Small steps

While we have moved away from the now discredited shock tactics used to warn children away from drugs in the 1980s, the last decade has seen slow progress in developing effective drug education. By **Andrew Brown.**

A few weeks ago I received a phone call from a parent worried that her child had come home from school distraught about the images used in a drug education session at his primary school, which included images of at least one dead drug user.

Talking to the school later the teacher told me that the presentation had been a regular staple of the drug education programme for the school over the last few years, but that it wasn't delivered with a 'just say no' message. It seemed, to me, to miss the point of good drug education.

There may be those that think that 'vivid' images will help put the dangers that drugs hold into context for children, helping reinforce their inclination not to take drugs. The trouble is that evidence from research, such as Mike Ashton's 1999 study, The Danger of Warnings, suggests that for the most vulnerable there could be a boomerang effect.

Since the call I've been reflecting on the development of drug education over the last decade, and whether it's time for a fresh way of thinking which will enable us to help ensure that children and young people move into their adult lives with the knowledge, skills and attitudes that can best protect them from the problems that drugs can cause.

The status of drug education hasn't changed. Statutory elements of drug education are carried out under the science curriculum, while Personal Social Health & Economic (PSHE) education remains an option. Most PSHE teaching is carried out by non-specialists: initial teacher training barely touches on the key concepts. The issue about what schools actually do about drug education does seem to have moved on in recent years. It's rare to hear people argue that drug education should not happen, even in primary schools. But what gets commissioned or delivered is variable.

In the survey we conducted to support the review of drug and alcohol education, we got the following results: 45 cent think the drug education they know is taught by skilled and confident staff, 52 per cent said that the drug education they know is based on the latest evidence and 68 per cent were able to agree that it meets the current curriculum requirements.

In my view the best way to improve on this situation is to make sure that senior leaders in schools are engaged and feel that drug education plays a part in the wider school agenda. School leaders need to be given quality standards against which they can start to measure the impact of what's going on in their schools. Any new drug education paradigm must understand the needs of children and young people, avoid causing any form of extra harm, have clear expectations, to learn from past mistake and successes and improve practice by applying principles and setting standards

Unfortunately not all drug education leads to young people avoiding drug and alcohol use, and, as we'll discuss, there are many who are sceptical that it is possible to create an education programme which leads to significant reductions in the numbers of young people using drugs.

However, there is broad consensus amongst prevention analysts that certain approaches to discussing drugs and seeking to prevent their use have been shown to be at best ineffective and at worst, can cause greater risks to young people.

This year, the well-regarded American organisation Child Trends produced a paper about practices to avoid in 'out of school' prevention programmes. These included attempts to scare children, using a didactic approach to teaching, and focusing on avoiding problem behaviours at the expense of encouraging positives. On the latter point they say: "Research finds that helping children and youth to develop well and achieve positive personal goals is more likely to reduce negative behaviours than are programs that simply highlight and focus on squelching bad behaviours."

The government's Independent Advisory Group on Drug and Alcohol Education, of which I was a member, said that we believed "a lack of clarity about what drug and alcohol education in schools is able to contribute to the wider drug prevention strategy has led to an over reliance on schools as a key mechanism in changing young people's drug using behaviour: an expectation that evidence shows schools cannot meet alone".

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We identified the need to engage parents as well as providing education and prevention interventions in community settings. Ofsted's last report on drug education, published in 2005, said: "Though poor assessment practice remains the key weakness in many schools, developing a better understanding of the

needs of the pupils is also an issue that requires attention. For example, we need to respond to pupils' requests for a greater emphasis to be placed on education regarding alcohol and tobacco, as they see these as the drugs that pose the most significant health risks to them."

UNESCO argue that a needs assessment should look for data from more than one source, involve young people in collecting the information and identify resources that might be helpful in addressing the issues that are raised. They suggest that those conducting the assessment should think about the current drug use situation and its causes and consequences. The way that some critics talk about drug education suggests they expect it to be able to act against as an inoculation against future drug use, when the data suggests that we should have much more modest expectations.

Like many people in the drug education field I spent much of the last few years waiting for the Blueprint research programme to complete its work and to report on the impact it had been able to achieve with those who had taken part. We had early reports on the implementation phase of the project, telling us that social norms theory was a challenge for teachers as much as pupils, that training for teachers was seen as helpful, and that the strategies used to engage parents hadn't been as successful as had been hoped.

But all of us were disappointed by the final impact report, where it became obvious that the research design wasn't robust enough to be able to give us useful information on whether the programme had changed pupil's behaviour.

A few weeks after the report came out I was called by a researcher at the Institute of Psychiatry asking whether I'd be interested in seeing some research that was able to show positive behavioural results. Dr Patricia Conrod had been researching the efficacy of targeted coping skills interventions in adolescents with personality risk factors and was about to publish her findings. She was able to show us that the short programme she had designed has been able to hold young people's binge drinking over the course of a year, while pupils in the control group increased theirs by 40 per cent. The same intervention had also been shown to reduce the uptake of drug use over the course of two years.

Other research in recent years has suggested that what happens outside the classroom could be significant in preventing drug use. One study, School effects on young people's drug use, by Adam Fletcher, concluded: "Interventions that promote a positive school ethos and reduce student disaffection may be an effective complement to drug prevention interventions addressing individual knowledge, skills, and peer norms."

Addressing 'peer norms' is an approach to prevention that has found that providing children and young people with information about the actual levels of substance misuse amongst their peers compared to what their peers believe levels of drug use are (the former is usually lower than the latter), can be beneficial. If drug education is going to remain a subject taught by non-specialists, with little training, the least we can do is provide some clear principles and standards that will help practitioners.

In the broader context of commissioning early intervention interventions a recent paper for Demos has argued for an independent centre for evidence-based practice which would "need to give support to service providers with respect to evaluation and evidence-based practice. Otherwise charities, particularly smaller ones, will simply be crowded out by the small number of programmes for which evidence already exists. Unless there is a more proactive model, it is difficult to see how the evidence base can be expanded".

The paper suggests that school-based commissioning requires considerably more support than is currently available.It has been over a decade since DrugScope, with *The Right Choices*, put together guidance on selecting drug education materials for schools. While that 1997 document still has much of value in helping educators choose the appropriate materials, it must be time to look at what we've learnt in the intervening time.

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