BEYOND 'JUST SAY NO'

Drug education in schools seems to be up a blind alley — approaches aimed at preventing drug use are ineffective and those aimed at reducing harm are unacceptable. Meantime AIDS is pushing back the frontiers of acceptable responses to drug users outside the school. Could drug education gain new dynamism from these developments?

Ian Clements, Julian Cohen and Pat O'Hare

IN 1986 DRUG education coordinators were appointed in most LEAs in the country. One of their tasks was to promote education in schools to "combat drug misuse". Very soon some came to the conclusion that the medicine wasn't working. Kids were using a variety of drugs, both legal and illegal, in spite of a growing amount of money spent on drug education materials. New packs are springing up every month, almost all aiming to prevent drug use among young people. Many teachers and youth workers are suffering from problem pack use.

It is our contention that drug education should go beyond primary prevention — the attempt to stop people taking drugs. Most of the kids who don't use drugs are not influenced by drugs education, in the same way that it doesn't influence those who do use. It has, at best, a neutral effect. Drug education should encompass the best aspects of primary prevention programmes. It should give information, it should get kids to examine their attitudes, to examine social, legal, political, historical, cultural and health issues. Most importantly, it should look at secondary prevention strategies, ie, how to prevent kids harming themselves from drug use. The decision-making plus enhancement of self-esteem approach is dishonest and cynical when applied to primary prevention, with which it has become synonymous.

This article is not meant as a blueprint or model for future harm-minimisation 'lessons', but rather as a contribution to the debate among drug educationalists.

Primary prevention fails

The first attempts at drug education were in the main *didactic*, with an explicit message that drugs should not be used. The main technique was to show young people the horrible effects of drugtaking to frighten them off. *Better dead*[1] is the classic example, a film often shown in a school hall to 200 youngsters. One problem with this approach is that for most of the audience the reality of drugtaking does not involve the needles, long-term use and addiction portrayed in the film.

Information-giving is another approach, based on the assumption that man is a rational being, ie, you can give information which will change attitudes which will show itself in a change of behaviour. Unfortunately, this sequence does not always happen in that order — people often modify their attitude to fit in with their behaviour. Some of the information given is inaccurate, sometimes deliberately so — "prophylactic lies".

Schoolchildren: told what to wear, to call teacher 'Sir'. Can drug education really 'empower' them?

The attempt to stop young people using drugs became more sophisticated and moved into the area of *skills*. The idea is that young people are given classroom practice in the skills required to live in a drug-oriented society (eg, decision-making skills) for later use in the real world. But there is no evidence that skills practised in school are of use in real situations and, in drug education, 'decision-making' usually really means saying no. Would it really be acceptable if the pupils decided to use these skills to say yes?

A further development is the *affective* approach. The assumption is that if we enhance young people's self-esteem, they will not need drugs. But is enhancement of self-esteem possible in many educational establishments, and is there necessarily a link between self-esteem and drugtaking?

In general primary prevention approaches of whatever kind:
— seem to be ineffective;[3]
— lack a social, cultural, and political dimension and focus on the individual, adopting a victim-blaming approach;[4]
— deal in stereotypes and isolate and castigate drug users as deviant;
— are negative and do not address the problems of young people who reject the message — any outcome other than not taking drugs must be seen as a failure;
— are based on flawed assumptions about behaviour change;
— focus on the expertise of the educator as opposed to young people's experience;
— do not take into account a period in everyone's life called adolescence during which people like to take risks.

PSE — new methods, same aims

The current consensus is that education about drugs should be integrated into a personal and social education programme (PSE).[5] These programmes aim to use participative learning techniques to enable pupils to make healthy and effective life choices from a wider range of options. Why then are drug education programmes aimed at primary prevention — designed to narrow choice — thought to fit so snugly into PSE, part of an educational philosophy meant to widen choice?

The reason could be that PSE aims and practice are not in harmony. Some staff may confuse the radical new classroom practice with a radical change in educational aims. But in much PSE-based drug education we find the same old primary prevention aims dressed up to look new.

The extent to which PSE could enlarge young people's area for responsible decision-making is limited by the contrary messages they receive from the whole school structure. Fundamental to the PSE approach is an acceptance of young people's choices which is clearly missing from educational institutions. While cliches such as 'decision-making skills', 'promotion of self esteem' and 'empowerment' are commonly regarded as objectives central to PSE work, these institutions (schools especially and possibly to a lesser extent youth centres) in fact devolve very little power to young people and accept only a very limited and prescribed range of attitudes and behaviours. In most schools and youth centres the majority of the decisions are made for them — when to attend, what to do, what to wear, even when to talk.

But the main reason why drug education 'fits' into PSE, is that, just like most drug education, PSE has generally failed to progress beyond personal education concentrating on the skills of the individual, and pays only lip service to social education. It is, as currently practised, rooted in an individual change or cultural adjustment model which blames individuals for being in their position, and attempts either to train them out of it or to train them to accept it.[6] This model places little emphasis on structural factors such as environment, social conditions, class, race, gender, etc,

Ian Clements is Specialist Adviser for Drugs Misuse with the Metropolitan Borough of Bury. Julian Cohen is Coordinator for Drugs Education in Tameside. Pat O'Hare is the Drugs Education Coordinator for the Metropolitan Borough of Sefton.

as influences on or reasons for people making decisions about their lives.

By not considering structural factors and only exploring personal skills, it becomes easy to decide in what way an individual is deficient and needs 'improving' — the standard is the educator's own lifestyle and value structure. Accordingly, drug education strategies based on primary prevention view drug use as 'wrong' or 'deviant'.

Preventing harm — new aims, same methods

Evidence that primary prevention does not work, and that it may even be counterproductive, has forced some educationalists to rethink their strategy. There is a growing recognition that lessons can be learned from the secondary prevention approaches being debated and practised by drug workers in the context of the current panic about HIV. Among drug workers, this harm-minimisation approach has become the norm in some parts of the country. The issue here is — how is drug workers' secondary prevention practice being reinterpreted for educational use?

The cornerstone of secondary prevention as practised by drug workers is the conviction that drug use is occurring and is often likely to continue, so the only realistic aim is to encourage 'sensible', less damaging use. This often takes place around specific concerns — injecting, sharing needles, HIV and other infections, and, with regard to solvent use, using smaller bags, not doing it alone, avoiding potentially dangerous environments, etc. Such approaches tend to focus on individual users and are mainly based on information-giving. The assumption is that many, especially novice, users lack the necessary information for safer drug use.[7]

In common with traditional primary prevention education, this approach implies a model of behaviour where information leads via rational thought to behaviour change. Also it is still focused on the individual and in danger of ignoring structural factors limiting freedom of choice.

The need to go beyond primary prevention in educational institutions is taking a number of forms, or rather, proposed forms — while many practitioners are beginning to talk about it, there is not a lot of innovative work actually being done.

One school of thought is that potential or actual drug users should be identified and worked with.[8] There are obvious difficulties in identifying, targeting and interacting with users, especially within educational institutions. While this may be relevant or possible in cases that come to light through actual drugtaking, it does not address the question of whether everyone should be educated about drugs within a harm-minimisation strategy, whether they are using or not. Quite apart from the fact that the whole thing could turn out to be a self-fulfilling prophecy — 'We need potential drug users and you are them' — there are considerations such as labelling, stigmatisation and stereotyping, and the fact that other young people may aspire to join this group to gain status.

The information-giving approach to harm-minimisation will possibly be limited in its effectiveness for the same reasons it has failed to achieve primary prevention objectives. Educationalists are now considering harm-minimisation strategies that go beyond giving information focusing on the risks run by individual drug users. For example, Keith Tones has outlined an approach which stresses skills (first-aid, counselling skills and helping strategies) as well as information about drugs and helping agencies.[9] We would regard this as a useful starting point.

Any approach to harm-minimisation must move away from detailed examination and questioning of an individual's drug using behaviour. We need to arrive at a point where drugs are seen in a wider social, community and political context. To be effective, we are suggesting that harm-minimisation needs to develop a non-judgmental understanding of drug use that does not stigmatise drug users, one practical application of which would be support for drug using members of the community rather than rejection.

The obvious question is whether existing educational institutions are able to adopt such a concept. The school environment and ethos is unlikely to allow such work to proceed overtly. Despite the fact that harm-minimisation work in schools is done around alcohol, it rarely stretches to other drugs, especially illicit drugs.

However, we do have a model for a harm-minimisation approach to drugs working within the current largely repressive, authoritarian school structures — alcohol education. We encourage people to 'drink sensibly', and could move towards this type of approach in relation to illegal drugs by educating parents, governors, teachers and others about the possibilities. Covert, piecemeal, unapproved initiatives by individual teachers are, necessarily, severely limited and whole school approaches will not be easy to develop. However, we must begin the task.

Areas of education other than schools might be more able to embrace harm-minimisation. For example, the youth and community service generally does not suffer from the structural and legal constraints of schools and its customers are the young people themselves rather than parents and governors.[10] Similarly, further and adult education are important areas to explore.

OUR UNDERLYING assumptions are that drug use is part of normal behaviour and will take place. The moral high ground has in the past been claimed by the 'just say no' lobby who, while accepting that some young people will ignore their advice, see these as inevitable casualties in their attempts to prevent drug use to the exclusion of other aims. Our view is that the moral high ground lies with developing strategies aimed at minimising harm to individuals and communities. □

The structure of drug education approaches

METHOD	AIM	
	Primary prevention (stop use)	**Secondary prevention** (reduce harm)
Didactic (explicit instruction, scare tactics)	*First attempts at drug education, still being used*	*For example, anti-injecting/ anti-sharing AIDS campaigns*
Information-giving ('the facts will speak for themselves')	*Now less popular in drug education because found to be ineffective*	*In some parts of Britain, the dominant approach in drugs work*
Skills (practice lifeskills needed to cope with drug environment)	*Dominant approach in drug education*	*Developing in anti-AIDS work in syringe exchanges, eg, injection skills*
Structural (appreciates social and environmental influences)	*Underdeveloped in drug education but recognised as a progressive approach*	*Undeveloped in drug education and ad hoc in drugs work*

Primary prevention is the dominant aim in drug education.
Secondary prevention is fundamental to much work with drug users.

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