Drug Education: An Entitlement For All

A report to Government by the Advisory Group on Drug and Alcohol Education

2008

Contents

Foreword by Eric Carlin, Chair of the Drug Education Forum 00

Executive Summary 00

Introduction 00

Chapter 1: An Analysis of the Problem 00

Chapter 2: The Recommendations 00

Annexes:

Annex A: Drug and Alcohol Education Advisory Group: Membership 00

Annex B: Drug and Alcohol Education Advisory Group: Terms of Reference 00

Annex C: Glossary of Terms 00

Annex D: Drug and Alcohol Education Advisory Group: Evidence Summary Paper 00

Foreword

Drug and alcohol misuse damages children and young people, their families and communities. By providing effective drug and alcohol education we can help to protect children and young people, supporting them to avoid harm in the first place or to get help and support before problems become too serious. We can also direct those who need it into treatment as swiftly as possible.

As Chair of the Drug Education Forum, I welcome this independent review of effectiveness of drug and alcohol education. I am pleased that the review has included alcohol, volatile substances and tobacco as well as illegal drugs. I also welcome the recognition that the delivery of drug education needs to be part of a whole programme of interventions, delivered in schools, colleges and community settings that promote and deliver the Every Child Matters agenda: supporting young people to stay healthy and safe; enjoy and achieve; thrive and participate as active citizens.

As part of this review, the Drug Education Forum undertook a survey of over 300 professionals, including teachers, youth workers and workers in voluntary organisations involved in delivering drug and alcohol education. They supported raising the subject's profile and importance and providing more training opportunities so that they can meet young people's needs more effectively. Moreover, they reminded us from the front line that implementing such measures will save lives, support young people's achievement and help build healthier, safer, more confident families and communities.

In recent years we have seen a fall in reported numbers of young people using illegal drugs. We have also seen promising evidence of the effectiveness of normative educational work in helping young people avoid drug or alcohol misuse. Whilst most young people do not misuse drugs or alcohol, we have become increasingly concerned at the rising amounts that under-age drinkers are consuming and the related problematic behaviours. There is no room for complacency.

The Advisory Group's recommendations are born of a thorough examination of the evidence about young people and drugs and what makes effective drug and alcohol education. They are also informed by the years of professional experience each member of the Advisory Group has brought to the process, and I look forward to the Government's response to this report.

I would like to take this opportunity to thank the Drug and Alcohol Advisory Group and the Department for Children, Schools and Families for undertaking this review and for involving the Drug Education Forum. I hope the recommendations will be accepted by Government and that we can work together to implement them, for the benefit of our young people.

Eric Carlin
Chair, Drug Education Forum

Executive Summary

1 Many young people in this country drink alcohol during their teenage years; a smaller proportion takes up smoking. Fewer still take illegal drugs and most of those who do experiment do not go on to develop drug misuse problems. We do know, however, that those young people who do drink are consuming more than ever before and that recent reductions in smoking have levelled off. We also know that when young people do take illegal drugs there can be serious consequences for their own health and well-being, and wider negative impacts on their families and local community.

2 The Drug and Alcohol Advisory Group believe that Government is right to focus action on reducing the levels of misuse of drugs, alcohol and volatile substances by young people; and reducing the harm experienced by children, families and communities as a result of drug misuse. We also believe that the responsibility for drug prevention should be shared between Government, families, schools, colleges, practitioners, the wider community and the media – each has a role to play in increasing the numbers of young people on the path to success.

3 There is much to be encouraged by in drug prevention. Overall illegal drug use by young people is declining and fewer young people are now reporting being offered drugs. But some problems remain. Class A drug use has been static since 2001 with around 4 per cent of 11-15 year olds saying they had used a class A drug in the last year. Despite improvements in the past 10 years, drug and alcohol education in schools, colleges and non-formal settings could still be better.

4 In light of the Children's Plan commitment to review the effectiveness of drug and alcohol education, the Drug and Alcohol Advisory Group was established to examine the available evidence of the effectiveness of information and education from all the sources available to young people: including parents, schools, colleges, the non-formal sector, the wider media and Government.

5 In addition to universal sources of information and education, we looked in detail at what schools, colleges and non-formal education providers were doing to support young people at risk of drug abuse, those who were already misusing drugs and those whose parents were engaged in drug misuse. Of particular interest to the Advisory Group was the concern that parents feel about their ability to protect their children and the interface between mainstream services such as schools and targeted support services.

6 Following the analysis of the evidence, and using the knowledge and expertise of the range of professionals who were members of the Advisory Group, we have developed a series of recommendations (summarised below and set out in more detail in Chapter 2) which we urge the Government to act upon.

Drug And Alcohol Advisory Group – Key Recommendations

- Increase parents' and carers' knowledge and skills about drug and alcohol education and prevention enabling them to better inform and protect their children;
- Improve the quality of drug and alcohol education by making PSHE a statutory subject – to enable schools and colleges to promote well-being effectively, and to improve the quality of training for PSHE teachers; and
- Improve identification and support for young people vulnerable to drug misuse in schools, colleges and non-formal settings.

The Aims of Drug and Alcohol Education

7 The Advisory Group recommends that the Government:

- Promote a wider understanding of the aims of drug and alcohol education among young people, parents, carers, the children's workforce and the wider media;
- Focus universal education and information on sustaining the choices of the majority of young people who do not take illegal drugs; increase protective interventions with young people vulnerable to drug misuse; and, where necessary, increase access to harm minimisation information and education for young people in targetted groups.

Equipping Parents and Carers to Protect their Children

8 The Advisory Group recommends that the Government:

- Increase parents' and carers' knowledge and skills about drug and alcohol education and prevention enabling them to better inform and protect their children through improved parenting support and a widespread communications campaign.

The Quality of Drug and Alcohol Education in Schools

9 The Advisory Group recommends that the Government should formalise the entitlement to drug and alcohol education and improve its quality by:

- Making Personal, Social and Health Education (PSHE) a statutory subject in schools, placing a duty on schools to adhere to guidance about drug and alcohol education – enabling schools to meet their statutory responsibility to promote well-being effectively; and
- Improving teachers' skills and confidence in delivering effective drug and alcohol education by exploring a specialist PSHE training route through initial teacher training and improving the quality of, and access to, continued professional development for PSHE teachers; and
- Making drug education central to the new well-being agenda, the well-being indicators and forthcoming guidance; and through amending the Ofsted inspection framework to make explicit a requirement to consider the contribution of drug and alcohol education to overall well-being.

The Quality of Drug and Alcohol Information and Education in Further Education (FE) and Non-Formal Settings

10 The Advisory Group recommends that the Government:

- Review the range of existing drug guidance across all settings and update, adopt and disseminate them to the field;
- Ensure that drug education is reflected in the Healthy Colleges Programme currently being developed by the Department of Health; and
- Strengthen the drug and alcohol elements of professional development for the wider children's workforce, applying all relevant professional quality standards.

Better identification and support for vulnerable young people

11 The Advisory Group recommends that the Government:

- Issue guidance on best practice in the screening and identification of vulnerable young people; including the use of vulnerability matrices and the Common Assessment Framework (CAF);
- Support schools in developing evidence based targeted prevention programmes, specifically to support young people at higher risk of drug misuse;
- Increase awareness of local young people's specialist drug misuse early intervention and treatment services by teachers and other relevant staff, as well as students and their families; and
- Establish clear procedures to ensure that young people with identified treatment needs are able to access the right services whilst continuing to receive education appropriate to their needs.

Research and Evaluation

12 The Advisory Group recommends that Government should:

- Continue to commission research and disseminate evidence of effective practice in drug and alcohol education, including building on the findings of the Blueprint study, when they are available.

Introduction

The Nature of the Issue

13 Many children, young people,[1] their parents and professionals believe that drug and alcohol education needs to improve. We believe that drug prevention is one of the critical social issues of our time and want to be sure that the education that is provided helps ensure that children and young people are protected from the harms that drugs can cause.

14 The Government's commitment to this review is welcome as it provides an opportunity to clarify what is meant by drug and alcohol education, assess the evidence about effective drug and alcohol education and the current structures for delivering it.

15 In carrying out the review, we found that there is much that is good about drug and alcohol information and education in formal and non-formal settings, in communities and in the home and over the past ten years drug education in schools has been improving. Nevertheless, there remains work to be done to continue to improve the quality and quantity of drug and alcohol education in England and the support we give to those who deliver it.

16 We acknowledge there are some encouraging signs, whilst some problems remain more stubborn:

- The rate of drug use among young people has been falling in recent years, with a sharper fall among vulnerable young people who have been a focus of much activity. However, Class A drug use has remained stable;
- The numbers of young people who have ever tried alcohol and who drink frequently continue to fall. However, among those who do drink, the number of units of alcohol consumed has more than doubled since 1990; and
- Parents and carers, who play a hugely important part in protecting children and young people from harms of all kinds, are expressing serious concern about their confidence and competence as drug educators, particularly at times of transition.

17 The need to understand and disseminate what works in drug and alcohol education *and* prevention, and to ensure that we maximise the contribution that education can make to helping young people make healthy choices, is now pressing.

18 The EU-DAP report concludes that 'substance abuse, including tobacco and alcohol use, is actually the predominant health problem in developed countries, accounting for 20 per cent of all deaths and 22 per cent of potential years of life lost. Primary prevention is probably the most efficient way of tackling this problem[2].' Drug and alcohol education makes an important contribution to primary prevention.

19 This review focuses therefore on how we ensure that all young people get their entitlement to effective drug education and prevention. It seeks to maximise the contribution that information and education; support for parents; and early intervention can make to ensuring more of our young people are on the path to success.

1 Children and young people are defined as those aged 0-19 and those with special needs up to the age of 24. – see glossary.
2 EU-DAP Results of the evaluation of a school-based program for the prevention of substance use among adolescents: Eudap final technical report n.2: 2006

The Changing Policy Landscape

20 The policy landscape in which drug education takes place is changing rapidly. In the past twelve months tackling young people's drug misuse has become a top priority for Government with the Department for Children, Schools and Families (DCSF) taking a lead across Government with:

- The Youth Alcohol Action Plan (June 2008);
- A new ten year Drug Strategy (February 2008);
- Two new Public Service Agreements – *Increase the numbers of Children and Young People on the Path to Success* and *Reduce the Harms from Alcohol and Drugs* – and a new national indicator measuring progress on reducing the level of young people's substance misuse;
- The Children's Plan (December 2007) which initiated this Review of Drug and Alcohol Education; and
- The Alcohol Strategy, *Safe. Sensible. Social*. (June 2007), which put young people as one of the top three priorities for the first time.

21 The Government's aims in all of this work are two-fold:

- To reduce the levels of misuse of drugs, alcohol and volatile substances by young people; and
- To reduce the harm experienced by children, families and communities as a result of drug misuse

22 These policies have been developed in the context of Every Child Matters and we believe that drug education and prevention has the potential to impact positively on all 5 national outcomes for children and young people:

- Being Healthy
- Staying Safe
- Enjoying and achieving
- Achieving economic well-being
- Making a positive contribution

The Advisory Group's Membership and Remit

23 The Advisory Group on Drug and Alcohol Education was established to take forward two key Children's Plan commitments: firstly to 'examine the effectiveness of current delivery arrangements for all drugs education – including alcohol – and act to strengthen them if necessary' (para 6.49); and secondly to 'strengthen and clarify the role of both schools and children's services in drug, alcohol and volatile substance misuse prevention….looking at what more we need to do to support schools in dealing with pupils who are misusing substances'. (para 6.56)

24 The Advisory Group was selected from a range of organisations on the basis of professional experience, expertise and personal knowledge. It was made up of experts in drug, alcohol and volatile substance information and education; representatives of further education and sixth form colleges as well as the non-formal and community education sectors; young people; non-departmental government organisations such as Ofsted and the Training Development Agency for schools; and key Government Departments including the Home Office, the Department for Children, Schools and Families (DCSF), Department for Innovation, Universities and Skills and the Department of

Health. A full membership list is attached at Annex A.

25 The Advisory Group's remit (terms of reference are attached at Annex B) included education and information about all drugs (both legal and illegal), alcohol and volatile substances. The Advisory Group examined universal information and education (that is information and education aimed at whole population groups) from all the sources available to young people including: parents; schools; further education colleges; Connexions; the youth service; the wider media; and Government websites such as FRANK.

26 In addition to universal information and education from a range of sources, the review also considered targeted interventions undertaken by schools and colleges. The scope of this review did not extend to the design, delivery or impact of targeted interventions from other agencies. The work of Drug and Alcohol Action Teams and Targeted Youth Support was out of scope, but consideration of the interface between universal drug and alcohol education and targeted services has been a key consideration.

27 The Advisory Group has also considered how best to enable schools and colleges and the non-formal sector to:

- Identify and support young people who are at risk of drug misuse;
- Identify and support young people who are at risk because of parental drug misuse; and
- Identify and appropriately refer young people who have begun to misuse drugs for support.

Working Methods

28 The Advisory Group met formally on three occasions and held a number of smaller informal working sessions. In developing its recommendations it drew on evidence, research and views from children, young people, parents, and key delivery partners. The Advisory Group was supported in its work by a cross-departmental officials group and secretariat services by the Drug Education Forum.

29 The Advisory Group also commissioned two bespoke surveys: one through Parentline Plus on parental attitudes to drug and alcohol education and one through the Drug Education Forum on effective drug and alcohol education. In addition, the Advisory Group has drawn on research into parents' views conducted by Directions Research and Marketing on behalf of DCSF. The Evidence Paper which underpins the Advisory Group process is attached at Annex D.

Chapter 1: An Analysis of the Problem

Young People and Substance Misuse

30 Young people grow up in a society where drugs of all kinds are widely used. Alcohol is used by a majority of adults and tobacco, despite the well documented health harms, can be purchased legally by anyone over 18. Young people are also surrounded by media images of drug use – often glamorising the use of certain drugs or of getting drunk. As a result, young people are highly aware of drugs. Around 90 per cent of 11-15 year olds have heard of drugs such as heroin, cocaine and cannabis and even less well known drugs such as LSD, poppers and methadone are known by around half of pupils.

Alcohol

31 For most people in this country alcohol is a socially acceptable drug and experimenting with it as a teenager is thought a natural part of growing up. Despite the media coverage, the facts are that fewer young people are drinking alcohol now than were doing so ten years ago[3]. Almost half of 11-15 year olds (46 per cent) say that they have *never tried* alcohol.

32 However, those who are drinking are consuming more alcohol more often: average consumption amongst those who do drink doubled from 5 units per week in 1990 to 10 units per week in 2000, and there is growing evidence of increases in liver cirrhosis in young adults being linked to higher levels of drinking at an earlier age, which is serious cause for concern.

Tobacco

33 In contrast, smoking is no longer a mainstream activity. Changes to advertising, and recent changes in the law on smoking in public places, have meant that it is becoming more and more socially unacceptable and this has been reflected in the declining numbers of young people smoking. Since 1994 there has been a downward trend in young people smoking, but this trend has levelled off since 2003 at around 9 per cent. Girls, young people experiencing poverty and those who have been excluded from school are all more likely to smoke than other groups.

Volatile Substances – Glue, Gas and Aerosols

34 The number of young people dying as a result of volatile substance (glue, gas, aerosols etc) abuse has been going down over the past ten years, but volatile substances are still the most lethal form of drug abuse by young people accounting for 8 deaths of under 18s in 2005 (the lowest since 1983). They are more often used by younger pupils: In 2006, 7 per cent of pupils in year 7 (11 and 12 year olds) say they have used volatile substances in the past year compared to 3 per cent of year 10 pupils (14 and 15 year olds). This is the only age where cannabis is not the most commonly used drug.

Illegal Drugs

35 The use of illegal drugs, on the other hand, increases with age. Very few children under the age of 12 take illegal drugs but by the age of 15, 21 per cent say they have taken a drug in the last year. Overwhelmingly this is likely to be the most common illegal drug, cannabis, which was used by 22.7 per cent of 15 year olds in 2006. A far smaller proportion of 15 year old pupils have taken a Class A drug in the past year – 7.7 per cent in 2006.

36 Whilst the figures on the use of illegal drugs by young people are worrying, it is important to set them in context. Fewer young people

3 Source: DH (2006) Smoking, Drinking and Drug Use among Young People in England

report being offered drugs than was the case in 2001 and of those offered drugs, significant numbers are refusing them. By the age of 15, the majority of young people 58 per cent will have been offered drugs, but only 24 per cent will have ever taken them. Overall, the use of illegal drugs by young people in this country is declining.

37 We know that the age at which young people begin taking drugs matters to longer term outcomes. Most young people who have ever used an illegal drug begin experimenting between the ages of 11 and 15 and therefore education delivered *before* this point is likely to be more effective in preventing initiation to drugs, and efforts to delay initiation are also likely to be effective in reducing long term harm.

38 We know that effects of even successful programmes diminish over time, so there is a strong case for regular reinforcement interventions rather than one off interventions.

39 We know that the number of times a young person takes drugs has an impact on longer term use, so efforts to reduce the frequency of consumption by those young people who have already begun to experiment with drugs are also important.

Young People's Views on Drug and Alcohol Education

40 Evidence also shows that young people want drug and alcohol education delivered in schools, which starts when they are young, and is relevant to the drugs they are likely to encounter – alcohol, tobacco and cannabis. In secondary schools and colleges young people particularly value the input of external contributors as they can add credibility and offer engaging activities for pupils and students.

41 In Ofsted's *Tellus 2 survey 2007* when asked what they thought of the information and advice they got about drugs and alcohol, over 26 per cent of respondents said they wanted more or better information on alcohol and smoking and 30 per cent wanted more or better information on illegal drugs.

'The involvement of young people is key in both the developing and reviewing of policies and PSHE Curriculum in reference to Drug and Alcohol education. Young People have the right to be heard under the UN Convention on the Rights of a Child, Article 12.

Young people know what they and their peers will react to and what they want to gain from drug and alcohol education.

In workshops at Penryn College, Cornwall, young people's priorities were to gain knowledge about the health risks of drugs use and safer choices as well as feeling positive about themselves.

Young people have a great voice to share and this can be collected in many different ways, from School Councils to focus and discussion groups. The voice of young people is an invaluable resource which can improve many other aspects and not just drugs education.'

David Callaghan, Member of the Youth Parliament and Advisory Group on Drug and Alcohol Education

42 This is echoed by the results of the public consultation on developing the new Drug Strategy 2008 which found that, 'Young people have lots of questions about the long-term effects of drug use, and feel that this is the type of information that would help them as they grow up. Crucially, they want to be able to make informed choices based on "real life" experiences. People their own age are felt to be best placed to provide these experiences, with a strong feeling that those wishing to educate and engage with young

people on the subject of drugs should be "experts" in their field'.

43 Yet, in 2007, Ofsted found that the extent to which the drug policy and curriculum planning are based on the assessed needs of pupils is unsatisfactory in around a quarter of primary and secondary schools. The Advisory Group believe that too many schools are over looking the expressed needs of their pupils.

Drug and Alcohol Education in Schools

44 It is in the social context – where young people are routinely exposed to alcohol, tobacco and likely to come into contact with illegal drugs in some form during their teenage years – that schools provide drug and alcohol education. So, what are we expecting schools to achieve?

45 The existing DCSF guidance *Drugs: Guidance for Schools* (2004) states that drug and alcohol education is a major component of drug prevention.

46 The stated aim of drug and alcohol education is to:

- 'provide opportunities for pupils to develop their knowledge, skills, attitudes and understanding about drugs and appreciate the benefits of a healthy lifestyle, relating this to their own and others' actions.'

47 The stated aim of drug prevention is to:

- 'minimise the number of young people engaging in drug use;
- delay the age of onset of first use;
- reduce the harm caused by drugs; and
- enable those who have concerns about drugs to seek help.'

48 Thus, drug and alcohol education in schools does not aim explicitly to impact on behaviour. However, as Ofsted makes clear in its 2005 report *Drug Education in Schools*[4], aims and expectations are not the same thing:

- 'The key aim of drug and alcohol education is to enable pupils to make healthy informed choices. Expectations of the impact of effective drug and alcohol education in our schools are high, far higher than they are for most subjects. The expectations of drug and alcohol education are that it will increase pupils' knowledge, change their attitudes and enhance their skills as well as having an impact on their behaviour'.

49 We support Ofsted's analysis and believe that 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. Whilst schools have a key role to play, the Advisory Group believes that other drivers for drug prevention across the whole community (including parents, carers, wider children's services, and the non-formal and community sectors) have been under exploited.

Parents, Carers and Drug and Alcohol Education

50 The evidence we have gathered as part of this review shows that parents are the single biggest influence on young people. Good parenting has significant positive effects on children's achievement – even after all other

4 Drug Education in Schools: a report from Her Majesty's Chief inspector of Schools 2005

factors affecting educational attainment have been taken into account[5].

51 Parenting has been shown to influence children's health behaviour. For example, adolescents raised by parents who are heavily involved in their lives (e.g. who *monitor* their behaviour) are less likely to use drugs. Similarly, provision of *warmth and support* by parents is associated with lower adolescent drug use.[6] There is also some evidence (albeit mixed) that parent-child *communication* about drugs and drug use is associated with reduced risk of early-onset use.[7]

52 But evidence shows that parents lack knowledge about drugs, and confidence about their knowledge of drugs, which in some cases inhibits their ability to communicate clearly and effectively.[8] Research undertaken to support this review shows that parents have differing attitudes to alcohol and other drugs.[9]

53 Parents believe that they know enough about alcohol to educate their children about it effectively and often draw on their own experiences with alcohol to inform them. Some believe that encouraging low level alcohol consumption in the home is beneficial, but many are unsure about where to draw boundaries and some can be subject to peer pressure from other parents – for example, on what age it is acceptable for teenagers to drink alcohol at a party. In our survey, parents said they wanted more guidance on how to educate their children about alcohol.

54 Parents are much less sure about their ability to educate their children about illegal drugs and fear that drugs are now more available, cheaper and more dangerous (for example, stronger strains of cannabis) than ever before. In many cases, parents do not have personal experience to draw on, nor do they have knowledge of the effects or risks of the illegal drugs their children might be exposed to. This has led to parents feeling out of their depth when attempting to educate young people, with a minority shying away from tackling the issue altogether.

55 Parents also appear unsure about where their responsibilities as drug educators stop and the school's and college's responsibilities begin. Many parents in our research were unaware that schools undertook to educate their children about illegal drugs.

56 The majority of parents also believed that cannabis was a gateway drug to other drugs such as heroin or crack. This is despite the evidence that most young people who experiment with cannabis do not go on to try any other drugs. This mistaken belief can lead to real fear when they suspect that their child may be experimenting with drugs. Better and more readily accessible information and advice for parents on alcohol and drugs and guidance on how to initiate conversations with young people about drug issues, should impact on parents ability to enable their children to make healthy choices and support the wider drug prevention agenda.

5 The Impact of Parental Involvement, Parental Support and Family Education on Pupil Achievement and Adjustment: A Literature Review Professor Charles Desforges with Alberto Abouchaar, DfES Research Report 433, 2003
6 Barnes, Reifman, Farrell, & Dintcheff, 2000; Barnow, Schuckit, Lucht, John, & Freyberger, 2002.
7 (Chassin, Presson, Todd, Rose, & Sherman, 1998; Jackson & Henriksen, 1997).
8 Velleman et al 2000
9 Information needs of Parents on Sensitive Subjects – Alcohol and Drugs 2008 Directions research and marketing

The Quality and Quantity of Drug and Alcohol Education in Schools

57 At present, elements of drug education in schools (such as the effects of drugs on the body) are taught as part of National Curriculum Science, but the bulk of drug education as defined by DCSF guidance, is expected to be delivered through PSHE, which is a non-statutory subject.

58 In reporting on the quality of drug and alcohol education, Ofsted examines how well it has increased pupils' knowledge, changed their attitudes and enhanced their skills. Ofsted is not tasked with looking at behaviour change as a measure of achievement for drug education.

59 On this basis, drug and alcohol education is deemed to be good in: 80 per cent of lessons at Key Stage 2; 50 per cent in Key Stage 3; and 75 per cent at Key Stage 4. At Key Stage 3 and 4, Ofsted report that in 16 per cent of lessons, opportunities for pupils to explore their attitudes towards drugs and to share their views with others are weak. Crucially, Ofsted did not observe any outstanding drug and alcohol lessons at any key stage.

60 At present, the Ofsted inspection framework does not require Ofsted to inspect individual subjects as a standard part of a school inspection. Instead, Ofsted is required to assess how well the school delivers against the ECM outcomes and how well it supports personal development. This is a realistic approach in short school inspections, but the Advisory Group has concluded that these aspects of a school's work are not given the same degree of priority as academic attainment in reaching a judgement about school standards. We believe that this is a contributory factor in the low status attached to PSHE within schools

61 The Advisory Group has concluded that the quality of drug and alcohol education provided in schools – when judged on the basis of improving knowledge, skills and attitudes and meeting young people's expressed needs – has been improving, but there is still more to be done.

62 Key to this is how well equipped teachers are to deliver effective and engaging PSHE. Initial Teacher Training (ITT) and Continued Professional Development (CPD) have a vital role to play here.

63 We know from Ofsted (2005)[10] that most primary and secondary Initial Teacher Training (ITT) courses are well designed and enable the great majority of trainees to meet the standards for Qualified Teacher Status (QTS) at a good level. But we know from the Blueprint delivery reports that many teachers who took part in the study were uncomfortable using the interactive teaching techniques most appropriate to the delivery of effective drug and alcohol education. They needed a good deal of training and support and many may have lacked the skills necessary to teach in this way.

64 We also know that there is a consistent link between teachers' academic and professional qualifications and pupil achievement, but there is no specialist ITT route for PSHE and PSHE coverage within ITT is minimal so there is currently no opportunity to enhance teachers' expertise in PSHE during this phase. Formal Continued Professional Development (CPD) in PSHE includes a route for those wishing to specialise in drug education, but nationally CPD in PSHE is under-subscribed.

10 Ofsted (2005). The Annual Report of Her Majesty's Chief Inspector of Schools 2004/5. HMI 2439

65 We also believe that the quality of PSHE is affected by difficulties in selecting, and effectively deploying, external contributors. Young people say they enjoy delivery by external contributors such as Theatre in Education, Life Education and peer educators. For this reason, many schools use external contributors and do so as part of an effective and well structured PSHE programme. However, some external contributors can be ineffective and it is difficult and time consuming for schools to make certain of the quality of external contributors in advance of them delivering sessions in school.

66 The National Healthy Schools Programme was launched jointly by the then Department for Education and Skills and the Department of Health and aims to improve the health behaviours of children and young people in schools. To achieve National Healthy Schools status, schools are required to demonstrate minimum evidence against the relevant criteria. For drug and alcohol education, National Healthy Schools Programme Guidance states that schools should have a:

- 'planned programme of PSHE in line with DCSF/ Qualifications and Curriculum Authority (QCA) guidance. They are also required to have a Drug Education policy and incident management policy…. Schools must have considered the QCA end of key stage statements in assessing progress and achievement, and this must inform school practice'.

67 We believe that the National Healthy Schools Programme is an important tool for raising standards in PSHE, but current guidance stops short of insisting on a gold standard in PSHE to qualify for National Healthy School Status. Currently, the guidance does not specify how much time schools should spend on PSHE, nor that staff should have access to the PSHE Continued Professional Development programme: much of what we know to be good practice in PSHE is still technically optional – even in schools with National Healthy School Status.

68 In addition to issues about the quality of drug education, the Advisory Group believe that there remain issues about the quantity of drug education young people receive. In 2002, Ofsted estimated that on average children received a total of 5.9 hours drug education a year in primary schools and 7.8 hours per year in secondary schools.

69 The Advisory Group believes that these figures mask a much more varied reality. As PSHE is a non-statutory subject it is open to schools to deliver as much or as little as they wish. There remains a minority of schools who deliver considerably less PSHE, sometimes using non-PSHE specialist teachers and suspended timetable days alone to discharge their commitments. In these schools, we believe children do not receive their entitlement to drug education within PSHE.

Identifying and Supporting Vulnerable Young People in Schools and Colleges

70 We cannot predict which young people will misuse drugs and alcohol, but we can identify a number of risk factors which make it more likely. Being in care, engaging in antisocial or criminal behaviour, truanting and having a parent or older sibling engaged in drug or alcohol misuse are all significant risk factors.

71 All schools and colleges have on roll some pupils who are vulnerable to drug or alcohol misuse and in some schools and colleges there will be a minority of pupils actually engaging in drug or alcohol misuse, or whose parents have drug misuse problems and who

are particularly vulnerable to the harms drugs can cause. But we believe that there is insufficient awareness amongst some school teaching and support staff of the difficulties, needs, risk and protective factors of vulnerable young people, and of their role in early identification and access to support.

72 The Common Assessment Framework (CAF), the Lead Professional and better information-sharing between services have been introduced to strengthen early identification and prevention. Schools and colleges may complete a CAF about any young person they have concerns about with a view to triggering additional support for the young person concerned.

73 We believe that there is too much local variation in the level of need required to trigger the CAF process. In many areas the CAF is only used once the young person has manifested problem behaviours and is not used as a tool for identifying the presence of risk factors. In other areas, a decision to undertake the CAF process goes hand in hand with consideration of the resource implications and the availability of services. In the Advisory Group's view, this means that some vulnerable young people may miss out on support which would otherwise enhance protective factors and reduce risk factors in their lives and thus help prevent later drug misuse.

74 We know that the reasons why young people start taking drugs can contribute to them developing drug misuse problems. Early identification and intervention with young people who have begun to use drugs is a vital harm minimisation activity. Evidence shows that there are a number of programmes which help young people to stop or reduce the use of drugs once they have begun taking them, for example, the Strengthening Families Programme[11].

Information and Education in Further Education and Non-formal Settings

Further Education

75 The Further Education (FE) sector provides a wide range of education and training opportunities for individuals from age 14 upwards. Learning opportunities are provided at all levels from basic skills to Higher Education. The FE system's primary purpose is to help and support people to gain the skills and qualifications they need to improve their employability and fulfil their personal potential.

76 In 2006-07 there were 1.45m under 19s in the FE sector. Developments in the 14-19 curriculum and Government measures to raise the participation age are likely to mean that growing numbers of young people, often those more vulnerable to drug misuse, will begin to be educated in FE settings. However, FE colleges are autonomous institutions and there is no statutory requirement for them to provide drug and alcohol education or to have a drug policy.

77 Whilst there is no statutory requirement to deliver drug and alcohol education, most colleges currently undertake it through a range of routes: pastoral care, information through student's union events, fresher's week manuals, and through inclusion within the mainstream curriculum.

78 Guidance produced by Drugscope for the FE sector in 2003[12], highlighted a range of

11 Foxcroft, D. R., Ireland, D., Lister-Sharp, D.J., Lowe, G. and Breen, R.D.I. (2003) Longer-term primary prevention for alcohol use in young people: a systematic review. Addiction 98, 397-411

12 Mapping of FE student service managers and LEAs on drug policies (2003)

difficulties in the provision of high quality drug education, including: too few trained staff; a lack of staff confidence in their ability to deliver drug and alcohol education; limited curriculum time; the need for effective partnership working between police, Connexions and local drug services; and student reluctance to engage in 'school' type drug education.

79 To deliver effective drug education, FE colleges need to know what has been delivered in schools in order to build upon it. Current evidence is that this is variable at the moment which the Advisory Group believes presents colleges with a number of challenges. In effect, they have groups of students from different schools with a wide range of knowledge and skills and differing prior experience of drugs and alcohol.

80 Drugs and alcohol is a difficult and sensitive area and the Advisory Group is concerned that the provision of drug education in FE settings and adherence to existing guidance is optional. We believe that the lack of a coherent national level approach to delivery and support for those delivering this will continue to impact negatively on the entitlement of all young people to high quality drug education.

Youth Service and Connexions

81 Youth workers and Connexions personal advisers work with the full range of youth needs and regularly come into contact with young people at risk of drug misuse and those already engaged in drug misuse. For example, over a ten month period from April 2007 Connexions personal advisers engaged in interventions with more than 54,000 young people who had disclosed a drug misuse issue. Both services offer advice, information and non-formal education to young people to help prepare them for the decisions they may have to make about drugs. This will sometimes involve onward referral to other services, including treatment providers.

82 In 2006, DrugScope, working with the National Youth Agency and a range of youth work trainers, produced guidance for youth service providers which details the activities youth workers should be capable of carrying out in relation to drug and alcohol education and in identifying and referring young people who are vulnerable because of drug or alcohol misuse.

83 In addition to day to day contact with a range of young people, the youth service has traditionally undertaken a wide range of specific drug prevention projects. At present there is a lack of quality evidence of the impact of non-formal drug education approaches. Evidence for the effectiveness of universal drug education suggests that the principles adopted in *Drugs: Guidance for Youth Services* are applicable, however there is a lack of systematic evaluation about the effectiveness of these interventions in non-formal settings from which to draw firm conclusions.

84 Since April 2008, responsibility for the Information, Advice and Guidance (IAG) delivered to young people through the Connexions service has transferred to Local Authorities and the Government has issued new Quality Standards for IAG. This includes the responsibility for advisers to be able to help young people 'to review and assess their decision making and goal setting in relation to health issues,' and to give young people opportunities 'to reflect on risk and behaviour'. Staff delivering this information should be 'appropriately qualified and have access to Continued Professional Development'.

85 The Advisory Group endorses the substance of the guidance for the youth service and the IAG standards, but believes that more needs to be done to ensure that all youth workers and Connexions personal advisers are equipped to deal sensitively and effectively with the range of drug and alcohol information, education and referral issues that they are likely to encounter, particularly in the context of Targeted Youth Support reforms.

Community Based Initiatives

86 There have been numerous community based drug prevention initiatives, mostly targeting deprived communities. Most focus on strengthening the social, cultural and environmental factors which militate against drug misuse. The Advisory Group believes that successful drug prevention can only happen where there is engagement with the wider community, but as yet there is little systematic evidence of the effects of these programmes.

Government Communications Campaigns

87 The FRANK campaign (which replaced the National Drugs Helpline) has targeted 11-21 year olds and the parents of 11-18 year olds, through national and local advertising, a website and helpline, local events, support for schools, GPs, the police and other groups. There has been good recognition of the advertisements amongst the target groups, and evidence of attitudinal change, with 27 per cent of young people who saw the advertisements said that they had made them think that drugs were more risky than they had previously thought.

88 The Government is also developing a social marketing campaign as part of the Youth Alcohol Action Plan aimed at changing young people's attitudes towards alcohol consumption, and has asked the Chief Medical Officer to review the latest evidence on young people's drinking in order to develop guidelines on young people and alcohol. The Advisory Group welcomes this.

The Wider Media

89 Young people are faced with the challenge of growing up in a culture that has widespread negative perceptions about them. The media commonly associates young people with problems such as anti-social behaviour and binge drinking. 71 per cent of media stories about young people are negative, a third of articles about young people are about crime[13]. Young people are keenly aware of their reputation in the community, with 98 per cent of them feeling that the media portrays them as anti-social[14], a view that was echoed in the Children's Commissioners' latest report to the United Nations[15].

90 At the same time, the media persists in focusing attention on the drug or alcohol use of some celebrities in a way which appears to accept drug misuse as a natural part of a 'celebrity' lifestyle. Perceptions about what celebrities do or think which is communicated to young people through the media does appear to have an effect. Evidence shows that 59 per cent of young people report that their celebrity idol has influenced some aspect of their attitudes or beliefs.[16]

13 Young People and the Media, Mori/Young People Now, 2005

14 *Respect? The Voice Behind the Hood*. YouthNet and the British Youth Council, 2006

15 The UK Children's Commissioner's report to the UN on the rights of the child: June 2008

16 Boon, S.D. , Lomore, C.D. (2001) Admirer-celebrity relationships among young adults: explaining perceptions of celebrity influence on identity. Human Communication Research. 27:432-465.

Chapter 2: The Recommendations

Drug And Alcohol Advisory Group – Key Recommendations

- Increase parents' and carers' knowledge and skills about drug and alcohol education and prevention enabling them to better inform and protect their children;
- Improve the quality of drug and alcohol education by making PSHE a statutory subject – to enable schools and colleges to promote well-being effectively, and to improve the quality of training for PSHE teachers; and
- Improve identification and support for young people vulnerable to drug misuse in schools, colleges and non-formal settings.

The Aims of Drug and Alcohol Education

91 The Advisory Group recommends that the Government:

- Promote a wider understanding of the aims of drug and alcohol education among young people, parents, carers, the children's workforce and the wider media;
- Focus universal education and information on sustaining the choices of the majority of young people who do not take illegal drugs; increase protective interventions with young people vulnerable to drug misuse; and, where necessary, increase access to harm minimisation information and education for young people in targeted groups.

Equipping Parents and Carers to Protect their Children

92 The Advisory Group recommends that the Government:

- Increase parents' and carers' knowledge and skills about drug and alcohol education and prevention to enable them to better inform and protect their children. We believe it can do this by:
  - providing information about drug education in schools and other settings (focusing on what is expected to be covered and when);
  - communicating the most effective strategies for dealing with drug and alcohol education in the home;
  - building on existing proposals for improving parental engagement with schools and initiatives such as Parent Support Advisers and Transition Information Sessions to include information to parents on drug and alcohol issues, particularly at primary school and at periods of transition;
  - using a widespread communications campaign to deliver these messages; and
  - committing to an ongoing dialogue with parents, carers and their representatives, to enable them to feed into ongoing policy development.

The Quality of Drug and Alcohol Education in Schools

93 The Advisory Group recommends that the Government should formalise the entitlement to drug and alcohol education and improve its quality by:

- Making PSHE education a statutory subject in schools, placing a duty on schools to adhere to guidance about drug and alcohol education, thus enabling schools to promote well-being effectively;
- Improving teachers' skills and confidence in delivering effective drug and alcohol education by exploring a specialist PSHE training route through Initial Teacher Training and improving the quality of and access to Continued Professional Development for PSHE teachers; and
- Making drug education central to the new well-being agenda, the well-being indicators and forthcoming guidance, and through amending the Ofsted inspection framework to make explicit a requirement to consider the contribution of drug and alcohol education to overall well-being.

94 The Government should also:

- Develop national level Quality Standards for all contributors to drug education in schools and colleges;
- Disseminate the findings from the Blueprint study when they are available;
- Strengthen the assessment of the quality of drug, alcohol, volatile substance and tobacco education as part of the process for gaining National Healthy Schools status; and
- Improve pupil needs assessment to ensure that drug and alcohol education is informed by consultation with young people; is appropriate to the age and developmental stage and prior knowledge of pupils; that it stretches all pupils; and that it is culturally appropriate, for example, reflecting differing communities' attitudes and beliefs about drug use, including community specific drugs (e.g. khat), where appropriate.

The Quality of Drug and Alcohol Information and Education in FE and Non-Formal Settings

95 The Advisory Group recommends that the Government:

- Review the range of existing drug guidance across all settings and update and disseminate them to the field;
- Ensure that drug education is reflected in the Healthy Colleges Programme currently being developed by the Department of Health; and
- Strengthen the drug and alcohol elements of professional development for the wider children's workforce, in particular by:
  - Engaging those involved in youth service workforce development to ensure all youth workers have the necessary knowledge and skills to provide education and support on drug and alcohol issues for the young people that they work with and for; and
  - Ensuring that the wider children's workforce is equipped to have that crucial first conversation with children and young people about drugs in any setting.

96 In addition, the Government should:

- Ensure that drug and alcohol Information, Advice and Guidance delivered through Connexions and other IAG providers comply with the national IAG quality standards; and

- Distil existing evidence into a few key messages which are delivered by all practitioners working in the non-formal and FE sectors and reinforced in all communications aimed at this age group; and
- Review, evaluate and disseminate models of community based provision which support the personal, social and health development of children and young people, and which aim to reduce the risk that they will have problems with drugs in the future.

Better Identification and Support for Vulnerable Young People

97 The Advisory Group recommends that the Government:

- Issue guidance on best practice in the screening and identification of vulnerable young people; including the use of vulnerability matrices and the Common Assessment Framework (CAF);
- Support schools in developing evidence based targeted prevention programmes, specifically to support young people at higher risk of drug misuse;
- Increase awareness of local young people's specialist drug misuse early intervention and treatment services by teachers and other relevant staff as well as students and their families; and
- Establish clear procedures to ensure that young people with identified treatment needs are able to access the right services whilst continuing to receive education appropriate to their needs.

98 In addition, the Government should ensure that:

- Workforce development measures led by Local Authorities are aimed at increasing the awareness of school teaching and support staff of the difficulties, needs, risk and protective factors of vulnerable young people, and their role in early identification and access to support; and
- Multi-agency working between schools and local Targeted Youth Support (TYS) services as they develop; using existing guidance on confidentiality and information-sharing, integrated working, and safeguarding children and young people at risk; and linking to the whole range of services available from both the statutory and voluntary/community sector through effective promotion.

Research and Evaluation

99 The Government should:

- Continue to commission research and disseminate evidence of effective practice in drug and alcohol education, including the findings of the Blueprint study, when they are available.

Annex A: Membership of the Drug and Alcohol Education Advisory Group

Alcohol Concern and Drugscope – Hajra Mir

Association of Chief Police Officers – Detective Superintendent Kevin Green

Association of Colleges – Deborah Ribchester

Association of School and College Leaders – Mike Griffiths, Headteacher, Northampton Boys School

Association of Directors of Children's Services – John Harris, Director of Children's Services Hertfordshire

Centre for Public Health (Liverpool John Moores University – Dr Harry Sumnall

Connexions – Rossalyn Simpson

Department for Children, Schools and Families – Ian Whitehouse (Chair)

Department for Children, Schools and Families – Yasmin Bevan (Advisor)

Department of Health – Ekow Armah

Department for Innovation, Universities and Skills – Steve Robinson

Drug Education Forum – Andrew Brown (Secretariat)

DrugScope – Dr Jenny McWhirter – Associate

Home Office – Jonathan Scanlan

Life Education – Stephen Burgess

National Children's Bureau – Jo Butcher

National Health Education Group – Jenny Rowley

NSCoPSE the national PSE association for inspectors, advisers and consultants – Brian Dobson

Ofsted – Margaret Jones

Parentline Plus – Hilary Chamberlain

ReSolv – Steve Lambert

RJ Consultancy Cambridge Limited – Ruth Joyce

The National Youth Agency – Richard McKie

Training and Development Agency and Involve – Dr Teresa Pointing

UK Youth Parliament – David Callaghan

DCSF officials supporting the work of the Group:

Jennifer Coupland, Noreen Graham, Sue Holley, Dr Richard Lumley, Laurence Russ, Marcus Bell and Matthew Scott

Annex B: Terms of Reference – Drugs and Alcohol Education Advisory Group

Remit

The Advisory Group on Drug and Alcohol Education has a remit to examine the effectiveness of the delivery arrangements for all drugs education and to make recommendations to the Secretary of State for Children, Schools and Families on how to improve them.

Education and information about all drugs – legal and illegal, alcohol and volatile substances – fall within the scope of the Advisory Group's remit. The Advisory Group should consider universal information and education (that is information and education aimed at whole population groups) from all the sources available to young people including: parents; schools; further education colleges; Connexions; the youth service; the wider media; and Government websites, such as FRANK.

In addition to universal information and education from a range of sources, the review should also consider targeted intervention undertaken by school and colleges. The scope of the review does not extend to the design, delivery or impact of targeted intervention from other agencies. The work of Drug Action Teams and Targeted Youth Support is out of scope, but consideration of the interface between universal drug education and targeted services is within remit of the Advisory Group.

The Advisory Group is also asked to consider how we can enable schools and colleges to:

- Identify and support young people who are at risk of drug misuse;
- Identify and support young people who are at risk because of parental drug misuse; and
- Identify and appropriately refer young people who have begun to abuse drugs.

The Advisory Group should pay particular attention to the findings of the Blueprint research programme as they emerge during the course of this review. They should also pay attention to work of the review of Sex and Relationship Education (SRE) which will run in parallel, exploiting synergies where they exist.

The focus of the review should be on increasing the numbers of young people on the path to success and intervening early to prevent problems developing. The Advisory Group will need to work within the constraints of the DCSF spending review settlement. They should focus on how available resources can be most effectively deployed using existing policy levers and breaking down barriers to effective co-ordination and co-operation.

The Advisory Group should draw on evidence, research and views from children, young people, parents, and key delivery partners. The Advisory Group will generate and agree the key issues on which to engage using three central themes:

- What is the purpose of Drug Education?
- What works?
- Delivery

Membership

The Advisory Group will be chaired by the Deputy Director of the Youth at Risk Division within DCSF. Members have been selected based on professional experience, expertise and personal knowledge. A full list of members will be circulated at the first meeting.

Working arrangements

The group and its members will:

- Consider the evidence, research and any consultation findings
- Commission the officials' working group to undertake further analyses and/or collection of views from young people, delivery partners and others with an interest
- Consult their own stakeholders and feed back views as appropriate

- Undertake specific pieces of work, such as inputting to the evidence gathering process
- Act as champions for effective drug education
- Report and make recommendations on the effectiveness of drug education to the Secretary of State by the end of June 2008
- Act as ambassadors for the recommendations and promote the delivery of the findings of the review

The group will meet at least three times:

18 March 2008 – Evidence Gathering, Discussion and Analysis: The Advisory Group will agree the terms of reference; consider and discuss the initial evidence summary; agree any sector specific consultation; commission further work from officials and/or agree to undertake further work to inform discussion at the second meeting.

30 April 2008 – Agreeing Action: The Advisory Group will review the work commissioned at the initial meeting; receive feedback on any sector specific consultation; start shaping their report and recommendations; and commission the officials' working group to produce a draft report for consideration at the final meeting of the Advisory Group.

21 May 2008 – Report and Recommendations: The Advisory Group will consider the draft report and agree on the final report's structure, content and recommendations.

Secretariat support to the Advisory Group will be undertaken by the Drug Education Forum, under the supervision of DCSF.

Confidentiality

Minutes, papers and advice are likely to be subject to FOI. To maintain trust between members of the Advisory Group, and to promote a free and frank exchange of ideas and views, we would ask that group discussions be treated as confidential and not discussed externally. Members are asked to clear lines with DCSF before talking to the media about the Advisory Group and its work.

Annex C: Glossary of Terms

Children and Young People: refers to all children and young people aged 0-19 and those up to 24 with special needs.

Drugs: The review of alcohol and drugs education has adopted the definition used by the UN Office on Drugs and Crime. This states that a drug is "a substance people take to change the way they feel, think or behave." It is a broad definition which encompasses tobacco, alcohol, volatile substances, medicines, legal and illegal drugs. Such a definition is particularly suitable for use when referring to prevention and treatment work with young people.

Drug Education: is an important aspect of the curriculum for all schools. It aims to increase pupils' knowledge and understanding and clarify misconceptions about: the short- and long-term effects and risks of drugs; the rules and laws relating to drugs; the impact of drugs on individuals, families and communities; the prevalence and acceptability of drug use among peers; the complex moral, social, emotional and political issues surrounding drugs develop pupils' personal and social skills to make informed decisions and keep themselves safe and healthy, including assessing, avoiding and managing risk; communicating effectively; resisting pressures; finding information, help and advice; devising problem-solving and coping strategies; developing self-awareness and self-esteem; enable pupils to explore their own and other peoples' attitudes towards drugs, drug use and drug users, including challenging stereotypes, and exploring media and social influences.

Drug Misuse/Abuse: is drug taking which leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence. It may be part of a wider spectrum of problematic or harmful behaviour and require specific interventions, including treatment.

Drug Use: is drug taking, for example, consuming alcohol, taking medication or using illegal drugs. Any drug use can potentially lead to harm, whether through intoxication, breach of the law or of school, college of non-formal settings rules, or the possibility of future health problems, although such harm may not be immediately apparent. Drug use may require interventions such as management, education, advice and information, and prevention work to reduce the potential for harm.

Key Stages: represent a child's progression through school. Key Stage 1 covers pupils from age 5 to age 7, Key stage 2 from 7 to 11, Key Stage 3 from 11 to 14 and Key Stage 4 from 14 to 16.

Non-formal Settings: 'Non-formal learning: learning outside institutional contexts (out of school) is the key activity, but also key competence of the youth field. Non-formal learning in youth activities is structured, based on learning objectives, learning time and specific learning support and it is intentional. For that reason one could also speak of non-formal education. It typically does not lead to certification, but in an increasing number of cases, certificates are delivered…' EU/Council of Europe (2002)

Parents and Carers: refers to parents of children, grandparents and other family members where they are the main care giver, and for children in local authority care, foster parents and the corporate parent.

Schools: refers to all maintained schools including Pupil Referral Units.

Transition: refers to movement between the main phases of education for example starting primary school, moving from primary to secondary education, moving from mainstream school to further education and leaving school. Transition also reflects any significant change that a child or young person is going through which may impact on their well-being such as parental divorce, bereavement and moving home. These transitions may be short or long, recur or happen once but whatever their nature, children and young people may require additional support during these times.

Annex D: Drug and Alcohol Advisory Group – Evidence Summary Paper

Introduction

1 This evidence paper has drawn from a number of research sources, both UK and international, large and small scale studies, quantitative and qualitative work. It is an important paper as it provides the basis from which the Drug and Alcohol Advisory Group recommendations build. The Drug and Alcohol Advisory Group has endorsed the paper as one which gives a good summary of what we know about drug and alcohol education. Additional sources of evidence used in *Drug Education: an Entitlement for All*, are referenced in the text.

2 The paper divides into four parts:

- *Part One – A history of drug education and primary prevention*, tracks the recent history of developments in the field;
- *Part Two – Young people, alcohol and drugs*, marshals the most recent data on young people's alcohol, tobacco, illegal drug and volatile substance misuse, alongside what young people tell us about drugs education, the risk and protective factors in young people's drug use, and what we know about what influences young people;
- *Part Three – Delivering drugs education in schools*, sets out what we know about the quality and quantity of current drugs education in schools; how teachers are trained to provide it; what we know about the effectiveness of school based programmes; and what we know about effective classroom practice.
- *Part Four – Wider sources of drug education*, reflecting the scope of the review, this section deals effectiveness of drug information and education from sources and settings other than schools. This section deals with colleges, youth work, community based initiatives, FRANK and other mass media interventions.

3 There are three annexes to the paper:

- *Annex 1 Definitions and scope* offers the definitions of drugs and drug education that we have adopted for the purposes of this review and re-states the scope of the review as set out in the Terms of Reference
- *Annex 2 Blueprint delivery findings* summarises the findings of the Blueprint programme to date
- *Annex 3 research findings, gaps and potential priorities*

4 The paper has been drawn together with input from a number of members of the Advisory Group, Dr Richard Lumley and Richard White (DCSF) and Dr Harry Sumnall of Liverpool John Moores University, for which I am most grateful.

Part One: A history of drug education and primary prevention

Summary

Drug education is an evolving science. Over the past 30 years we have developed a body of evidence about the type of interventions that do not impact on young people's drug taking behaviour. We now have some evidence from new programmes which appear to have a statistically significant and durable impact on substance misuse onset rates, but this is largely from overseas sources and some of it requires further independent evaluation. The Blueprint programme was designed to test the effects of what the evidence suggested was effective practice in drugs education in a UK context.

1 Drug education and prevention interventions in the 1970s aimed to prevent substance misuse by giving young people information about the risks associated with drug and alcohol use. This was based on the hypothesis that increased *knowledge* about the detrimental effects of substance misuse would have a corresponding impact on young people's attitudes, which would in turn influence behaviour. These programmes generally sought to instil fear of the consequences of experimentation with drugs. Evidence shows that this approach did not impact upon reducing young people's drug taking behaviour.

2 The early 1980s saw the development of *affective programmes* which grew from a hypothesis that drug and alcohol misuse was not caused by lack of knowledge about the ill effects of substances, but was in fact a result of low self esteem. Affective programmes aimed to prevent or reduce the scale of substance misuse through enhanced personal and social development. There is no evidence that this type of programme impacts on drug use behaviour, although there is some evidence of improved drug knowledge, attitudes and self efficacy.

3 The late 1980s saw the growing use of *social influence programmes*. These were based on the hypothesis that drug use stems from direct or indirect social influences from peers and/or the media.[17] These programmes aim to strengthen young people's resistance skills. There is little evidence of reduction in drug use as a result of these programmes.

4 More recent programmes have attempted to marry elements of all previous approaches into programmes designed to ensure that young people have the *knowledge, skills and attitudes* to make safe and sensible decisions about drug use. Analysis shows that these multi-faceted programmes show a marked improvement in young people's knowledge and skills, which in certain circumstances (for example, schools being particularly dedicated to drugs education) can have a small impact on drug use and drug harm behaviour.[18]

17 G J Botvin, *Prevention in schools, In Ammerman RT, Prevention and societal impact of drug and alcohol abuse. Mahaw, [NJ] Lawrence Erlbaum Association*

18 T.E. Dielman, School-Based Research on the Prevention of Adolescent Alcohol Use and Misuse: Methodological Issues and Advances, *Journal of Research on Adolescence, 4:2, pp271-293, 1993*

G.J. Botvin, E Baker, L Dursenbury, E.M. Botvin, and T. Diaz, Long-Term Follow-Up Results of a Randomized Drug Abuse Prevention Trial in a White Middle Class Population, *Journal of the American Medical Association, 273:14 1995*

R.Midford, Does Drug Education Work? *Drug and Alcohol Review, 19:4 2000*

N.S Tobler and H Stratton, Effectiveness of School-Based Drug Prevention Programs: A Meta-Analysis of the Research, *Journal of Primary Prevention, 18:1 1997*

5 More recently, the Cochrane Collaboration published in 2005 (a systematic review of school-based prevention of illicit drug use, where 29 of the 32 studies included were randomised controlled trials) concluded that there was little collective evidence of added value from multi-faceted programmes.

6 The *Life Skills* programme, developed by Gilbert Botvin in the USA, appears to be one of the most successful multi-faceted drug education programmes. It combines drug information with resistance skills training, but also aims to tackle the underlying psycho-social factors in the origin of drug use.

7 A six-year follow up study in America showed that there were 4% fewer cannabis users among students who had received at least 60% of the Life Skills programme. The programme was also shown to have positive effects on reducing the numbers of those who used more than one of either: cigarettes, alcohol or cannabis. Across the various measures of combinations of cigarettes, alcohol and cannabis, the percentage reductions ranged from 3%-8%. Overall, Life Skills appears to have a statistically significant and durable preventive effect on substance use onset rates though the size of these effects is consistently small.

8 There are some methodological issues with the Botvin evaluation which mean that further *independent* evaluation is required which should include analysis of the effects arising from different levels of participation in the programme, and the effects on different types of population.

9 In response to a lack of UK based evidence, the *Blueprint programme* (funded by the Home Office) was set up to synthesise evidence of effectiveness in drug prevention, and to develop and evaluate a bespoke drug prevention education programme in England.

10 At the time of *Blueprint's* inception, the international evidence base showed that programmes which tackled drug prevention through a number of channels: media, schools, parents etc (multi-component programmes) were generally more successful than school based interventions alone. *Blueprint* therefore implemented five connected strategies for drug prevention which focused on:

- Schools – including teacher training, a specifically designed drug education curriculum, support from School Drug Advisers and others;
- Parents – through information booklets, the opportunity to attend a Blueprint lesson and parenting skills workshop;
- Local media campaigns – to raise awareness of the programme and encourage participation;
- Health policy – working with trading standards services to increase retailer compliance with legislation on the sale of alcohol and tobacco;
- Community – through the engagement of Drug Action Teams and Drug and Alcohol Action Teams in local authorities.

11 The *Blueprint* practitioner and delivery reports published in November 2007 look at how far actual implementation was consistent with intended delivery plans. A summary of the *Blueprint* delivery findings is attached at Annex 1.

12 The final *Blueprint* report is due for publication in June 2008. It will cover, amongst other things, young people's attitudes to drugs, the quality of communications between young people and their parents about drugs, and

the impact of the *Blueprint* programme on young people's drug taking behaviour. The *Blueprint* findings will be critical in informing the work of the Drugs and Alcohol Advisory Group. We expect to have access to emerging findings as the review progresses.

13 The ACMD 2006 report, *Pathways to Problems*, argued for a reassessment of what it is realistic to expect from drugs education delivered in schools. The new Drug Strategy (February 2008) and Youth Alcohol Action Plan (due in Spring 2008), also position drug education as one element of a wider prevention strategy.

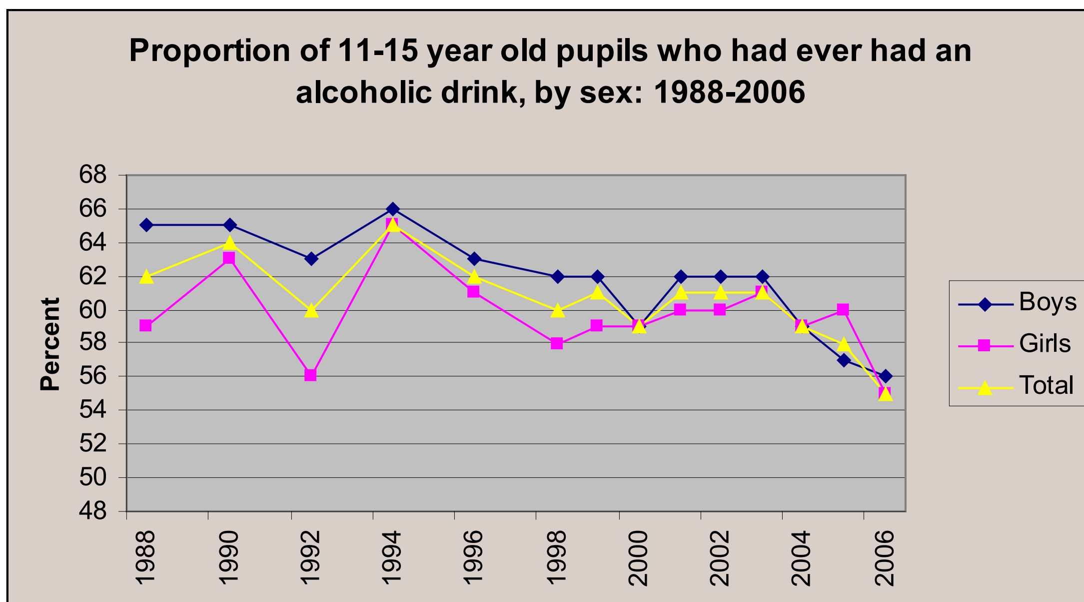
Part Two: Young people, alcohol and drugs

Summary

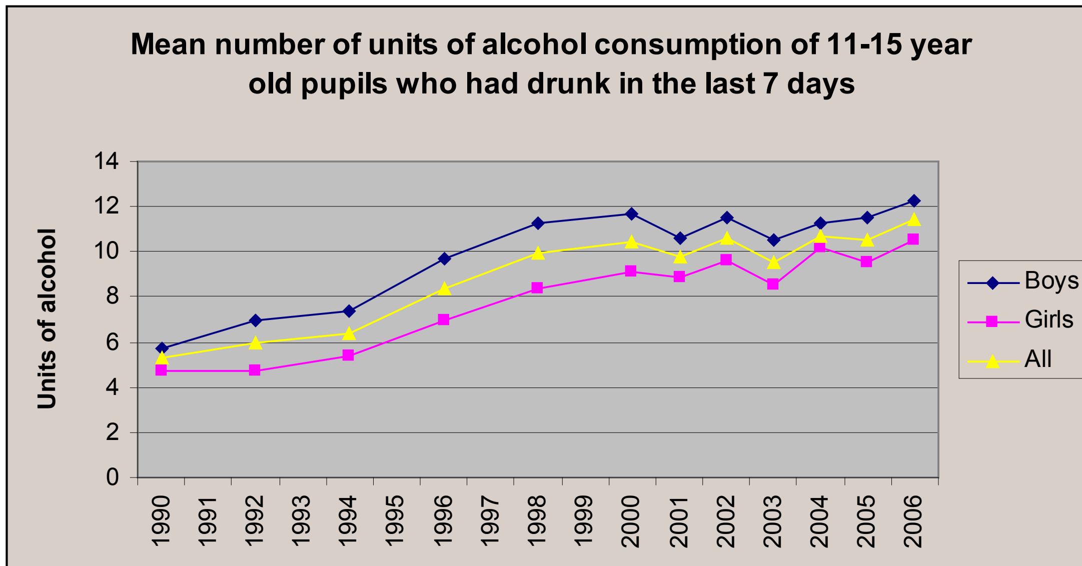
The number of young people drinking is going down, but levels of consumption amongst those who do drink is going up. Reductions in smoking during the late 1990s have now plateaued at 7% of boys and 10% of girls. Volatile substance misuse is going down (5% of 11-15 year olds), but it's still the form of substance abuse most likely to cause a young persons instantaneous death. Overall use of illegal drugs by young people is declining (cannabis use 10% in 2006 down from 13% in 2001). Class A drug use has been static since 2001 at around 4% of 11-15 year olds saying they had used in the last year.

Alcohol

14 There are no national guidelines on what level of alcohol is safe for young people to drink. Since 2001, the proportion of young people aged 11-15, who said that they have *never* drunk alcohol has risen – from 38% to



Source: DH (2006) Smoking, Drinking and Drug Use among Young People in England



Source: DH (2006) Smoking, Drinking and Drug Use among Young People in England

its current 46%. Some 21% of young people reported drinking alcohol in the past week, down from 26% in 2001.

15 While the number of young people drinking alcohol has declined, those who are drinking are consuming more alcohol, more often. The average weekly consumption of alcohol reported by young people who drink aged 11-15 years doubled in the 1990s, from an average of 5 units per week in 1990 to 10 units per week in 2000.

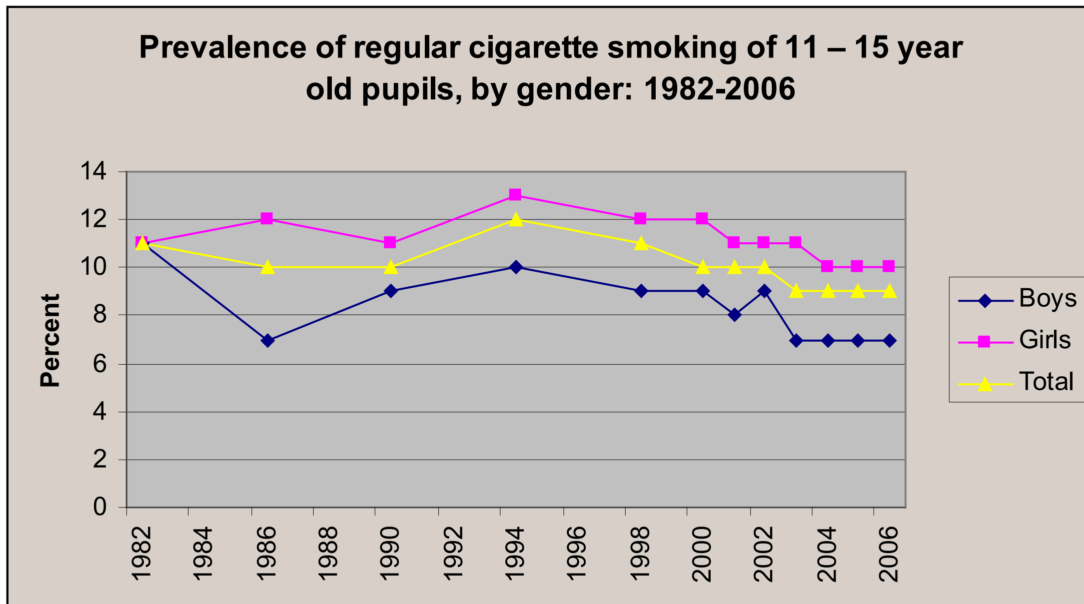
16 Over the past six years, self-reported levels of consumption of alcohol by older adolescents who drink has remained stable, while younger adolescents' consumption has steadily increased. Those 11-13 year old boys who drank in the last week consumed 11.9 units per week in 2006, up 6.4 units from 2001. Those 11-13 year old girls who drank consumed 8.4 units a week in 2006, up 2.7 units since 2001.

17 The most common reason young people give for consuming alcohol is to help socialise with their peers. Children's levels of drinking are linked with their parents' drinking and broader parental influences, including parenting styles and family structures. Whether drinking is supervised by parents also impacts on consumption: the same group of young people will consume more alcohol when unsupervised. Young people up to the age of 16 most often obtain and drink alcohol in the home.

18 There is a growing evidence base of the harms linked to young people's alcohol consumption – growing levels of liver cirrhosis among people in their 20s, the possible links between alcohol consumption and impaired adolescent brain development and alcohol consumption can act as a risk factor for a wide range of other types of 'problem' teenage behaviour (including teenage pregnancy, offending, victimisation and illicit drug use).

Tobacco

19 The prevalence of regular smoking by 11-15 year olds in England has fluctuated since 1982 but has been on a downward trend since 1994 – among boys it has dropped from 11% to 7% and among girls from 13% to 10%, but the downward trend has levelled off since 2003 with an overall rate of 9%. The



Source: DH (2006) Smoking, Drinking and Drug Use among Young People in England

prevalence of smoking is also strongly related to age. In England, only 1% of 11-year-olds were regular smokers in 2005, compared with 16% of 15-year-old boys and 25% of 15-year-old girls. Young people from lower socio-economic groups are more likely to smoke. Young people who have been excluded from school are more than twice as likely as those who had not to be regular smokers.

Volatile substance misuse

20 Trends in the use of volatile substances show a reduction in use. Statistics in 'Smoking, drinking and drug use among young people in England in 2006'[19] indicate that 5% of pupils aged 11 to 15 used either glue, gas, aerosols or solvents while the report covering 2005 showed 7% reported taking volatile substances (glue, gas, aerosols or other solvents) in the last year, compared with 8% in 2003. In the report covering 2005 12% of 11-15 year olds had used cannabis as compared with 7% who had taken either glue, gas, aerosols or solvents. Headline figures for 2006 show that 10% had used cannabis with 5% having used glue, gas aerosols or solvents; based on these latest figures, use of both have fallen by 2 percentage points in the 11-15 age group.

21 In 1991, VSA (volatile substance abuse) caused more deaths among 10–18 year olds in the UK than leukaemia or drowning. Following a national advertising campaign and measures to restrict access to volatile substances in 1992, deaths of under 18s fell by an estimated 62% from the number predicted by the underlying trend. The estimated fall of 19% amongst adults was not statistically significant. Since the campaign there has also been a further significant fall in the annual totals of all VSA deaths, from an average of 77 per year in 1993-1998 to an average of 59 per year in 1999-2005.

22 This shows that the fall in deaths since 1990 was predominantly among young people. Among adults there was a levelling rather than a fall.

19 Smoking, drinking and drug use among young people in England in 2006 National Centre for Social Research and the National Foundation for Educational Research for the Department of Health

Proportion of 11- 15 year old pupils pupils who took individual drugs in the last year: 2001-2006[a,b]

Type of drug	Year 2001 %	2002 %	2003 %	2004 %	2005 %	2006 %
Cannabis	13.4	13.2	13.3	11.3	11.7	10.1
Any stimulants	5.6	6.2	6.1	5.4	6.2	6.2
Cocaine	1.2	1.3	1.3	1.4	1.9	1.6
Crack	1.1	1.0	1.2	1.1	1.0	0.8
Ecstasy	1.6	1.5	1.4	1.4	1.5	1.6
Amphetamines[c]	1.1	1.2	1.2	1.3	1.2	1.2
Poppers	3.4	4.3	4.0	3.4	3.9	4.2
Any psychedelics[d]	2.4	1.8	2.4	2.3	2.4	2.2
LSD	0.7	0.7	0.6	0.7	0.6	0.7
Magic mushrooms	2.1	1.5	2.1	2.0	1.8	1.4
Ketaminee	e	e	e	e	0.4	0.5
Any opiates	0.8	0.8	0.9	0.7	0.9	0.7
Heroin	0.7	0.7	0.8	0.7	0.8	0.5
Methadone	0.2	0.2	0.2	0.1	0.2	0.3
Glue, gas, aerosols or solvents[f]	7.1	6.3	7.6	5.6	6.7	5.1
Tranquillisers	0.5	0.4	0.5	0.4	0.4	0.4
Anabolic steroids	0.2	0.2	0.2	0.2	0.3	0.5
Other drugs	0.6	0.4	0.7	0.4	0.6	0.2
Any Class A drug	4.3	3.7	4.3	3.9	4.4	4.3
Any drug	20.4	19.7	21.0	17.6	19.1	16.5
Any drug (excluding volatile substances)	16.1	15.9	16.3	14.0	15.0	13.4

Source: DH (2006) Smoking, Drinking and Drug Use among Young People in England

a Estimates from 1998 to 2000 not shown, as they are not comparable with estimates from 2001 onwards because of the change in the way that drug use was measured.

b Estimates are shown to one decimal place because of generally low prevalence rates.

c Surveys from 2004 onwards asked about 'speed and other amphetamines'.

d The 2005 and 2006 estimates for psychedelics include ketamine.

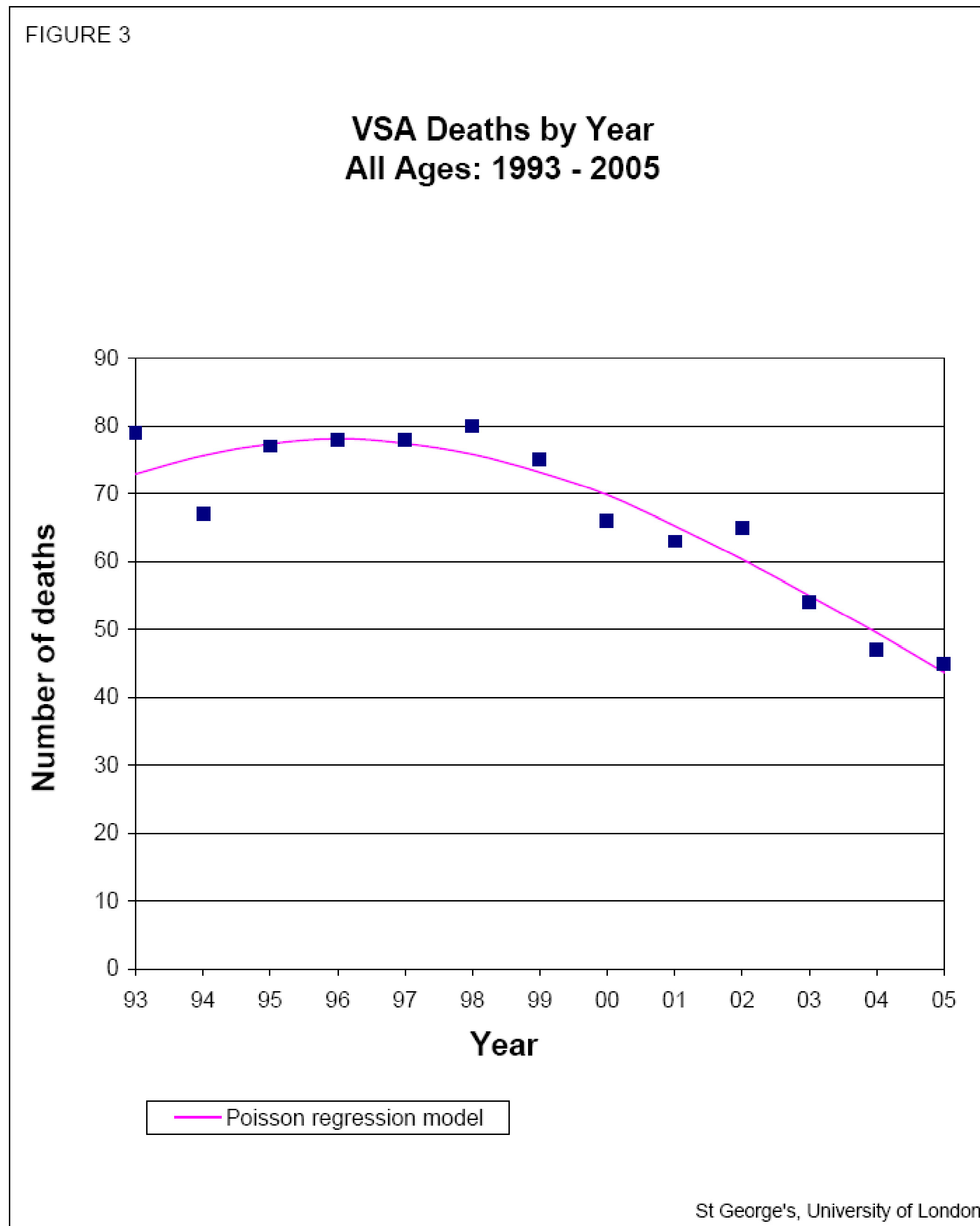
e Ketamine was measured for the first time in 2005.

f The 1999 survey asked about 'glue or solvents' as one category, and 'gas' in another category. From 2000, questions were asked about a single category, 'glue, gas, aerosols and other solvents'.

Illegal drugs

23 The prevalence of cannabis use in the UK is among the highest in Europe. The prevalence of first cannabis use by the age of 13 ranges from 0-4% in Bulgaria, Estonia, Greece, Italy, Latvia, Lithuania, Cyprus, Hungary, Malta, Poland, Finland, Sweden, Norway, and Turkey and 5-8% in all other countries except the United Kingdom, where the figure is 13%.[20] But the number of pupils in England ever

20 Drug use and related problems among very young people (under 15 years old) European Monitoring Centre for Drugs and Drug Addiction, 2007



offered drugs has declined from 42% in 2001 to 35% in 2006.

24 The prevalence of drug use in England had also declined since 2001. In 2006, 24% of pupils said they had ever used drugs, and 17% had taken any drugs in the last year. In 2001, the corresponding proportions were 29% and 20%. Pupils were more likely to have taken cannabis in the last year (10%, an overall decrease from 13% in 2001) than any other illegal drugs. The proportion of pupils who had taken any Class A drugs in the last year has stayed at around 4% since 2001.[21]

21 Smoking drinking and drug use among young people in England 2006 National Centre for Social Research and the National Foundation for Educational Research

Children at risk of drug misuse

25 Evidence cannot predict which children will misuse substance or go on to become drug dependent. Research has, however, identified risk factors which correlate with higher levels of drug taking.

- **Parental drug misuse** UK research shows that at the age of 15, young people whose parents had used drugs during the previous year were more than twice as likely to have used drugs themselves, compared with those young people whose parents had not used drugs.
- **Sibling drug misuse** research in several countries shows that among children with drug-using siblings the rates of drug use are much higher than among children with siblings not using drugs.
- **Truancy and exclusion** The Crime and Justice Survey 2003 shows that when comparing drug use in across vulnerable groups, truants showed the highest levels of drug use.
- **Ethnicity** is a complex issue in relation to drug misuse. Analysis of the 2005 school survey for England shows that pupils of mixed ethnicity were more likely than any other group to have taken drugs in the last year, and Asian pupils were least likely to have done so.
- **ADHD, Conduct and mental disorders** children affected by attention deficit (hyperactivity) disorder and conduct disorder (CD) are considered at risk group of future drug use.
- **Young offenders and those in care** are also at higher risk of engaging in drug taking behaviour.

26 The 2007 Home Office report Risk, protective factors and resilience to drug use: identifying resilient young people and learning from their experiences.[22] Shows that for 10-16 year olds key factors associated with increased risk of taking any drug are:

• serious anti-social behaviour;	• being unhelpful;
• weak parental attitude towards bad behaviour;	• early smoking;
• being in trouble at school (including truanting and exclusion);	• not getting free school meals;
• friends in trouble;	• minor anti-social behaviour.

Awareness of drugs

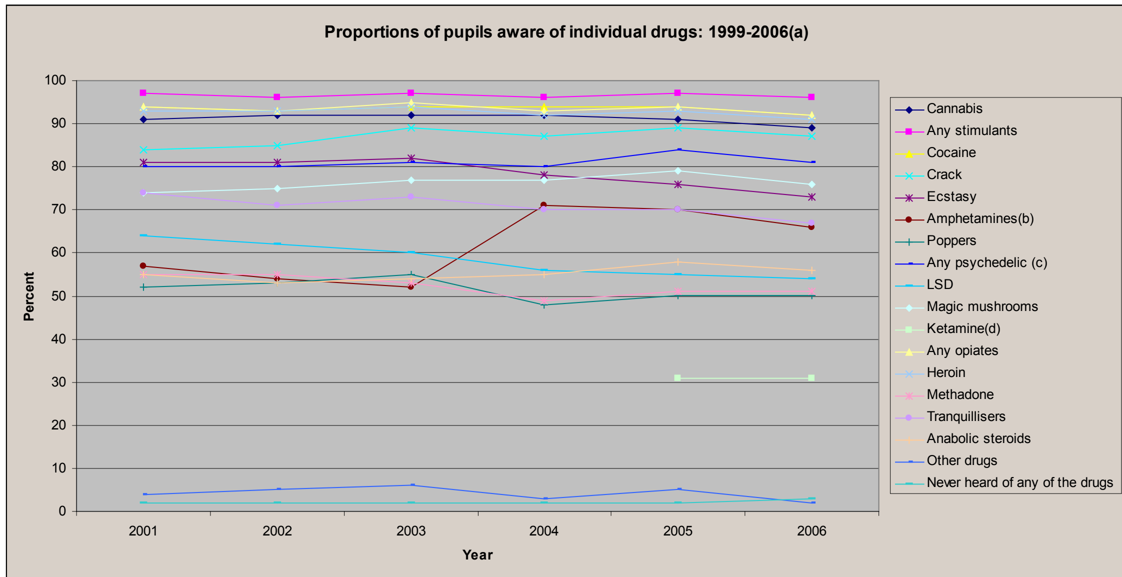
27 Young people are highly aware of illegal drugs. In 2006, around nine out of ten pupils had heard of cocaine (92%), heroin (91%) and cannabis (89%). Even less well-known drugs, for example LSD, poppers and methadone, were known of by around half of pupils. Only 3% of pupils reported that they had never heard of any of the drugs listed, an increase since 2001 (2%)[23].

Offers of drugs

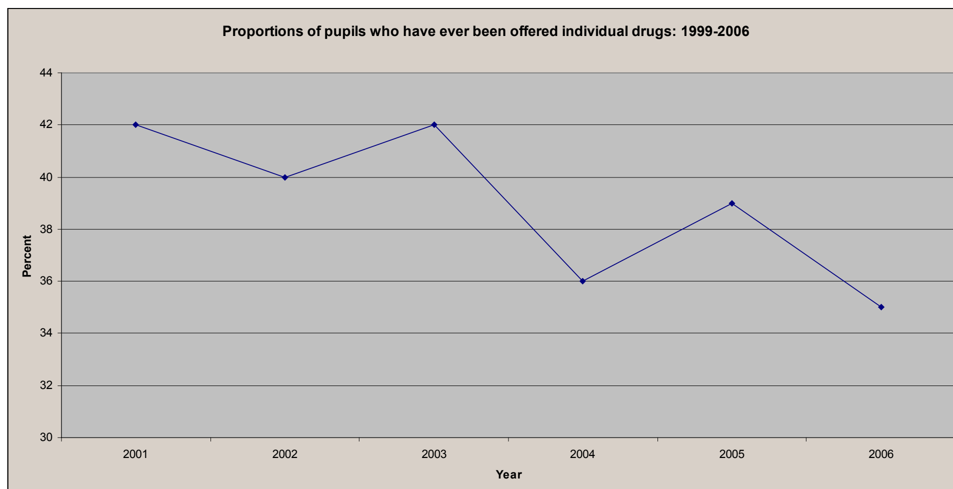
28 Just over a third (35%) of pupils reported ever being offered drugs. This proportion has varied from year to year since 42% in 2001, with an overall downward trend.

22 *Risk, protective factors and resilience to drug use: identifying resilient young people and learning from their experiences*: Home Office Online Report 04/07 L. Dillon et al Home Office: 2007

23 Source: DH (2006) Smoking, Drinking and Drug Use among Young People in England



Source: DH (2006) Smoking, Drinking and Drug Use among Young People in England
a Estimates from 2001 onwards are not comparable with estimates from previous years because of the change in the way that awareness of individual drugs was measured.
b Surveys from 2004 onwards asked about 'speed and other amphetamines'.
c The 2005 and 2006 estimates for psychedelics include ketamine.
d Ketamine was measured for the first time in 2005.

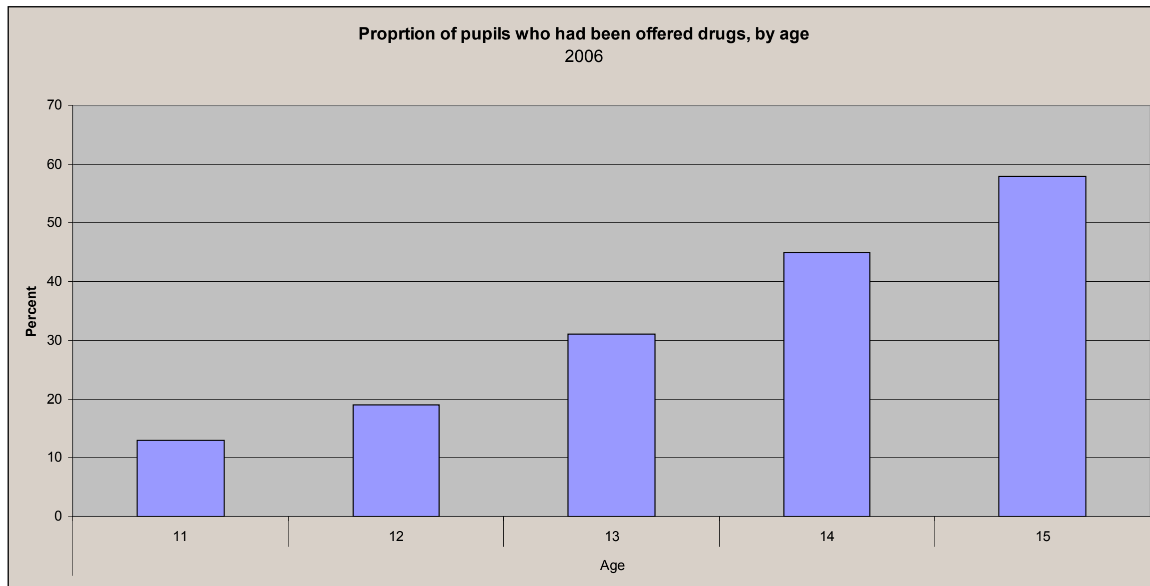


29 Boys were more likely than girls to have been offered drugs (37% of boys, 34% of girls), and the likelihood of having been offered drugs increased with age, from 13% of 11 year olds to 58% of 15 year olds.

30 Pupils were most likely to have ever been offered cannabis; although the proportion reporting this has fallen from 27% in 2001 to 23% in 2006. But whilst the proportion of pupils offered drugs looks high, significant numbers of pupils being offered drugs are refusing them.

Deciding not to take drugs

31 Underlying young people's decisions not to use drugs was a perception that drug use would be incompatible with their current lifestyle and what they planned or wanted for



Source: DH (2006) Smoking, Drinking and Drug Use among Young People in England

themselves in the future. Young people identified the following reasons for choosing not to use drugs.

- **The disapproval of significant people**, in the young people's lives of drug use;
- **The fear of legal consequences**, which ranged from not wanting to break the law, to fear of the impact of a possible criminal record on their life aspirations;
- **Incompatibility with achieving career aspirations**, young people thought, for example, it could prevent them from obtaining qualifications, or the physical fitness required for certain career paths.
- **Being too busy** – these young people made extensive use of their spare time – to follow hobbies, do part time jobs and undertake voluntary work;
- **Being a parent** was not perceived to be compatible with using drugs. Those who were already parents did not have time to engage in drug use and did not want to place their child at risk. Others who wanted to become parents in the future wanted to stay healthy and be good role models for their children;
- **Previous negative experience with cannabis** had made some decide not to use again;
- **Fear of damaging health** now and in the future was noted as another reason not to use drugs;
- **Fear of addiction** was noted by some. While this tended to be associated with Class A drugs, it also seemed to discourage young people from experimenting with other drugs too;
- **Not wishing to lose control** of themselves and do something they would regret;
- **Having alternative sources of getting the 'buzz'** that users got from drugs – these included drinking alcohol and certain hobbies;
- **Having alternative sources of support** meant that young people did not need drugs as a way of coping with their problems. The sources of support

included alcohol or tobacco, supportive relationships, and other sources of stress relief such as using a punch bag, going for a bike ride, or going to the beach to '*chill out*'.

32 Young people usually cited several of these reasons as having shaped their decision not to use rather than a single one. It was evident from the way in which they discussed the factors that they were very much interlinked.

The age of onset

33 Whilst very few children under the age of 12 take drugs, and drug dependence by the age of 15 is extremely rare, early initiation of drug use is considered to be a strong predictor of future addition, use of more than one drug, and poorer health and educational outcomes[24]. A large representative study of 17 year olds in France found that two thirds of respondents who smoked cannabis for the first time before the age of 12 were daily users by the time they were 17, whereas those who did not start smoking cannabis until the age of 16 or 17 were mostly occasional smokers[25].

Repetition of use

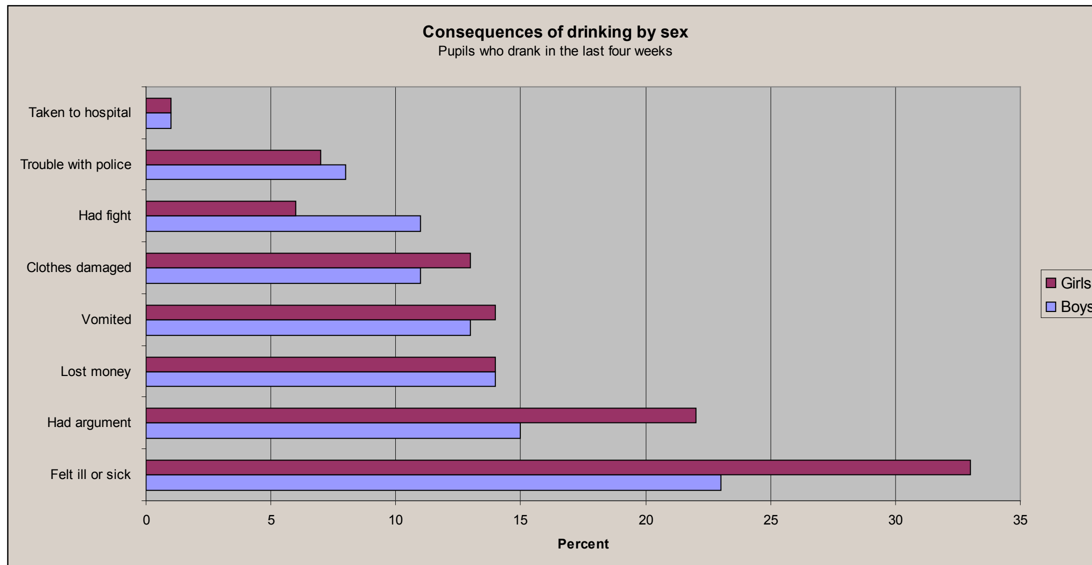
34 The natural course of cannabis use, abuse and dependence during the first decades of life,[26] a 10 year study showed that the number of repetitions of use is a factor in long-term use of cannabis. 56% of all repeated users (five times or more) at baseline reported cannabis use at 4-year follow-up. Ten years later, this proportion had decreased slightly to 46.3%. Repeated (five times or more) users were almost three times more likely to report repeated use at 10-year follow up, compared with those who had used cannabis fewer times. Peer use of cannabis, life-events and alcohol dependence also predicted use of cannabis at 10-year follow-up.

35 Conclusions among youth who have used cannabis repeatedly (five times or more) cannabis use is fairly stable and rates of remission relatively low until age 34 years. Patterns of progression suggest that early targeted preventive measures should delay first use and reduce the number of experiences using cannabis, as these factors appear critical in progression to persistent cannabis use and cannabis dependence.

Drug Harms

36 Pupils who had drunk alcohol in the last four weeks were asked if anything had happened to them when they had been drinking. Pupils were most likely to have felt ill or sick; this was more common among girls (33%) than boys (23%). Girls were also more likely than boys to have had an argument (22% compared to 15%). Similar proportions of boys and girls reported losing money or other items (14% of boys and girls); vomiting after drinking alcohol (13% of boys, 14% of girls); damaging clothes (11% of boys, 13% of girls) and getting in trouble with the police (8% of boys, 7% of girls). However more boys than girls reported getting into a fight (11% of boys, compared with 6% of girls). A small proportion of pupils (1%) reported being taken to hospital after drinking in the last four weeks. The pattern of these experiences was generally similar across age groups. (Source:

24 Gfroerer, J, Wu, L and Penn, M (2002) Initiation of Marijuana use: trends, patterns and implications, SAMSHSA, Bethesda, USA
25 Drug use and related problems among very young people (under 15 years old) European Monitoring Centre for Drugs and Drug Addiction, 2007
26 Axel Perkonigg, Renee D. Goodwin, Agnes Fiedler, Silke Behrendt, Katja Beesdo, Roselind Lieb, Hans-Ulrich Wittchen (2008) The natural course of cannabis use, abuse and dependence during the first decades of life Addiction 103 (3) , 439–449



Source: DH (2006) Smoking, Drinking and Drug Use among Young People in England

DH (2006) Smoking, Drinking and Drug Use among Young People in England).

37 All of these negative outcomes were reported by at least a few pupils who said they had not been drunk, but the proportion of pupils who reported each type of incident after drinking increased sharply with the number of times they had been drunk. For example, 11% of pupils who had not been drunk had felt ill or sick when drinking, compared with 45% who reported being drunk three or more times over the last four weeks. (Source: DH (2006) Smoking, Drinking and Drug Use among Young People in England).

38 Joint study by LJMU's Centre for Public Health, Trading Standards North West and the Home Office on 15 and 16 year olds in the north west of England also noted that Binge drinkers are also more likely to be involved in alcohol-related violence. For instance, those who binge drink three or more times a week are more than five times more likely to be involved in alcohol-related violence than individuals who drink but do not binge. (Source: LJMU's Centre for Public Health, Trading Standards North West and the Home Office (March 2008)'Risky Drinking in North West School Children and its Consequences: A Study of Fifteen and Sixteen Year Olds').

39 Young people aged from 10-25 who took drugs in the last 12 months were significantly more likely (than those who did not) to have committed an offence. This was true for both serious and frequent offending. Just under half (46%) of those who had taken any drug in the last 12 months had committed an offence in the same time period compared with 19 per cent who had not taken any drug[27].

What influences young people?

Parents

40 Parents are the single biggest influence on young people. Evidence shows that good parenting has significant positive effects on children's achievement – even after all other

27 Young People and Crime: Findings from the 2005 Offending, Crime and Justice Survey D. Wilson, et al: Dec 2006

factors affecting attainment have been taken into account[28].Parenting styles at the extremities (i.e. authoritarian/ aggressive and laissez faire) have both been shown to be risk factors in drug use. Parents' attitudes to drugs influence young people's attitudes, which in turn influence their behaviour.

41 Parenting style has also been shown to influence children's health behaviour. For example, adolescents raised by parents who are heavily involved in their lives (e.g. who *monitor* their behaviour) are less likely to use substances[29] Similarly, provision of *warmth and support* by parents is associated with lower adolescent use.[30] There is also some evidence (albeit mixed) that parent-child *communication* about substances and substance use is associated with reduced risk of early-onset use.[31] But parents may lack knowledge about drugs, and confidence about their knowledge of drugs, inhibiting their ability to communicate clearly and effectively.[32]

42 Attempts to engage parents in school based drug prevention work have experienced serious difficulties in recruitment and retention of parents. The *Blueprint* delivery reports show that despite concerted effort to recruit parents, schools achieved on average 6% attendance at the parenting courses linked to the programme.

43 There is also a lack of evidence about the effectiveness of drug education programmes which focus on family intervention and parent education. More research is needed to identify which types of family-orientated interventions are effective in the UK. It may not be necessary to design completely new interventions as it may be possible to adapt international interventions for a UK setting. It should also be possible to revisit existing family interventions to allow for more structured impact evaluation.

Peers

44 Friends and peers become increasingly important to young people during their teenage years, peaking in influence at around the age of 15[33]. Peers play an important role in the process by which young people experiment with and develop a sense of themselves[34]. Young people tend to mirror the behaviours of their friends, with risky behaviour such as drinking and drug taking influenced by what friends do. Peers can have a small influence on academic attainment, and at school peers appear to be a more important influence for the behaviour of boys and those from disadvantaged homes.

Schools

45 Schools and teachers are an important influence on young people. Teenagers overwhelmingly view doing well at school or college as important to them: nearly seven in ten (69%) say this is very important and virtually all the remainder (29%) say it is fairly

28 The Impact of Parental Involvement, Parental Support and Family Education on Pupil Achievement and Adjustment: A Literature Review Professor Charles Desforges with Alberto Abouchaar, DfES Research Report 433, 2003
29 Leventhal & Brooks-Gunn, 2000; Li, Stanton, & Feigelman, 2000.
30 Barnes, Reifman, Farrell, & Dintcheff, 2000; Barnow, Schuckit, Lucht, John, & Freyberger, 2002.
31 (Chassin, Presson, Todd, Rose, & Sherman, 1998; Jackson & Henriksen, 1997).
32 Velleman et al 2000
33 Cole, D., Maxwell, S., Martin, J., Peeke, L., Seroczynski, A., Tram, J., Hoffman, K., Ruiz, M., Jacquez, F. and Maschman, T. (2001) The development of multiple domains of child and adolescent self concept: a cohort sequential longitudinal study, Child Development
34 Nurmi, J. (2004) Socialization and self-development. Channelling, selection, adjustment and reflection. In Lerner, R and Steinberg L. Handbook of Adolescent Psychology

important[35]. And in the main young people appear happy at school: 85% of 14 year olds are happy, just 3% not[36].

The Media

46 Young people are faced with the challenge of growing up in a culture that has widespread negative perceptions about them. The media commonly associates young people with problems such as anti-social behaviour and binge drinking. 71 per cent of media stories about young people are negative, a third of articles about young people are about crime[37]. Young people are keenly aware of their reputation in the community, with 98 per cent of them feeling that the media portrays them as anti-social[38].

47 At the same time, the media persists in focusing attention on the drug or alcohol use of some celebrities in a way which appears to accept substance misuse as a natural part of a 'celebrity' lifestyle. Perceptions about what celebrities do or think which is communicated to young people through the media does appear to have an effect. Evidence shows that 59 per cent of young people report that their celebrity idol has influenced some aspect of their attitudes or beliefs.[39]

Part 3: Delivering drugs education in schools

Summary

Drugs education has improved since 1997. But in its most recent reports Ofsted could find no examples of outstanding drugs education. Young people get regular drugs education from reception onwards in science and PSHE. They average 5.9 hours a year in primary and 7.8 hours per year in secondary. The amount of PSHE as a whole has been squeezed within the curriculum. Most teachers use research to inform practice. We know what makes effective classroom practice, but this may be challenging for some teachers. Only recently has evidence begun to emerge of alcohol and drug prevention programmes which impact on behaviour and these are from overseas. Young people want more and better drugs education from people who know their subject, but the majority of young people are not consulted about the content of drugs education in schools. External contributors are valued by teachers and young people, but the quality can be variable.

Drugs in the curriculum

48 Drugs education is delivered in schools through the statutory elements of science in the national curriculum and the non-statutory PSHE curriculum. Through science, pupils are taught about drugs and the harmful effects of drug abuse from key stages 1 through to 4. This includes the role of drugs as medicines and the associated benefits and negative consequences of drug use and abuse,

35 Home Office (2005) Offending Crime & Justice Survey, internal DCSF analysis unpublished]
36 DfES (2004) *Longitudinal Survey of Young People in England*, internal DCFS analysis [unpublished]
37 *Young People and the Media*, Mori/Young People Now, 2005
38 *Respect? The Voice Behind the Hood*. YouthNet and the British Youth Council, 2006
39 Boon, S.D. , Lomore, C.D. (2001) Admirer-celebrity relationships among young adults: explaining perceptions of celebrity influence on identity. Human Communication Research. 27:432-465.

including their harmful effects on health and the body. According to QCA, drug, alcohol and tobacco education should enable pupils to increase their knowledge and understanding of drugs, alcohol and tobacco, and to explore attitudes and develop skills for making healthy, informed choices.

The quality of drugs education

49 In reporting on the quality of drugs education, Ofsted examines how well drug education has increased pupils' knowledge, changed their attitudes and enhanced their skills. Ofsted is not tasked with looking at behaviour change as a measure of achievement. On this basis,

Drug education is deemed to be good in:

- 80% of lessons at KS2;
- 50% in KS3; and
- 75% at KS4.
- At KS 3 and 4 Ofsted report that in 16% of lessons, opportunities for pupils to explore their attitudes towards drugs and to share their views with others are weak.
- Ofsted did not record any outstanding drugs education at any key stage.

50 In 2007 Ofsted also found that the extent to which the drug policy and curriculum plan are based on the assessed needs of pupils is unsatisfactory in 25% of primary schools and 25% of secondary schools.

51 But Ofsted report that quality of teaching about drugs had improved in both primary and secondary schools since 1997, as had progress in the development of policies and curriculum plans for drug education. Ofsted also reported that the transition from primary to secondary school (from KS2 to KS3) is weak, with not enough being done to ensure continuity and progression of learning.

52 The report found that whilst the concerns of many teachers and parents were about the involvement of young people with illegal drugs, Ofsted said that the overwhelming majority of young people saw alcohol and tobacco as a much greater threat. Ofsted also found that few drug education programmes made links to other related PSHE themes such as sex education. In 2002 only 20% of primary pupils and 45% of secondary pupils were consulted by schools about the content of drug education.

The quantity of drugs education

53 In 2002 Ofsted reported the following number of hours per year given to the teaching of drug education in PSHE and Science.

Table 1. Number of hours per year spent on drug education in primary schools

Year	R	1	2	3	4	5	6
PSHE	3.0	3.0	3.5	3.5	4.0	4.0	5.5
Science	1.0	2.0	2.0	2.0	2.0	3.0	3.5

54 In the primary phase, PSHE remains the most common context in which to locate drug education. Since 2000, there has been an increase in the time allocated in PSHE to teaching about drugs. Teaching about drugs is also occurring at different times: in the most effective schools such changes have followed consultations with the pupils.

Table 2. Number of hours per year spent on drug education in secondary schools

Year	7	8	9	10	11	12	13
PSHE	5.0	5.0	5.5	4.5	3.5	2.0	2.0
Science	3.0	2.0	4.0	3.5	3.0	–	–

55 In the secondary phase, PSHE is again the usual context for drug education. The time allocations are relatively even, reflecting, in part, the fact that schools are developing drug education programmes where topics are revisited for reinforcement as well as coverage in greater depth. The range of drugs covered is also progressively broader.

56 Research by Manchester University in 2004[40] into PSHE in primary schools shows that the percentage of teaching time devoted to PSHE has fallen since1997. At Key Stage 1 it has fallen from 5.1% to 3.6% whilst at Key Stage 2 it has fallen from 4.4% to 3.2%. To put this in context, however, the amount of time spent on science, geography, art music and design and technology has also fallen, whilst time spent on English, maths and ICT has increased at both Key Stages 1 and 2.

Teacher training for drug education

57 We know from Ofsted (2005)[41] that most primary and secondary ITT courses are well designed and enable the great majority of trainees to meet the standards for Qualified Teacher Status (QTS) at a good level. A study is currently being carried out on behalf of the DfES (Becoming a Teacher Research, Hobson et al) which is exploring the experiences and impact of different ITT routes on induction and early professional development. There is no specialist ITT route for PSHE.

58 Once qualified, national level teacher **continued professional development** (CPD) in PSHE takes one academic year and involves 30 hours guided learning and the production of a portfolio. During the course, teachers (and school nurses who make up 15% of participants) choose between modules in sex and relationship education, drug education and emotional health and wellbeing. This year a new module in economic well-being and financial capability will be introduced. Around 2000 participants complete the training every year. Successful completion of the course counts as 30 credits at level 3. There is an average 20% vacancy rate on each course. This nationally led training is supplemented by a range of shorter locally delivered training.

59 There have been no high quality evaluations of the effectiveness of specialised teacher training on drug education quality and outcomes. However, evidence about CPD in general suggests that teacher's workload, financial cost and a lack of time are key factors inhibiting their participation. This is further reinforced if the CPD provided does not meet the teacher's needs and does not take into account their experience and specialism[42].

Informing effective drug education

60 In a 2004 survey of primary and secondary school teachers, 42% said they frequently use research to inform professional development or classroom practice. Only 5% reported that they never used research (MORI 2004)[43], so

40 CFAS Manchester University 2004

41 Ofsted (2005). The Annual Report of Her Majesty's Chief Inspector of Schools 2004/5. HMI 2439

42 Day, C., Stobart, G., Sammons, P., Kington, A., Gu, Q., Smees, R. & Mujtaba, T (2006) *Variations in Teachers' Work, Lives and Effectiveness*, DfES Research Report No. 743.

43 Market and Opinion Research International (MORI) (2004) *Mori Teacher's Omnibus Survey* National Education Research Forum (NERF), DfES.

the lack of an extensive and/or conclusive UK evidence base on effective drugs education is likely to impact on practice.

61 To inform practice, policy makers and educationalists must look to overseas studies or evidence from specific alcohol and drug prevention programmes, such as the Botvin *Life Skills*. These inevitably throw up issues of replicability in a UK context.

Which programmes are having an impact?

62 When looking at alcohol reduction, research to underpin the development of the NICE guidance on school based alcohol interventions, 2007, found evidence of effectiveness for *Strengthening Families, Life Skills Training,* and a culturally focused curriculum for Native Americans students.

63 Three classroom programmes: *School Health and Alcohol Harm Reduction project (SHAHRP)*; Botvin's *Life Skills*; and *Protecting me, Protecting You*, demonstrated evidence of reducing alcohol use in the short-term. To quote from SHAHRP:

'Over the period of the study (from baseline to final follow-up 32 months later), students who participated in the SHAHRP programme had a 10% greater alcohol related knowledge, consumed 20% less alcohol, were 9.5% less likely to drink to harmful or hazardous levels, experienced 33% less harm associated with their own use of alcohol and 10% less harm associated with other peoples use of alcohol than did the control group.'[44]

64 A brief intervention led by school nurses – *STARS for Families programme* was also effective at producing short term reductions in alcohol. It was also cost effective, but it promoted abstinence which may not be appropriate in a UK context.

65 There is also evidence to suggest that programmes that begin early in childhood, combine school-based curriculum intervention with parent education such as *Linking the interests of families and teachers (LIFT)* which was shown to delay the time that participants first became involved with antisocial peers, as well as the time to first patterned alcohol use, to first marijuana use, and to first police arrest[45] and the *Seattle Social Development programme (SSDP)* which impacted upon the age at which young people tried smoking and alcohol.[46] In addition, the *Healthy School and Drugs Project*[47], which targeted secondary school students, had short-term effects on alcohol use. The longer term effects of the programme have not been examined.

66 When looking at illegal and other drugs, the Cochrane Collaboration also found interesting results. The collaboration published a systematic review of 32 evaluations of school based drug prevention programmes in 2005[48]. The aim of the review was to evaluate the effectiveness of the programmes in improving knowledge, developing skills, promoting change, and preventing or reducing drug use when

44 Drug Education News, February 2008

45 Eddy, J et al An elementary school-based prevention program targeting modifiable antecedents of youth delinquency and violence: Journal of Emotional and Behavioral Disorders, Vol. 8, No. 3, 165-176 (2000)

46 Hawkins, J. David, Richard F. Catalano, Rick Kosterman, Robert Abbott, and Karl G. Hill, "Preventing Adolescent Health-Risk Behaviors by Strengthening Protection During Childhood," *Archives of Paediatric Medicine,* Vol. 153, 1999, pp. 226-234.

47 Cuijpers P, Effective ingredients of school-based drug prevention programs: A systematic review *Addictive Behaviors, Volume 27, Issue 6, November-December 2002, Pages 1009-1023*

48 Faggiano F, Vigna-Taglianti F D, Versino E, Zambon A, Borraccino A, Lemma P, '*School based primary prevention for alcohol misuse in young people*', Cochrane Database of Systematic Reviews, 2002.

compared to the normal curriculum. The majority of the studies were undertaken in the US.

67 The review found that programmes designed to increase drug knowledge were effective in enhancing knowledge to some degree. Programmes promoting social skills were more widely used and were effective in increasing drug knowledge, decision making skills, self esteem, resistance to peer pressure and drug use including both marijuana and heroin (when compared to the normal curriculum). The effects of the programmes on assertiveness, attitudes towards drugs and intention to use were not clearly different. There was a lack of evidence of longer term impacts. In terms of programme design, the programmes were interactive and used external educators.

68 Whilst the majority of the interventions reviewed by Cochrane, were US based, a large scale European randomised trial is currently underway and showing early positive results. The EU-DAP 'unplugged' programme is a multi-centre European randomised controlled trial involving 143 schools in 7 countries. The programme was designed to curb initiation to drugs and delay the transition from experimental to addicted behaviour of the following drugs: alcohol, tobacco, cannabis and other drugs. Effectiveness of the programme is measured by a reduction in the prevalence of drug use. The programme involves 3 month, I year, 2 year and 4 year follow-up. To date results are available for the 3 month follow-up.

69 Following a 3 day training course, teachers delivered 12 one-hour units per week. The curriculum consists of three parts i) knowledge, risks and protective factors (such as a negative attitude toward substance use) ii) interpersonal skills, beliefs, norms and realistic information about prevalence; iii) intrapersonal skills, such as coping competences, problem solving/decision making and goal setting. The programme was delivered in 3 variants: class curriculum alone, class curriculum plus side activities involving peers; class curriculum plus activities involving parents.

70 The results following the 3 month follow-up show a degree of protection for students in the intervention group compared to the control group. Those receiving the programme smoked 12% less during the past 30 days compared to the control group. In addition, the frequency of drunkenness in the past 30 days was reduced by 28% and 31% for at least once and regularly respectively, and the consumption of cannabis was reduced by 23% and 24%, at least once and regularly respectively.

Drug testing and the use of sniffer dogs in schools

71 There is scant evidence of drug testing and the use of sniffer dogs changing young people's drug taking behaviour. A large study in Michigan involving 76,000 pupils found no difference in the prevalence of drug use among students in schools where drug testing was conducted compared with those where it was not.[49] Although other smaller scale studies on individual schools in the US have shown a reduction in the prevalence of drug taking.

What works in the classroom?

72 Whilst evidence about drugs education in schools is neither extensive nor conclusive, we know quite a lot about how to deliver

49 Yamaguchi R, Johnston, L D, O'Malley P M. 'The relationship between student illicit drug use and school drug-testing policies'. *Journal of School Health*, 2003; 73: 159–64.

effective drug education in the classroom. This includes:

- **Interactive** (as opposed to didactic) teaching techniques. These involve group activity, discussion and role play;
- **Normative education** where young people see that both the actual rates of drug use, and the approval of drug use, are lower than they think they are;
- Educating young people **before the usual onset** of drug taking: delivering programmes to young people between the ages of 11-14;
- **Multi-component programmes** where in school education is one component in a wider campaign involving parents, the media, other agencies with an interest and the local community, but it is still unclear as to which components of multi-component programmes contribute to overall effectiveness.[50]

73 We also know that drug education is more effective when taught by **teachers who have acquired the necessary subject knowledge**.

What do young people say about drugs education?

74 In the Ofsted *Tell us 2 survey 2007* when asked what they thought of the information and advice they got about alcohol and drugs, over 26% of respondents said they wanted more or better information on alcohol and smoking, 30% on drugs. The perceived need for improvement was higher for year 8 pupils (33%) than year 10 pupils (28%).

75 This is echoed by the IPSOS/MORI Drug Strategy 2008 report which found that:

"Young people have lots of questions about the long-term effects of drug use, and feel that this is the type of information that would help them as they grow up. Crucially, they want to be able to make informed choices based on 'real life' experiences. People their own age are felt to be best placed to provide these experiences, with a strong feeling that those wishing to educate and engage with young people on the subject of drugs should be 'experts' in their field".

76 Young people want drug education in schools but they 'want it to be better, using practical methods, delivered by someone who gives them a balanced view and has motivation and knowledge to deliver it'[51].

77 Feedback from young people in the Mentor Youth Involvement Project showed they thought drug education should start early with the basics and be built on gradually as young people got older. Young children (e.g. aged 5-8) should be taught something about the potential dangers of drugs. For example, to prevent young children finding alcohol and drinking it. However, if delivered to young children, messages about illegal drugs need to be thought through very carefully in order to avoid making them anxious. Young people should be made aware of the issues around illegal drugs before the transition from primary to secondary school.

78 According to Ofsted in 2002 only 20% of primary pupils and 45% of secondary schools were consulted by schools about the content of drug education.

External contributors

79 Young people say they enjoy drugs education delivered by external contributors, finding it relevant and engaging. Almost 80% of primary schools use external support in

50 Jones et al (2006) *Universal Drug Prevention*. Liverpool, NCCDP
51 Mentor Youth Involvement Project: Feedback on Drug Strategy Consultation Nov. 2007

teaching about drugs. The involvement of the school nurse (43% of schools) and the police (45% of schools) has increased since 2000. Primary schools are also making effective use of theatre-in-education groups (27% of schools) and 'Life Education Caravans' (11% of schools)[52].

80 Of secondary schools, 66% involve the police in teaching about drugs, although only 13% involve the school nurse. There has been a significant increase in the use of theatre-in-education groups in teaching about drugs: 44%, compared to 20% in 2000.

81 There is some available evidence of the effectiveness of external contributors to class room based drug and alcohol education, but the *quality* of the evidence on the role of external visitors is often poor.

82 Evidence from methodologically sound outcome evaluations demonstrate the following:

- Exclusively police delivered interventions are ineffective in modifying substance use behaviour in the short or long term, but they can impact in the short term on attitudes, knowledge and skills.
- Intense, structured educational packages delivered by peers, nurses, health educators, guest experts and older mentors have all been shown to have long term impact on behaviour, skills, attitudes and knowledge, but the impact on knowledge, attitudes and skills is greater than the impact on behaviour.
- Brief interventions can have a short term impact on behaviour, attitudes, knowledge and skills.[53]

Theatre in Education

83 Evidence shows that theatre can be an effective means for raising awareness of drug use issues, it can be highly effective in engaging the interest of pupils of all ages and it can be an effective trigger for discussion. It is a good activity for prompting interactive, participatory engagement of the sort advocated for effective drug education. There is little longer-term follow up evidence and that which exists, tracks pupils for only 3 months after the intervention. There is some evidence of changes to knowledge, skills and attitudes, but little evidence of behaviour change.

Peer Educators

84 Pupils receiving peer-delivered education believed that they had increased knowledge and they rate the sessions positively, as did their teachers. Young people report feeling able to talk freely in group sessions and approve of the lesson content provided by peers. Further, peer educators can become positive role models and a valuable resource for younger pupils.

52 Drug Education in Schools: Ofsted 2002

53 Literature Review on the Role of External Contributors in School Drug, Alcohol and Tobacco Education. David White, Emily Buckley, Judith Hassan, Centre for Health Psychology, Staffordshire University: 2004

Part Four: Other formal sources of drug education

Summary

There is no statutory requirement for FE colleges to deliver drugs education, but many do undertake it through a variety of routes. There has been no systematic evaluation of the effectiveness of the drugs education delivered in FE settings. Youth Workers and Connexions personal advisers come into contact with young people at risk of drug misuse and those already engaged in drug misuse. Both services offer information to young people to help prepare them for the decisions they may have to make about drugs, and the youth service has undertaken specific drug prevention projects with young people. Again there is no systematic evaluation of the effectiveness of these interventions. FRANK is the Government campaign to inform young people about drugs. There is some evidence of attitudinal change amongst young people as a result of FRANK, but there has been no attempt to evaluate whether this has led to behaviour change.

Colleges

85 FE colleges are autonomous institutions and there is no statutory requirement for them to provide drug education or to have a drug policy. DrugScope's 2003 report[54] cites a number of barriers to the provision of effective drug education including: too few trained staff; a lack of staff confidence in their ability to deliver drugs education; limited curriculum time; need for effective partnership working between police, Connexions and local drug services; and student reluctance to engage in 'school' type drug education.

86 Whilst there is no statutory requirement to deliver drugs education, many colleges undertake it through a range of routes: pastoral care, information through student's union events, freshers' week manuals and through inclusion within the mainstream curriculum. There is a lack of evidence about the effectiveness of drug education delivered in Further Education settings.

87 McCambridge and Strang undertook research into the effects of motivational interviewing on the alcohol, tobacco and illegal drug use of 200 young people aged 16-20 in further education colleges in London in 2004. All were regular cannabis users with one third of these also engaged in stimulant use. Each young person received a one hour motivational interview.

88 In a randomised controlled trial 3 months after the intervention, the group had reduced their use of cigarettes, alcohol and cannabis, mainly through moderation of ongoing drug use rather than cessation. Effect sizes were 0.37 (0.15–0.6), 0.34 (0.09–0.59) and 0.75 (0.45–1.0) for reductions in the use of cigarettes, alcohol and cannabis, respectively.

89 A follow up study one year after the intervention showed that there was little enduring effect from the intervention. The researchers concluded deterioration of effect was the most likely cause.

Youth Work

90 There is very limited evidence of the effectiveness of drug education policies and practices in the Youth Service. Provision of education is diverse and there are a number of different models of intervention. Most Youth Work is directed at drug issues at tier 1 (universal information for all young people to

54 Mapping of FE student service managers and LEAs on drug policies (2003)

Project	Mode of Recruitment	Age of Contacts	Contact Rate	Current Drug Use/Drug Use History
Hyson Green Youth Action Project, Nottingham	Entry to programme	13-18	34 programme entrees	Low level substance use mainly limited to alcohol and cannabis
Higher Risk Intervention project, implements with young people living in care in Liverpool	Entry to programme	14-19	15 programme entrees	33% had used cocaine and amphetamine
Saffron Lane Young People's Project, Leicester	Street-based outreach	13-18	22 per month	Low level substance use mainly limited to alcohol and cannabis
Visions for Youth, Merseyside	Mostly street-based outreach	14-18	8 per month	
Taunton Detached Youth Project, Somerset	Street-based outreach; attendance at project/youth centre; mobile bus	18-25	12 per month	Heroin used by nearly 25% Amphetamine and ecstasy used by over 10% of participants

inform and prepare them for decisions they may have to make about drugs) and tier 2 (where young people may be exhibiting the first signs a problem with drugs or alcohol, and may require more targeted information and support around substance use, that is directly aimed at the young person's behaviour or concerns).

91 Drug Prevention Through Youth Work, 2001[55] report looked at five case study projects to address two key questions: whether and how interventions in direct contact with young people outside schools can have an impact on their knowledge, attitudes and behaviour; and how to attract and retain young people's

55 Drug Prevention Through Youth Work (2001) Jenni Ward and Tim Rhodes

interest in such projects. The five case study projects were:

92 Quantitative data was not available on the extent to which drug use behaviour altered among the young people participating in these projects.

93 DrugScope's 2003 report on drug education in the youth service[56], found that some youth workers believed that some young people were resistant to drug education in youth work settings. Youth workers were also reluctant to place too much emphasis on drugs education and, in particular, schools were identified as a more appropriate setting for drug education, particular for younger children (8-12 years).

94 The policy review of children and young people, a discussion paper from the Treasury and DfES January 2007, looked at in-depth analysis of youth provision from the US, including extended school and youth programme models, found participation to be linked to:

- improvements in attitudes towards school, academic performance, school attendance and discipline;
- avoidance of drug and alcohol use, decreases in delinquency and violent behaviour, awareness of safe sex; and
- increased skills for coping with peer pressure; decreased behavioural problems; improved social and communication skills; and better self-confidence and self-esteem.

Connexions

95 The Connexions Service integrates careers, health and youth services and aims to deliver co-ordinated advice and support to all teenagers. It also prioritises the needs of young people at risk of disaffection, underachievement and of not making a successful transition to adulthood.

96 In the 10 months from April 2007-Jan 2008, Connexions personal advisers recorded 3.8m interventions with young people. Just over 54,000 of these were interventions with young people who had disclosed a substance misuse issue. At this point we do not have evidence to show how many of these were information giving and how many were referred on to further services.

Community based initiatives

97 Community based prevention initiatives have tended to target deprived communities and universal prevention programmes delivered in this setting have not been widely assessed.

FRANK

98 The FRANK campaign (which replaced the National Drugs Helpline) has targeted 11-21 year olds and the parents of 11-18 year olds. It involves national and local advertising (television, radio and press) a website and helpline, local events, support for schools, GPs, the police and other groups. FRANK has four key aims

- To ensure that all young people understand the risks and dangers of drugs and their use and know where to go for advice or help;

56 Drug Education policies and practice in the youth service in England: a report for DrugScope and the National Youth Agency London (2003) DrugScope

- To provide parents with the confidence and knowledge to talk to their children about drugs;
- To support the work of professionals working with vulnerable young people; and
- To ensure those with drug problems get the support they need, and help prevent young people from becoming problematic drug users.

99 Following publication of *Drugs: protecting families and communities*[57] FRANK will be extended to provide access to support and intervention, to support local campaigns and school-based education, and to target key audiences.

100 Evaluation of the most recent FRANK campaign (April 2007) showed that 29% of 11-21 year olds polled could recall FRANK advertisements. There is evidence of FRANK changing the attitudes of young people towards drugs. Of the young people who recall the advertisements 27% said they 'made me realise that drugs are more risky than I had thought'. However, 21% said that 'the ads had made no difference to the way I think about drugs.' There has been no evaluation of whether awareness of FRANK has led to behaviour change.

Other Mass Media Interventions

101 The Cochrane Collaboration reviews of mass media interventions[58] examined six studies and concluded that two were effective in influencing the smoking behaviour of young people. A Norwegian study found that a mass media campaign aimed at girls was more effective in influencing smoking behaviour than no intervention at all.[59]

Annex 1 Definitions and scope

The aims of drug education (taken from Drugs: Guidance for Schools 2004)

102 Drug education is a major component of drug prevention. Drug prevention aims to:

- minimise the number of young people engaging in drug use;
- delay the age of onset of first use;
- reduce the harm caused by drugs; and
- enable those who have concerns about drugs to seek help.

103 The aim of drug education is to provide opportunities for pupils to develop their knowledge, skills, attitudes and understanding about drugs and appreciate the benefits of a healthy lifestyle, relating this to their own and others' actions.

104 Drug education is an important aspect of the curriculum for all schools. It should:

- increase pupils' knowledge and understanding and clarify misconceptions about:
  - the short- and long-term effects and risks of drugs
  - the rules and laws relating to drugs
  - the impact of drugs on individuals, families and communities
  - the prevalence and acceptability of drug use among peers

57 Drugs: protecting families and communities The 2008 drug strategy HM Government, 2008

58 Sowden A J, Arblaster L. 'Mass media interventions for preventing smoking in young people'. *Cochrane Database of Systematic Reviews*, 1998; (4).

59 Sowden A, Stead L. 'Community interventions for preventing smoking in young people'. *Cochrane Database of Systematic Reviews*, 2003; (1).

  - the complex moral, social, emotional and political issues surrounding drugs
- develop pupils' personal and social skills to make informed decisions and keep themselves safe and healthy, including:
  - assessing, avoiding and managing risk
  - communicating effectively
  - resisting pressures
  - finding information, help and advice
  - devising problem-solving and coping strategies
  - developing self-awareness and self-esteem
- enable pupils to explore their own and other peoples' attitudes towards drugs, drug use and drug users, including challenging stereotypes, and exploring media and social influences.

105 All schools need to set realistic aims for their drug education which include the above and which are consistent with the values and ethos of the school and the laws of society, as well as appropriate to the age and maturity of pupils.

What is a drug?

106 The review of alcohol and drugs education has adopted the definition used by the UN Office on Drugs and Crime. This states that a drug is "a substance people take to change the way they feel, think or behave." It is a broad definition which encompasses tobacco, alcohol, volatile substances, medicines and illegal drugs. Such a definition is particularly suitable for use when referring to prevention and treatment work with young people.

What is substance use?

107 This refers to the using of substances which requires an education, advice and information intervention as opposed to one with a treatment focus. It is still possible that harm might result from the use of the substance through intoxication, illegality or health problems, although this may not be immediately apparent.

What is substance misuse?

108 This relates to substance use which harms health or social functioning. It may be physical or psychological dependency or substance use that is just one of a range of problematic or harmful behaviour (HAS 1996). Such substance misuse requires substance misuse treatment.

What's within the scope of this review?

109 Education and information about all drugs – legal and illegal, alcohol and volatile substances – fall within the scope of the Advisory Group's remit. The Advisory Group should consider universal information and education (that is information and education aimed at hole population groups) from all the sources available to young people including: parents; schools; further education colleges; Connexions; the youth service; the wider media; and Government websites such as FRANK.

110 In addition to universal information and education from a range of sources, the review should also consider targeted intervention undertaken by school and colleges.

Annex 2 Summary of Blueprint Delivery Findings

Teacher Training

111 All teachers were required to undertake Blueprint training and were provided with supply cover funding to do so. This comprised a two-day course in autumn 2003, prior to the delivery of the Year 7 lessons, and a similar course in autumn 2004 prior to the Year 8 lessons. Trainer-led review days encouraged teachers to reflect on their experiences after the Blueprint lessons in the spring term of each year.

112 The general approach of the training was to take teachers through each of the 15 lessons in detail, modelling how each activity would be delivered in the classroom. The Teacher training appeared to have been largely implemented as intended. The majority of teachers left the training with higher levels of self-rated confidence and competence to deliver the lessons successfully.

113 Evidence from several different evaluation strands suggests that it is unlikely that materials alone would have been sufficient to prepare teachers, in terms both of confidence and skills acquisition, to teach the Blueprint curriculum as intended.

The Blueprint Curriculum

114 Fifteen Blueprint lessons were developed for delivery in Year 7 (ten lessons) and Year 8 (five lessons). There was a strong emphasis on social-influences, normative education approach which recognised peer and media influences but also sought to develop resistance and assertiveness skills and to address misconceptions about the prevalence of drug use among young people.

115 Teachers' adherence to the Blueprint lesson content (i.e. coverage of specified subject matter and activities) ranged from 65% to 82% across the lessons, with a mean score of 72%. Adherence was higher for Year 7 (74%) than Year 8 lessons (68%), suggesting that teachers became more relaxed about departing from the lesson scripts over time.

116 Timing proved challenging. The main reason for this was that some lessons were too packed with content and teachers found it difficult to cover everything in the scheduled time.

117 There was higher fidelity to modes of delivery involving teacher-pupil interactive learning (e.g. teacher-led whole class discussion) than to those involving pupil-pupil interaction (e.g. pair or group work) or teacher-led inputs and presentations. Teachers were more faithful to approaches involving values clarification, developing decision-making skills and information acquisition, and less faithful to approaches concerned with social influences, risk assessment and resistance skills, although differences in scores were minor.

118 Some teachers did not appear to understand the underpinning messages, particularly in lessons which supported normative education, social influences and harm minimisation approaches, and this in turn appeared to impact on pupils' learning.

119 Pupils generally engaged enthusiastically with the Blueprint lessons and appreciated their lively, informal nature. Ratings of the Blueprint lessons were generally more positive than ratings of equivalent lessons in comparison schools.

120 A number of factors potentially explained why lessons were not always delivered with fidelity, including unrealistic timing for lesson activities, inadequate preparation by teachers or limited confidence with interactivity.

121 A small minority of teachers were anxious that it would be difficult to maintain classroom control during some of the more interactive activities. Some teachers felt that some lesson activities were too difficult for some pupils. Other teachers, however, employed coping strategies such as using mixed-ability groups or allocating learning support staff to groups that were struggling with activities.

122 Just over half of the observed lessons were delivered to at least 75% fidelity to content and methods. The majority of observed teachers were faithful most of the time to Blueprint's intentions when delivering its core elements – those learning activities which were clearly based on research evidence regarding what constitutes effective practice in drug education. The normative education lessons did not always realise their full potential, nor did the activities addressing risk and social influences.

SDA School Support

123 Blueprint provided funding to extend the existing role of School Drug Advisers (SDAs) to support the Blueprint programme. Each of the four Blueprint Local Education Authorities (LEAs) used the funding differently, including spreading it across a multidisciplinary team of both LEA and Primary Care Trust (PCT) workers and using it to support a sole adviser.

124 The amount and nature of support provided by the SDA teams varied considerably. A wide range of factors potentially explained this variation, including difficulties experienced by SDAs in accessing school timetable information and varying perceptions among teachers. Interviews with a sample of teachers suggested they had mostly been aware of the offer of SDA support but that some did not feel they needed it, although it was not possible to establish if this applied across all schools.

125 The overall aim of the SDA support was to increase teachers' confidence and competence to deliver Blueprint. Although teachers' confidence and competence to deliver Blueprint were generally found to have increased throughout the programme, it is impossible to judge the perceived impact of any one element – the training, the experience of delivering the lessons, the SDA support – on this increase. Greater clarity on how SDAs were expected to support Blueprint lessons in practice would have been useful, both for teachers and SDAs themselves.

Parent Component

126 The Blueprint Parent Component comprised a number of elements, including a drug information booklet; magazines containing activities for parents to do with their children to reinforce the learning from Blueprint lessons; the opportunity to attend Blueprint Lesson 10, which involved pupil presentations; and the opportunity to contribute to a review of the drug policy in their child's school.

127 The core of the Parent Component was a series of parenting skills workshops. It was intended that one or more series of workshops would be offered to parents of children receiving Blueprint lessons in all 23 Blueprint schools. The workshops covered bullying, communication, talking about sex, relationships and drugs, stress, problem behaviour, and parents looking after themselves.

128 It was planned for between three and six workshop series to be run in each school. Up to 12 'community consultants', trained local parents, were expected to be involved in

parent recruitment. Out of 3,602 parents invited to attend the launch events, 307 subsequently attended: approximately 6% of all Blueprint parents. The response rate generally worsened as the programme progressed, despite the introduction of telephone calls as well as letters to all parents. Recruitment events specifically tailored to Black and Minority Ethnic parents had limited success in getting them involved. As the launch events were the main channel for recruiting parents to workshops, attendance at workshops was also low.

129 Workshops went ahead in only ten of the 23 schools, and attendance per school ranged from 1% to 14% of invited parents. The workshops appear to have been largely well delivered. However, some parents sometimes seemed awkward and embarrassed, and the small numbers at workshops could limit the depth of discussion and constrain the type of activities which could be used.

130 There was some relationship between parental attendance and a school's level of disadvantage, with lower attendance tending to be associated with greater disadvantage, although this was not always the case. In the Parents' Survey, a majority of parents reported not having heard of the Blueprint parent events, suggesting that the recruitment was insufficiently intensive or that the methods were inappropriate. Possible reasons included parents feeling they did not have time, not seeing the value of the events, and being reluctant to mix with other parents.

131 The potential value of the community consultants was limited by the fact that only one was recruited and trained, rather than 12 as planned. The Blueprint timetable meant there was limited time before the first launch events to harness local agencies' contacts, expertise and credibility in support of the recruitment process. It also meant that most of the launches and workshops took place after the Year 7 lesson delivery period, when parents' interest in Blueprint might have begun to wane.

132 A majority of parents recalled seeing at least one Blueprint parent booklet, and the minority who carried out the activities suggested in the magazine with their child found that they helped facilitate discussion about drugs. Only 3% of parents attended the Lesson 10 presentations.

133 Overall, delivery of the core Parent Component activity, the launches and workshops, departed substantially from original intentions. The aim, therefore, of involving parents in the drug education of their child appears to have been only partially met.

Media Component

134 The Media Component was designed to support and reinforce Blueprint's core work with young people and parents. Its aims were to raise awareness and understanding of Blueprint, "deliver Blueprint's key messages on norms and shared action in drug prevention", and encourage active participation in the programme. An external public relations agency was contracted to generate news coverage of Blueprint, advise on stakeholder communications, and manage media relations throughout the programme.

135 In total, 196 pieces of media coverage of Blueprint were generated. Nine roadshows were staged as part of the media work. These involved portable drugs awareness displays set up in supermarket foyers, staffed by representatives of the media contractor and Home Office Blueprint teams. Around a fifth to a quarter of young people and parents were aware of media coverage of Blueprint.

However, the criteria by which message penetration was measured were somewhat limited.

Health Policy Component

136 In the second year of Blueprint the Home Office provided grants of £50,000 to Trading Standards (TS) services in the four Blueprint local authority areas to increase retailer compliance with legislation governing the underage sale of tobacco, alcohol and solvents. TS services were given relative freedom to devise and develop their own projects, but were asked to address six intervention themes: retailer education and training, youth education, proof-of-age work, test purchasing, prosecutions and publicity.

137 The decision to start the Health Policy Component in the second year of the programme had a number of impacts: reduced timescales in which to plan, deliver and evaluate the projects; less scope to integrate local supply reduction strategies with other programme components; fewer opportunities to build impact and response measures into other programme components; and limited ownership of and involvement in Blueprint by Trading Standards services and project co-ordinators.

138 Despite these constraints, the health policy projects made some significant contributions to the Blueprint programme. The most important were the development of two award winning retailer education resources, both of which made innovative use of interactive communication technologies, and the testing of over 800 premises across the four project areas (up 57% on the previous year).

139 The projects fell short of the ambitious 95% retailer compliance target set for them, but this was partly because other initiatives had a confounding effect of focusing attention on so-called "problem premises". In addition, given the short timescales involved, any impact the projects had on retailer compliance was not likely to materialise until after the formal evaluation period.

Community Component

140 The Community Component of Blueprint was less clearly defined than other components. Despite a stated intention to "co-ordinate the programme delivery with the activity of drug prevention practitioners" and "develop a foundation for the sustainable adoption of the programme within and across the work of these stakeholders", it was initially unclear how this would be achieved, and no ring-fenced funding was provided for a discrete programme of work, nor was a lead contractor appointed.

141 One early Home Office expectation had been that Drug Action Teams/Drug and Alcohol Action Teams (DAT/DAATs) would play a key role in Blueprint, and that Blueprint could be integrated with their activity in a number of ways. However, for various reasons, DAT/DAATs subsequently had only minor involvement while the role of SDAs in supporting the programme became larger than originally anticipated.

142 In addition to school support, SDAs were required to liaise with local agencies about Blueprint; support Blueprint media work, parent activities and drug policy review in schools; and manage the 'Drug Alliance' programme.

143 Implementation of the 'Drug Alliance' varied across the four areas. One LEA managed the process largely as recommended, and found the experience helpful in terms of fostering discussion between agencies and raising quality and ethical concerns. Another LEA

proposed to incorporate some of the Alliance principles and activities into existing school drug education consortia, but not to set up new structures specifically for the Alliance. In a third LEA, plans for adopting the Alliance principles were still evolving at the end of the data collection period, while in the fourth LEA, the Alliance was felt to be beyond the remit of the workers who had taken on the Blueprint SDA role.

144 School drug policy review did not form a major part of the Blueprint work of either SDAs or schools, although the small number of schools which drew on Blueprint materials and experiences in reviewing their drug policy reported finding them helpful. SDAs had limited involvement in Blueprint parent and media work.

Annex 3 Summary Table of Research Findings, Gaps and Priorities[60]

Interventions

Tier 1 services are universal drug education and interventions aimed at all young people, regardless of their level of risk. Any professional group in contact with young people delivers tier 1 services; specialist knowledge about drugs is not necessarily needed.

Intervention	Evidence Grading					Nature of Evidence
	*	**	***	****	*****	
School-based drug prevention (aged 11+)				✓		Effectiveness shown but more effective in those at low risk. Programmes based on life skills1 show most consistent effects
Primary school based drug prevention	✓		✓			Should focus upon family intervention and parent education, and school organisation and behavioural management
Peer Education	✓		✓			Findings are mixed
Family Intervention	✓		✓			Little UK research has been undertaken
Community based drug prevention	✓	✓				Lack of research evaluating universal approaches
Mass Media	✓		✓			Standalone interventions are not effective
Parent Education	✓			✓		Some evidence for effectiveness based on related factors

* Warrants further research; ** based on practitioner experience (i.e. good practice); ***medium quality finding; **** medium to good quality finding; ***** consistent, good quality finding.

60 Table reproduced from Annual Review of Drug Prevention The National Collaborating Centre for Drug Prevention H Sumnall et al: 2006

61 Botvin life skills evaluation

You can download this publication or order copies online at
www.teachernet.gov.uk/publications

Search using ref: DCSF-XXXXX-2008

Copies of this publication can be obtained from:

DCSF Publications
PO Box 5050
Sherwood Park
Annesley
Nottingham NG15 0DJ
Tel: 0845 60 222 60
Fax: 0845 60 333 60
Textphone: 0845 60 555 60

Please quote the ref: XXXXX-2008XXX-XX

ISBN: XXX-X-XXXXX-XXX-X

PPXXX/D16(7926)/1008/XX

© Crown copyright 2008

Extracts from this document may be reproduced for non-commercial research, education or training purposes on the condition that the source is acknowledged. For any other use please contact ***hmsolicensing@opsi.gsi.x.gov.uk***