# DRUG EDUCATION IN THE PRIMARY SCHOOL

**Why primary school drug education is needed and how it could be done. Sensitivity to children's existing drug knowledge and concerns is the key.**

**Ron Greer**

"EDUCATION ABOUT illegal drugs at primary level is rare. Nevertheless, many children aged 8-12 are well aware of drug issues and ask about them." This quote from the DES publication *Drug Misuse and the Young* (1985) supports the need for drug education in the primary school.

A common argument against such education is that increasing a child's awareness of drugs might increase their curiosity and result in more experimentation. This presupposes that children have little knowledge of drugs in the first place and that school is their only source of information.

Research by the HEA Primary Project Team does much to refute these ideas.[1] A 'draw and write' technique was used to investigate how children aged 4-11 saw the world of drugs. It showed that children aged 6 and upwards know far more about drugs than we might have thought. Much of this knowledge is thought to reflect the influence of television.

## Practice in primary schools

If primary school children have already begun to develop perceptions about drugs, then it would seem only sensible to check these out and see if the information they already have is correct. In some primary schools this is already being done.

There is considerable variation in drug-related teaching in primary schools nationwide. In terms of content it is not unusual to find work being done on pills and medicines, on smoking and on alcohol, often as part of a planned health education curriculum. Illegal drugs and solvent abuse are not always part of this formal plan but may be discussed if they arise spontaneously in the classroom.

In terms of teaching methods, the 'thematic' approach seems the one most favoured. Drug education often finds itself within planned themes like 'Myself' or 'Keeping Safe' and occasionally within topical themes such as 'The Olympics'. (The Ben Johnson affair produced considerable mileage for discussion within a theme of 'cheating' in one of my middle schools.)

***Teachers must avoid going in with a prepared script unrelated to the children's experiences***

In general, primary schools have a more flexible approach to education compared to secondary schools, which are much more subject-conscious and restricted by the timetable. Cross-curricular approaches to themes such as drugs are commonplace in the primary sector but far less prevalent in secondary schools.

Three teaching resources for use in primary schools are worthy of note — the HEC *My Body* Project;[2] *Health Education — Drugs and the Primary School Child*;[3] and the *Good Health Project — The World of Drugs*.[4]

The *My Body Project* is used by many schools. Aimed at 10-12 year olds, it has had a considerable impact since its introduction in 1983. The emphasis is on trying to stop children from starting to smoke, as opposed to trying to stop them smoking. Research has shown that children working on the project are half as likely to start smoking as control groups.[5]

The *Good Health* series from Central TV has recently published a unit called *The World of Drugs*. Developed by the HEA Primary Project Team, this includes work on 'What is a Drug', 'The Drugwise Rule Book', and 'Resisting — Saying No'. The pack is said to emphasise the involvement of pupils in a variety of activities including making decisions, thinking creatively, using language, number play, and drama.

*Health Education — Drugs and the Primary School Child* (for ages 9-11) aims at "equipping young people and those who care for them with the knowledge and skills which may help them to reduce the chances of encountering drug-related problems." The approach is "deliberately low key, interweaving drug education into a broader safety theme". The pupils' module contains a series of exercises on building self-esteem and specifically looks at alcohol, smoking and solvent abuse.

Also notable is the work of the Life Education Centres, which use a travelling health education exhibition aiming to start school and pupils on a continuing programme using a set of workbooks. They emphasise that much of the work has to be done by the schools, but there is a danger that the 'roadshow' might be used as a 'one-off' or as an alternative to the school developing its own programme.

## Be assertive; do as you're told

It's when we consider *why* this teaching is happening — its aims — that we move into contentious areas. It might be argued that as a child progresses through school there should be a shift away from simple 'do this, don't do that' messages towards developing their own decision-making abilities. In this way a child becomes progressively more responsible for their health-related choices.

Often behind this approach is the theory that if a person values themself they will be more likely to make healthy choices than someone with little self-esteem.[6] It is also claimed that

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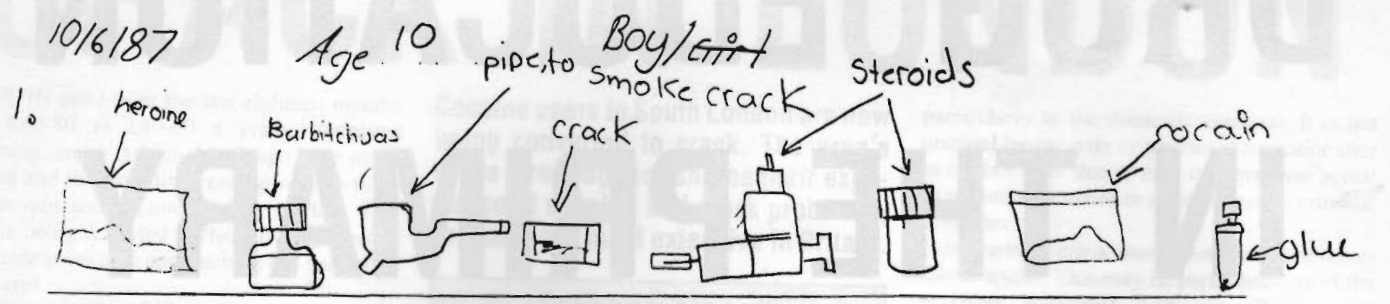
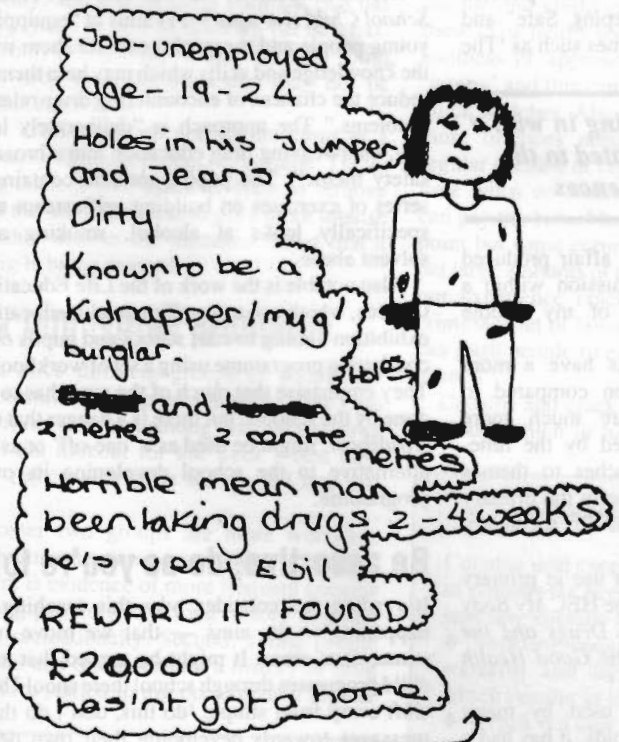




redundunt undertaker Started drug pushing 1981 Age 42 and has bad temper, and con Artist

3. He most probberely going to sell them to teenagers or even to any one.




3. I THINK that man was going to leave the bag here so he could have given it to one of his friends so he could sell it and they could have shared the money between them.

**▲ A response from an Ealing schoolboy to the HEA Primary Project Team's 'draw and write' technique (see box opposite for details). What one 10-year-old thought would be in a bag of drugs and what he thought of the person who'd dropped it. Drawn over two years ago the reference to smoking crack in a pipe and to steroids shows a surprising awareness of contemporary drug issues.**

**◀ This from an 11-year-old girl demonstrates the point that even before secondary school stereotypical images of drugtakers as 'bad' or 'sad' are strongly developed. Along with cocaine, heroin, uppers and downers and glue, the bag this unsavoury character dropped included a gun, a knife and a rope.**

## A child's eye view of drugs

The Primary Project research team at Southampton University elicited children's perceptions of the world of drugs by asking them to plug gaps in a story line about drugs.

Over 2000 children aged 4-11 years were asked to 'draw and write' their responses to the following prompts.

1. Two children were walking home when they found a bag with drugs inside it. Draw what you think was in the bag.
2. Who do you think lost it?
3. Draw what you think that person was going to do with it.
4. Draw what the children did with the bag.
5. What would you have done if you had found it?
6. Can a drug be good for you/help you? If so, when?
7. Can a drug be bad for you/hurt you? If so, when?

At five years of age children already linked the notion of drugs with a 'bad scene' and drug users were portrayed as teenagers or criminals.

By age 7 stereotypes of drug users as easily recognised 'baddies' were common but still most children mentioned only tablets, medicines or powders as possibilities for the contents of the bag.

By age 8-9 more than a quarter mentioned heroin or cocaine and drug user/dealer stereotypes had flowered into sometimes quite detailed potted biographies. Drug users are seen as either bad or sad. Concepts of addiction and dealing for profit were beginning to emerge and the children were capable of describing methods of use in great detail.

The trend to equating 'drugs' with illegal and dangerous substances was even further developed in the 10-11-year-olds.

See reference 1 for source

**See opposite for how some children responded to the questions**

1. HEA Primary Project Team. *Jugs & herrings*. Southampton University, 1986 Unpublished.
Linda Blackburne. *Times Educational Supplement*.:12 August 1988, p.6.
2. Health Education Council (HEC). *My body*. London: Heinemann Education, 1983.
3. TACADE/HEC. *Health Education—drugs and the primary school child*. 1986.
4. *The Good Health Project: set two*. Forbes Publications, 1988.
5. Dave McLeary. "Helping children to make their own decisions: the my body project." *Health Education Journal*: 1986, 45(1).
6. Keith Tones. "Promoting the health of young people — the role of personal and social education." *Health Education Journal*: 1986, 45(1).
7. HEA Primary Project Team. *Health for Life 1*. Nelson, 1989.
*Health for Life 2* forthcoming from the same authors and publisher.
8. Advisory Council on the Misuse of Drugs. *Prevention*. Home Office, 1984.
9. Department of Education and Science. *Drug Misuse and the Young*. 1985.

children with high self-esteem are able to deal with peer pressure, a major influence on young children's attitudes and behaviour and of particular significance in relation to drug choices.

Many schools agree in principle with this autonomous, informed decision-making objective, yet in practice are more inclined towards narrower goals such as stopping children smoking or using illegal drugs or solvents. Teachers can find it difficult to reconcile giving clear messages like 'Never take other people's medicines' and 'Don't take (illegal) drugs', while also encouraging informed choices.

'Letting go' sufficiently to encourage children to make their own informed choices and be assertive may be difficult enough in a health education lesson. But there seems little point in developing these skills in the classroom if the whole school ethos is geared to blind obedience and submissiveness from the pupils. A dollop of assertiveness served up in the classroom can easily be overwhelmed by a bellyful of 'keep still and be quiet' at lunchtime.

## What if they say 'yes'?

Primary prevention is seen as the fundamental aim in most schools. But what of children already using drugs? Are harm minimisation strategies appropriate for primary school children?

If we are seriously concerned about the future health of our children it would be irresponsible to concentrate exclusively on primary prevention. But in any school, and particularly at primary level, a harm minimisation approach must be adopted very cautiously. The main problem is that while younger pupils may know about illegal drugs, all but a minute percentage do not use them and are not considering using. Most will be violently 'against drugs'. Telling them how to avoid harm from illegal drug use is irrelevant and potentially counter-productive.

Here more than ever there is a need to avoid going in with a prepared script that does not relate to the children's concerns and experiences. Far better to use open exercises to probe their drug awareness and then to respond to the drug issues that emerge.

So, for instance, a small group exercise based on the question 'What do people do that makes them unhealthy?' might lead to a discussion in which it emerges that an older pupil has been seen sniffing aerosols. The opportunity is there for the teacher to point out that this is an extra-dangerous practice without risking inserting ideas not there in the first place.

There is clearly a place for harm minimisation messages about alcohol and tobacco and possibly, among older pupils, solvents, but beyond this a responsive 'dipstick' approach is most appropriate.

## Some ways forward

What would a good primary drug education programme look like? The list below includes some of the elements. It is offered as a basis for discussion.

◆ **Varied teaching strategies.** Children have different preferred styles of learning so it is important to provide a rich diet of experiences through a variety of teaching approaches. The emphasis should be on active learning methods, including small group work and role play. My recent experience of piloting a puppet show exploring issues relevant to drug education clearly demonstrated the potential of this medium, particularly for 6-9 year olds.

◆ **Need for a developmental framework.** A flexible health education framework is needed which moves the child on as they grow out of the egocentric stage, where they find it difficult to see the other person's point of view, through to a more socially responsible one. Topics and themes can be re-introduced at these later stages from a correspondingly different perspective or focus.

◆ The recently published resource *Health for Life 1* from the HEA Primary Project Team, a teachers' planning guide to primary school health education, looks very useful in this respect. *Health for Life 2* specifically provides more activities on key themes, including "The World of Drugs".[7]

◆ **Attitudes and skills as well as information.** "Drug education should not concentrate solely on factual information about drug misuse.[8] This view of the Advisory Council on the Misuse of Drugs is particularly true with children of primary school age, where an over-emphasis on the drugs themselves could glamorise the subject. A well balanced drug education programme also involves attitude and skill development. Helping children clarify their values on drug issues is a prerequisite to their making informed choices.

Peer pressure can be an enormous influence on children, but learning how to handle it without losing friends involves much more than training children to 'Just Say No'. Being able to be assertive without being aggressive and finding ways that both parties to the interaction can be 'winners' is a more subtle skill, but one more likely to be employed.

Just as important is encouraging cooperative working and respect for others so pupils do not attempt to twist their classmates' arms in the direction of something they clearly do not want to do.

◆ **Whole school approach.** What happens in lessons is only a part of the pupil's total school experience. The other parts can sabotage progress towards healthy, autonomous decision-making. Drug education (like other aspects of health education) should be seen in the wider context of the school as a health promoting community, rather than as something which goes on only in lessons. Schools should be working towards "creating a climate of support, confidence and fulfilment in which drug misuse is unlikely to flourish".[9]

◆ **Involve the parents.** Parents/community workshops allow the exchange of information and ideas between parents, teachers and the local community. Parents should be made aware of the need to begin drug education at primary level and be given the opportunity to experience some of the activities that their children might do in school.

Often this does much to allay some of the concerns parents have about broaching drug issues with this age group. The parents' own drugtaking behaviour can have a major influence on their children's attitudes and behaviour, and this needs to be discussed.

WE LIVE IN a drug-orientated society. Perhaps on this basis alone we have a responsibility to educate our children to live in a world of drugs. Many children's first drug experiences occur while they are at primary school. To delay drug education until the secondary phase surely makes little sense. ■