Mentor

Protecting children from alcohol and drugs

Alcohol and drug education in Brighton and Hove

Mentor UK

February 2016

PSHE Education

Brighton & Hove City Council

Brighton & Hove City Council

1 INTRODUCTION

1.1
Alcohol and drug education (including tobacco) is currently delivered within the non-statutory framework of personal, social, health and economic education (PSHE) in English schools. Some elements of alcohol and drug education are delivered as part of the national curriculum through science, although relying on the science curriculum alone to deliver elements of health education is considered 'not yet good enough' (Ofsted, 2013).

1.2
Mentor UK is currently commissioned to deliver the Alcohol and Drug Education Prevention and Information Service (ADEPIS) for schools in England, and has a prominent role in supporting the delivery of alcohol and drug education nationally. Mentor UK have been commissioned to evaluate the provision of alcohol and drug education within the Brighton and Hove area, encompassing both the resources offered to schools through the local authority, as well as how schools are supported to deliver an evidence based curriculum.

1.3
We would like to express thanks to all of those who took part in this project and review, in particular the children and young people of Brighton and Hove who took part in the pupil focus groups and offered their views so willingly and insightfully throughout. The support of the staff at the school involved and at Brighton and Hove City Council is also acknowledged as key to the success of the project.

1.4
Further information on Mentor UK can be found on the website, including the work of ADEPIS. Alternatively, you can get in touch directly via adepis@mentoruk.org

2 THE LOCAL PICTURE

2.1
The education landscape in Brighton and Hove consists of 48 primary stage schools, 10 secondary schools and 6 SEND provision schools. There is also a pupil referral unit.

2.2
In response to local needs, the recent Joint Strategic Needs Assessment (2013) identifies alcohol tobacco and substance misuse as high impact social issues. It also identifies the 'strong curriculum programme for drugs and alcohol' as a particular strength of the local approach to reducing harm caused to young people. Building on this is identified as a recommended future priority through 'support(ing) primary, secondary and special schools to deliver a quality programme of drug and alcohol education...' Recommendations from this report should therefore be viewed as underpinning these identified strategic local priorities.

2.3
The Safe and Well at School Survey (SAWSS) is run annually across Brighton and Hove, and provides key data for use by schools, strategic planners and service providers. The survey has a large sample which adds to its validity, and also gives important data on trends over time. Reports are currently produced for KS2, KS3 and KS4, all with interpretations of key annual and trend data.

2.4
In addition to the universal provision of alcohol and drug education provided in schools across the area, specialist support is available for young people via the commissioned ru-ok? service which schools are able to refer pupils to. Advice and support is available through school based drop-ins staffed by the school nursing service and youth service. This is also a signposting service for referrals to ru-ok? as well as smoking cessation services. The youth service also offers targeted group work provision through the 'Reflect' programme which schools can request for identified pupils. The provision of these services should be seen as part of the wider whole school approach to supporting the health and wellbeing of pupils.

3 A SUMMARY OF RECOGNISED BEST PRACTICE

3.1
PSHE delivery has been subject to a great degree of scrutiny in recent years, including reports by Ofsted (2013), the Commons Education Select Committee (2015) and Stonewall (2014). More recently, support for statutory PSHE has been declared by four influential, cross-party Commons Select Committees, highlighting the increased appreciation of the subject in the development of life skills in children and young people.
Supporting and enabling schools to adopt evidence based practice has been a key theme throughout this process of development, championed by organisations including the PSHE Association, Mentor UK, the Sex Education Forum and Brook amongst others.
Common themes promoted across these reports and identified best practice include:

- Dedicated curriculum time for PSHE delivery
- Increased CPD and support for teachers delivering PSHE
- Adoption of a 'whole school approach' to promoting positive child health and wellbeing
- Curriculum content informed by what is relevant to pupils needs in each school
- Engagement of the whole school community including parents, governors and support staff

3.2
Specific best practice around alcohol and drug education has been identified and promoted by Mentor UK through a range of briefings, events, and the production of a set of quality standards (2014) by the ADEPIS service. This is against the backdrop of no update to DfE guidance on alcohol and drug education since 2004. Additionally it is worth noting that the UNODC International standards on Drug Use Prevention, the inclusion of random drug testing in schools has been recognised as having no or negative preventative outcomes (this would include use of dogs). This view is supported by current DfE and Association of Chief Police Officers (ACPO) guidance on responding to drug related incidents in schools. This current review of provision in Brighton and Hove is informed and underpinned by this evidence based practice.

Recent anecdotal evidence from local schools has indicated an increase in the numbers of young people involved in supplying substances both on and off school sites. Engagement in supply activities can often be a consequence of wider vulnerabilities and risk factors in a young person's life. This requires further investigation to establish a strong evidence base, and a wider multi agency response encompassing safeguarding, education, and services preventing the exploitation of children and young people.

4 ACTIVITIES

4.1
The review encompassed a range of data collection methods to inform recommendations. Using a variety of collection methods helps validate the outcomes and recommendations provided. These methods included

- Desk based review of resources produced by Brighton and Hove Education and Standards Team
- Review of the Safe and Well at School Survey (SAWSS) questions and report
- Surveys of PSHE co-ordinators, teachers, and parents
- In-depth meetings with PSHE co-ordinators
- Pupil focus groups
- Learning walks in schools
- Discussions with wider school support services

5 REVIEW OF CURRENT RESOURCES

5.1
Brighton and Hove City Council currently provide schools with a range of support materials to help with their alcohol and drug education and wider PSHE delivery. This includes guidance on policy development, curriculum planning, parental engagement and a survey to assess pupil views on their health and wellbeing. When taken together, these resources underpin the development of a whole school approach to improving health and wellbeing in schools, thus supporting best practice.

5.2: Drug, Alcohol and Tobacco Education Curriculum Framework

- Year 7 - The current learning outcomes develop age appropriate skills and knowledge. Where possible, the skill development should be highlighted as key to supporting learning in Y8-11 to protect against schools concentrating on 'the facts'. A new resource on caffeinated and energy drinks can be found here, as well as the ADEPIS briefing here.
- Year 8 - The wording of the current learning outcomes shows clear progression from Yr7. The knowledge based outcomes also show how any knowledge acquisition needs to be placed in the context of application into practice, which is great to see. There are also clear indications that schools should be challenging negative social norms through their alcohol and drug education curriculum, following ADEPIS recommendations. Furthermore, supporting pupils to be more media literate and critical supports later learning around wider risk taking behaviours.
- Year 9 - A spiral approach is again evident here, with content moving from alcohol and cannabis to include novel psychoactive substances (NPS). Again, this should be reinforced by local data, as well as highlighting that skills learnt in relation to assessing and managing risk are applicable to all substances. Schools are also encouraged to make more specific links with other risk taking behaviours here which is positive to see. An additional resource to add is the recent Home Office NPS toolkit. While it is titled for informal educators, it has considerations for more formal settings too.
- Year 10 - The outcomes at KS4 are now making stronger links for pupils with other aspects of risk taking behaviours, notably with sexual health. This is entirely appropriate, follows current best practice, and supports pupils in making links to higher risk situations they may find themselves in. Further examples of developing a spiral curriculum can be seen in coverage of polydrug use, and in developing skills to support themselves and others.
- Year 11 - As above, although care needs to be taken in how harm reduction messages are delivered in universal settings - particularly for teachers who may use the framework without looking in detail at further guidance. While these messages are entirely appropriate when delivered in a sensitive and well planned way, when delivered in a rushed way or by untrained or unsupported staff, these messages can unintentionally normalise substance use.

This could potentially be the harm reduction resource linked to via Pier2Peer. On its own it contains very useful information for those who are already using, but not necessarily for use in a universal setting.

While the framework gives an excellent starting point for new PSHE leads to plan a programme of study around, it should also be noted that some schools may already have a planned programme of study for alcohol and drug education. In these cases, it would be expected that the framework document be used to underpin current provision rather than mirroring it. Further discussion of this was made possible during the school visits and discussion with local PSHE leads which is covered later in the report.

5.3: Drug Related Incident Guidance

The current incident guidance does follow best practice recognised by DfE, ACPO, PSHE Association and Mentor-ADEPIS. Dealing with drug related incidents (DRIs) is a complex process and one which schools can find daunting, sometimes resulting in knee jerk responses which may not best support the wellbeing of pupils involved. The policy guidance used by Brighton and Hove helps break down the responses into more manageable steps, and section 2 sets this out very well. Putting support for children and young people central to this helps keep focus on this key element.

Section 3 sets out the tiered level of support available locally to pupils and their families around substance misuse issues. As well as helping school staff identify what level of support may be suitable for an identified pupil, this can also help reinforce the school's role in providing quality drug education as part of a multi agency response. The strength of this framework is key in building on any universal provision which is offered through PSHE in schools.
The practice of searching pupils on school premises is something which has seen changes to DfE guidance in recent years, so it is appropriate for this to be covered within a substance misuse context. It is perhaps worth noting that the most recent DfE guidance was written before the Psychoactive Substances Bill being brought to parliament, meaning some novel psychoactive substances (NPS) may not immediately fall into one of the categories listed. Therefore, it may be useful to specifically refer to NPS alongside 'illegal drugs' or 'something likely to cause injury'.

Using the ACPO guidance to support advice around the use of drug dogs and testing helps increase its validity. This section rightly highlights the ethical implications of these approaches. It may also be advisable to consider highlighting the prevalence, or indeed lack, of these approaches locally to reinforce the fact that schools are highly unlikely to pursue them.
Guidance relating to the discipline of pupils involved in DRIs also follows best practice by distinguishing between pupils being in possession for personal use or for supplying ('dealing'). It is also appropriate to distinguish between those sharing with friends and those dealing for profit, so it is great to see that included here. In practice, schools may not distinguish between these two categories when deciding on a disciplinary response, but highlighting it here can help overcome this barrier.

5.4: CPD - training and PSHE consortium

All PSHE leads interviewed expressed strong support for the role of the current PSHE Consortium. These regular meetings provide a supportive environment where staff from different schools can share practice, ideas and receive peer support. Additionally, it represents a route for trends and information on local intelligence to be shared between schools and public health colleagues.

Alongside the Joint Practice Development Days and wider PSHE CPD, the consortium represents a good forum for developing CPD in PSHE leads. It should be noted however, that time needs to be dedicated to disseminating these practices to relevant teachers in each school.

5.5: SAWSS questions review

A review of the content of the questions of the SAWSS was conducted to evaluate the effectiveness of this tool. As part of the review, some recommendations were made in order to allow the opportunity to include normative messages within the survey. Further discussion of how schools and PSHE leads are using this data is provided later in this report.

6 SCHOOL VISITS

6.1
Visits were carried out over a six week period between October and November 2015. Seven secondary schools took part in this element of the evaluation, to varying degrees depending on availability. Recruitment of schools was initially undertaken through the local Standards and Achievement, and Public Health teams with expressions of interest sought from secondary schools across the area. This was followed up by a member of Mentor staff attending one of the well established PSHE Consortium meetings, in order to give schools more information on the proposed approach to be taken, as well as having some input on what would work well for them in creating the least disruption possible. It was agreed that visits would include focus groups with pupils, meeting with the PSHE lead and other staff, and organisation of a learning walk where possible. Success in engaging school visits had a strong correlation with those who attended the initial consortium meeting. It should therefore be noted that this could have resulted in a positive bias towards schools and PSHE leads displaying good practice. However, attendance at the consortia does not reflect a whole school approach to health and wellbeing in these schools.

6.2
Without exception, those schools who took part exhibited strong commitment to the project and any potential recommendations arising from it. Furthermore, the pupils who engaged in the focus groups were a credit to their schools, and their honesty and willingness to share their thoughts were much appreciated.

7 PUPIL FOCUS GROUPS

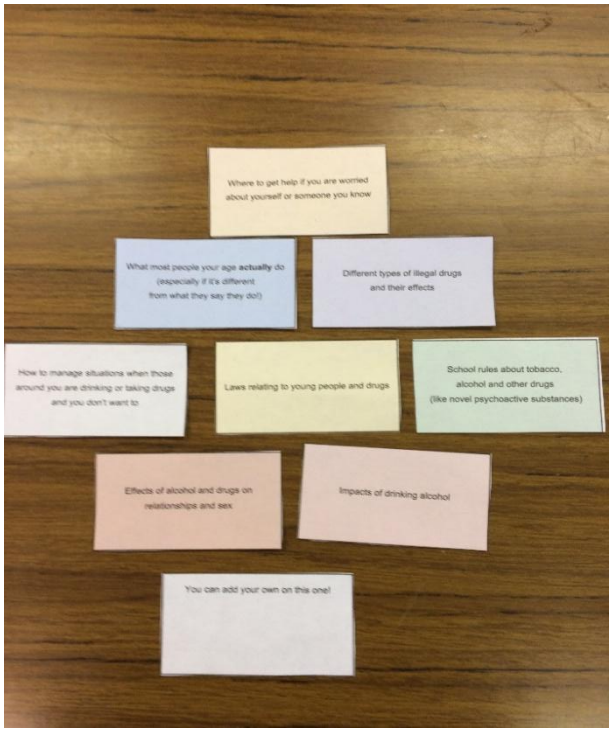
7.1
Pupil focus groups were organised in 5 schools. At the initial PSHE Consortium meeting, it was agreed that groups would run more effectively if split between KS3 and KS4. This would help ensure younger pupils could be encouraged to share their views without feeling intimidated by older members of each group. For similar reasons, schools were encouraged to find 8-10 pupils for each group to maximise the input of those present.

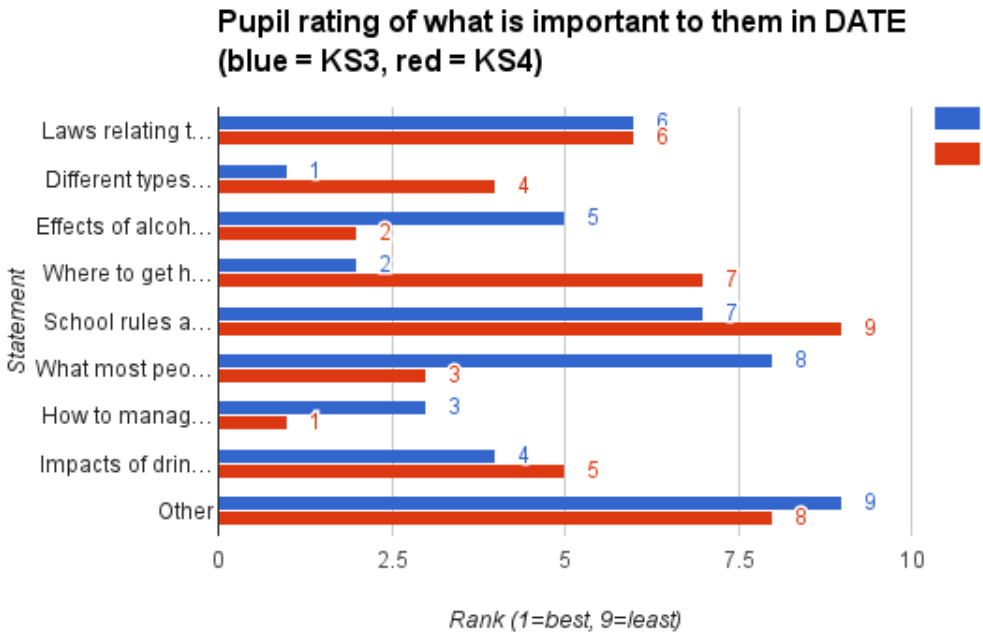
7.2
Each group was asked a selection of open questions relating to both the content and wider policy implications of the provision they currently receive. A brief discussion was held on each question with the facilitator recording some responses, and pupils writing their own response on a post-it note. Finally, they were asked to work in small groups to complete a 'diamond 9' activity on what they consider the most important topics to them. This activity was based on statements from Mentor UK's toolkit for reviewing drug and alcohol policies in schools (2012). Some additional statements were added based on SAWSS data and local knowledge.

7.3
The organisation of these groups by school staff, as well as the participation of pupils in the groups, was excellent across all schools. Pupils gave honest, thoughtful views, giving some interesting insights not only into their alcohol and drug education, but also how this compares to other PSHE topics and the wider school curriculum. For safeguarding reasons teachers were present for the groups, but this did not seem to restrict pupils highlighting areas of weakness in the provision they received. The potential impact of this was further minimised through the facilitator highlighting the fact that feedback was being used to improve their provision, as well as the opportunity to write their own comments separately and confidentially.

7.4
Collated results from the diamond 9 activity are shown in the chart below, along with some key feedback from the open question element of each focus group. The limited sample size comprising the focus groups means care should be taken in applying these views to the population as a whole, however pupils were often chosen randomly to represent the year groups of their schools to minimise selection bias. The results from KS3 pupils show they consider knowledge around alcohol and drugs to be important.
The results from KS4 pupils show an appreciation of the need to develop skills to support them in real life situations. Coupled with the data from SAWSS and the What About YOUth survey, this tallies with an increased exposure to alcohol and drug related situations in their lives at this time. KS4 pupils therefore expressed a need for increased opportunity to practice skills in negotiating safe ways out of difficult situations, in managing potential impact on friendships and relationships, and in understanding what is 'normal' behaviour amongst their peers. This is

supportive of the 'social norms' approach promoted by the Standards and Achievement Team in order to address misperceptions among young people of what is 'normal' behaviour for their peers.





7.5

Pupils also offered invaluable insight through a series of open questions and discussions. Key themes emerged across all schools which included:

- A strong appreciation of the importance of effective alcohol and drug education for them and their peers
- A desire for increased profile of the importance of alcohol and drug education and wider PSHE - pupils consistently reported how they enjoyed the freedom to express ideas and explore key issues as a group. They felt this wasn't offered elsewhere in the school curriculum. They also felt delivery needed to be maximised within the curriculum rather than offered in tutor time or as drop days
- Knowledge of teachers was key to the success of the sessions, with pupils often being able to pick up when a teacher had a lack of knowledge or confidence. This could be read alongside the fact that non-specialist PSHE teachers may be delivering these sessions and raises the importance of CPD for these staff
- Pupils across both key stages liked a mix of delivery methods, with some expressing frustration at too much reading from screens and power points. Videos were appreciated as a way of initiating discussion and to start linking their learning to real life situations
- Pupils across both key stages said they liked the use of external speakers used for relationship and sex education delivery, and therefore would like to see the same for their drug and alcohol sessions. However, other pupils also explained how the lack of external speakers gave more time for open discussion and debate which was rated of high importance to them
- Overall enjoyment and high satisfaction of the drug and alcohol lessons. Pupils within schools offering tutor time delivery expressed more of the frustrations highlighted above than counterparts in schools with timetabled delivery

8 'EFFECTIVENESS' OF CURRENT PROVISIONS AND REFLECTIONS ON CURRENT SUPPORT

8.1
Assessing the impact, or 'effectiveness' of alcohol and drug education can become problematic as we either look at this through an educational or behavioural perspective. This is reflective of the unique position alcohol and drug education and wider PSHE finds itself in, straddling both the education and health policy spheres with their corresponding methods for measuring 'effectiveness'. Evidence on a positive correlation between improved health and wellbeing and academic performance is strengthening, with Public Health England producing a recent briefing for schools on this (2014). For the purposes of this activity, 'effectiveness' was measured through assessment and evaluation of the current curricula being delivered in schools, alongside reported changes in behaviour as recorded by the SAWSS. Responses recorded through the pupil focus groups were also taken into account in this process. As with many public health interventions, it should be noted that school will represent one of a myriad of influences on behaviour change in young people - albeit a very significant one.

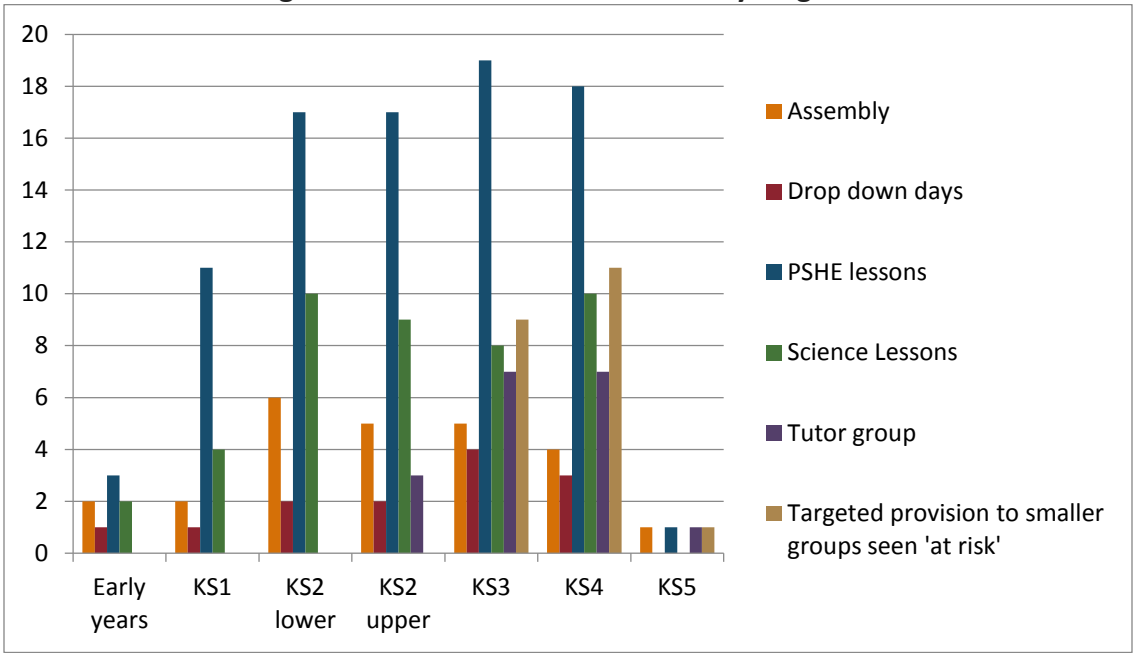
8.2 Mode of delivery:

8.2.1: As expected, there are currently variations in how alcohol and drug education is delivered in schools across the city. In all schools, however, this was placed within a wider PSHE curriculum which gave opportunities for cross curricular links to be made. No schools who took part were observed to be delivering their entire programme through a 'drop-down day' approach, which would have been considered least effective. Two schools were delivering via the school's tutor time system. While this ensures all pupils receive alcohol and drug education, limitations include less control over what is delivered by each tutor and an increase in planning and administration by the PSHE lead. In these schools it was commented how this approach was necessitated by a removal of timetabled PSHE sessions, so was seen as a way to protect delivery against wider curriculum pressures.

8.2.2: Six schools were observed to be delivering their alcohol and drug education via dedicated curriculum time. This reflects recognised best practice identified by Ofsted (2013), PSHE Association (2015) and Mentor-ADEPIS (2014), amongst others. Benefits of this approach were observed to be greater profile of the subject across the school, including SLT, teachers and pupils. This approach was supported by a dedicated core team of PSHE teachers alongside the PSHE lead, which helped with consistency of delivery and the ability to meet individual CPD needs. In support of this, results from the teacher survey showed that 95.1% (n=39) of schools currently provide drug education as part of teaching, one school delivers it in some subjects and in ad hoc events, whilst one school claimed to be looking at developing this further (and currently does not provide it as part of the teaching). In the majority of cases, alcohol and drug

education delivery starts from Upper Key Stage 2 onwards, with only 9 schools delivering some levels of drug education from Key Stage 1.
It is very reassuring to see that, in general, drug education seems to be integrated into, and delivered through timetabled curricula, either through the PSHE education curriculum, or the science curriculum. A further point to note is the difficulty raised when planning for a spiral curriculum of alcohol and drug education over the transition from KS2 to KS3, particularly where pupils enter KS3 via a range of feeder primary schools, all of whom may be delivering their alcohol and drug education differently.

How alcohol and drug education is delivered in each key stage



Only five establishments were delivering alcohol and drug education through drop down or collapsed timetable days, respectively in the early years, upper KS2 and KS3, however these seem to be complementary to delivery through PSHE or science curricula. The same is valid for those schools delivering drug education through assemblies. All respondents indicating delivery through assemblies also indicated delivery either through PSHE or science lessons, or in most cases through both. This seems to show that schools who took part in the survey generally reflect best practice for effective drug education delivery, which advises that education establishments avoid delivering drug education through standalone sessions.

On the other hand, the sample seems to be showing a certain weakness with regards to targeted support and education for children and young people ‘at risk’. Only 11 out of 41 respondents indicated that the school offers targeted provision to ‘at risk’ or most vulnerable students (respectively at Key Stage 3, Key Stage 4, and Key Stage 5). Ideally these targeted sessions should be identifying pupils at risk of substance misuse before issues develop, rather

than being reactive once a drug related incident has occurred. Evidenced based examples of this can be seen via programmes such as RisKit and Risk-Avert.

8.2.3: A key limitation across both delivery approaches was the need to rely on non-specialist teachers, albeit to differing extents. This meant part of the curriculum was delivered by a more transient teaching team with less opportunity for CPD and the gaining of knowledge and experience in delivering the subject. This is common practice and difficult to change as the non-statutory nature of PSHE means it is often used as a 'filler' subject in teachers who have reduced main contact time throughout any given school year.
Insights from the teacher survey showed that the majority of respondents recognised to be confident and able to access effective teaching resources, feeling the school is well equipped for all areas needed (47.5%, n=19), or mostly equipped except for a few gaps (37.5%, n=15). However, 15% of respondents (n=6) feel that at times the resources that are accessing are either not ideal or need updating. Another identified gap (34.1%, n= 14) was availability of targeted resources for working with pupils seen as 'at risk'. One respondent noted:

"CWP (Christopher Winter Project) resources are great and we plan to follow these quite rigidly. In terms of particular responsibilities and dealing with issues outside of our resource programme more training or advice would be useful".

8.2.4: Respondents were also asked about perceptions of their own, and others confidence in teaching drug and alcohol education. Just over half of the participants (56.1%, n= 23) claimed to have received any training or CPD around drug education. When asked about their own confidence in teaching drug education, only 3 respondents (7.3%) claimed to be very confident, whilst the vast majority (85.4%, n=35) stated to feel mostly confident but would welcome some additional support. Only one respondent claimed not to feel confident when sensitive issues arise. Two respondents also highlighted that in order to maintain the confidence, teachers' knowledge need to be kept up-to-date, and that availability of lesson resources when local problems arise would be very helpful to tackle time constraints. One respondent noted:

"The biggest challenge is to creating an engaging programme for students that includes all of the key information during the time allocated to PSHE in the school. Students enjoy being able to discuss the topic in lessons as well as taking facts and up to date information from lessons".

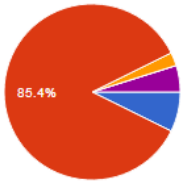
When asked about other teachers' confidence in teaching drug education in practitioners' local settings, respondents highlighted a slightly different scenario. Only 2 (4.9%) respondents claimed to perceive other teachers in their settings to be very confident, 61% (n=25) perceived them to be mostly confident although some additional support would be welcomed. 24.4% (n=10) seemed not to think that other teachers are confident when sensitive issues arise, 4.9% (n=2) felt that other teachers are not confident at all, and another 2 respondents found it hard to answer this question.

“Good resources are essential - invest in some! Make it topical! Don't be afraid - respond to topics in the news... don't worry about saying - can I get back to you? Have everyone ask a question for the box, not just one person, in order to approach misconceptions sensitively”.

8.2.5: A common perceived strength of delivery was in delivery of harm reduction messages, which was mentioned by both PSHE leads and wider support services. While this approach is entirely appropriate for those already using or at risk of using substances, care does need to be taken in how this message is delivered and conveyed to pupils. Too strong a focus on these messages can create misperceptions among pupils that most young people are drinking alcohol or using drugs. To negate this, these messages need to be delivered where a specific need is identified amongst a group and also in a depersonalised way. For example, messages should not be delivered using personalised language such as 'you can minimise risks by...'. Where harm reduction approaches are deemed necessary, these should also be delivered in conjunction with sessions to develop skills in assessing and negotiating risk. This approach is supported through the pupil focus groups calling for increased focus on skill development.

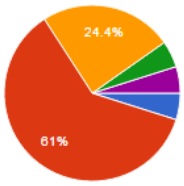
Perceptions of teaching confidence in alcohol and drug education

How confident do you feel in delivering drug education?



Very confident	3	7.3%
Mostly confident, but I would welcome some additional support	35	85.4%
I am not confident when sensitive issues are raised	1	2.4%
Not confident	0	0%
Other	2	4.9%

How would you judge the confidence of other teachers in your setting delivering drug education?



Very confident	2	4.9%
Mostly confident, but I think they would welcome some additional support	25	61%
Not confident when sensitive issues are raised	10	24.4%
Not confident	2	4.9%
Other	2	4.9%

8.3 Assessment

Assessment of drug and alcohol education and wider PSHE has been identified as an area for improvement nationally by Ofsted (2013) and others. Schools are currently not required to report on achievement in PSHE, but including elements of this in reports to parents is recommended practice. Across those schools taking part in the evaluation, a range of tools were observed:

- In one school, a standalone qualification was delivered in year 8. This gave a useful framework for non-specialist PSHE teachers to follow, thus increasing confidence in delivery

- Examples of self and peer assessment were observed in the majority of schools, commonly using a 3 step method recommended by the PSHE Association with pupils 'working at', 'working towards', or 'working beyond' end of key stage statements. This is underpinned further by the local PSHE Programme of Study which all schools made reference to.
- In one school, an additional KS4 qualification is offered to justify curriculum time. This gives pupils, teachers and SLT valuable feedback on pupil performance, as well as the potential to track positive outcomes in drug and alcohol education
- Feedback on pupil progress in PSHE is provided through the school's regular report system, as well as ad-hoc methods including stickers and achievement cards. While these tools may seem small, they help normalise the achievement of PSHE topics as something of importance, and raise the profile of the subject amongst parents. This is something to be built on in a wider whole school approach across the area.

8.4 Resources:

With regards to the external support used by practitioners who took part in this survey, it is clear that the majority of establishments rely upon a Local Authority adviser for the following information: General advice on drug and alcohol education (60.9%, n=25), advice on school drug policy (54.6%, n=22), classroom resources (60.9%, n=25), factual information about drugs and alcohol (34.1%, n=14), and staff training (58.5%, n=24). Other key sources of information and advice were officially recognised websites, such as Talk to FRANK or the PSHE Association, and the Police. Respondents were also asked what type of additional support they would like to receive from either the Local Authority or other external providers. 68.3% (n=28) asked for classroom resources, 56.1% (n=23) for updates on policy developments relevant to drug and alcohol education, 46.3% (n=19) asked for updates on research about effective drug and alcohol education, 41.5% (n=17) wanted best practice guidance, and 36.6% (n=15) would also like to receive case studies of good practice from other schools.

In the teacher interviews, PSHE leads also expressed a need not necessarily for 'off the shelf' lesson plans, as these resources may not be compatible with a school's current delivery model. Selections of activities on specific topics which they could adapt and incorporate into their current programmes were seen as more appealing. The Pier2Peer web resource was seen as a useful way to share such resources, although those newer to the subject expressed a desire for it to be more user friendly and easier to navigate.

8.5 Further Local Authority support:

In addition to the local resources discussed earlier, the teachers interviewed also spoke about wider support received - predominantly through the Standards and Achievement team. This encompassed the PSHE consortium meetings which were unanimously referred to as positive and key to their work. PSHE leads spoke of the consortium as being a city wide 'team' which not only served as a regular route of communication, but also one for sharing good practice and resources. In part this is also fostered by the fact many PSHE leads have been in post for a

number of years, but this close knit nature was also commented on by a lead who was new in post in their school.

A critical point for continuity of delivery in a school is when a change of PSHE lead occurs. A recent change in one of the schools saw a proactive response from the local authority, with focused 1-1 support being offered through the Standards and Achievement team. This PSHE lead commented on how that practice helped allay initial fears about picking up a new subject, and gave them confidence in their planning and communication with those delivering within their school.

9 SUMMARY AND RECOMMENDATIONS

9.1
Substance use among young people in Brighton and Hove has rightly been identified as an area of need and further development in reducing the harm associated with this. While local public health indicators have played a role in this process, useful insight has been gained through the Safe and Wellbeing at School Survey. The provision of alcohol and drug education in local schools is seen as a key component of the city wide approach to address this issue.

At school level, the commitment of those PSHE leads who took part in focused interviews was found to be very strong, which is underpinned by the regular PSHE Consortium meetings, providing dedicated time for the sharing of good practice and resources. Not unexpectedly, schools were observed to be delivering their alcohol and drug education using a variety of methods, from the use of tutor-led activities in tutor time, to dedicated PSHE teams delivering the topic as part of timetabled curriculum time. While it was pleasing to see an absence of approaches focussed around off timetable 'drop-down days', delivering alcohol and drug education as part of timetabled provision still needs to be promoted as the preferred method, and one supported by the available evidence base. Where lessons were observed, these were delivered in a supportive and engaging way, and were well supported by effective resources and confident teachers. While it was also pleasing to see elements of harm reduction within these sessions, great care needs to be taken if alcohol and drug use is not to be normalised as part of this approach. Furthermore, wider whole school approaches need to be furthered to maximise the impact of effective classroom delivery and to impact positively on pupil choices around alcohol and drug use.

9.2
One of the concerns acknowledged by staff and pupils alike, was the need to rely on untrained staff delivering a programme. This was more pronounced in schools only offering tutor time as a mode of delivery, which in part has been negated by the strong leadership of PSHE leads in these schools, supported by the Standards and Achievement team. This should be seen in the wider context of PSHE being a non-statutory subject and therefore not a part of training for newly qualified teachers, nor perhaps high on the list of topics for INSET. Building on the good support offered locally should be a priority, as well as finding flexible ways to enable those that need it to access CPD activities.

Without exception, pupils involved in the focus groups displayed a strong commitment and appreciation of the subject, which in the main is a great reflection on the current standard of provision. They really appreciate the time given to discuss alcohol and drug related issues in a flexible and supportive way which results in them displaying real satisfaction with the subject. However, they were also able to suggest ways to improve their provision even further,

including increased variety in styles of delivery, and better support for teaching staff to deliver the subject and answer questions effectively. If anything, they would like to see even more alcohol and drug education as part of their timetables, and in particular more time to develop skills to negotiate 'real world' scenarios they are likely to encounter.

9.3

The local offer of support from Public Health and the Standards and Achievement team, plays a key role in both the planning and delivery of alcohol and drug education. It was particularly pleasing to see the focussed support offered to a new PSHE lead in ensuring they were able to ensure consistency of delivery at a point where the profile of the subject could have dropped. Along with recommended programmes of study, example policies and delivery of the SAWSS, this proactive support offered to schools should be seen as a key factor in the strong profile afforded to alcohol and drug education across the area, and one worth protecting.
Having this good standard of provision in schools gives a strong base to build targeted and specialist support for young people with increased need around alcohol and drug issues. Increased clarity on this local offer would help strengthen the roles played by universal, targeted and specialist services to maximise the support young people are able to access, and subsequently reduce the harms associated with this.

For ease of analysis and dissemination, recommendations are presented across areas reflecting a sustained city wide approach.

9.4 Standards and Achievement Team, with support from wider services

1. Maintain and enhance PSHE Consortium meetings - focusing on skill development in pupils
2. Maintain and enhance Pier 2 Peer website for shared resources, improving usability
3. Identify and respond to ongoing CPD needs locally - particularly around approach and delivery skills for non-specialist PSHE teachers
4. Continue to provide focused support for new PSHE co-ordinators at point of transition
5. Increase support for city wide normative messages, for example:
    1. template posters
    2. inset cards for homework diaries
6. Incorporate recommendations and current guidance documents into a new 'drug, alcohol and tobacco education strategy'. This should be owned by a relevant strategic group and obtain commitment from head teachers, public health and education across Brighton and Hove

9.5 Schools - wider whole school approach

1. School leaders to support CPD needs of staff delivering alcohol and drug education - particularly non-specialist teachers. Consider introducing '15 minute forum' model being used in some schools already
2. Ensure named governor is in place for alcohol and drug education
3. Strengthen links with Youth Services and ru-ok? delivering tier 2 and tier 3 interventions. This should include earlier identification of pupils displaying risk taking behaviours
4. Enhance communication of successes with parents, and increase engagement with parents on risks of alcohol use. Utilise parent evenings as well as consider joint events

9.6 Schools - curriculum and pupil voice

1. Utilise pupil voice to enhance normative messages gained from SAWSS data and the local Public Health Schools Programme
2. Actively contribute to PSHE Consortium meetings and Pier 2 Peer resources
3. Brand resources with local and national services to increase awareness of available support
4. Build on current strong knowledge base to deliver a life skills approach - with particular focus on managing real life situations and the impact of drugs and alcohol on wider relationships
5. Seek PSHE curriculum details from key feeder primary schools to minimise duplication at KS3, thus maximising effectiveness of input at this stage