Making the case for drug education

Patrick Hargreaves considers different approaches for getting effective messages across to young people.

Measuring the effectiveness of educational interventions on health-related behaviour is something of a chimera. The wide range of confounding variables together with the likelihood of incidental, unplanned or delayed effects makes evaluation of such work extremely difficult. However, the difficulty of measuring impact does not mean it doesn't exist; an assumption non-educationalists are sometimes rather quick to make: 'Most schools in the UK provide drug education programmes. Research indicates that these probably have little impact on future drug use. There should be a careful reassessment of the role of schools in drug misuse prevention. The emphasis should be on providing all pupils with accurate, credible and consistent information about the hazards of tobacco, alcohol and other drugs' (Advisory Council on the Misuse of Drugs [ACMD], 2005).

First, let us define our domain. Drug education considers all drugs including medicines, volatile substances, alcohol and tobacco. This article will concentrate on school-based drug education as part of personal, social and health education. However, drug education goes on in a wealth of settings – formal, informal and vicarious in the family, through the media and among friends. Herein lies the first hurdle for evaluators to clear; that of trying to factor out a huge range of confounding variables whenever an assessment of an educational programme is attempted, but more of that later.

What is PSHE education?

'PSHE education is Personal, Social, Health and Economic education. It is a planned programme of learning opportunities and experiences that help children and young people grow and develop as individuals and as members of families and of social and economic communities' (PSHE Association, 2011). Its aim is not to determine how people should behave. PSHE education is about the provision of information and the development of knowledge, skills and attitudes that enable young people to make effective choices which will help them to live happy, healthy, successful lives, now and in the future.

It also provides an opportunity for them to reflect on issues that do not arise elsewhere as part of the formal curriculum; for example, understanding themselves, their interests and needs, managing challenging relationships, understanding their personal response to risk and recognising the contribution they make to the wider community. Its effectiveness must be judged on educational outcomes.

Broadly, drug education programme delivery styles fall into three categories. Two are based on information and rational decision making, one of which also takes account of socio-cultural influences, and a third that is rather more complex.

Behavioural model

The most basic model of drug education is a behavioural one. Its premise is that we respond to a stimulus to change behaviour. The model assumes that we know and understand the benefits of change (for example, giving up smoking) then make a rational decision based on costs and benefits. Key to the model is that we have an incentive to change; feel our present behaviour is disadvantageous; believe the benefits outweigh any costs and feel competent to realise our aim. This model is the basis of many past educational approaches and informs ACMD views today.

However, in practice, we know that knowledge alone is not enough to change our behaviour, so educational approaches based only on information will indeed be ineffective. The statutory obligations on schools around drug education are slim, meaning that it may merely be addressed within the science curriculum, a knowledge-based programme. Fear arousal, too, is also

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ineffective and may even impact negatively, exaggeration breeding contempt for the overall health message.

Health related decision making is very much more complex than a series of rational calculations based on factors over which you may have no immediate control.

Normative education model

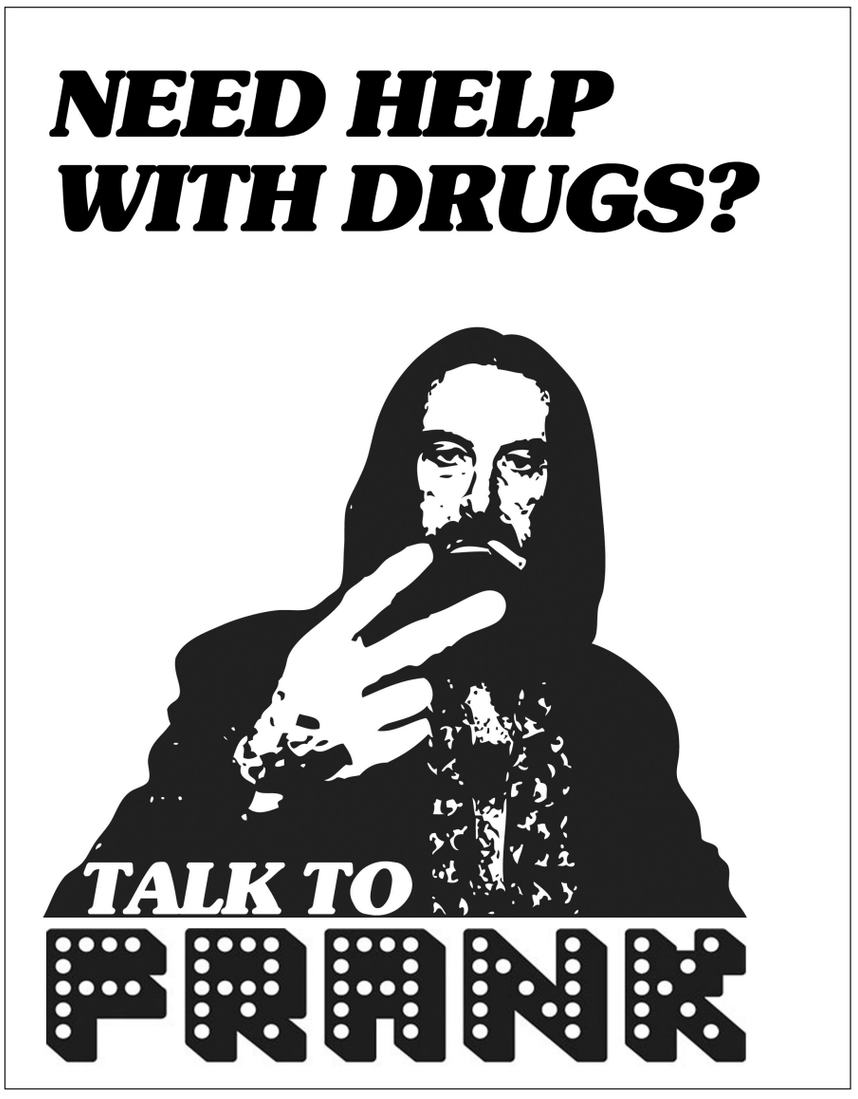
Normative education also sees health choices as rational choices but recognises that our behaviour is determined also by our attitudes and intentions, moulded and reinforced by our social group.

It is important to realise that perceived social norms are often informal. For example, young people may believe that most people in their age group regularly consume alcohol. However, this norm may be influenced by a few prominent members of their peer group, or by an exaggerated view generated by, for example, the media. Challenging perceived norms by providing feedback of prevalence data and encouraging discussion and reflection on the facts has been shown to be effective in several studies.

Interactive learning model

Interactive learning is arguably the most important aspect of effective drug education, providing a stimulus for young people through group investigation, simulation and role play to identify and avoid risky situations, develop skills to manage situations involving drugs, and be able to avoid particularly harmful misuse. In interactive teaching the teacher becomes facilitator, creating a safe and supportive environment where young people can consider new and challenging information and ideas. Risk is explored, offering the opportunity to develop 'risk competence' – the capacity to recognise, assess and manage risk and benefit in stimulating and challenging situations. Studies here have shown that young people with stronger social skills are more able to resist peer influence and abstain from misuse for longer.

Evidence suggests that different approaches, combined, will be more effective than focusing on one or another.



Evaluation – a cautionary note

We have already considered some of the difficulties facing programme evaluators.

In addition, most programme evaluations are based on questionnaires regarding young people's risk behaviour. Such questionnaires are compromised by various issues: e.g. the notorious inaccuracy of self-report data on offending/risk behaviour; young people responding how they think you want them to (or the opposite!); subtleties of behaviour change not measured, such as patterns, styles or frequency of use or attitudinal change which young people (indeed adults) may find difficult or impossible to identify or verbalise; or the lack of good longitudinal data. 'When you're working with 13 year olds, it can be 10 years before you see the impact you've had' (Clare Checksfield, Chief Executive, Crime Concern).

A strategy for drug and alcohol education

If we revisit the quote at the beginning, we can see the progress that has been made in the ACMD's understanding of these models over the five years since the publication of the Pathways report (2005). This progress is exemplified by the cut and paste job done on it to inform their response to the recent Drug Strategy consultation (2010). They say, 'The emphasis should be on providing all pupils with accurate, credible and consistent information about the hazards of alcohol and

other drugs'. They go on to say, 'However, the ACMD stresses that research has indicated that such programmes have little impact on drug use', i.e. it's no good but it's what we know so we'll carry on anyway. It was this attitude that prompted my resignation from the ACMD in December.

The European quality standards study cited in the response does not agree that quality work in schools has little impact. Further, the response claims consistency with World Health Organisation guidelines. Those recommendations, in fact, advocate a needs-led, young person centred, life skills approach. Evidence and evaluation from the Drug Education Forum, Drugscope, MentorUK, the PSHE, The National PSE Association for Advisors, Inspectors & Consultants, The National Children's Bureau, Ofsted and the National Institute for Health and Clinical Excellence, all concur with this view.

Young people do not need information about the hazards of alcohol and other drugs but accurate, credible and consistent information about alcohol and drugs full stop. Further, this should not, in fact, be the emphasis but the basis, and by itself it will indeed be ineffective. Education must not be confused with information giving. It is simply inadequate to consider only behaviour and possible consequences, we also need to address motivators. Young people must develop their decision making, risk analysis and life skills from nursery throughout their educational careers. They must discuss, debate and consider drugs in a socio-cultural context alongside sex, relationships, risk, offending and so on. In this way, educational interventions can and do deliver significant positive outcomes and there is actually a wealth of evidence that demonstrates this. This is particularly the case in the area of alcohol misuse, a major focus of current concern, which is certainly good news in the light of the Independent Scientific Committee on Drugs' (ISCD) 'Drug harms in the UK: multi criteria decision analysis', clearly showing alcohol to be our most harmful drug overall (Nutt et al., 2010).

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The Department for Education (DfE) are at this moment conducting an internal review to determine how it can support schools to improve the quality of all PSHE teaching, including drug (and alcohol) education. We need the DfE, Department of Health and the Home Office to develop, fund and implement a co-ordinated education programme based on harm reduction including quality training in Teaching and Learning. Twelve years ago the government invested heavily in PSHE Education with the appointment of Drug Education and Sex and Relationships Education Advisers in most authorities. Most of these posts have now gone as a result of spending cuts.

However, over the last decade (not incidentally, I would suggest) we know that smoking, drinking and drug use among young people are all down (over the last decade) and conception among 15-17 year olds (at 38.2 per 1000) is the lowest figure for 30 years (NHS Information Centre, 2011). This is within an environment of increased availability and decreased price, a huge illicit tobacco and alcohol market and an explosion in new psychoactive substances available on the internet, together impacting disproportionately on the young. This shows not only that there is no room for complacency but also demonstrates the folly of an over reliance on enforcement and tax hikes to influence behaviour, without input from education. ■

For further information on *Just for a laugh*, an interactive, young person centred risk education resource, winner of the national MentorUK CHAMP Award (promoting Children's Health through Alcohol Misuse Prevention) 2010, go to www.leswatts.co.uk/just.html

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References

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