

# MAKING A HASH OF IT

It was expected to decide whether a well structured, well resourced, evidence-based drug education programme could contribute to reducing youth substance use, yet the £6m Blueprint study ended up a scientific shambles. Analysis by **Mike Ashton**

The great store set in the Blueprint study's potential to "trigger a fundamental assessment of the place of drug education" in UK drug policy has led to equally great disappointment that it was unable to fulfil this promise. This final report argued that methodological limitations meant no conclusions on Blueprint's preventive impacts could be drawn from the study. Though undoubtedly true, the study can still be examined for signs that the programme might have had an impact; details below.

That such signs were lacking reinforces the view that drug education in secondary schools makes little contribution to the prevention of problems related to drinking and illegal drug use though the evidence in respect of smoking is stronger.

Given that just 30 schools were available, the study decided against splitting them evenly, arguing that the samples would be too small to detect the programme's impacts even if in reality these existed. Instead it opted to test whether the programme could be implemented in 24 schools, leaving just six schools which did not implement Blueprint. Though not randomly selected or formally matched, these six seem sufficiently like the 23 Blueprint schools, one school opted out, to be used to discern any signs that Blueprint might have had an impact which would have been confirmed by a larger study. Indeed, this seems to have been the initial expectation.

In each of the three study areas the two non-Blueprint schools were selected to be on more or less opposite ends of a scale of socioeconomic deprivation.

The result was a sample very similar on a range of social, economic and other indicators to the children in the Blueprint schools. In 2005 a Blueprint leaflet described the six schools as "control" schools which would be used to "assess and examine the impact that the Blueprint Programme has had on... prevalence of drug use among the Year 7 cohort until they reach Year 10".

EVEN BEFORE THE LESSONS, TWO PER CENT OF PUPILS IN BLUEPRINT SCHOOLS ANSWERED FIVE OUT OF SIX QUESTIONS CORRECTLY, A GAP WHICH REMAINED VIRTUALLY UNMOVED BY THE LESSONS

Describing the study's design shortly after the lessons had been completed and before the results were known, the Department of Health's lead on the project still saw the six schools as "comparison schools", and while describing the trial as exploratory rather than definitive, was still hoping it would assess "impacts on ... prevalence and harm" and "identify any potential for Blueprint to impact on behaviour change". Given the similarity of the six schools to the Blueprint schools in the

same areas, this last ambition does not seem unrealistic.

The study provided at least five measures of recent or frequent substance use for which the numbers are large enough to look for signs of an impact on more serious forms of substance use: smoking in the past week; similarly with drinking; drinking at least once a week; using any drugs in the past month; using cannabis in the past year.

By the end of the study, on none of these measures did fewer Blueprint pupils use than non-Blueprint pupils. Since before the lessons the pupils started at very similar use levels, this also means there was no sign that Blueprint retarded growth in substance use any more effectively than the usual lessons in the non-Blueprint schools.

Many more Blueprint than non-Blueprint pupils felt their drug education lessons were an important source of information, but this did not mean that as a result they were better informed. Even before the lessons, slightly more (two per cent) pupils in Blueprint schools answered five out of six questions correctly, a gap which remained virtually unmoved by the lessons (three per cent at years 9 and 10). For example, by year 10, 58 per cent of Blueprint pupils remained unsure whether, or actually believed, that cannabis is more dangerous than heroin, compared to 53 per cent in the non-Blueprint schools. Such a fundamental knowledge gap persisting towards the end of compulsory schooling seems to cast doubt on the educational as well as the preventive performance of the Blueprint programme.

Encouraging conclusions about the ability of schools to implement programmes like Blueprint must be tempered by the fact that the 23 schools were selected for their ability and willingness to take on this work. Only schools in their health and drug education work were invited to join the study, yet despite financial inducements, of the 122 invited, just 45 applied. It cannot be assumed that the majority which did not apply would have been as well placed to deliver the lessons, let alone those which did not qualify to be invited to join the study.

Of the possible reasons why Blueprint appears to have had disappointing impacts, the most likely is that no matter how well structured, school-based drug education generally has at best minor prevention impacts. Among the other

possibilities are that Blueprint's lessons largely displaced lessons timetabled for personal, social and health education, which may themselves (as perhaps in the six non-Blueprint schools) have been an effective intervention.

Also Blueprint relied on so-called 'normative education', comparing survey data on actual adolescent substance use levels with what are usually overestimates made by pupils. However, some teachers did not understand or adequately implement this core component, and even when they did, more often than not, some pupils simply did not believe the survey data, particularly in respect of the ubiquitously 'normal' activity of drinking. The lessons were seen as overly prescriptive by some teachers;

there may have been inadequate tailoring to the varying substance use knowledge, attitudes and use patterns of pupils in different classes, and too little scope for responding to how the pupils themselves responded to the lessons.

However, mixed and generally inconclusive findings of a prevention impact from school programmes targeting substance use do not negate the possibility that general attempts to create schools conducive to healthy development will affect substance use along with other behaviours. Nor do they relieve schools of the obligation to educate their pupils on this important aspect of our society.

■ **For source info go to:** [http://findings.org.uk/count/downloads/download.php?file=Blueprint\\_1.txt](http://findings.org.uk/count/downloads/download.php?file=Blueprint_1.txt)

## BLUEPRINT: THE BIG IDEA

The Blueprint drug education programme was piloted in 23 schools in the North-West and East Midlands regions of England during the spring terms of 2004 and 2005. Funded by the Home Office, at its core were 15 lessons delivered across the first two years of secondary schooling when children were generally aged 11 and 12.

Teachers received six days' training and were supported by school drug advisers and other local professionals. Through interactive teaching methods, the lessons aimed to equip pupils with the knowledge and experiences to make informed choices about drug use. This work was reinforced by information for the pupils' parents intended to promote effective communication about drugs with their children. Parents were sent fact sheets and communication advice and invited to parenting skills workshops. The wider community was involved through a media relations programme raising understanding and awareness of Blueprint, through funding enabling local authorities to work with other agencies to reduce underage sales of alcohol, tobacco and solvents, and through an attempt to develop shared principles for drug education across local prevention practitioners.

Originally it was intended to recruit a comparison sample of schools against which the impact of Blueprint could be assessed. However, it was calculated that this would require at

least 50 schools, a number beyond the scope of the evaluation. So instead an evaluation led by the Open University and the Institute for Social Marketing (ISM) at the University of Stirling focused on how well the programme was implemented in the 23 Blueprint schools and the reactions of target groups such as pupils and parents. Another six local schools not assigned to the programme provided some context, but did not act as a comparison group. An attempt was made to follow up about 3000 pupils before they received the lessons until the year after they had finished, when pupils were in year 10 and aged 15–16. Surveys assessed pupils' drug use, attitudes, beliefs and reactions to the lessons. Their parents or carers were also surveyed to gauge awareness and opinions of Blueprint.

The evaluation found that pupils enjoyed the lessons, in particular active teaching methods such as role-play, had good recall of drug knowledge, and gained experience of how to deal with drug offers. The vast majority said the lessons were an important source of information about drugs. Parents approved of their children being taught about drugs, were engaged by the Blueprint materials, and said the programme had increased their knowledge and helped them communicate with their children about drugs. As expected, as pupils grew older, smoking, drinking and drug use all became more common. Drug

taking was associated with previous use, truancy and exclusion. Many pupils over-estimated how many of their peers smoked and drank, but fewer overestimated drug use. Pupils with relatively high estimates of peer substance use tended to be girls, older, and to have been truant and/or excluded from school. Pupils considered drinking more acceptable than smoking or drug use.

But pupils from the six schools which did not implement Blueprint were also positive about their drug education, nearly half saw these lessons as an important source of information, they demonstrated high recall of drugs knowledge and, again, their parents approved of their children receiving drug education at school.

The evaluators concluded that while most Blueprint components were successfully implemented, engaging parents in workshops proved difficult, suggesting that more effective methods are needed to make the most of the important influence parents have on their children. Other suggestions were that future programmes might focus more on the pupil and parent components and on coordinating these, and less on community, health policy and media components. This type of initiative could benefit from being implemented earlier. Most children who take drugs start to experiment from age 11; introducing drug education in primary school could pre-empt this stage in their development.