

Facts, not scare stories, must be at the heart of any drug education strategy. **Jenny McWhirter** on how stressing that most young people do not use drugs can steer children away from trying them.

# Credibility drive

**W**HAT would a well-planned drug education lesson look like? If you could be a fly on the wall you might observe pupils and teachers (alone or with a colleague from another organisation) begin by agreeing a set of ground rules for how they will work together. The teacher would set out the objectives of the lesson, based on a prior assessment of the pupils' needs and then would act in the role of facilitator rather than 'lecturer'. The non-didactic teacher will be able to set tasks for individuals, pairs and groups and work with pupils as they make their own contributions to the lesson, based on their existing knowledge and understanding.

But what if this knowledge or understanding is flawed? In some cases the teacher might direct pupils to other sources to find the correct information, extending pupils' skills in accessing information in a variety of formats. But if that misunderstanding is about the extent of drug use by young people of the same age or in the same community the teacher should be prepared to offer credible, reliable information about the actual prevalence and give pupils an opportunity to reflect on what this information means for them. Why? Because this most common misunderstanding can have a profound influence on young people's drug-related decisions.

## EVALUATION

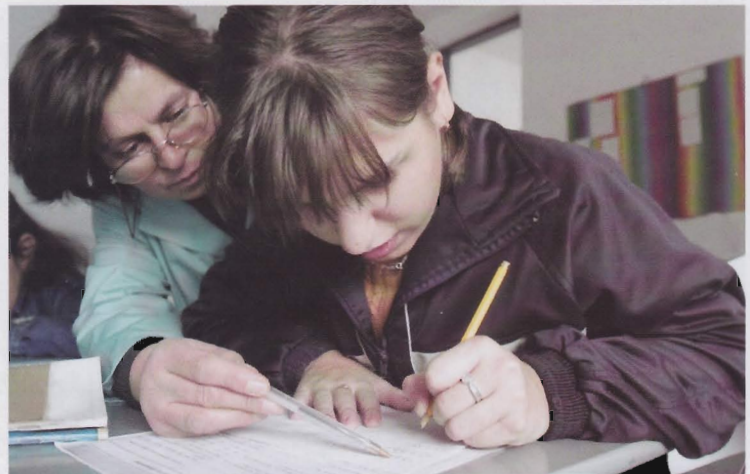
Drug education has always been one part of our approach to drug prevention, but what do we know about what works? Are those who say drug education doesn't work right? Do we all mean the same thing when we talk about 'what works?' Will we ever be able to make real evidence-based decisions about how to spend scarce resources?

Evaluating drug education is tricky. It is possible to demonstrate increases in knowledge and understanding of drugs (including alcohol, tobacco and medicines) while making no difference to behaviour change on a population basis. It is even possible to demonstrate changes in attitudes and intentions to use drugs, whilst having no impact on the use of drugs by the target population.

But some studies offer evidence that it is possible at least to delay first drug use by some young people. This in itself is a worthwhile aim, since the younger someone is when they first use tobacco, alcohol or other substances, the more likely they are to have problems with illegal drugs at a later stage. This is probably due, not to a gateway effect, but more to

the association between early drug use and other risk factors such as poor achievement at school, mental health problems, living with drug-using parents or lack of positive relationships with adults in the family or community, among others.

In spring 2007 we will have the first results from 'Blueprint', a major Home Office research project on drug education. Whatever the outcomes of this project we will certainly know more about the implementation of evidence-based drug education in England than before. Much has already been written about Blueprint, and many have expressed concern about the cost of the study. There are also concerns about the transferability of the approaches used, since it is based on research evidence obtained mainly from the USA and Australia. This is largely because these governments have invested in high quality evaluation research projects. But can what works in the US work in the UK?



Most people interested in drug education await the results with interest and some with trepidation. If the evidence is not clear, what will it mean for the future of drug education in this country? Only time will tell. In the meantime *Druglink* will be examining some of the basic principles on which Blueprint has been based and which are recommended in *Drugs: Guidance for Schools*, published by the DfES in 2004.

In this article I want to examine the approach known as normative drug education, and explore how education approaches based on social norms means going beyond the classroom to community leaders, parents and the media.

## PREVALENCE

Normative drug education means ensuring that young people know the true prevalence of drug use in their peer group, and also know how acceptable, or unacceptable, drug use is amongst their peers and wider community. While it is true that drug use amongst young people has risen since the 1970s, it also true that most young people in England do not use illegal drugs. According to the most recent figures 81 per cent of 11-15 year olds and 74 per cent of 16-24 year olds had not used any illegal drug in the last 12 months. Of those who do use illegal drugs, most do so infrequently or for a short period of their lives. Only one to two per cent of any age group use Class A drugs and the vast majority of us never have problems with drugs.

Despite this, young people commonly overestimate the prevalence of drug use amongst their own peers, sometimes by as much as four times, so that their perception is that the majority of their peers are using illegal drugs. This causes two problems. Firstly, as parental influence wanes and the influence of peers increases, the perception that 'everyone' is doing drugs exerts a powerful influence to join the crowd. Secondly if 'everyone' is doing drugs and harmful effects are not apparent, then the claims of teachers, parents and others about the risks are clearly exaggerated. This undermines efforts to be honest about risk taking since even balanced information will seem overstated.

Normative education addresses these misperceptions by ensuring young people have access to credible information about drug use in their communities and amongst their own age group. In the US this has been used in combination with other approaches in drug education programmes for elementary school pupils, such as Life Skills. In these programmes evidence has been found for delaying first use of tobacco and alcohol as well as cannabis, although the effects can be short lived. Normative programmes have also been used on college campuses, particularly for alcohol education, where both students' perceptions of drinking and drinking itself have been reduced (see <http://alcohol.hws.edu>).

According to researchers working in the field of social marketing, normative education gives strong support to young people who have decided that they do not want to use drugs. It also helps those who intend not to use drugs but are not sure of their own capability to resist the influence of their peers when the situation arises. It does this by reinforcing healthy behaviours and demonstrating that those who do not use drugs are not a tiny minority. This makes normative messages an important tool in universal drug education, as part of Personal Social and Health Education in schools and the youth service. There is also some evidence that normative messages can be effective in reducing drug use amongst higher risk groups, although this is disputed.

Every approach to drug education has its critics. Some are concerned that normative messages cannot address the needs of the more vulnerable young people whose drug use is underpinned by complex social issues. Some researchers have identified that, as with many marketing campaigns, young people can get switched off by constant repetition of the

## DRUG EDUCATION: THE FACTS

In England, drug education is part of the statutory science curriculum. Many schools also offer drug education as part of Personal, Social and Health Education (PSHE) for which there is a non-statutory framework.

As PSHE is non statutory, teachers are only required to become 'familiar with' the PSHE framework as part of their initial teacher training.

The DfES currently offers a limited number of places on continuing professional development courses for PSHE teachers in drug and sex and relationship education.

In January 2005 Ofsted said that PSHE is improving, especially in schools where teachers had received specialist training. However, in a specific report on drug education later the same year Ofsted also said that teachers do not have sufficient understanding of pupils' needs with respect to drugs.

Drugs guidance for schools (DfES 2004) states that effective drug education:

- Addresses knowledge, skills and attitudes
- Provides developmentally and culturally appropriate sensitive information
- Challenges misperceptions young people hold about drug use and their peer's reactions to drug use
- Uses interactive teaching techniques
- Involves parents and carers as part of a wider community approach

Drug education should be part of a whole school approach to health and is most effective when it is delivered by teachers. Visitors such as police officers can add value to, but do not substitute for teachers.

same or similar message. And not all young people see themselves as followers. Those who prefer to see themselves as innovators may also be resistant to these approaches.

## WIDER SOCIETY

But if a normative approach to drug education is going to have any impact, it has to go beyond the classroom into staff rooms, living rooms and even newsrooms. Some of those most resistant to the message that most young people don't use illegal drugs are teachers and parents - and it's not hard to see why this might be. Headlines such as 'Cocaine floods playgrounds' and the pressure on schools to introduce random drug testing all give the impression that drug use by those of school age is much greater than it really is. As we saw from Mike Ashton's article 'Commercial Breakdown', in the last issue of *Druglink*, well-meaning and sophisticated public information campaigns can create the impression that it is normal to use a particular drug, and lead to increased, rather than decreased, use.

This has been recognised by the Blueprint project, and the multi-component approach adopted has involved schools, parents, local retailers and importantly the local press. Whether the project has changed perceptions of drug use by young people remains to be seen. •

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