

Niall Coggans

Thirty years of drug education: whose learning curve?



In an era of the evidence base and the overarching question “what works?” it is vital that we accept the lesson that 30 years of drug education has taught us: you cannot expect drug education to have a high impact on drug use *per se*. And given this perspective, while a great deal of hot air has been generated about the best approach to drug education, another – and perhaps more fundamental – aspect of the great effectiveness debate still remains unanswered: how much of a difference does even the ‘best’ drug education approach make?

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In the late 1960s, educational interventions based on factual information or fear arousal were the norm. But the *real* fear that greater knowledge about drugs would lead to more drug use meant that, for example, during the Nixon era, the American federal government proclaimed a moratorium on the dissemination of drug information.¹ To a certain extent, Nixon was right. In broad terms, information-based drug education – whether non-arousal or founded on fear arousal techniques – does not prevent large numbers of young people from trying drugs. More specifically, the selective nature of the information utilised in fear arousal campaigns is,

in many cases, likely to be contradicted by young people's direct or indirect experience of drugs – a large proportion of young people, whether drug users or not, will be aware of drugs and their effects and will consequently be resistant to unobvious messages.²

But this is only half the story, and it indicates where America went wrong in the early 1970s. Because without accurate information people cannot be expected to make informed decisions about whether or not to use drugs and, if they do so, how to minimise risks.

And so the effectiveness of drug information programmes should really be measured in terms of effective communication of information rather than primary prevention. The emergence of harm reduction as an educational goal a decade ago highlighted both the need to reappraise these criteria and also the need to reconsider not only the limits but also the benefits of information-based education (which, in large part, is undoubtedly what harm reduction is).³ In short, the expectations of accurate information provision should be closely related to what the intervention sets out to achieve.

Skilling for life

While it is not realistic to expect information to prevent widespread experimentation with drugs, the life skills approach to drug education is more promising in delaying onset of drug use. In broad terms, life skills, social influences and resistance training approaches to drug education are based on the assumption that young people become involved in drug use because they lack the 'appropriate values', self-esteem or 'life skills' such as communication and decision-making skills. Such programmes also often accept that those who do use drugs will at least be better prepared to minimise risks if they possess good interpersonal and decision-making skills, as well as an understanding of drug-related risks.

These approaches were developed in the 1970s, and many of the lessons learnt over 20 years ago still apply today. For instance, the benchmark study carried out in the Netherlands which highlighted the advantages of an emphasis on 'individual adjustment' and the development of

'social maturity' has stood the test of time.⁴

Since then, this type of approach has been widely deployed and adapted. In the 1980s, one particular version – 'resistance training' – achieved notoriety by focusing on 'Just Say No'. And in the nineties, there has been an increasing emphasis on the life skills 'package', multi-component interventions which co-ordinate a myriad different educational elements ('drugs' being just one of them) and formats, including programmes for schools and parents as well as the use of mass media and community-wide action.

But while there is some evidence that life skills programmes can delay onset of drug use or inhibit a move to harder drugs,^{2,5,6,7,8} the extent to which these programmes are effective requires some further thought.


How successful is success?

A recent meta-analysis of 120 school-based programmes assessed effectiveness across a range of measures including drug use.⁹ This study defined two major types of programme on the basis of content and delivery methods: namely, 'interactive' (which employ more participative teaching and learning methods¹⁰) and 'non-interactive' (using more didactic methods, such as those deployed by the DARE education programme¹¹). The interactive programmes were found to achieve significant changes in knowledge, attitudes and drug use, while the non-interactive programmes affected only knowledge. A clear bill of health for life skills, then.

But a number of points call the scale of interactive education's success into question (and please note the words I use – 'scale of success' not just 'success'). Firstly, the meta-analysis found that the scale of success of the more effective programmes was still very small, which means that large numbers of young people will go through such programmes and still go on to use drugs, whether at the level of experimentation or more protracted drug using careers. Moreover, it may be the case that those most likely to be influenced by life skills programmes will be the least likely to become dysfunctional drug users in the first place.

Secondly – and this is where one of the principal lessons of the last 30 years has yet to gain widespread recognition – it is not realistic to expect life skills education or any education to stop all young people from trying out drugs. It may not even be realistic to expect a high proportion to be influenced. This is because the best interpersonal skills and highest self-esteem cannot stop young people using drugs if they want to. In other words, it is one thing to facilitate development of cognitive or interpersonal skills – it is quite another to instil a high value on the non-use of drugs.

Given the many factors which



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influence the development of young people, life skills programmes should be considered as only one aspect of a wider drug education and prevention strategy. As well as the skills required to avoid risky behaviour, young people need accurate information about drugs. Moreover, drug education within the school setting should be compatible with, and supported by, personal and social education programmes, pastoral systems and school ethos, all of which should enable young people to develop positive self-regard as well as generic personal and social competencies.

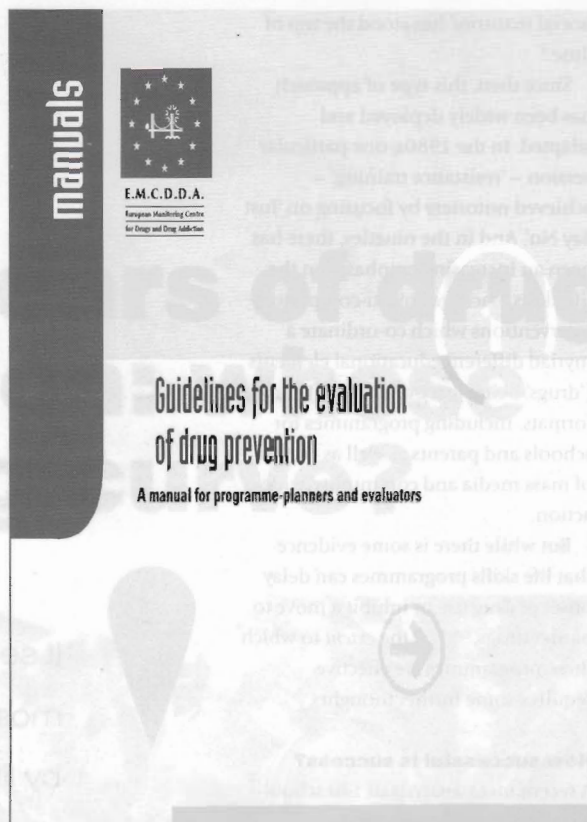
Towards good practice

Understanding the needs of a target group and ensuring that aims and objectives are clearly defined and realistic might seem like a statement of the obvious, but there is a world of difference between understanding needs and knowing how best to meet them on the one hand, and making assumptions about needs and how to meet them on the other.

Drug education needs will vary in relation to a range of factors, including age, development of personal and social competencies, attitudes, beliefs and drug-related behaviour. Good practice should be predicated on how well these differing factors are taken into account and the use of educational methods that can meet actual needs.^{12,13}

In this context, there is a pressing need for wider understanding of evaluation and effectiveness. It is simply not good enough to proceed on the basis of good faith alone – there must be evidence from past interventions to support the use of a chosen drug education approach, if only to ensure that it and its practitioners are beyond reproach. And to be able to reach that stage, current and future drug education interventions have to be evaluated so that we can better understand what is and is not effective.

When drug education programmes are evaluated and indications of effectiveness are found it is important to avoid an over-interpretation of the data, as results may very well be atypical or influenced by factors other than the intervention. Currently, *Project Charlie* is seen as a model for good practice in drug education, but the UK data are based on a very small sample of young people.⁹ And so, while perhaps indicative of an effective drug education programme, one can only be cautiously optimistic about such results until fuller and further evaluation can reveal the nature and extent of any programme's effectiveness with larger and different groups of young people.



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Looking ahead

Predicting the future is always fraught with difficulties, but in terms of what a drug education and prevention strategy might look like in the 21st century, it is certainly possible that there may be a more differentiated overall strategy involving not only a range of inputs from a variety of agencies but also a range of strategic educational goals ranging from primary prevention through to harm reduction.

It also seems likely that there will be greater differentiation in terms of the range of interventions available for different target groups, such as universal drug education for the wider young population and specific interventions tailored to the needs of vulnerable groups.¹⁴ Moreover, while schools have traditionally been the main setting for prevention programmes, parents may become more and more involved in multi-strand interventions.

Greater sensitivity to cultural factors and belief systems could also help drug education become more effective. Working with the grain of popular culture is more likely to produce better results than anti-drug exhortations from culturally remote figures. Paradoxically, such sloganeering may actually be counter-productive.¹⁵

All these developments can certainly be foreseen in the new ten year national drug strategy.¹⁶ It envisages life skills education (albeit, non-drug) beginning in the primary school as a basis for later interventions involving a range of inputs, including youth work, peer education and community-wide approaches. There is also a recognition of the need to ensure integration of drug education within wider personal, social and health education in schools.

Above all, without a good theoretical and evidential basis for the content and processes employed by drug education interventions, effectiveness is unlikely to improve. This, coupled with realistic and achievable goals for drug education and wider public understanding of the actual nature and extent of drug-related risks, could only but help in the management of a phenomenon that we have begun to accept as a continuous and permanent part of our culture ■

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