DRUG & ALCOHOL FINDINGS *Hot topic*

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GO Drug education yet to match great (preventive) expectations

School-based drug education was and for many remains the great hope for preventing unhealthy or illegal substance use and the dominant form of universal prevention applied to all regardless of their risk for developing substance use problems. Across almost an entire age group, it offers a way to divert the development of these forms of substance use before they or their precursors have taken root.

Though the promise is clear, the fulfilment is less so. When results on drinking from studies up to mid-2010 were subjected to the standard assessments of a Cochrane review, of 39 which had evaluated curricula covering substance use generally, 24 were found to have had no statistically significant impacts on drinking, and in another three impacts were confined to certain subgroups of pupils. Other studies had tested alcohol-specific programmes, but the reviewers found their results less convincing.

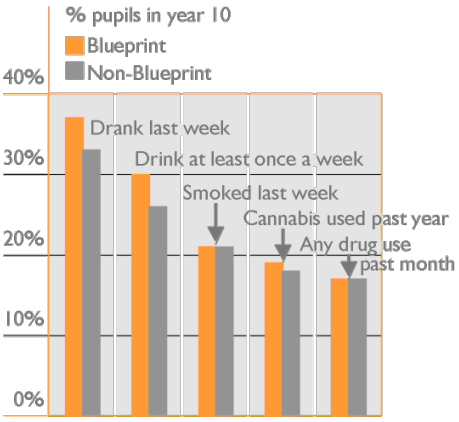
A companion review had focused on impacts of similar programmes on use of illegal drugs. The results favoured programmes which aimed both to develop pupils' generic self-management, personal and social skills, and to equip them to better resist pressures to use drugs by correcting misperceptions about how common use is, increasing awareness of media, peer and family influences, and teaching and practising refusal skills. These programmes "showed, on average, small but consistent protective effects in preventing drug use, even if some outcomes did not show statistical significance."

How thin the evidence was can be appreciated by focusing on use of the drugs of greatest concern including heroin, cocaine and psychedelics, gathered together in the review under the term "hard drugs". Of the 51 studies it analysed, it seems just two found universal school-based drug education programmes had significantly retarded use of these substances, and these were variations on the same US curriculum (1 2). In both cases it was growth in the average frequency of use which was retarded, and in both cases it was unclear whether this was due to the programme itself, or to the selection of keen or specialist educators to do the teaching while comparison lessons were delivered by the usual run of teachers. One of the studies – the largest and most recent of the two – also assessed what proportion of pupils had ever tried these substances by the one-year follow-up. Among programme schools the risk of this happening versus not happening was 20% higher – substantially in the wrong direction, but with small numbers, not statistically significant.

English and European trials disappoint

Most disappointing for Europe and for the UK were results from the English Blueprint trial and from the seven-nation European trial of the Unplugged programme.

The multi-million pound trial of the Blueprint programme implemented in 23 schools in England in 2004 and 2005 was the largest such study in the UK. Its programme featured advanced interactive teaching methods reinforced by parental and community-wide components, the impacts of which its government funders expected to "trigger a fundamental assessment of the place of drug education" in UK drug policy. If it did, it would be to confirm that drug education in secondary schools makes only a minor contribution to the prevention of problems related to drinking and illegal drug use, though the evidence in respect of smoking is stronger. By the end of the follow-up period, on none of the most relevant measures was there any sign that Blueprint had retarded growth in substance use any more effectively than usual lessons in the non-Blueprint schools ▸ chart. If these are the results when schools are aided by a research team offering training and support beyond that normally available, the preventive impact of such programmes in normal practice is very unlikely to be substantial, and very likely to be no greater than usual teaching.



By the end of the follow-up period, on none of the most relevant measures had the English Blueprint programme further retarded growth in substance use

Unplugged was the largest European drug education trial ever conducted and tested a sophisticated US-style social influence programme. Cochrane's reviewers pronounced it among the few to have promise as a model for reducing drink-related problems. At a follow-up 15 months after the lessons ended, its best results were registered in respect of having been drunk (14% in Unplugged schools v. 18% in comparison schools) or drunk three or more times (4% v. 6%). The remaining five of the seven measures of substance use were also on average lower among Unplugged pupils, but these differences did not meet usual criteria for statistical significance. The generalisability of the results to all schools and all pupils, the feasibility of the programme, and the validity of the findings themselves, were seriously undermined by the loss of both schools and pupils to the study. This meant its findings could only be considered applicable to the roughly half of schools prepared to take on the burden of the research and interventions, and to the minority of the entire pupil population taught in such schools and who completed the researchers' surveys. Among schools which did take on the intervention, the parental and peer-leader supplements did not prove feasible and implementation of the core curriculum itself was, the researchers said, "just moderate". Unplugged probably did have some of the intended effects, but the results were patchy, modest and usually statistically insignificant.

Inherent contradictions

Inherent contradictions

What might lie behind such disappointments can be divided into at least two possibly interrelated domains: contradictions in principle, shortfalls in practice. Among the first is the contradiction between the objectives of education and those of prevention: the former seeks to empower children to think for themselves and open up new horizons, the latter to channel thoughts, attitudes and actions in ways intended by programme developers and teachers. Then there are potential contradictions *within* prevention programmes themselves. Some aim to *limit* young people's autonomy in their choice of friends and substances by *extending* autonomy in decision-making, to *encourage* conformity to non-drug use values by *discouraging* conformity to other young people, or to develop team work and *social solidarity* without accepting that youngsters may express this by *sharing* substance use with their peers.

> *Education seeks to empower children to think for themselves, prevention to channel them in pre-ordained ways*

Commenting on the generally poor preventive impact in particular of school-based prevention programmes, an internationally recognised authority reminds us that for young people, smoking, drinking and drug use are among the symbols distinguishing their identities and their sub-societies from those of adults – a "performance" in front of other young people to mark their belonging to the group and to distinguish them from 'outsiders', yet at the same time markers of their passage to adulthood. Stressing that they are too young for these adventures risks bolstering their attraction as markers of being 'grown up'. School programmes founder because "Drinking, smoking, and drug use are part of worlds of youthful sociability. These worlds mostly operate away from the adult worlds of the home and the school, and in fact are often resistant to adult efforts to intervene in their operation. The fact that school-based drug education is school based is one of its difficulties: it is an attempt by the adult world to impact on the worlds and subcultures conducted by young people themselves."

Perhaps hampered by such contradictions, the main practical shortfall is that impacts on substance use are usually at best minor and short-lived. At first the newer normative education approaches appeared to offer hope, curbing use by showing pupils that their friends and peers were less likely to have tried drugs than many believed – that *not* using was 'normal'. Blueprint and the EU-Dap trial were among those which tarnished this promise, partly because youngsters who drink, smoke or use drugs probably have friends doing much the same. However, the tactic still has some research support.

In a wider context it may be unrealistic to expect any preventive impacts of school-based drug education to surface above the much more profound effects of the child's parenting, their position and integration in society, and the nature of that society. In a US follow-up study of over 12,000 adolescents, connectedness with adults and school were consistently associated with positive health choices, including reduced levels of alcohol and drug use. It's not that the school is unimportant, but that what is important is not specific lessons, rather the fostering of supportive, engaging and inclusive school cultures which offer opportunities to participate in school decision-making and extracurricular activities. These are associated with better outcomes across many domains, including non-normative substance use. As well as facilitating bonding with the school, such schools are likely to make it easier for pupils to seek and receive the support they need. In these ways schools seem to build up protective factors and diminish risk factors in their pupils in ways in which specific drug education teaching may be able to contribute to, but only as a minor element.

Aim at harm, not use?

Rather than education inevitably having little preventive impact, perhaps we are measuring and seeking to prevent the wrong things. One possibility is to switch the objective to harm reduction rather than preventing or delaying substance use as such (1 2), particularly for alcohol in countries where its use is accepted and widespread, even among teenagers.

Most recent UK finding comes from Northern Ireland, where the Australian 'SHAHRP' alcohol harm reduction curriculum has been adapted for local secondary schools. An evaluation found it curbed the growth in alcohol-related problems during the teenage years and also meant pupils drank less. Effects were most apparent when the lessons had been taught by voluntary-sector drug and alcohol educators rather than the schools' own teachers, and among the just under half of the pupils who before the lessons started at age 13–14 had already drunk 'unsupervised' without adults being present.

Findings in Northern Ireland paralleled those from the original programme in Australia, where harm-reduction effects were greatest among the higher risk pupils who had already drunk without adult supervision; at each follow-up point they experienced about 20% fewer harms than control pupils. A derivative of SHAHRP has also more recently been evaluated in Australia, where compared to pupils in control schools it retarded age-related increases in the amount drank and resultant harms. As in Northern Ireland and in the previous Australian study, the lessons were most effective among children who started the trial most engaged with drinking – in this case, not defined as unsupervised drinkers, but the roughly a fifth of pupils who at the start of the trial usually drank heavily when they drank. Though this was not the case in a smaller Australian pilot study, still the pattern of results is indicative of the potential for harm reduction lessons to reduce risk where such reduction is most needed – among higher risk teenagers who may see the lessons as more relevant, and who may already have experienced the harms the lessons aim to help them avoid.

This *is* education

Another possibility is to treat drug education *as* education, divorcing it from prevention objectives. According to an international authority on alcohol prevention, "curricula might well be based on general educational principles, rather than framed by ideology. Students are citizens and potential future consumers, and with respect to these roles, it is appropriate to provide them with biological and social science information about psychoactive substance use and problems, and to encourage discussion of the intellectual, practical, and ethical issues these problems raise." In this vision, in drug education as in other topics, schools are seen as 'teaching about' agencies rather than the 'teaching to' (or not to) implied in a preventive role.

Rejecting pre-set prevention objectives, in very similar terms one of Britain's most experienced and influential drug educators has called for drug education to come in to line with education on other sensitive issues such as politics, religion, and abortion: "identifying objectivity, ensuring factual accuracy, inviting balance, neutral 'chairing' of discussions, etc ... Young people know when they are being trusted to think for themselves, and when they are not. The older they get, the more they reject education which assumes that only manipulation and control can prevent their making the wrong decisions, and which presents them with ready-made rights and wrongs, as if we had failed them so dramatically that they cannot work these out for themselves."

Other ways to prevent

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As the UK's National Institute for Health and Care Excellence has recommended in respect of drinking, reducing related problems relies mainly on policy initiatives which tighten alcohol availability in ways which affect the entire population whether they choose it or not, rather than attempting via education or other means to change individual choices about drinking. However, this is not an either/or choice; curtailing availability may be dominant in effectiveness, but does not preclude attempts to inform and/or influence individual choices, especially if policymakers exercise *their* choice not to dramatically tighten availability through measures like setting a high minimum price.

If the prevention role of secondary school education is downplayed, we may instead see that role moving down the age range and being incorporated in general early-years character development, for which promising results have been found. Interest has centred on the Good Behaviour Game, a classroom management technique implemented in the first years of primary schooling. Well and consistently implemented, by age 19–21 it has been estimated that this would have cut rates of alcohol use disorders from 20% to 13% and halved drug use disorders among boys. In the Effectiveness Bank you can read our analysis of the study and of a practitioner-friendly account of their work from the researchers.

Another approach is to engage the parents, something it has generally proven difficult to do in Britain. In Sweden this difficulty was partly overcome by capitalising on the fact that schools start each term with a parent information meeting. Across the final three years of compulsory schooling, the Örebro Prevention Programme used these meetings to advise parents to maintain a zero-tolerance stance towards youth drinking and to communicate clear rules to their children, reinforced by inviting parents to sign agreements about their positions on (among other issues) youth drinking. Pupil surveys revealed a substantial retardant effect on how often pupils had been drunk, an effect no less apparent among high-risk pupils who said they had already been drunk before the programme started.

However, a later Swedish trial conducted by researchers not involved in the programme's development failed to replicate these initial findings, a not uncommon pattern when prevention programmes emerge into more routine implementation after successful trailblazing projects often led by the programmes' developers.

Accepting the initial results as an indication of the programme's potential, the question remains whether it would have the same potential in drinking cultures like that of the UK. A trial in the Netherlands of a Dutch version may be a better pointer to how it would perform in Britain. If so, it suggests that it would be an effective *addition* to alcohol use prevention lessons, but not the standalone success it was at first in Sweden.

UK policy and practice

Despite repeated calls, the natural home for substance use education – personal, social and health education – remains outside the national curriculum, leaving no set mandate on schools (or model for schools not required to implement the curriculum) to tackle substance use, other than teaching in the first years of secondary school focused on the effects of recreational drugs.

Another deep hole in support for drug education was left when in 1993 central funding for local authority health/drug education coordinators was withdrawn, depriving local areas of advice and support, and depriving Britain of a corps of practical experts who had been developing their joint understandings of how to do drug education since 1986. The network of coordinators in 135 posts was rapidly denuded, the experts scattered, and no alternative 'university' of practice emerged to take the place of coordinators' network. The fear soon seemed to be realised that without their support for drug education, it would be marginalised as schools focused on mainstream subjects. Nevertheless, many individuals from among their ranks remained influential, a sign of the professional development fostered by the initiative.

For the UK today the most important guidance on alcohol education was issued in 2007 by the National Institute for Health and Care Excellence (NICE). It said education "should aim to encourage children not to drink, delay the age at which young people start drinking and reduce the harm it can cause among those who do drink". Recommendations included ensuring alcohol education is an integral part of science and personal, social and health education (PSHE) curricula. The committee stressed that education should be adapted to its cultural context, noting that in the UK "alcohol use is considered normal for a large proportion of the population [and] a 'harm reduction' approach is favoured for young people".

Those views were reinforced in a set of standards on preventing harmful drinking issued by NICE in 2015, which stressed that "Learning and teaching about alcohol should be contextualised as part of promoting positive messages and values about keeping healthy and safe ... information-giving is not as effective in engaging children and young people in the topic and in affecting attitudes, values and behaviour."

Inspections in 2012 of PSHE lessons suggest English schools were far from adequately implementing NICE's recommendations. Only in just under half the inspected schools had pupils learnt how to keep themselves safe in a variety of situations, and the deficits were particularly noticeable in respect of drinking. Inspectors found that although pupils understood the dangers to health of tobacco and illegal drugs, they were far less aware of the physical and social damage associated with risky drinking. The report attributed these deficiencies in part to inadequacies in subject-specific training and support for PSHE teachers, particularly in teaching sensitive and controversial topics.

In respect of alcohol, harm reductionists among educators would have the backing of the National Institute for Health and Care Excellence. But even if for illegal drugs too, harm reduction is a more realistic goal than use prevention, adopting it would see schools swimming against the tide of national policies in the UK which have de-emphasised harm reduction as an overarching principle.

Thanks for their comments on this entry to Blaine Stothard, independent consultant in health education based in London, England, Andrew Brown, Alcohol Programme Implementation Manager at Public Health England, and David Uffindall, formerly Coordinating Tutor for Health Education at the North Yorksshire Education Authority in England. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Last revised 09 May 2016. First uploaded 01 September 2010

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