risk of dropping out (McAndrews, 2001), decreasing student links with school and, potentially, discouraging students from self-reporting substance use problems (Paglia & Room, 1999). An emphasis seemed to be placed on a punitive orientation because school suspensions were the severest forms of discipline used in the schools and they constituted the first line of approach in alcohol-related refractions. However, the vice-principals stressed that they did try to view and understand each situation separately. Following the initial response, remedial approaches were taken by referring students to the addictions counsellor and parents were always contacted.

Policy on student alcohol use is one element of a comprehensive strategy that contributes to a healthy school environment. Although there is little research to date on policy related to student substance use in schools, preliminary research findings showed a clear association whereby the probability of substance use was higher when the school norms reflected greater tolerance towards the use of substances (Kumar et al., 2002). Taking into consideration the impact that zero-tolerance policy may have on students, it is suggested policy approaches need to

be implemented consistently and include consequences that incorporate educational strategy, early intervention, referrals, and in-school suspensions (Nova Scotia Department of Health, 2002). In the current study, the school policies on offenses related to alcohol use in the schools included immediate suspensions, referrals, consultation with the parents, and potentially police involvement.

Open and Transparent Approach to Issues of Student Alcohol Use

Although the open approach was evident across the schools, one participant, in particular noted that the open approach of the school towards alcohol education and addictions was a positive change from previous "behind the scenes" approaches. Addictions was now viewed and discussed openly within the school and not silenced. Having an addictions counsellor available to the students was an example provided to illustrate this open approach. Furthermore, the presence of a counsellor strictly for students with issues in addictions appeared to promote more constructive attitudes towards to those who may need help regarding their substance use. According to the literature these attitudes facilitate help-seeking by reducing stigmas associated with substance use behaviours (Erikson, 1997). The National Treatment Strategy Working Group (2008) goes on to say, "Stigma (negative attitudes) prevents people from getting services and supports they need" (p. 2). The open approach is moving towards facilitating the policy process in early identification and intervention of student alcohol problems by promoting more positive attitudes towards addictions.

Informal Policy and Ad-hoc Practices

The processes for student referrals to the counsellor included the opportunity for students to refer themselves to the counsellor, or for teachers or students who were aware of someone that

was in need of help to talk to the counsellor out of concern for them. However, participants reported that there was no formal referral process to the addictions counsellor included in the policy.

There was not a consistent process in place to identify students that were in need of assistance related to alcohol use. Although one participant noted that the early identification of students in need of assistance was viewed positively, there was no clear systematic approach for this to occur. Friesen et al. (2008) reported there was a "clear relationship between frequency of drinking and grades achieved at school" (p. 27) and provides an academic rationale for schools to formalize the detection of early problems and provide appropriate referrals.

Another informal policy included parents being involved with alcohol-related infractions however, it appeared that in these schools, there was no formal system in place to actively include the parents in educational programs. Furthermore there were no formal plans to initiate this process, but the participants noted that this was a need.

Even though the above strategies were moving towards a more remedial approach in alcohol prevention, the participating schools seemed to favour an *ad hoc* approach in assessing or screening youth to identify when students were in need of support. It appeared that staff was working from the assumption that they were doing the best they could and that someone would be there to do what was in the students' best interest.

Indicators of Policy Efficacy

In the school settings involved in this study, there was no system in place for tracking the level of student alcohol use, for measuring the effectiveness of the alcohol-related programs or for identifying issues students would like to be included on alcohol prevention. The vice-

principals acknowledged that they dealt with far more drug-related offenses in school compared to alcohol related offenses and that they did not have a systematic approach to measure student usage or evaluate present programming and policy. The participants recognized that students were participating in alcohol related events after school hours. Once again the evaluation of the program was informal, based upon the assumption that if there were no complaints, and infractions had not increased then the approaches to policy and program did not need to change. It seems that the success of the program was left up to the discretion, conscientiousness, and time of the administrators. These approaches left me to wonder what informed the curriculum and the policy. It was not clear if the administrators viewed what the students were doing outside the purview of the school as important to address in the present school curriculum and policy.

Discussion of Policy-in-implementation

For this purpose of this study the policy-in-implementation phase involves the delivery of the program and includes data arising from the interviews with the teachers and counsellors. I present a discussion of four themes that emerged from the interviews. These themes are: the impact of time, developmental significance of content, applying curricular content: realistic approach, and parent and community effect.

The Impact of Time

Although there is limited research that indicated the number of program hours necessary to achieve positive results in the prevention of alcohol use in youth; the length of the session (hours), number of sessions (sessions/week) or duration of the program, it is known that occasional presentations did not have any measureable effects on student drinking behaviours (Hawks, Scott, & McBride, 2002). However, in general it has been viewed that the more time

spent (hours) on a program the better the outcomes. In the current study, the amount of time in the curriculum that was dedicated to alcohol prevention was covered in 2 hours, "… a two day unit, one hour each day" (R3, W1, I) over the period of a term. Outside the curricular content a participant summarized the practice well by saying, " … everybody in the school supports giving them information where it fits in" (R2, C2, Q2).

Participants who delivered the curricular content identified there was limited time in which to deliver the information. Naturally, time affected the content that was delivered (amount, depth) the method of delivery, limited potential for alteration of program including the possibility for guest speakers. The teachers also agreed that skills training was an important aspect to include however, one teacher stated, "it takes hours to practice the skills in a really solid way" (R1, W1, S) and they did not have the time to do this effectively.

Another remarks, that helped to illustrate the issues that arose specifically due to the lack of time dedicated to the prevention of alcohol was, "I'm not in two days going to be able to say to them, okay, this is wrong, you shouldn't do this" (R2, W2, C). In light of this comment it appeared that this participant was not confident in the ability of the current approach to be effective under the present circumstances. So then did the lack of time force this teacher to target one group of students' needs over another group? How was the content prioritized?

I also wondered did the other professionals, who were not teaching the curricular content, feel to be necessary to teach content related to alcohol prevention in their subjects because they there was a need or because more is better? This may have also been due to the fact that there wasn't a clear idea of when or what content was delivered in the *Wellness 10* curriculum.

Although there is no definitive answer regarding number of program hours necessary to promote change there is agreement among alcohol prevention program reviews that effective educational programs on alcohol should be based on local prevalence data (McBride et al., 2003). However, I suggest that students' needs and program relevance might need to be considered when determining the amount of time necessary to create an effective program.

Developmental Relevance of Content

Tobler et al. (1999) reported that drug education program failures could be attributed to lack of engagement in student interest because of developmental inappropriateness and activities being too abstract. In the current research, the participants commented on the importance of presenting information that was pertinent to what the students were experiencing in relation to the use of alcohol. An example that was shared by a participant was the importance of discussing drinking and driving at an age where the students were driving or about to drive rather than at grade 9 when students were not yet driving.

Other known important elements in efficacy of alcohol prevention programs include the timing of programs and tailoring of the programs using local prevalence data. More specifically, the greatest intensity of intervention needs to be focused at the first stage and 'booster sessions' at the second and third stage, which might include up to eight sessions. For interventions to be most effective three stages in students' behavioural development have been suggested; immediately prior to experimentation with alcohol, when students experience initial exposure, and when prevalence and context of alcohol use increases (McBride et al., 2003).

Applying Curricular Content: A Realistic Approach

The content that was covered within the curriculum included information such as the harms of drugs and alcohol, and decision-making, which included how to make decisions around the use of substances. Furthermore, a participant stated that students were given information on where to seek help when needing support and how to get connected to get help. Skills training was also talked about but not practiced in class.

An important comment was that even though there was a curriculum, "…obviously each instructor does his own thing uses the same materials but … the focus is a little bit different" (R1, W2, I). This participant expressed that he taught from "the standpoint of giving them the information and show them basically the causes and different things that can occur… here's the information, you make the decision on whether or not this is right for you" (R2, W2, I). He called his approach the "realistic approach" and further explained that this meant to him, "I know they are using before they are of age".

What I understood from the teachers was that they felt the best way to help students in the time that they had was to provide them with accurate information because they were certain that most of the students were using alcohol even though it was illegal for students to drink before the age of 19 in Saskatchewan. I felt a tension from the teachers when they were speaking about this and in retrospect I believe it was because they knew they were to teach the message of abstinence; however, as this participant acknowledged, he knew that many were already using alcohol. In essence this teacher was attempting to teach what was relevant to the majority of students, in other words, a realistic approach.

Roberts (2008) suggests that controversy exists on whether the message of abstinence is the best approach for universal curriculums because a significant percentage of students use alcohol in high school years and often in risky ways. He goes on to say that the message of abstinence may not meet the needs of all students because these youth are already using and they may have the basic information around alcohol use. It is understandable that the teachers felt an obligation to teach students the necessary information to make knowledgeable decisions but also important to recognize that controversy exists with this approach for numerous reasons. As noted by Poulin (2006), first and foremost, school administrators have a "duty of care" (p. 4) to students by law and policy where alcohol is an illegal substance, and the school boards have adopted abstinence as a goal. Poulin (2006) also outlines that other issues exist such as, what the appropriate chronologic age of students to present this information. Furthermore, when are they developmentally capable of making informed decisions around harm reduction (recognizing the difference between harm minimization as condoning use)? Finally, there is limited evidence supporting the harm reduction approach targeting youth. Although all of these issues need to be addressed, clear messages need to be established. At this time messages that identify abstinence as the best option to avoid risks and harms are recommended along with resistance skills training, and skills to help youth reduce hazardous use and harms (McBride, 2003).

The National Treatment Strategy Working Group (2008) proposed a tiered approach to risks and harms related to substance use including alcohol use. The tiered approach was designed to meet a spectrum of needs, from those who do not use to those who are high-risk users. This approach seems to be consistent with the above literature.

Parent and Community Involvement

Teacher participants agreed that parental involvement in students' lives was important when students were making decisions around the use of alcohol. Various comments inferred the importance of parents and communities in the preventive role with students and one participant in particular seemed to capture many teachers' views, "but its a combination, its home, giving the same message, its the school giving the same message, its their peers …it has to come from more than one avenue" (R1, C2, C). When the teachers spoke about students who came from homes where the use of alcohol was permitted or parents were not aware of the use of alcohol by their children I sensed a feeling of powerlessness or hopelessness in their roles in affecting students' decisions.

In one school where information nights were organized and few parents showed up, a participant seemed to resign herself to the point where she had done all she could by stating, "I think it is too difficult to be doing anything different or better…we're the school, we can't affect home life or you know the community…and the community tolerates it" (R1, C1, CI). I was not sure if this portrayed a feeling of apathy, hopelessness or a sense of frustration.

Discussion of Policy-in-experience

Policy-in-experience phase of this study was recognized through student questionnaires and focus groups. I will discuss the findings that emerged from the student questionnaires and focus groups into the four main themes: relevant information based on student current use, content to engage, engaging methods of deliver: use of interactive approaches, and messages in alcohol prevention. Following the themes I present student perceptions of their behaviours with alcohol.

Relevant Information Based on Student Current Use

Bandura (2004) stated that, although programs based on knowledge alone are not considered to be effective, students need accurate information in order to make decisions regarding their behaviours. Just over half of the grade 11 students, in the current study, reported that they had one or two classes about alcohol in general and one-third did not recall taking any classes with education pertaining to alcohol. As already stated earlier, it is not known how much information is necessary for alcohol prevention programs to be effective, accurate information is necessary based on the current trends of use. Based on the observation that many students in the current study did not recall information on alcohol brings to mind a number of questions as to why this was so. Was the students' inability to recall information due to a lack of information presented (amount), the lack of relevance of the information (content), or the delivery method employed in the teaching of it? Although many of the students in study reported that there was enough information on alcohol and that it was informative, a significant amount of students reported the material was not relevant.

As mentioned, Tobler et al. (1999) suggested that the efficacy of drug and alcohol educational programs might be associated with lack of engagement of student interest due to developmental inappropriateness and method of delivery. Student participants in the current study not only suggested that information needed to be focused at the grade nine level but also identified the content that needed to be focused at the grade eleven level, the method of delivery to be used, and rationale. The participants stated, "in grades seven and eight no one really cares, oh it's never gonna happen and then in grade nine, they say I'll never do it, and bam, everyone who didn't drink, drinks" (R3, S4, I). There was congruence in what the students were saying

with the current research, where the largest proportion of students reported they first drank in grade nine, and reported that this was their first time to drink to the point of getting drunk. This data supports McBride's (2003) basic recommendation to base timing of programming on local data on student usage. McBride (2003) suggested basing timing on the Canadian picture and focusing more education at the middle level of education in Saskatchewan (Grade 7-8) when most Canadian youth reported first drinking, whereas the students' in the current schools suggested providing data at grade nine level. In summary, students suggestions were very much in agreement with what McBride (2003) suggested, provide data at three stages, prior to use, at initial exposure and at the final stage where different risks are posed. Students in this study suggested increasing education at the grade 11 level where the use of alcohol is more prevalent and students are now driving, and the context changing.

Content to Engage Students

The messages that students heard from approaches taken within the schools in regards to the prevention of alcohol use included: abstain from using alcohol, when you become of age; use in moderation, and various harm reduction messages. Suggestions that students made to improve program efficacy included the teaching methods and content. Specific to content, participants reported that scare tactics and focusing on the risk of youth becoming alcoholics are ineffective because they are not accurate, and students know people who drink occasionally do not become alcoholics. Suggested content appropriate to the grade nine level included: ways to resist peer pressure and to tell the grade nine's that it is okay not too drink and once again the rationale for focusing this material at this time was because this is when participants recalled started drinking.

As there was no information focused at the upper high school levels, participants recommended increasing information at this age. Content suggested for the upper years included not only how to make decisions on whether to drink, but also harm reduction messages such as information focusing on drinking and driving. In the focus groups, student participants reported that along with accurate information, they would like to hear about the benefits of not drinking as well as personal stories related to those who have become alcoholics and those that suffered consequences due to their use. Other ideas included: presenting messages and opportunities on how to say no, and how to resist peer pressure to drink in certain situations. Furthermore, that these messages be presented focusing solely on drinking and not included with information on other psychoactive agents. When presented with other drugs, alcohol was viewed as more socially acceptable and not as much of a problem as hard drugs, "so in comparison to drugs its not as bad." Therefore, information and skills training need to be specific to alcohol because if "… you pile alcohol, drugs, heroine in one presentation and alcohol sort of gets lost… alcohol is overshadowed" (R3, S4, I).

Although participants did report that information was given to students with examples of what to say if they wanted to say "no" to drinking, students suggested including information on resisting peer pressure, refusal skills, and resistance skills. Almost one quarter of the students in the current study did not recall information on refusal skills, decision making or peer pressure related to alcohol use. Over half of the students reported that they agreed or somewhat agreed that there was an appropriate amount of information on how to resist using alcohol. There is controversy about the effectiveness of skills training (Paglia & Room, 1999), and there is also "limited information on when to introduce these types and aims and messages" (Roberts, 2007,

p. 29). What is known is that decision of content and timing is “best made on the basis of the consumption patterns in a region – the most relevant information being the prevalence of hazardous patterns (e. g., Binge drinking, drunkenness, use of more than one substance, and use in risky situations such as before driving), however, the prevalence of past year substance is also relevant (Roberts, p. 29). Roberts (2007) goes on to say that based on local data, each school board and health district need to make decisions when to “focus on reducing hazardous patterns of use” (p. 29). Interesting to note, students in the current data confirmed Roberts (2007) findings, they identified that an important time for content to be delivered was when students initiated drinking (grade nine), and when risks of drinking increased (grade 11). Even though the participants in three focus groups identified that they were unsure of what teaching approaches would be effective to those already drinking because they had already made the decision to drink. They thought that some of the approaches that have been used were helpful to make them stop and think before taking part in risky behaviours, such as content on drinking and driving. Other suggestions students had were geared towards encouraging students to identify the harmful effects of risky behaviour when using alcohol by writing, reflection, and by the use of presentations on real life situations.

Although there is much debate about what seems to be the best instructional approach for each given set of circumstances, the participants in the current research suggested a very logical approach. Along with accurate information, refusal skills need to be practiced in grade nine. In addition to this, more education needs to be implemented at the grade eleven/twelve level along with resistance skills. Consistent with the research, students stressed that skills training needed to be specific to alcohol-related situations, which is also supported by research (Botvin, 2002).

Although, controversy exists regarding resistance skills training based on the notion that youth choose to drink for a number of reasons and are not necessarily pressured by their peers to drink but choose their peers based on commonalities. One group of students agreed in the current study and did report that they felt a strong sense of pressure, “kids feel pressure,” and although

> I don’t feel direct pressure to drink. There is no one who is specifically saying, hear drink this, the thing is you go to a party and like everyone around you is drinking. There are 14 people drinking, and you are the only one not drinking and indirectly it affects you and makes you want to drink (R1, S4, SS)

These participants did recommend teaching content that includes, not only how to resist peer pressure, but also to draw on the positives of not drinking and have people share personal stories on how this is working in their lives. Along with content the students strongly suggested that methods of delivery are important in increasing effectiveness of programs.

Engaging Methods of Delivery: The Value of Interactive Approaches

Tobler and Stratton (1997) identified that interactive programs have an effect that was at a minimum twice as effective as non-interactive programs. Furthermore, that the opportunity for students to practice and exchange ideas acts as a method for change and is more critical than the content of the program (Tobler et al., 1999). Students in the current study concurred with the sentiments of the statement: “When you are in grade 9, you look up to the grade 12’s. They should talk to grade 9’s about alcohol stuff, and it’s okay if you don’t want to. That would have more influence than any of the teachers” (R1, S4, I).

Students reported that the information based on alcohol prevention was based on lecture type approaches that they stated were ineffective in keeping their attention. Just under half of the students reported that the material was presented in an interesting manner. Along with these

comments, all groups consistently reported that hearing personal stories would be highly effective. Personal stories that included relevant messages to the participants included: benefits of abstinence, those addicted, families of addicts, and victims of drunk drivers. McBride (2003) identified that the role of the teacher in methods that increase student interactivity includes that of a facilitator than a presenter, correcting misperceptions and offering information as needed. Specific interactive techniques that work well include, "role-plays, socratic questioning, simulations, brainstorming, cooperative learning, peer-to-peer discussion and service-learning projects" (Roberts, 2008, p. 25).

Dissemination of information was reported to be important with the manner or tone of presentations also significant. Students suggested, "give information without being bossy" (R1, S1, I). Moreover, even content such as statistics can be presented in an engaging manner by making it personal.

Engagement includes, "Attitudes and behaviors that can be affected by teachers and parents, and shaped by school policy and practice" (Willms, 2005, p. 9). The suggestions students provided included, content, timing of information and methods to increase cognitive, behavioural and emotional engagement, as identified by Fredericks et al. (2004). *Cognitive* engagement can be increased by providing age-appropriate information based on current prevalence data providing relevant information; *behavioural* engagement can be enhanced using interactive strategies and emotional engagement by the use of personal stories that students have identified that are relevant to them.

Based on these definitions of engagement and the strategies that the students presented, a question that comes to mind is, does engagement improve student self-efficacy. Bandura (1986)

described four factors that shape efficacy as: mastery experience, vicarious experience, social persuasion and affective state. If students are given the opportunity to observe skills modeled by others (vicarious experience), and receive feedback and encouragement from others (social persuasion) and given the opportunity to practice skills (mastery experience) in an atmosphere that decreases anxiety but increases excitement (affective state) would this increase self-efficacy? If this were the case, then the interactive strategies appear to be ways that might increase self-efficacy. Bandura (1986) stated that learning how to deal successfully with potentially dangerous situations successfully expands and strengthens an adolescent's sense of efficacy. However, strengthening self-efficacy is best accomplished by successfully being guided and mastering skills, which in turn provides the knowledge and skills needed to perform these skills in risky situations (Bandura, 1986). Successful management of problem situations instills strong belief in one's capability or self-efficacy.

Schooling includes many potential influences on adolescents' self-efficacy (Schunk & Meece, 2006). These influences include how instruction is structured. Instruction affects the ease or difficulty or learning. Methods such as interactive instruction have been identified as significant influences in the success of alcohol prevention programs (Tobler et al., 1999). Students in the current study reported on their confidence in different contexts. More students reported that they were highly certain that they could resist the urge to drink when the situations where things were going badly or argument with a close friend than in positive situations such as celebrating or where they often drank. This might suggest that students would benefit by practicing skills in positive situations to enhance their confidence in such settings.

The students reported being confident in being able to get friends' support, parent's support or teachers' support if they chose not to drink, the students reported as follows. They were more confident that they could get their friends support if they chose not to drink than their parents and more confident in getting professional help than teachers help. According to Bandura (1997), "…adolescents who feel efficacious to withstand peer pressure discuss with their parents the predicaments they face" (Bandura, 2006, p. 25). In light of these results one might conclude that parents might need to initiate discussions with students.

Messages in Alcohol Prevention

Adolescent development takes place in a variety of social contexts but mainly, the home, in school or through peer networks. The approaches taken within the schools towards the prevention of alcohol use included, abstinence, use of alcohol in moderation, and harm-reduction. In tandem with these universal program approaches, the school policies consisted of a zero-tolerance approach. Also interesting is that one group reported not hearing much about alcohol use in school except when it came up in rules such as no alcohol was allowed at football games.

The messages that students reported hearing regarding alcohol use differed between the school, home and media. Based on the current research, students were more likely to hear that it was not okay to use alcohol in school than in the home from their parents or from the media. The largest proportion of the students reported that they received mixed messages from their parents and many of the students felt that their friends felt it was okay to use as well as almost half of the students felt that the message from the media was that it was okay to use. The information gathered from students on the questionnaire were consistent with the data gathered in the focus

groups. Within the focus groups students reported that if they were on teams they should not drink. Within the focus groups one student reported that even if the school tells you that it is not good to drink the family is also a large influence and need to be saying the same thing. According to the Primary Prevention Attitude and Use Report (Education Council Foundation, 2009) parents need to be sending a no use message to students and peers need to give one another courage to not use. Bandura (2006) agreed that peers are an influential force but do not take the place or role of family however, he also stated that the processes by youth weigh and combine the source and information are not well understood. Understanding that the messages that students are receiving all play a role in prevention it is important to note that the "schools exist within a broader community and can influence students beyond the walls of the school building" (Nova Scotia Department of Health, 2002, p. 8).

Implications for Understanding of Student Behaviour, Theory, Policy, Practice, and Future Research

The literature and the findings show that there are many approaches that contribute to the efficacy of prevention of alcohol programs. I begin this section by discussing the implications of findings of this study for our understanding of student's perceptions of their alcohol related behaviour. Next I present a revisiting of the conceptual framework (implications for theory). Finally, I provide implications for program policy, practice, and future research.

Students' Perceptions of their Behaviour in Relation to Alcohol

I examined the findings of this study in comparison to the findings of a recent study of Manitoba students' perceptions of their behaviours and their use of alcohol (Friesen et al., 2008). This comparison is presented here for a number of reasons: to relate and compare similarities and

differences in trends and patterns with students of similar age to provide a broader perspective of the local culture of alcohol use as well as validate the current findings. The Manitoba study (2008) was chosen for comparison rather than the CAS (2005) because the sample group from Saskatchewan was small in the CAS and the limited questions for comparisons. The Manitoba study was chosen because of the similarity of populations, the parallel questions used in the questionnaires, and the comparable age of the student populations.

Students' Perceptions of Alcohol Use

The Manitoba study (2007) is presented in light of the low-risk drinking guidelines established by the former Addiction Foundation of Manitoba. It is important to outline that even though drinking alcohol has become normal for youth, low-risk drinking guidelines have been established for adults and are used with this understanding when looking at youth alcohol use (Adlaf et al., 2005). Also important to note is that the legal drinking age in Saskatchewan is 19 whereas the legal drinking age in Manitoba is 18. Due to differences in some of the items asked in the questionnaire, comparisons presented are limited to student perceptions of alcohol use in the previous 12 months, frequency and amount of drinking in the previous 12 months, drinking at least 5 drinks on at typical drinking day, risk indicators, and drinking and driving.

Table 5.10 contains a summary of comparative data from the studies concerning student perceptions of their drinking.

Table 5.10

Data Comparison: Student Perceptions of their Alcohol Use

Use Category	Manitoba Males	Manitoba Females	Total N=740	Current Study Males N=226	Current Study Females N=226	Total Current Study
Past year drinkers	74%	76%	75%	86%	77%	82%
Former drinkers	82%	85%	84%	0	2%	2%
Lifetime abstainers				9%	14%	11%

As illustrated in Table 5.10, the findings are similar in the current study and in the Manitoba study (2007) there were slightly more students in the current study that reported drinking in the 12 months before the study, than in the Manitoba study. Eighty-two per cent of the students in the current study reported that they drank alcohol within the previous 12 months while 75% of students in the Manitoba study reported that they drank alcohol within the 12 months prior to the study. On the question of female student consumption of alcohol during the 12 months prior to the survey, proportions were similar in the two studies. Seventy seven percent of female students in the present study reported that they drank alcohol within the previous 12 months and 76% of female students from Manitoba reported that they drank alcohol within the previous 12 months. Eighty six percent of male students in the present study reported that they drank alcohol in the previous 12 months compared to 75% of the male students in the Manitoba study reported that they drank alcohol in the previous 12 months.

In both populations the percentage of students reporting that drank alcohol in the past year was lower than the percentages reporting that they drank alcohol in their lifetime, which may indicate that some students may have tried alcohol and then stopped using it. Overall, in the current study a higher percentage of students reported drinking within the previous year than in the Manitoba study (82%, 75% respectively) and the main difference being that there are more male students that reported drinking in the current study than in the Manitoba study (86%, 74% respectively).

Frequency and Amount of Drinking

In this section I include comparisons of similar categories used in each of the studies in relation to the frequency and amount students have drank in the previous 12 months. The percentage of students that reported having just a sip of alcohol in the previous 12 months in the current study was 3% and in the Manitoba study was 8%. Students that reported drinking alcohol less than once a month in the Manitoba study was 32% and in the current study 25% reported drinking once a month or less often. Students that reported drinking one to three times a month in the Manitoba study was 34% and in the current study 24% reported drinking two to three times per month. Thirteen percent of the students from the Manitoba study reported drinking once a week within the last 12 months and 15% of the students from the current study reported drinking one to two times per week. In the Manitoba study 10% of the students reported drinking two to three times per week, 3% of the students in reported drinking alcohol 6 to 7 times per week and in the current study 1% of the students reported drinking 6 or more times per week. Fifteen per cent of the students in the current study reported using alcohol at special events such as Christmas and weddings.

Binge drinking (5 drinks) is classified as heavy drinking. It may occur irregularly and infrequent or regularly and frequently. Statistics Canada, *Health Indicators* (2004) defined heavy drinkers as drinkers that reported drinking 5 or more drinks on one occasion at least 12 times per year. Students from the current research and in the Manitoba study reported that they drank five or more drinks on a typical day. More specifically, 40% of students in the current study reported drinking five or more drinks on a typical drinking day and 58% of students from the Manitoba study reported drinking five or more drinks on a typical drinking day. These results suggest that a significant number of students in the present study and Manitoba were drinking at a level beyond the recommended safe drinking guidelines (e.g., drinking at least five drinks on one occasion) which increases their risk for harmful consequences such as using poor judgment, exposing oneself to unplanned or unwanted sexual activity or driving or riding in a car with an impaired driver. As stated above, in the current study, 40% of the students reported drinking on a typical drinking day at a level exceeding the recommended safe drinking guidelines. Along with the harmful consequences associated with binge drinking, it is a known risk factor for later problem drinking (Adlaf et al., 2005). A considerable amount of students in the current study then are at risk for later problem drinking.

Risk of Alcohol Dependence and Related Problems

According to the data collected in the present study and in Manitoba, students reported that alcohol use is common within the student population. Amongst both populations, students reported drinking frequently and some reported exceeding safe levels of drinking. Establishing the extent to which students are drinking and the consequences of their drinking is helpful in

identifying that appropriate resources are made available or developed for the student population (Friesen et al, 2007).

The implications of student drinking and their associations with harmful drinking behaviour have been the topic of research and policy attention. The Addiction Foundation of Manitoba included a new measure of alcohol and drug dependence in their survey package. The set of measures was called the Atlantic Alcohol Risk Continua (AARC) to assess alcohol dependency on a continuum of 'no risk,' 'low risk' 'medium risk' and 'high risk' (Friesen et al., 2008). A total of 10 questions were used in the AARC and of these 10 questions, six were asked in the present study. Table 5.11 summarizes the six questions that were used in the survey in Manitoba and the current study.

Table 5.11

Risks Related to Alcohol Use

AARC Indicators	Current study (2009) N=452	Manitoba (2008) N=377
Tension with family or friends	16%	17%
Been in trouble with police	17%	7%
Consumed alcohol in AM	2%	8%
Injured yourself	25%	18%
Driven after drinking	23%	10%
In an accident after drinking	2%	2.5%

Table 5.11 illustrates that more students in the current study than in the Manitoba study reported being in trouble with police due to their drinking (17%, 7% respectively). More students in the Manitoba study reported drinking alcohol in the morning (8%, 2% respectively) however, more students in the present study reported having injured themselves due to drinking (25%, 18% respectively) and having driven after drinking (23%, 10% respectively). Using the AARC, the scores were calculated based on the responses to these questions, ranging from 0 (did not endorse any problem indicators) to 10 (endorsed all 10 problem indicators). The students were placed into a risk category once each of these scores was calculated. The categories were non-drinker, low risk (0 indicators), medium risk (1 or 2 indicators) and high risk (3 or more indicators). In the Manitoba study, 19% of the male students and 24% of the female grade 11 students were considered high-risk drinkers according to AARC, in the current study, 29% of males and 29% of females were considered medium risk, and 30% of males and 28% of females were considered low risk.

Based on the AARC, "almost one half of students in the senior grades in the Manitoba study were considered to be medium/high risk" (Friesen et al., 2008, p. 25) and it was suggested that they would benefit from learning more about their alcohol use which would include the risks and consequences of alcohol use more fully. In the current study, some students reported that they did experience consequences such as those identified in Table 5.11 related to drinking and in some areas at a higher percentage than students in the Manitoba study; students in the current study may also benefit from learning more about risks and consequences of alcohol use related to their use.

Driving Behaviour While Drinking

In Saskatchewan, drinking and driving remains the number one contributing factor in fatal collisions and in 2008 the rates of collisions increased by 12.5% from 2007 which increased the rated of injury and death (Saskatchewan Government Insurance, 2009). Motor vehicular accidents continue to be the number one cause of death in youth. The rate of students drinking and driving is of concern because impaired driving and its impacts result in some of the severest consequences of alcohol use (Friesen et al., 2008). In Manitoba, 13% of grade 11 males and 10% of females "had driven after consuming alcohol" in 2007 (Friesen et al., 2008, p. 25) and in the current study, 36% of males and 16% of females reported having driven after consuming alcohol. For grade 12's in the Manitoba study the rates of reported drinking and driving increased from the grade 11 rates in both males and females (30%, 16% respectively).

Forty three per cent of students in the current research reported being a passenger with a driver who had drank alcohol and 23% of students reported driving within 1-2 hours of drinking alcohol. Based on the above results Friesen et al. (2008) suggested that "students may be less likely to drink and drive", but do ride with someone who has been drinking, there is an indication for the "need for more education in understanding the consequences of impaired driving" (p. 26). The current research had similar results for students that rode with someone who was drinking but more students reported drinking and driving. This might also suggest the need for more education for students on the effects of alcohol and consequences of impaired driving.

Other Indicators for Alcohol Dependence

Earlier research has shown that drinking before the age of 15 is a risk factor for alcohol dependence and other high-risk behaviors. The study in Manitoba found that students who drank

before the age of 15 “are more likely to binge drink” (Friesen et al., 2008, p. 26) as well as drink more frequently. It was also found that these students were more likely to score higher on the alcohol risk scores (which correlated with lower grades), skip work or school, engage in criminal/problem behaviours, getting into physical fights, shoplifting, failing class as well as other offenses, and less likely to do well in schools (p. 26). There was a clear negative relationship found between frequency of drinking and grades achieved at school.

In the current study, 44% of the students reported that their first drink of alcohol (more than just a few sips) occurred before grade10 or age 15, which might suggest that they would score higher on the alcohol risk scores, have lower grades, and be more likely to engage in high-risk behaviours. Early interventions might be effective in supporting students if strategies were in place to identify early warning signs such as marks dropping or student absenteeism.

Revisiting of Conceptual Framework

The components of my conceptual framework are useful to elaborate on the findings in my study. My conceptual framework guided my research and included the components of effective prevention programs according to Bandura (2004) and student engagement. The components of effective prevention programs included: informational, social and self-management skills, self-efficacy building and the enlistment, and creation of social supports for personal change. In what follows, I present the summary of data under the four components that Bandura (2004) identified as effective prevention program, and then discuss the study’s implications on practice, policy, and research.

Informational Component

Information about alcohol use is received from a variety of sources within the schools, home, and their social environments. Bandura (2004) stated the informational component of prevention programs informs the students of the health risks and behaviours. Although it is not known exactly how much information is needed, exactly what is needed and at what point in the developmental process this information is needed, it is known that students need accurate information regarding alcohol and its effects for programs on the prevention of alcohol to be effective (Roberts, 2008).

When students are engaged in the learning process, they tend to learn more (Bandura, 2004). The school setting can provide opportunities or challenges to their developmental process in the engagement process. By identifying the different realms of engagement and how we may increase engagement, the effectiveness of our programs may be improved. Fredericks et al. (2004) defined engagement as multifaceted in nature, with the components being behavioural, emotional, and cognitive engagement. For these authors, commitment or investment are central to engagement and imply levels or degrees of engagement. Behavioural engagement includes students being involved in learning and academic tasks through listening, being attentive, and contributing in class (Finn & Rock, 1997). In relation to emotional reactions to academic content, there are four components of value: interest, attainment value, utility value, and cost (Fredericks et al., 2004). Cognitive engagement in school stresses investment in learning and involves self-regulation or being strategic.

Although it is not clear how much information is needed for programs to be effective, many students could not recall any information being taught about alcohol with most students

recalling one or two classes in relation to alcohol and skills pertaining to its use. In addition to these points, although many participants found the classes informative and they believed there was enough information presented, a significant proportion reported that the classes were not very informative and irrelevant. Based on the large portion of the students who did not recall information on alcohol prevention and reported that the classes lacked relevance, the students did not appear to be engaged in the learning process. Although difficult to identify what, in particular, contributed to the lack of engagement, during the focus groups, students responded by suggesting what content they felt would be relevant, at what age and how to present the information to improve program efficacy.

Participants' suggestions included content that was age-specific, which not only included information about alcohol but also pertained to skill development. In addition to these components, participants recommended that information be incorporated at the older age groups along with interactive methods of delivery. In more general terms, participants offered suggestions that increase behavioral, emotional, and cognitive engagement through the use of relevant content, interactive methods in which students can practice new skills.

Social and Self-Management Skills

The second component included the development of social and self-management skills for "effective preventive practices" (Bandura, 2004, p. 158). Skill management is developed through practice and feedback (Bandura, 2004). Students reported that content related to skills was provided, but the practicing of skills was not done in the present curriculum in relation to the prevention of alcohol. The literature supports the practice of teaching students skills to limit their risk-taking behaviour, but in order to be effective, need to be tied directly to alcohol-related

scenarios (Botvin, 2000). The students also, reported that they had classes on the decision-making process, but this process was not related to alcohol use. In adjunct to learning skills, they need to be practiced so that students can become confident in using them.

Sense of Efficacy

Four factors that shape efficacy are: mastery experience, vicarious experience, social persuasion, and affective state (Bandura, 2004). Self-efficacy is affected by actual performance, vicarious experiences, verbal persuasion, and emotional responses. Within the current study, students reported on their confidence levels in certain situations to refuse the urge to drink and their ability to obtain support related to their alcohol use. More students reported that they were confident that they could resist the urge to drink in a negative peer context such as an argument with a close friend than in positive situation such as celebration. As Bandura (1986) stated, strengthening self-efficacy is best accomplished by successfully being guided and mastering skills, which in turn provides the knowledge and skills needed to perform these skills in similar situations (Bandura, 1986). It might be that these students need to practice these skills to become more confident in these situations.

With regard to the students' confidence in being able to get friends', parents' or teachers' support if they chose not to drink, the students reported as follows. More students reported being confident in being able to get friends' support, as compared to being able to get their parents' support. More students also reported confidence in being able to get professional help rather than teachers' help.

The information from the questions regarding students' self-efficacy appear congruent with the consistent suggestions from the students that role-playing and practicing skills would be

effective in improving program efficacy. In addition to the questions on self-efficacy, students were asked about their confidence in the program in general. Although most students reported they felt the program to be ineffective, I wondered if they were basing this assessment on the goal of abstinence or the goal of reducing harms? Students in two of the focus groups agreed that the information they had received were effective in making them more *aware* about the harms of the program and when they were making decisions such as drinking and driving. However, another groups suggested that more information was needed for the program to be effective.

Social Supports

The last component is enlisting and creating social supports for personal change (Bandura, 2004). Personal change can occur at all stages of the continuum of health. In the current study, in addition to reporting on students' confidence in finding help if they chose not to drink, students reported on their ability to find support within the school when needing to speak to someone. A significant number of students reported not being able to find the support in school when needed. Many students in the current study reported they were aware that there was an addictions counsellor in the schools; however, many students were unaware of the processes available to refer themselves to the counsellor; a significant proportion of students reported they were not confident they would be able to find help in school if needed.

Schools have an opportunity to help students by providing students and staff with a strategy for early intervention and a referral process for counselling, and treatment services (Nova Scotia Department of Health, 2002). Clearly identifying a process for students to be able to access services and developing a strategy for staff to refer students, enhances the potential for early intervention, and help-seeking by students.

Implications for Program Policy

A comprehensive policy includes clearly written rules, regulations and consequences along with a strategy to guide education, intervention, and referral to appropriate agencies (Nova Scotia Department of Health, 2002). In tandem with this statement, researchers agree that effective programming needs to be based upon needs relevant to young people in the program (Tobler et al., 1999: White & Pitts, 1997). Programs based on current prevalence data including patterns of use, and risks and harms associated with this use, best reflect student needs.

Along with the strategy for education, the identification of the goals and principles of the program is essential to guide both the program and policy. In this research, professionals reported using various approaches; in turn, students reported hearing various messages. Even though there is a lack of research supporting the recommended harm-minimization approach, the current findings have shown that some of the professionals may be using this approach. However, in light of the different messages that students are receiving and the far-reaching effect that schools play in students lives, identifying an approach that would guide the policy and programs has the potential to improve program efficacy by providing a consistent message. Furthermore, comprehensive school health encourages active partnership and collaborative planning among all persons who can contribute to enhancing the well-being of students. Roberts (2007) suggested that planning be done in tandem with the health regions.

This study showed that there were many *ad-hoc* policy responses that took place in the school. In particular, many students reported that they were unclear of the processes to access support services. Policies to improve transparency of student services would enhance availability

of support to students. The development of a system to recognize students for early referral would also aid in supporting students.

Emerging from the current research was the finding that teachers did not receive professional development training in the area of alcohol prevention. In light of these findings, it would be beneficial to include a description of training for school personnel, which details student prevalence, updated policy, and legal issues. Training might include identification of risks and signs of substance use or abuse, and harm minimization concepts. Staff professional development could be supported by or done in collaboration with the School Community Councils. This initiative could be a useful catalyst for the process of including and informing parents about students' alcohol use and relevant research, and approaches to support students' health and wellbeing. It would be movement towards parental active participation.

Finally, there is strong relevance and implications that have emerged from this research for the need for meta-policy. Educators, board members and those in the policymaking field need to look at the way in which policy is articulated and evaluated. More specifically, school boards need to look at how student voice, teacher voice, and parent voice inform policy intelligence. The development of meta-policy would provide a process by which to include input from stakeholders to ensure that policies are relevant and ensure ongoing evaluation.

At a broader policy level, implications from this research reveal a need for support from the ministry of learning to identify what is informing curriculum. Students and teachers identified that increased time dedicated to presenting information on alcohol prevention is necessary to be effective.

Evaluation

Evaluating program enabling policy is critical of its ongoing success and leads to it improvements in promoting healthy behaviour among students. In the current study, the policy related to alcohol use was evaluated by the level of infractions related to student alcohol use in schools, and from any comments that were brought forth to the administrators. As stated by Guba (1985), "It is never policy that is tested but only some treatment or program undertaken in the name of the policy, together with the experience of that treatment or program by the target group and other affected stakeholders" (p. 11). Based on the above, any evaluation of policy related to the prevention of alcohol use by students should include process, impact, and outcome evaluation. Process evaluation could include the level of satisfaction of the policy makers with the policy and with the policy development process (planning, implementation, evaluation and follow-op) (Nova Scotia Department of Health, 2002, p. 27). Impact evaluation would determine the policy awareness level among members of the school, the number of alcohol related infractions on the school property and the larger community, and the policy compliance level amongst students and staff. The outcome evaluation would determine any changes in student alcohol use, including: delay of onset of use, prevalence, student attitudes, knowledge, perception of risks and harms related to alcohol use. The findings of this research showed the valuable input that students have into improving program efficacy and support outcome evaluation. In addition to these parameters, suggestions about programming from students need to be considered.

Implications for Programs and Practice

In light of the literature and the results of this research, modifications for educational practice and programs should be considered when working with youth on alcohol prevention. The areas for change would include school programming and professional practice.

First, in the area of programs, both students and teachers identified that time was an important element in the curricular program that included content on alcohol use. More specifically, the teachers indicated there was not enough time allocated to teach the information and skills in a manner necessary for the program to be effective and the students concurred. Along with this, the students reported that content needs to be provided at the high school level. In fact, grade 11 and 12 students did not have a compulsory health component where the information might have been delivered. Hence, after grade 10 there was no formal program in place to offer the recommended information. Students did identify that in light of the fact that time was an issue, the use of peers in the form of student-led groups could help in some content delivery. Student-to-student interaction has shown the most positive influence in student substance use (Tobler & Stratton, 1997). Therefore, the use of peer mentorship programs would be an additional effective means of conveying information to students. It is vitally important to establish sustainable peer led groups for long-term effectiveness. Along with student-led groups, increasing time dedicated to alcohol prevention may be necessary to increase the efforts in alcohol prevention using interactive techniques.

Given the findings that emerged from this research, the majority of students reported that they drank alcohol by grade 11 and many students indicated that more information needs to be presented along with the practice of skills, the proportion of time dedicated to alcohol education

within the school curriculum needs to be revisited. The present subject-based system does not allow for this information to be presented at the senior high school levels. Along with this, the present curriculum at the grade 9 and 10 does not allow for the material to be presented effectively. Although the students are receiving information in a variety of classes, teachers are not aware of what is being taught in other classes. A more coordinated approach including subjects such as, Christian ethics, law, and health needs to be implemented. In addition, it is important to ask, what is informing the present curricular health content. As one student stated, “it’s not really a hot topic” and “personally I don’t see much in the school about alcohol, anything other than the odd football game or in a school event like that I think it is mandatory on behalf of the school to tell the students that there is no drinking” (R1, S4, M). The Saskatchewan Education Indicators report (1994) identified that health of children impacts their learning. Changes may need to be instituted to provide health classes at the senior high school levels to incorporate various topics including alcohol education. To support these instrumental changes, colleges might need to recognize these classes for admission.

According to the current research, students are using alcohol at various rates. In addition, students reported that conflicting messages were being delivered within the school programs; these messages were not consistent, nor did they appear to be always developmentally appropriate. In light of this information areas for professional practice may need to include informing the professionals of current data on prevalence and harms associated with students’ use, the different resources and approaches available along with information based on evidence-based approaches is necessary for a comprehensive school approach to not only exist but to be practiced. In light of the research findings, using the approaches such as skills-training and other

evidence-based approaches could assist in student engagement in programming, and ultimately improve program efficacy.

The next area that is vital to alcohol prevention is in the area of support services for students regarding their alcohol use. A considerable number of students did not feel confident that they would be able to find help in the school. Along with this information, students did not seem to be aware of how to access services. There is a need for transparency in the process for students to access support.

Teachers and vice-principals identified there was limited active parental involvement that occurred within the current programs around alcohol education. Moreover, a vice-principal identified the need for parent groups such as Al-anon within the schools. The presence of the group would further decrease stigmatization of addictions and thus promote a more open approach. Bandura (2006) indicated that although peers are an influential force they do not take the place or role of family. Many students reported they heard from their parents the message that it was okay to use than not use. The teachers identified that in order for alcohol education to be effective, the parents need to be involved. Current rates of student alcohol use, the risks and issues around student alcohol use, and services available to the students and families need to be conveyed to the parents. Along with this, the present school community councils might participate in supporting alcohol education by actively seeking support and educating the community and advocating for needed system changes, such as increasing health education to youth.

Implications for Further Research and Methodological Reflections

First, I start by reflecting on my methodological framework, Guba's (1985) *Domains Model*. One of the strengths of this model was that it provided an explanatory manner in which to present the findings of my research. It provided a place for input from all stakeholders. However, the main shortcoming of this framework was that it was linear in nature and therefore did not allow for feedback. Adding a loop from policy-in-experience to policy-in-intent would provide for input related to contextual changes, stakeholders, and outcome indicators to evaluate and change policy as needed.

The area of youth alcohol prevention has been researched for a number of years which has contributed to the present practices and understanding of school based programming. This study brings to the forefront the significance of many questions already posed in published literature. For example, based on the rates and amounts of alcohol use that students reported, and the approaches that were reported being used in the schools, further research needs to be done in the area of harm-minimization, and harm-reduction approaches. With the understanding that legal and policy ramifications exist, research is necessary to identify at what ages these approaches are best used to promote the health of youth.

The literature also clearly states that zero tolerance approaches to alcohol prevention in the area of school suspensions are not recommended for reasons already discussed. Research in this area could include both qualitative and quantitative approaches, and include parents as well as children to provide a broad spectrum of results to bring light to this area.

Although it is recommended in the literature that curricular programs (related to the prevention of alcohol use be based upon current prevalence rates, it is not clear how to distribute

the information to the students that are using alcohol at different rates and experiencing different harms. Research is needed to not only identify the level of students risk but to explore what information students would find relevant in relation to their level of use.

From both vice-principal and teachers views, parents need to become more active in the prevention of alcohol use. Research is necessary to identify effective ways to engage parents and methods to inform them.

Alcohol prevention programming has already proven to be effective however; further research in this area would benefit students, their families, schools, and the larger communities. During the course of my research, reflection was a continuous process on what I did and how I would have done differently. First, as I watched how focused the students were at answering the surveys, I understood how important it was to construct and choose questions and be mindful to the time it took them to complete. I decided that a step approach might have been more productive in developing the student questionnaire. By first interviewing the vice-principals and teachers about what they included in the curriculum with relation to alcohol prevention, I would have had more insight specifically towards developing questions to ascertain students' perceptions of alcohol (knowledge). I also would have included more questions on the questionnaire regarding students' perceptions of policy, in particular, to the policy regarding student perceptions of suspensions as a means of discipline. Finally, the AARC indicators should be used to provide a detailed picture of students' perceived levels of alcohol use and associated risks.

While collecting data, I occasionally had the feeling that I wasn't getting the whole story; that maybe things were not quite as being portrayed. When I asked questions during one

interview, questions weren't being answered fully or the topic of conversation was changed. In addition to this, in one of the schools, it was difficult to find space that was quiet and confidential to interview teachers. At times it was necessary to move to different locations during the interviews when interruptions occurred or there were too many distractions. Surveys could be done with multiple teachers to combat the issues of data triangulation, space, and teacher availability. In addition to the surveys, teacher interviews could be done to answer the research questions more fully.

Space was also difficult to find to conduct focus groups appropriately. In two of the schools, classrooms were used and seating was not optimum to generate discussion however, the students worked well, were very cooperative, and were understanding. Furthermore, time permitting and if the location allowed for a more relaxed conversation, it would have been helpful to collect data regarding the type of information that to students' perceived would be useful at various the stages of their use.

I felt privileged to have been allowed into the schools that participated in my study. It was an honor to have the participants share their views with me so openly. At times I felt that I was a bother to ask yet another question because it was obvious how busy the teachers were however, they were always more than willing to share their views.

Concluding Comments

This research explored students' perceptions of prevention of alcohol use programs in four schools. Teachers and vice-principals perceptions' were collected to provide contextual data for the findings. Students' perceptions of their behaviour also provided the research with contextual information. Similar to other Canadian youth, most students in the current study

reported that they drank in the previous year with many students doing so with high frequency and consuming more than five drinks on one occasion. Surprisingly, despite the common messages related to drinking and driving, almost 40% of students reported driving with someone who had been drinking within the previous year.

Significant findings from this research included students' views about the need for increased information at the high school levels. Furthermore, findings from the research showed that engaging students might be improved by providing developmentally appropriate information using interactive methods including the opportunity to practice resistance skills. Students identified when the information would be beneficial in improving program efficacy, the content and preferred methods of delivery that may improve cognitive, behavioural, and emotional engagement.

This research along with the literature suggests implications for policy and practice. Adoption of goals to guide alcohol prevention programs based on current prevalence data on youth alcohol use might be best determined using a collaborative approach. Explicitly stated policy that includes educational strategy congruent with its policy goals to guide school programming would allow for a consistent form of communication at all educational levels: school, home, and community. To support a comprehensive program with clear and consistent messages, policy needs to include the educative approach, professional development, and the consequences to infractions, referral processes, and evaluative measures to be used. According to the data, students are using alcohol in various amounts and their needs differ. Systematic collection of data to monitor youth alcohol use and risks and harms associated with this use, and

student input about educational programs appear to be a logical step towards improving student engagement in programs and the efficacy of alcohol prevention in youth.

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Appendix A – Letter To Director Of School Division

Department of Educational Administration

28 Campus Drive,

University of Saskatchewan, S7N 5E5

Dear *(Name of Director)* of *(Name of School Division)*:

Re: Invitation to partake in research project

My name is Marcella Ogenchuk and I am working towards a Doctor of Philosophy Degree in Educational Administration. I am conducting research entitled, *Alcohol Prevention Programs: Examination of Grade 11 Students' Perceptions,* for completion of my degree.

Purpose and Procedure: The purpose of this study is to better understand high school students' perceptions regarding alcohol prevention programs. This study will require Grade 11 students to participate in a computer based survey. The survey will take approximately 45 minutes to complete. Some students may choose to take part in a focus group as well which will be additional one hour that will not be done during school hours. Principals, teacher and counsellors will be interviewed in the schools that student focus groups will be conducted.

Potential Risks: There will not be any direct risks involved.

Potential Benefits: The potential benefits of this study may include new insight regarding high school students' use of alcohol as well as their perceptions of alcohol prevention programs, although these benefits are not guaranteed.

Storage of Data: Consent forms will be stored separately (from materials used) to avoid association of names to any given set of responses. All data containing identifying information will be securely stored and retained at the University of Saskatchewan for five years, in accordance with the University of Saskatchewan guidelines.

Confidentiality: All information will be kept confidential. Names of participants, their respective schools or school division will not be divulged. Confidentiality and anonymity will be ensured, as far as possible, through the use of pseudonyms in reference to the participants and school divisions involved in this study.

Questions: If you have questions concerning the study at any time, please feel free to contact me at the numbers provided above. This study has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on (insert date). Any questions regarding the rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out of town participants may call collect.

Following your written consent, using the (Name of School Division)'s website, I will find the contact list for principals of the schools in your division. I will telephone the principals, explain the purpose of this study, and ask if his/her school would be interested in participating in the study. If the principals convey an interest in the study, I will provide a written description of the study, a copy of the survey, focus group and individual semi-structured interview questions, and a consent/assent form indicating the participant's rights (see Appendixes).

In compliance with the Behavioural Research Ethics Board (Beh-REB) at the University of Saskatchewan, the (Name of School Division) and selected participants have the right: (a) not to participate in the study, (b) to withdraw from the study at any time without being penalized in any form, (c) to withdraw from the study and thus have any collected data pertaining to him/her destroyed and not included in the study, and (d) of privacy, anonymity, and confidentiality. Participants will be assured of these rights in their invitation letter and through a signed

consent/asset form. In keeping with the University of Saskatchewan guidelines, at the completion of the study, all documents, transcript, taped recordings, and notes will be secured at the University of Saskatchewan, in the office of my department supervisor, Dr. Keith Walker, for five years.

Enclosed are two copies of a written consent form for your consideration. If you decide to accept the invitation for the (Name of the School Division) to participate in this study, please sign and date both consent forms. Return one consent form to me in the self-addressed stamped envelope or through a fax or email. Please maintain one copy of the consent form for your records.

In case you have any concerns or require additional information, you may contact Dr. Keith Walker my supervisor at 966-7623. You may also contact me by e-mail my address is marcella.ogenchuk@usask.ca.

Thank you for considering this request.

Yours Sincerely,

Marcella Ogenchuk

Appendix B – Invitation Letter for Principals, Teachers and Counsellors

February 2009

Dear *(Principal or Teacher)*,

You are invited to participate in a study entitled *Alcohol Prevention Programs: Examination of Grade 11 Students' Perceptions*. Please read this form carefully, and feel free to ask questions you might have.

Purpose and Procedure: The purpose of this study is to generate information regarding the high school students' perceptions regarding alcohol prevention programs. This study will require you to participate in a discussion with other students. The discussion group will take about one hour. I may request a follow-up interview with you if additional information or if clarification is needed. You will have the opportunity to review the information collected and discuss any thoughts, and add, alter, or delete information from transcripts as appropriate.

Potential Risks: There will not be any direct risks involved.

Potential Benefits: The potential benefits of this study may include new insight regarding high school students' perceptions of alcohol prevention programs that can influence future policy and prevention programming although these benefits are not guaranteed.

Storage of Data: Consent forms will be stored separately (from materials used) to avoid association of names to any given set of responses. All data containing identifying information will be securely stored and retained at the University of Saskatchewan for five years, in accordance with the University of Saskatchewan guidelines.

Confidentiality: All information will be kept confidential. Names of participants, their respective schools or school division will not be divulged. Confidentiality and anonymity will be ensured, as far as possible, through the use of pseudonyms in reference to the participants and school divisions involved in this study.

Right to Withdraw: You are free to withdraw for any reason at any time without penalty. In the event of withdrawal, the data collected with you and tape recordings will be destroyed.

Questions: If you have any questions concerning the study, please feel free to ask at any point; you are also free to contact the researchers at the numbers provided above if you have questions at a later time. This study has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on (insert date). Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out of town participants may call collect." The researcher will email participants the aggregate results of the interview if requested.

Consent to Participate: I have read and understood the description provided above; I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I consent to participate in the study described above, understanding that I may withdraw this consent at any time. A copy of this consent form has been given to me for my records.

Researcher: Marcella Ogenchuk, Department of Educational Administration, University of Saskatchewan. Contact numbers 966-1757 or 966-7628.

______________________________ ______________________________

(Name of Participant) (Date)

______________________________ ______________________________

(Signature of Participant) (Signature of Researcher

Appendix C – Invitation to Students

Dear Students,

My name is Marcella Ogenchuk and I am a Doctoral Student in Educational Administration. I am a inviting you to participate in a study entitled *Alcohol Prevention Programs: Examination of Grade 11 Students' Perceptions*. Please read this form carefully, and feel free to ask questions you might have.

Researcher: Marcella Ogenchuk, Department of Educational Administration, University of Saskatchewan. Contact numbers 977-1757 or 966-7628.

Purpose and Procedure: The purpose of this study is to examine high school students' perceptions regarding alcohol prevention programs. This study will require you to participate in a focus group. Your participation in this study is optional and is not a requirement for any class.

Potential Risks: There will not be any direct risks involved.

Potential Benefits: The potential benefits of this study may include new insight regarding high school students' use of alcohol and perceptions of alcohol prevention programs although these benefits are not guaranteed.

Storage of Data: All data containing identifying information will be securely stored and retained at the University of Saskatchewan for five years, in accordance with the University of Saskatchewan guidelines.

Confidentiality: All information will be kept confidential. Names of participants, their respective schools or school division will not be divulged. Confidentiality and anonymity will be ensured, as far as possible, through the use of pseudonyms in reference to the participants and school divisions involved in this study.

Right to Withdraw: You may withdraw from this research at anytime without penalty. In the event of withdrawal, the data collected from you will be destroyed.

Questions: If you have questions concerning the study at any time, please feel free to contact the researcher at the numbers provided above. This study has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on (insert date). Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out of town participants may call collect. The researcher will email participants the aggregate results of the interview if requested.

Consent to Participate: I have read and understood the description provided above; I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I consent to participating in the study described above, understanding that I may withdraw at any time. A copy of this consent form has been given to me for my records.

___________________________________ ________________________________

(Name of Participant) (Date)

____________________________________ _______________________________

(Signature of Participant (Signature of Researcher)

Appendix D - Principal Interview Questions

a) When I comes to alcohol prevention in this school, what kinds of conversations have been taking place over the last couple of years?

b) What situations or stories would you say typify the challenges, successes and attitudes of staff, teachers, and students with respect to alcohol prevention in this school?

1. What is the school level policy on alcohol prevention?

2. Tell me about the components of your drug and alcohol prevention programs in your school?

3. Tell me what policies you have in place within the school related to student behaviour and alcohol use?

4. Beyond curriculum and direct teaching what other activities in this school or sponsored by the school support alcohol prevention?

5. Tell me what you think is being done well in your school in the area of alcohol prevention.

6. Tell me what do you think needs to be done better in the area of alcohol prevention?

7. Tell me what you see as your challenges with respect to alcohol prevention programs in this school?

8. To what extent, it at all, are the students involved in any way with the development of the program or policy? If so what insights have they been able to offer you and your staff team?

9. Tell me who might have valuable information in your school with respect to formal program or informal program and alcohol prevention – someone with experience in teaching the program or with involvement in specific initiatives?

10. What indicators do you and the staff have that your alcohol prevention program, initiatives, activities and policy are working in the way you hope they might?

11. Have there been any assessments of the alcohol prevention programs or initiatives? If so, what was learned?

12. Are there any aspects of alcohol prevention that I have missed and you feel ought to be mentioned?

Appendix E – Teacher/Counsellor Interview Questions

1. Can you tell me the general school orientation towards the prevention of alcohol in youth?

2. What role do you play in the alcohol prevention programs in your school?

3. How long have you taught this program?

4. What inservice have you had on the alcohol prevention programs?

5. Can you tell me how long you spend on the unit or the programs/interventions?

6. Can you tell me how many times you meet with the students?

7. Can you tell me about the approach/es you used on the units in alcohol prevention? (ie. is the focus abstinence, drinking in moderation, etc?)

8. Can you tell me if you feel this approach is effective? If yes, how? If not, how would you do things differently?

9. Can you tell me about the information that is covered in the program?

10. Is there information that you think of that would make these programs more effective?

11. Can you tell me about any skills that are taught in this class?

12. What methods do you use to deliver the content?

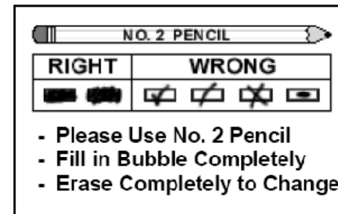
13. Can you tell me what you think is the most important aspect of these programs?

14. Can you tell me how confident you are that this program is making a difference?

15. Are there any aspects of alcohol prevention that I have missed and you feel are important?

Appendix F – Student Survey

Youth Alcohol Prevention:
Perception, Knowledge, and Use Survey 2009



About the Questionnaire:

This questionnaire deals with your understandings and feelings about alcohol and whether you use alcohol. The questionnaire also touches on information regarding your use of alcohol in relation to other behaviours such as driving. The information you will provide will help in a variety of ways: it will help me to understand more fuller about students' alcohol use, as well as the general views of students may help this and other schools, in planning or changing future alcohol prevention programs.

It is important that you answer each question as honestly and straightforwardly as possible.

Of course, individual student answers will not be shown to your parents or teachers. In fact, no information about individual students will appear in the research reports. There is no way your answer sheet can be traced back to you.

Your participation is voluntary. You do not have to participate if you do not want to. You may skip any questions with which you are not comfortable. There is no direct benefit to students who participate in the survey.

INSTRUCTIONS: Please shade in the bubble that corresponds with your chosen answer.

You will know that this is NOT a test - there are no right or wrong answers.

DO NOT PUT YOUR NAME ON THE QUESTIONNAIRE.

The first few questions are about you and your background.

1. Are you male or female?

- ☐ Male
- ☐ Female

2. What grade are you in (majority of classes this term)?

- ☐ Grade 10
- ☐ Grade 11
- ☐ Grade 12

3. How old are you (closest age)?

- ☐ 16 years
- ☐ 17 years
- ☐ 18 years
- ☐ 19 years

4. So far in this school year, what best describes your overall average on all your courses at school (approximately)?

- ☐ Below 50%
- ☐ 50% - 59%
- ☐ 60% - 69%
- ☐ 70% - 79%
- ☐ 80% - 100%

The next few questions ask about alcohol education and rules that you have had at your present school.

From what you can remember,

5. How many classes or presentations did you have that talked about decision-making, peer pressure, assertiveness or refusal skill relating to your use of alcohol?

- No classes
- 1 or 2 classes
- 3 or more classes

6. How many classes did you have that talked about alcohol?

- No classes
- 1 or 2 classes
- 3 or more classes

7. Does your school have rules about the use of alcohol on school property or at school events?

- Yes
- No
- Don't know

8. The rules about the use of alcohol in school are followed consistently.

- Agree
- Somewhat agree
- Somewhat disagree
- Disagree

The next few questions are based on your knowledge regarding alcohol consumption.

9. The term BINGE DRINKING includes drinking ...

- 2 or more drinks during an evening
- 3 or more drinks during an evening
- 4 or more drinks during an evening
- 5 or more drinks during an evening
- I don't know

10. Alcohol is a depressant of the Central Nervous System and therefore slows your reflexes.

- Yes
- No
- I don't know

11. Males and females react to alcohol in the same way.

- Yes
- No
- I don't know

12. The earlier you start drinking the more likely you are to become dependent on alcohol.

- Yes
- No
- I don't know

In the classes you took relating to the prevention of alcohol use:

13. To what extent is the material/content presented informative?

- Not at all informative
- Not very informative
- Somewhat informative
- Very informative
- There were no classes on alcohol prevention

14. To what extent is the information relevant to you?

- Not at all relevant
- Not very relevant
- Somewhat relevant
- Very relevant
- There were no classes on alcohol prevention

15. To what extent was the material presented in an interesting manner?

- Not interesting at all
- Not very interesting
- Somewhat interesting
- Very interesting
- There were no classes on alcohol prevention

16. My teacher's presentation of the information on alcohol prevention has been helpful in the overall effectiveness.

- Disagree
- Somewhat disagree
- Somewhat agree
- Agree
- There were no classes on alcohol prevention

17. In regards to the effects of alcohol, an appropriate amount of information has been provided.

- Disagree
- Somewhat disagree
- Somewhat agree
- Agree
- There were no classes on alcohol prevention

18. An appropriate amount of information in regards to how to resist using alcohol was presented.

- Disagree
- Somewhat disagree
- Somewhat agree
- Agree
- There were no classes on alcohol prevention

How much do you think youth risk harming themselves (physically or in other ways) if they ...

19. Try one or two drinks of an alcoholic beverage once.

- No risk
- Slight risk
- Medium risk
- Great risk
- Don't know

20. Take one or two drinks nearly every day.

- No risk
- Slight risk
- Medium risk
- Great risk
- Don't know

21. Take four or five drinks nearly every day.

- No risk
- Slight risk
- Medium risk
- Great risk
- Don't know

22. Have one or two drinks once or twice nearly each weekend.

- No risk
- Slight risk
- Medium risk
- Great risk
- Don't know

23. Have five or more drinks of alcohol once or twice nearly each weekend.

- No risk
- Slight risk
- Medium risk
- Great risk
- Don't know

In the next part of this survey I would like to know your levels of confidence about your decisions, skills and supports around your use of alcohol.

Rate your degree of confidence by filling in the bubble from 0 - 10 using the scale given below:

I am confident that I can ...

	0 Cannot do at all	1	2	3	4	5 Moderately can do	6	7	8	9	10 Highly certain can do
24. ... get my friends to support me if I choose not to drink.											
25. ... get a teacher's help if I am concerned about my use of alcohol.											
26. ... get my parents to help me in making a decision regarding my drinking.											
27. ... get professional help if I feel I need to talk to someone regarding my alcohol use.											

I am confident that I could resist the urge to drink ...

	0 Cannot do at all	1	2	3	4	5 Moderately can do	6	7	8	9	10 Highly certain can do
28. ... if I felt that everything was going badly for me.											
29. ... if something good happened and I felt like celebrating.											
30. ... if i were in a situation where I had often drank.											
31. ... if I had an argument with a close friend											
32. ... if someone were to pressure me to 'be a good sport' and drink with them.											
33. ... if I were enjoying myself at a party.											

The next questions are about the use of alcohol. Please answer them even if you have never tried alcohol.

34. How many of your closest friends use alcohol?

- ▭ None of my friends
- ▭ About 1/4 of my friends
- ▭ About half of my friends
- ▭ About 3/4 of my friends
- ▭ All of my friends

35. When (if ever) did you FIRST drink more than just a few sips of alcohol?

- ▭ Grade 4 or before
- ▭ Grade 5
- ▭ Grade 6
- ▭ Grade 7
- ▭ Grade 8
- ▭ Grade 9
- ▭ Grade 10
- ▭ Grade 11
- ▭ Never used alcohol in lifetime

36. If you HAVE NEVER use alcohol, which of the following is the ONE MOST IMPORTANT reason why you have never tried drinking?

- ▭ Most of my friends do not drink
- ▭ My parents to not drink
- ▭ I think it is bad for my health
- ▭ i think I might not be able to stop
- ▭ I would get into trouble with my parents
- ▭ I cannot afford to buy alcohol
- ▭ I have other things I enjoy
- ▭ Many reasons
- ▭ Not applicable

37. When (if ever) did you first drink enough alcohol to feel drunk?

- ▭ Grade 4 or before
- ▭ Grade 5
- ▭ Grade 6
- ▭ Grade 7
- ▭ Grade 8
- ▭ Grade 9
- ▭ Grade 10
- ▭ Grade 11
- ▭ Never used alcohol in my lifetime
- ▭ Never drink until I feel drunk

The next few questions relate to your use of alcohol in the last 12 months.

For the next questions, ONE DRINK means
1 bottle/can of beer (about 341 ml = 12 ounces)
OR
1 glass of wine (about 118 ml = 4 ounces)
OR
1 shot glass of liquor (about 30 ml = 1 ounce)

38. During the LAST 12 MONTHS, have you tried alcohol (beer, wine, or liquor) for the VERY FIRST TIME?

- ▭ Yes
- ▭ No
- ▭ Never tried alcohol in my lifetime

39. In the LAST 12 MONTHS, how often did you drink alcohol - beer, wine, coolers or hard liquor (rum, whisky, vodka, gin, etc.)?

- ▭ Never used alcohol in my lifetime
- ▭ Drank only at special events (Christmas or a wedding)
- ▭ Had a sip of alcohol to see what it's like
- ▭ Once a month or less often
- ▭ 2 or 3 times a month
- ▭ 1 to 2 times a week
- ▭ 3 to 5 times a week
- ▭ 6 or more times a week
- ▭ Drank, but not in the last 12 months

40. In the LAST 12 MONTHS, how many times (if ever) have you been drunk at school?

- ☐ Never
- ☐ Once
- ☐ 2 or 3 times
- ☐ 4 or 5 times
- ☐ 6 or 7 times
- ☐ 8 or 9 times
- ☐ 10 or 11 times
- ☐ 12 or more times
- ☐ Not in the last 12 months

41. In the past 12 months, has your drinking caused tension or disagreement with family or friends?

- ☐ Yes
- ☐ No
- ☐ Don't drink alcohol

42. Have you ever been seen by a doctor or been in a hospital as a result of drinking alcohol?

- ☐ Yes
- ☐ No
- ☐ Don't drink alcohol

43. Have you ever been warned by the police related to your use of alcohol?

- ☐ Yes
- ☐ No
- ☐ Don't drink alcohol

44. How often during the LAST 12 MONTHS have you found that you were not able to stop drinking once you had started?

- ☐ Never
- ☐ Less than once a month
- ☐ About once a month
- ☐ About once a week
- ☐ Daily or almost daily
- ☐ Don't drink alcohol

45. How often during the LAST 12 MONTHS have you not done things you were supposed to do because of drinking?

- ☐ Never
- ☐ Less than once a month
- ☐ About once a month
- ☐ About once a week
- ☐ Daily or almost daily
- ☐ Don't drink alcohol

46. How often during the LAST 12 MONTHS have you felt the need for a first drink in the morning?

- ☐ Never
- ☐ Less than once a month
- ☐ About once a month
- ☐ About once a week
- ☐ Daily or almost daily
- ☐ Don't drink alcohol

47. How often during the LAST 12 MONTHS have you been unable to remember what happened the night before because you had been drinking?

- ☐ Never
- ☐ Less than once a month
- ☐ About once a month
- ☐ About once a week
- ☐ Daily or almost daily
- ☐ Don't drink alcohol

48. Have you or someone else been injured during a time when you were drinking?

- ☐ No
- ☐ Yes, but not in the last 12 months
- ☐ Yes, during the last 12 months
- ☐ Don't drink alcohol

49. Has a relative or friend or a doctor or other health care worker been concerned about your drinking (perhaps suggested you cut down)?

- ☐ No
- ☐ Yes, but not in the last 12 months
- ☐ Yes, during the last 12 months
- ☐ Don't drink alcohol

The next set of questions is about the last four (4) weeks.

50. In the LAST 4 WEEKS, how many times has drinking alcohol resulted in your becoming drunk (that is, you had so much to drink that you threw up or you lost control of your actions)?

- ☐ Once or twice
- ☐ 3 or 4 times
- ☐ 5 or 6 times
- ☐ More than 6 times
- ☐ None
- ☐ Never, I got drunk but did not lose control

51. In the LAST 4 WEEKS how often did you drink alcohol (liquor, wine, beer, or coolers)?

- ☐ Once or twice
- ☐ 3 or 4 times
- ☐ 5 or 6 times
- ☐ More than 6 times
- ☐ Did not drink alcohol in the last 4 weeks

52. How many times in the LAST 4 WEEKS have you had 5 OR MORE DRINKS of alcohol on the SAME OCCASION?

- ☐ Once
- ☐ 2 times
- ☐ 3 times
- ☐ 4 times
- ☐ 5 or more times
- ☐ Did not drink alcohol in the last 4 weeks
- ☐ Did not have five or more drinks of alcohol on the same occasion in the last 4 weeks

53. On a typical day when you are drinking, how many drinks containing alcohol do you have?

- ☐ 1 drink
- ☐ 2 to 3 drinks
- ☐ 4 drinks
- ☐ 5 to 7 drinks
- ☐ 8 or more drinks
- ☐ Don't drink alcohol

The next section is about driving a car, motorcycle or other motor vehicles.

54. In the past 12 months, how often have YOU driven a motor vehicle within an hour or two of drinking two or more drinks of alcohol?

- ☐ Never
- ☐ One or two times
- ☐ Three or four times
- ☐ Five or six times
- ☐ More than six times

55. In the past 12 months, how often have YOU not used a seatbelt as a passenger or driver of a vehicle within two hours of drinking two or more drinks of alcohol?

- ☐ Never
- ☐ One or two times
- ☐ Three or four times
- ☐ Five or six times
- ☐ More than six times

56. In the past 12 months, as a driver, have you been in a motor vehicle accident, after drinking in the two previous hours?

- Never
- One or two times
- Three or four times
- Five or six times
- More than six times

57. In the past 12 months, how often were you a passenger in a vehicle with a driver who had been drinking alcohol?

- Never
- One or two times
- Three or four times
- Five or six times
- More than six times

The next section asks about help-seeking.

58. In the past 12 months, did you feel you need support, counseling or advice about your alcohol use?

- Yes
- No
- Not relevant to me

59. If you felt you needed support, counseling or advice about your alcohol use, were you able to find the support you were looking for from school resources?

- Yes
- No
- Not relevant to me

60. If you felt that you needed support for your alcohol use, are you confident that you could find help?

- Yes
- No
- Not relevant to me

61. In the past 12 months, have you accessed any services or received support to deal with your alcohol use?

- Yes
- No
- Not relevant to me

62. Have you been in a treatment program during the LAST 12 MONTHS related to your alcohol or drug use?

- Yes
- No
- Not relevant to me

The last sections include messages about alcohol use. What message do you get about the use of alcohol ...

63. ... from your parents?

- It is not okay to use
- Mixed message
- It is okay to use
- None

64. ... from your friends?

- It is not okay to use
- Mixed message
- It is okay to use
- None

65. ... from teachers at school?

- It is not okay to use
- Mixed message
- It is okay to use
- None

66. ... from athletic team coaches at school?

- It is not okay to use
- Mixed message
- It is okay to use
- None

67. ... from club advisors at school?

- It is not okay to use
- Mixed message
- It is okay to use
- None

68. ... from TV, radio, movies, music?

- It is not okay to use
- Mixed message
- It is okay to use
- None

Additional information.

Please feel free to add anything else that you think would be helpful for me to know.

Concerning Sexual Behaviour:

You may skip the questions with which you are not comfortable.

69. The LAST TIME you had sex, did you drink alcohol or use drugs before having sex?

- ▭ Yes
- ▭ No
- ▭ I am not sexually active

70. In the past 12 months, have you had unplanned sex?

- ▭ Yes
- ▭ No

71. In the past 12 months, did you have unplanned sex after using alcohol or drugs?

- ▭ Yes
- ▭ No

Thank you for participating in this survey!

Appendix G – Student Focus Group Questions

1. What message does the school portray about alcohol prevention?

2. How do you see teachers actually trying to help students understand and think about alcohol and alcohol prevention in your school?

3. What classes are provided to you in regards to alcohol prevention? (Identify and describe them briefly?

4. In the classes that you have participated in that have elated to the topics of alcohol prevention, tell me about the approaches taken by the teachers, for example, abstinence, moderation, harm-reduction.

5. In your views to what extent are these approaches effective? How so? If not, how would you do thinks differently?

6. To the best of your recollection, what have been some of the most relevant types of information in the program and in what ways were these relevant to you?

7. Is there alcohol prevention information or ways to communicate this information that you can think of that would make these programs more helpful to you?

8. Tell me about any skills that you would feel you'd like to develop that would be helpful to you in relation to alcohol prevention?

9. Are there any skills that you would feel you'd like to develop that would be helpful to you in relation to alcohol prevention?

10. Can you tell me what the best way would be to learn these skills? And why?

11. In what way has the program provided support to you?

12. From your perspective and experiences, tell me about how the programs are delivered? (method)

13. Is the way information delivered helpful to you?

14. From your experiences, can you tell me how confident that you are that this program is making a difference?

15. On this topic is there anything else you would like to tell me that you think would be helpful for me to know?

16. What would be the best way to tell you teachers would be helpful to you in the area of alcohol prevention?

Appendix H – Transcript Release Form

In respect to the study, *Examination of High School Students' Perceptions of Alcohol Prevention Programs,* I, ____, have reviewed the complete transcript(s) of the interview in this study, and have been provided with the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview with Marcella Ogenchuk. I hereby authorize the release of this transcript to Marcella Ogenchuk to be used in the manner described in the consent form. I have received a copy of this Data/Transcript Release Form for my own records.

________________________________ ________________________________

Participant Date

________________________________ ________________________________

Researcher Date

Appendix I – Ethics

UNIVERSITY OF SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB)

Certificate of Approval

PRINCIPAL INVESTIGATOR
Keith D. Walker

DEPARTMENT
Educational Administration

BEH#
09-002

INSTITUTION(S) WHERE RESEARCH WILL BE CONDUCTED
University of Saskatchewan

STUDENT RESEARCHERS
Marcella Ogenchuk

TITLE
Alcohol Prevention Programs: Examination of Grade 11 Students' Perceptions

ORIGINAL REVIEW DATE	APPROVAL ON	APPROVAL OF:	EXPIRY DATE
24-Dec-2008	05-Feb-2009	Ethics Application Consent Protocol	04-Feb-2010

Full Board Meeting ☐ Date of Full Board Meeting:

Delegated Review ☒

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: *http://www.usask.ca/research/ethics_review/*

John Rigby, Chair
University of Saskatchewan
Behavioural Research Ethics Board

Please send all correspondence to:

Research Ethics Office
University of Saskatchewan
Box 5000 RPO University, 1602-110 Gymnasium Place
Saskatoon SK S7N 4J8

Appendix J – Letter of Attestation

Letter of Attestation

This letter of attestation is in relation to the inquiry audit of the Ph.D. dissertation written by Marcella Joann Ogenchuk entitled "Alcohol Prevention Programs: Examination of Grade 11 Students' Perceptions."

The purpose of this study is to "explore the perceptions of alcohol prevention programming of Grade 11 students in selected high school settings and to ascertain the rates of alcohol used among those students."

Utilizing a case study design information regarding current prevention policies in the schools was obtained by interviewing school principals. Interviews were then conducted with teachers and counselors to determine the context in which the students were learning and included collecting data about the programs that were being delivered. In the final phase, 452 student questionnaires were administered and four focus groups were undertaken to explore students' perceptions of alcohol prevention program

The Audit Procedure --Verification and Accuracy of Transcripts and Disk Recordings.

1. Consent and Data/Transcript release forms

All Authorization, Agreement to Participate and Student Consent to Participate forms

a) list the authorizing for the study,
b) list the participants, student and non-student, and
c) are signed by the appropriate authorities, the participants and the researcher.

2. Selection of Samples for Verification and Accuracy of Taped Recordings to Transcripts:

a) Procedure and Observations for disk to transcripts tests:

There are 6 interview tapes provided. Three tapes are randomly chosen and the first interview on each is selected for testing. The first page of each and then 3 times during fast-forwarding, the tapes were paused to compare audio statements to the transcripts to note any discrepancies.

b) Accuracy of Quotations in Relation to Data Sources

All comparisons between recordings and transcripts were positive. The words spoken on disk were the words that appeared in transcripts.

3. Accuracy of Dissertation Chapter Four References to Transcripts:

a) Procedure and Observations for Chapter 4 references.

I was unable to trace specific references in chapter 4 to the interview working papers.

b) Accuracy of References in Dissertation to Disk Recording Transcripts.

Not done.

4. Inspection of Ethics Proposal and Certificate.

I have reviewed the candidate's **Certificate of Approval** from the Behavioral Research Ethics Board (Beh-REB) signed by the Chair of that board. The candidate has followed the terms of that approval.

5. Summary

Despite minor omissions the transcripts are accurate transcriptions of the recorded interviews.

Eric Campbell

Eric Campbell, B. Comm., M.B.A. (Queens) (retired member Institute of Internal Auditors and Association of College and University Auditors)

2010-06-18