Could do better an evaluation of drug education

THE LAST HALF of the '80s saw the initiation and development of drug education programmes for use in schools throughout the UK. The Scottish Education Department was instrumental in the development of materials and training and also funded an independent evaluation of the impact of drug education.

The evaluation took place between 1987 and 1989 and represents the first major UK assessment of the 'skills-based' approach to drug education dominant in current thinking. The bulk of this article deals with the implications of the findings; see page 16 for a summary of the research itself.

A key aspect of school-based drug education initiatives across the UK was the use of standard drug education packages, which largely replaced reliance on ad hoc forms of drug education using information and fear-arousal materials including pamphlets, videos or strict homilies from teachers.

The packages in greatest use in Scotland were Drugwise 12-14 and DrugWise 14-18. Both eschewed the fear-arousal approach and minimised the informational content of the teaching. Instead these packs aimed to assist young people to clarify their attitudes and values; to develop decision-making, rejection and discussion skills; and to raise awareness of alternatives to drug use.

US studies have reported that such skills-based approaches have had some positive impact in preventing initiation into smoking, but the Scottish evaluation clearly showed that the impact of these recent developments in drug education are, at best, of minor significance. Although the education raised levels of drug-related knowledge, there was a neutral impact on attitudes to drugs and on reported use of illegal drugs, alcohol, tobacco and solvents.

Some will conclude from this that drug education has been a waste of time. However, the value of evaluation lies in the willingness to learn from findings. This will entail a fresh look at what we expect from drug education, at how we target primary prevention attempts to prevent drug use, and at how we address the needs of those young people who will nevertheless experiment with drugs.

LESSONS FOR TEACHER

What accounted for the lack of impact of drug education found in our study? A number of issues were identified that have relevance to good drug education practice.

Maintain credibility. Drug educators have an important role as credible sources of information and should at all times avoid tendentious input. Misleading assertions, such as passing off opinions as fact, will detract from the success of an educational programme, especially where the target audience is knowledgeable about the drug scene, as many young people are.

Avoid stereotyping. There is a widespread assumption in drug education materials that young people take drugs because they lack self-esteem or are weak in the face of peer-group pressure. However, this assumption of personal or social inadequacy is often simply negative stereotyping of drug users.

There is evidence that people with positive health practices do have higher self-esteem than others, but positive health practices and high self-esteem do not necessarily preclude the use of drugs. Other studies have reported that often those with a leadership role in their peer group are the first to experiment with drugs and are more likely to try out new experiences. The role of low self-esteem in drug use has been over-simplified to the point that use of the concept sometimes appears to be code for moral inferiority.

Inform decisions, don't make them. A key feature of drug education is 'decision-making': that is, providing the kinds of information needed for an individual to make

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an informed choice about drugs. But the assumption is always that an ‘informed choice’ must be to choose to say ‘no’. In reality, ‘decision-making’ sessions are decision-implementation sessions, with the decision to say ‘no’ supplied by the teacher. Even in drug education packages emphasizing the life skills approach, there were cases where the ‘say no’ message was implicit or explicit in the content. Particularly in the hands of an insensitive teacher, telling young people not to do something they find attractive runs counter to good educational practice – it simply will not work. Many young people reject, or even resist, being told what to do.6

Incorporate harm reduction. The type of drug education evaluated in our study (because it was the type in circulation at the time) was primary prevention aimed at preventing initiation into drug use. This objective is inappropriate for young people who are already experimenting with drugs. Given the variable levels of drug experimentation in different schools, there is a need for drug education which enables young people to understand drugs and how to avoid harm from drugs, as well as education that seeks to prevent use.

Towards ‘whole school’ health

Our study clearly provides lessons for drug educators to learn and it would be of some concern if school-based drug education did not develop beyond its present form. But there is some reason to be optimistic. School drug education has, to some extent, attempted to take on board the findings of previous evaluations – in marked contrast to mass media campaigns which still subject us to the old fear-arousal messages of personal and social disintegration, despite evidence that this approach has no positive impact on people likely to take drugs. The recent Drugs – the Effects Can Last Forever campaign is an example of this approach.

Since our evaluation report was submitted, the Health Education Board for Scotland (formerly SHEG) has published wide-ranging proposals for promoting good health, emphasizing the need for a whole-school approach which coordinates policy and permeates health education throughout the curriculum.7

“"The assumption is that an informed choice must be to say no”

This is a heartening development. Case studies in the evaluation highlighted the need to establish a healthy school system, in which various aspects of the ‘hidden’ and the formal curricula work together to produce an environment conducive to health promotion. In addition to any formal drug education agenda, these aspects include teacher-pupil interactions and the standards and values implicit in the way the school operates.

For example, attempts to enhance decision-making skills will be undermined in schools where all the decisions have already been made for the pupils. A whole-school approach is a necessary precondition of effective health education, whatever the focus. Nonetheless, the extent to which these proposals will be adopted remains to be seen.

READERS OF DRUGLINK will recall an article which predicted the ineffectiveness of primary prevention and the need for harm-reduction strategies. Since then the same team have developed a harm-reduction package, Taking Drugs Seriously.8 It will be interesting to see how far this or similar materials penetrate into schools. After all, parents of young potential drug users should surely want to know if the needs of their children are being catered for. And this is a sizeable constituency.


FOR MORE INFORMATION

■ CONTACT THE AUTHORS at the Centre for Occupational and Health Psychology, University of Strathclyde, Marland House, George Street, Glasgow, telephone 041-552 4400 ext. 2244.

■ CHECK DRUGLINK for the announcement of ISDD’s publication of the National Evaluation of Drug Education in Scotland by Niall Coggans et al, the research report on which this article was based. Available from ISDD later this year.


■ ISDD’S INFORMATION SERVICE is available on 071-430 1993.
FINDINGS OF THE NATIONAL EVALUATION OF DRUG EDUCATION IN SCOTLAND

The Scottish evaluation\(^2\) started by identifying the range of drug education experience to be found among pupils in their second, third or fourth years of secondary schooling (13-16-year-olds). This was carried out by surveying 106 mainstream secondary schools, a quarter of all these schools in Scotland. In each a senior member of staff responsible for drug education provided extensive information about the materials used, which pupils participated, and the training teachers had undertaken.

Subsequently, a total of 1197 pupils drawn from 20 schools completed questionnaires. Teachers were not present while the pupils completed the questionnaires, but members of the evaluation team were available to answer any questions.

Within the pupil sample four categories of drug education experience were represented (see panel).

Underlying this categorisation is the assumption that exposure to the full programme of a package should be more effective than (in descending order of impact) partial exposure, non-pack drug education, or no drug education at all. It was possible to test this hypothesis using the sample of pupils. The schools selected were either urban deprived or urban non-deprived. Social class was defined both at the level of the whole school and at the level of the individual pupil.

The prevalence of the Drugwise 12-14 pack made it impossible to include any groups of second-year pupils who had experienced drug education which was not based on this programme. Nonetheless, there was a sufficient range of drug education experience to answer the following questions:

? Does the level of drug education influence the impact on target populations?
? Is the effect of drug education influenced by age?
? How do the effects of drug education relate to social class?
? Are there sex differences in the outcome of drug education?

Our main interests were in establishing whether drug education in the late 80s had made pupils less likely to take drugs, more knowledgeable about drugs, and whether as a result of the education they became more anti-drug in their attitudes.

What teachers believed drug education achieved. A sample of 97 senior secondary school staff were asked about the impact of drug education on pupils' drug-related knowledge, attitudes and behaviour. Each was responsible for the development and implementation of drug education in their respective schools, including the schools from which the pupils were drawn. As no objective measures underlied their responses, it has to be assumed that these were based on beliefs or opinions.

These teachers expressed considerable confidence that as a result of the education pupils knew 'slightly more' or 'much more' about drugs; 69 per cent believed that pupils were 'more' or 'much more' anti-drugs; and 72 per cent believed that pupils were 'less likely' or 'much less likely' to take drugs.

What drug education actually achieved. Statistical analysis assessed the effects not only of drug education but also of age, sex, and social class on levels of knowledge, attitudes to drugs and reported drug use. The analysis controlled for any confounding effects of the other background factors.

What we found was that drug education only had an effect on drug-related knowledge: its impact on both attitudes to drugs and reported drug use was neutral. For illegal drug use, the finding of no decrease in usage may simply reflect the fact that use levels were already low. The same could not be said of alcohol and tobacco where use levels were relatively high; here too, education failed to reduce usage.

Given that the drug educators' aims were to have a broad impact in terms of all drugs, legal and illegal, it is of some concern that there was no effect on consumption of these more widely used drugs.

Belief and reality. The finding that drug education had a positive influence on levels of drug-related knowledge supports the vast majority of teachers in their view that pupils knew more about drugs as a consequence of drug education.

In the case of drug-related attitudes, the outcome finding does not support the majority view of school staff that pupils are more anti-drugs as a result of drug education — though on average the young people in the study had fairly stereotypical anti-drug perceptions and attitudes, regardless of their drug education experience.

On likelihood of drug-taking, the findings are in marked contrast to the beliefs of the majority of school staff that pupils would be less likely to take drugs as a result of drug education. Drug education had no effect on levels of drinking, smoking, solvent abuse or illegal drug use.