

“We don’t get taught enough”

An assessment of drug education provision in schools in England

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October 2015

Abstract

Purpose: The purpose of this paper is to investigate the provision of drug education in schools in England by exploring the views of young people and teachers. The study synthesises the commonalities between experiences of teaching and learning and, in doing so, offers insight on policy and practice.

Design/methodology/approach: The paper incorporates two pieces of research: a survey of 590 secondary school pupils in London that generated insight on the collective experience of drug education; and a survey of 288 teachers in primary and secondary schools throughout England, supplemented by 20 in-depth interviews. The paper also draws on learning from the practical implementation of the Alcohol and Drug Education and Prevention Information Service (ADEPIS).

Findings: The research provides insight into the current status of drug education provision and outlines key constraints to effective delivery. The paper also presents ADEPIS as a potential framework for supporting schools.

Research limitations/implications: The research incorporated a relatively small number of schools and only accessed the views of young people in London; the results therefore require further substantiation. There is also a need for further evaluation of ADEPIS, including comparison with schools that develop drug education practice independent of external guidance.

Practical implications: The paper highlights the need for improvement in drug education, with implications for national policy, particularly in relation to subject-specific teacher training, increased central guidance, and the statutory status of PSHE.

Originality/value: The research fulfils the need to represent the voices of young people in discussions on drug education, as well as contributing to wider debates around improving the quality of drug education.

Keywords: Schools, Drugs, Education, Prevention, PSHE, Alcohol.

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Accepted 27 July 2015. *Drugs and Alcohol Today*, Vol. 15 No. 3, 2015, pp. 127-140
(c) Emerald Group Publishing Ltd, ISSN 1745-9265. DOI 10.1108/DAT-03-2015-0014.

Introduction

Alcohol and drug education has changed dramatically in the last fifty years. The dominant practice in the 1960s of ‘instilling fear of the consequences of drug use’ was subsequently replaced by the more pragmatic approach of conveying factual information about the effects of drug use (Tobler, 2001), until De Haes and Schuurman suggested that both methods can have negative effects on young people (De Haes & Schuurman, 1975; Ashton, 1999; James, 2011). Foxcroft and Tsertsvadze’s review of universal school-based prevention (2011) concluded that programmes which implement life skills, social influence, resistance skills and normative education are more successful than others; correspondingly, most existing research now suggests that effective programmes combine a mix of cognitive (information), affective (personal and social development), and skills development (resistance skills and normative education) techniques (Dusenbury & Falco, 1995; White & Pitts, 1997; Tobler, 2001; Stead & Angus, 2004).

Why school-based alcohol and drug education is important¹

School-age and teenage years are critical in terms of experimentation with drugs and the development of behaviours that can lead to dependence and/or abuse in adulthood. The earlier young people start to use psychoactive substances, the more likely they are to develop drug abuse disorders in later life (UNODC, 2013); equally, early initiation of alcohol (Foxcroft & Tsertsvadze, 2011) – or early drunkenness (Kuntsche et al., 2013) – is predictive of later heavy drinking and associated problems; and four out of five smokers begin before adulthood (Faggiano et al., 2014).

There is evidence that prevention programmes can mitigate chronic drug addiction. Jit et al. (2009) demonstrated that delaying young people’s uptake of smoking has a lasting impact; and Grant et al. (2001) concluded that the probability of alcohol dependence in adulthood is reduced by 10% every year that drinking is delayed. There are, therefore, significant long-term benefits to programmes that reduce and/or delay first use or prevent the transition from experimental use to addiction. As the most efficient way of reaching large numbers of young people, schools represent the best setting for universal preventive interventions (Faggiano et al., 2014).

There is a distinction between drug prevention, which aims to prevent, delay or reduce the harms of drug use; and drug education, which informs about the facts, consequences and social context of drug use (Stothard, 2006). The outcomes of drug education are more limited than those of more comprehensive prevention programmes, such as the Good Behaviour Game; but it does not necessarily follow that drug education cannot contribute to preventive outcomes.² Many of the key components of effective prevention – age-appropriate information, normative education, interactive teaching, social resistance skills – can be incorporated into drug education (Dusenbury & Falco, 1995). Drug education is unlikely to effect widespread behaviour change (Dom & Murji, 1992); however, by grounding drug education curricula in evidence from drug prevention and providing information and opportunities for discussion (Parker et al., 1995), it might contribute small preventive effects as well as broader educational benefits (Dom & Murji, 1992). And, as Strøm et al. (2014) advise, even small effects can make a significant population-level difference.

What we should be doing now

School-based prevention can lead to reductions in alcohol misuse and ‘small but consistent protective effects’ regarding illicit drug use (Botvin et al., 1995; Foxcroft & Tsertsvadze, 2011; Faggiano et al., 2014; Strøm et al., 2014). But certain practices, such as adopting scare tactics or providing information without addressing wider social contexts, are ineffective (Stothard, 2006; McWhirter, 2009); indeed, emphasising the dangers of drugs may enhance the status of drug-taking (Cragg, 1994). The success of school-based interventions is determined by a variety of factors, including accurate and age-appropriate information, normative education, social resistance skills,

wider health-related education, the number of sessions, and regular follow-up to reinforce learning (Dusenbury & Falco, 1995; White & Pitts, 1997; Cuijpers, 2002; McWhirter, 2009). Normative education, which challenges misconceptions about how common and acceptable substance use is among peer groups, is particularly influential (Hansen & Graham, 1991; Donaldson et al., 1994; White & Pitts, 1997). However, effective drug education relies on a combination of elements, with none of the aforementioned successful in isolation, and a greater number of elements associated with more success (White & Pitts, 1997; Stead & Angus, 2004; Martin et al., 2013).

Another key factor is the style of teaching and learning. Cuijpers's meta-analysis of school-based drug prevention programmes (2002) found that peer-led delivery is more effective than adult-led, and that interactive learning is a key characteristic of effective prevention. Similarly, Stead and Angus (2004) concluded that interactive drug education, founded on active participation and discovery learning, has a greater impact than didactic, teacher-led delivery. Their conclusion reflects learning from school-based drug prevention, where interactive methods show positive change in both knowledge and attitudes, while non-interactive teaching leads only to improved knowledge (Tobler, 2001).

Rationale for investigation

Twenty years since the publication of the UK's first national drugs strategy, which pledged 'an effective programme of drug education in schools', schools have not adopted universally good practice (Stothard, 2006). While the 'tell them the awful facts approach' has lost credibility, it continues to be adopted by some schools (Ashton, 1999), along with other techniques that have known negative outcomes (Stead & Angus, 2004; Ofsted, 2013). Although there has been an array of national guidance for school-based drug education (Dusenbury & Falco, 1995; Butcher, 2004; DfES, 2004; McWhirter, 2009; DfE, 2012; DfE, 2013b; Boddington et al., 2014), this has not led to consistent, high quality provision. PSHE (personal, social, health and economic) education is often unvalued and under-resourced, leading to low quality drug education.³

Recent investigations by Ofsted suggested inconsistent practice. In 2010, a quarter of schools 'required improvement' in PSHE, with drug education in particular suffering on account of variable teaching, poorly-planned lessons and a lack of curriculum time (Ofsted, 2010). Subsequently, *Not Yet Good Enough* (Ofsted, 2013) found that PSHE is failing in 40% of schools. Ofsted's conclusion that students largely had good knowledge about the effects of drugs but deficiencies regarding broader skills suggests that many schools deliver information in isolation.

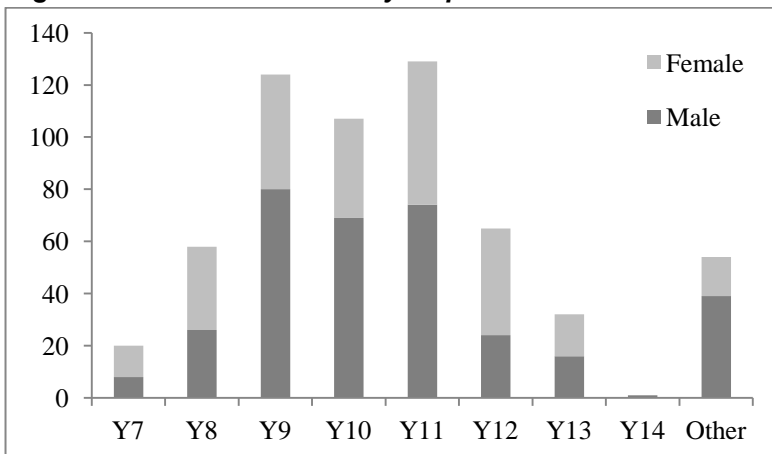
Evidence of inconsistent and low-quality practice prompted Mentor to carry out research to better understand the current status of drug education and its impact on young people; and to provide a platform for supporting schools to improve provision. The paper includes findings from two pieces of research: a London Youth Involvement Project (LYIP) survey of 600 young people; and a nationwide survey, with follow-up phone interviews, investigating the provision of drug education in nearly 300 schools, carried out by the Alcohol and Drug Education and Prevention Information Service (ADEPIS).⁴ The paper also draws on learning from the practical implementation of ADEPIS resources and guidance.

The two studies present several limitations in terms of the recruitment, size and reach of the sample. However, although neither study is necessarily representative of the population as a whole, they offer useful insight into the status of drug education. School education in the UK is devolved and procedure differs in each of the four countries; findings in this paper are relevant to England only.

LYIP findings: young people's experience of drug education in London

In 2011, LYIP recruited a team of Youth Advisors to identify key issues for young people in London in relation to alcohol and other drugs, with the aim of giving young people a voice in debates around drug prevention.⁵ Youth Advisors carried out research among peers focusing, among other priority areas, on drug education in schools. A questionnaire for secondary pupils was created and distributed online, in schools and through youth groups.⁶ The survey was designed by the Youth Advisors who elected not to include tobacco.

Figure 1: Breakdown of survey respondents.

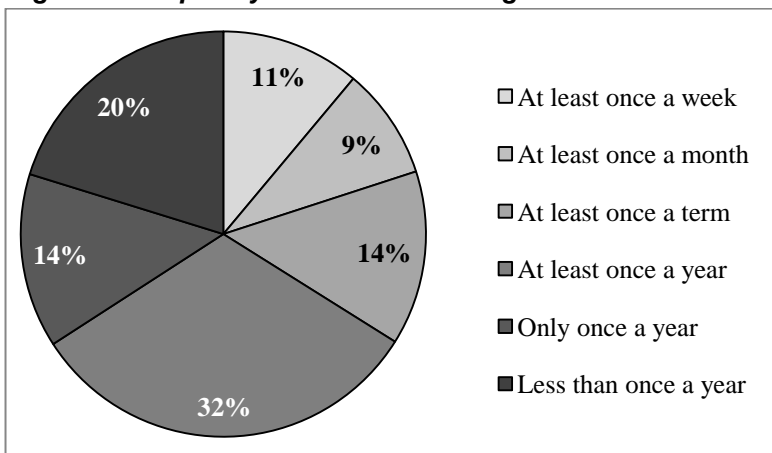


The survey received 590 responses (337 male; 253 female) from 185 schools in 27 London boroughs. Although there was a wide range of respondents, some from Year 7 and others as old as 20, the majority (63%) were in Years 9, 10 and 11 (age 13-16); and 85% were enrolled in Years 8 to 12 (age 12-17). Not all respondents completed the survey in full; any percentages given refer to the proportion of those that answered specific questions.

Frequency of delivery

More than a fifth (22%) of young people said they had not received any drug education at secondary school. The majority of respondents who had not received any drug education were still in Key Stage 3 (age 11-14) and might therefore access drug education later in their school career; however, even in Key Stages 4 (age 14-16) and 5 (age 16-18) 13% of respondents said that they had never been given any information about alcohol and other drugs. Almost a quarter (24%) of the category 'other' had received no drug education; given these respondents were mostly older students, at sixth form or in college, it might be the case that provision has improved since they were enrolled in secondary school.

Figure 2: Frequency of alcohol and drug education.



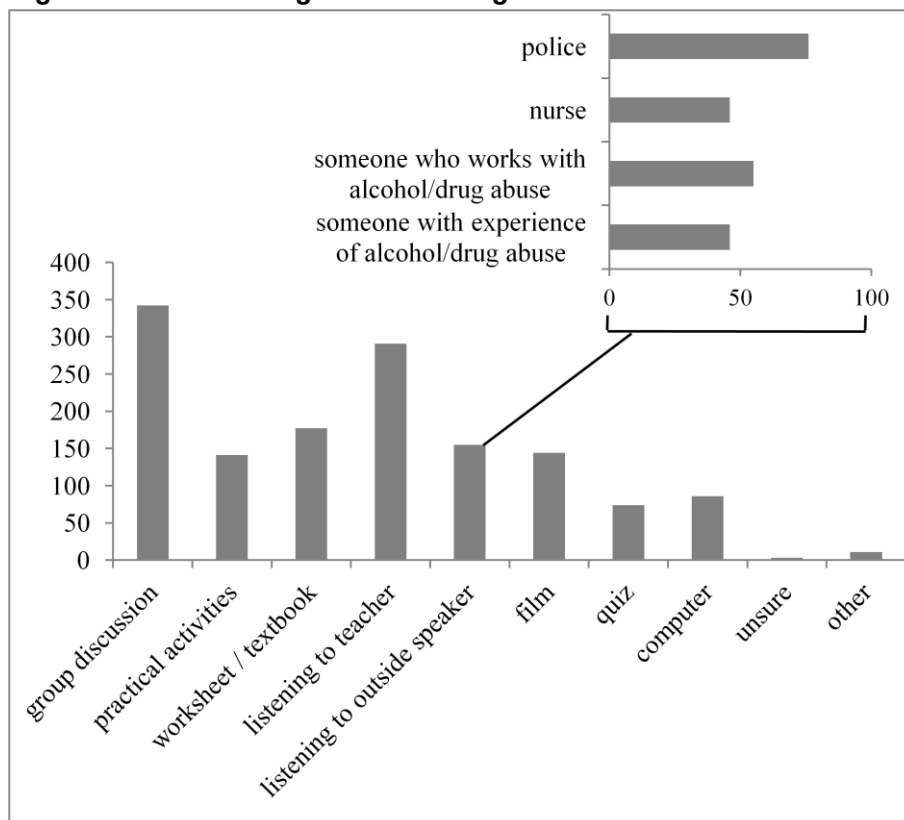
Although the majority of respondents had received some form of drug education, for many it occurred sporadically: *figure 2* shows the frequency with which young people received information about alcohol and other drugs. Including the young people who had not experienced any drug education, 48% of students received drug education once a year or less.

Across the sample, 38% thought that school provision of drug education was ‘not enough’, with one respondent asking for more information about ‘everything in general, because we don’t get taught about it enough’. Just over half of young people considered the time allocated to drug education to be ‘just right’, while 5% believed it was ‘too much’. Unsurprisingly, those who received drug education less often were more likely to be dissatisfied: 63% of those who received drug education less than once a year thought it was insufficient, compared to 46% of those who received it once a year only, and 28% among those who received it more than once a year.

Mode of delivery

Young people reported widespread variety in modes of delivery and topics covered across the 185 schools. *Figure 3* demonstrates the varied experience of young people: drug education was delivered in a wide range of forms – from dictation to group-work, worksheets to computer quizzes. Students most commonly received lessons in PSHE (67%), but drug education ranged across the curriculum, in science (43%), ‘tutor’ or ‘form’ time (23%), school assemblies (13%) and ‘drop down days’ (9%), with students often experiencing a mix.⁷ Similarly, while drug education was delivered most often by PSHE and science teachers, young people collectively experienced the full range of teaching staff.

Figure 3: How was drug education taught?

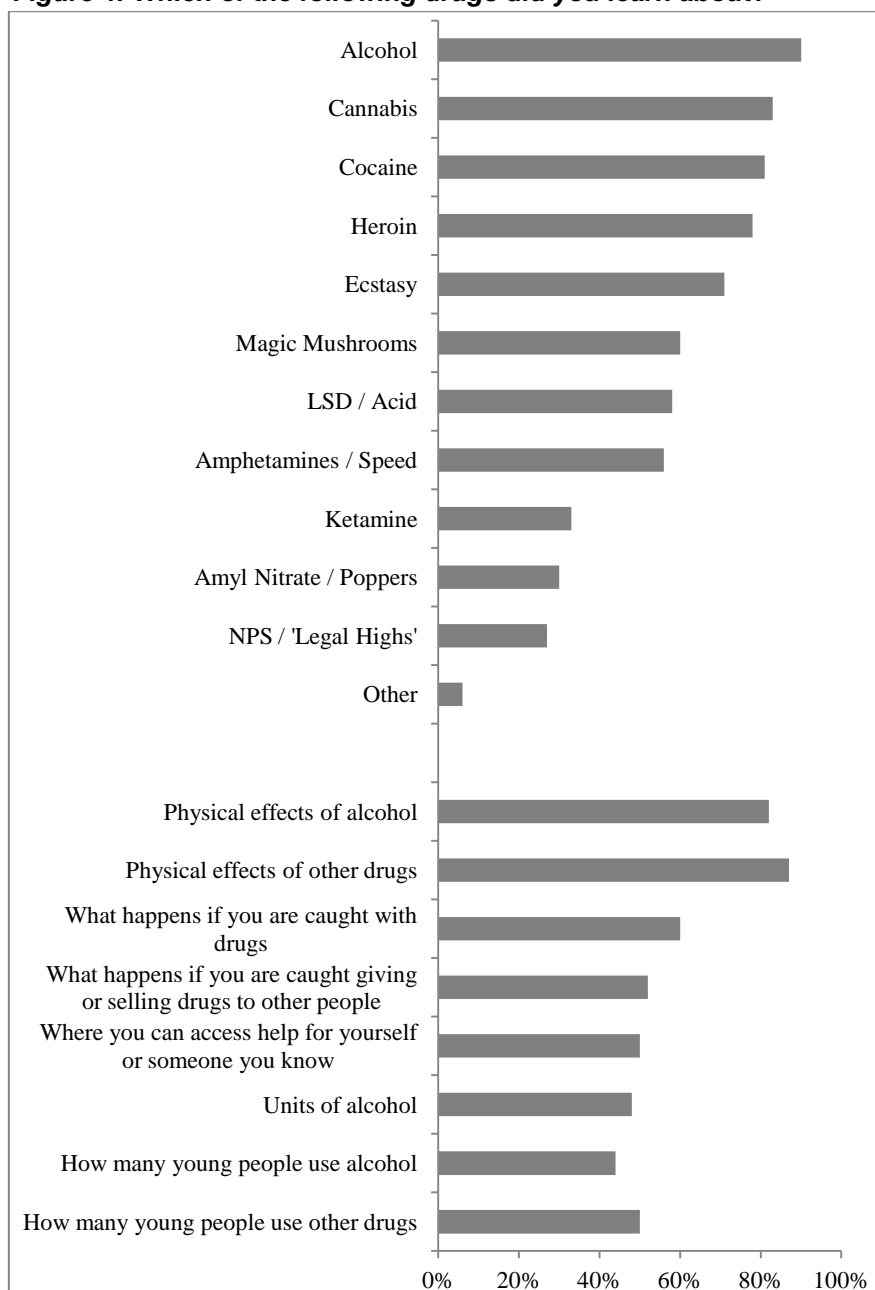


There was no discernible correlation between mode of delivery and the satisfaction of young people, largely because the number of other variables – frequency of delivery, type of teacher, type of lesson, age that drug education is received – made it impossible to distil clear findings. However, the fact that only two-thirds of survey respondents (68%) agreed with the statement, ‘I trust the drug education I get in school,’ suggests that such inconsistency does not instil confidence in young people.⁸ Furthermore, the inconsistency of drug education delivery raises concerns about whether schools are applying evidence-based practice.

Scope of drug education

Figure 4 shows the coverage of different drugs within the drug education received by survey respondents. Among young people, the use of alcohol, tobacco (not included in this research) and cannabis are far more widespread than other drugs (ONS, 2013); this is reflected by the high percentage of young people who were taught about alcohol (90%) and cannabis (83%) in school-based drug education. However, some of the more significant of the other drugs that are used by young people (ONS, 2013), such as ketamine, amyl nitrate and new psychoactive substances (NPS), were not so well covered in schools: a third or fewer of young people surveyed could recall learning about these three categories of drugs.

Figure 4: Which of the following drugs did you learn about?



Most young people were taught about the physical effects of alcohol (82%) and other drugs (87%) on the body; although, when asked what they would like to learn more about, a third of respondents sought more information about the 'effects and consequences' of drug use – both short-term physical and psychological effects and long-term health consequences. Fewer than half of young people knew how many of their peers used alcohol and other drugs, which is significant given evidence of the effectiveness of normative education approaches (Hansen & Graham, 1991). Furthermore, only half

of participants were taught practical information about units of alcohol, the legal consequences of drug possession and distribution, and where to access help for alcohol and/or drug issues, all of which were highlighted by respondents as major gaps in learning. Most drug education covered core 'extrinsic' skills relevant to young people in relation to alcohol and other drugs. Four out of five (81%) respondents had discussed peer pressure to use alcohol or other drugs and three quarters (73%) talked about decision-making around alcohol and drug use. A much smaller number (38%), however, reflected that this had developed their confidence in making decisions around alcohol and other drugs.

ADEPIS findings: drug education in schools across in England

LYIP revealed the inconsistency of drug education in schools in London, in terms of frequency, content and delivery. The project's findings led Mentor to develop ADEPIS with the aim of investigating provision at a national level and developing resources and guidance to support schools to deliver quality, evidence-based drug education. The project's early development was informed by the findings of a research paper commissioned by Mentor and the PSHE Association to investigate the current status of drug education in England.

The research (Boddington et al., 2013) comprised a detailed online survey of 288 teachers from 288 schools across England, and twenty follow-up telephone interviews. The majority of respondents (54%) were from secondary schools, with a quarter from primary schools (24%) and other institutions (22%) such as further education colleges and pupil referral units.⁹ The sample was not randomised; schools were sourced through the PSHE Association mailing list, meaning that respondents were already in receipt of some information around drug education. It is likely that schools that do not actively engage with the PSHE Association's guidance and resources place less emphasis on drug education than the schools in this sample; this research therefore may present a rosier picture of drug education than the reality.

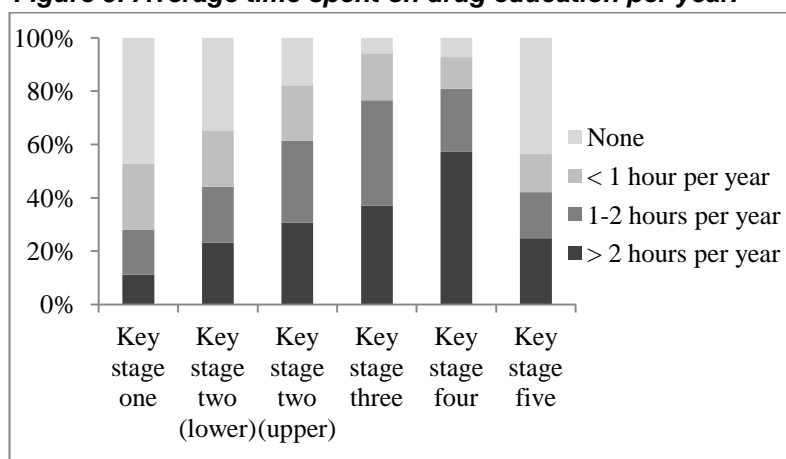
Frequency of delivery

There was consensus among primary school teachers that drug education should not take place until Key Stage 2 (age 7-11), for fear of teaching children 'more than they already know'. Just under three quarters of primaries provided some drug education in Key Stage 2, although a quarter of these did not address illicit drugs. *Figure 5* shows that the vast majority of schools provided some drug education during Key Stages 3 and 4; however, 5% of secondary schools did not provide any drug education, and a further 5% only delivered drug education in one of Key Stages 3 and 4. Further, although most schools provided drug education for pupils between the ages of 10 and 16, the overwhelming majority offered less than two hours per year. Although students receive more hours of drug education as they move up through the key stages (up until Key Stage 5), the impact of such low intensity is likely to be limited.¹⁰

Access to resources and support

Although 86% of schools had a whole-school drugs policy, the majority of teachers stated that their policy was restricted to guidelines for managing drug-related incidents and safeguarding students, rather than a more holistic framework that incorporated education. Despite the prevalence of drugs policies, frequently they offer little practical guidance to teachers for delivering drug education.

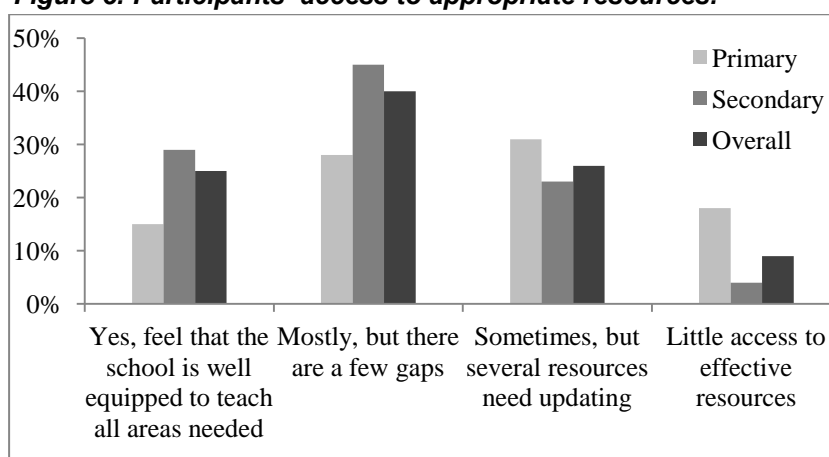
Figure 5: Average time spent on drug education per year.



There was general agreement that most teaching materials were targeted at secondary schools. Consequently, only 45% primary school teachers felt confident that they always or mostly had access to effective teaching materials, compared to 74% among secondaries; a further fifth of primary school respondents had no access to useful resources. While this problem was more acute among primary schools, the vast majority of teachers (81%) indicated they would benefit from more classroom resources, suggesting widespread lack of confidence in teaching drug education.

When asked to identify the classroom resources which would be most useful, primary schools teachers stressed the need for substance-specific information: 50% sought material on alcohol, 44% on illegal drugs, 43% on tobacco. A similar number, 43%, stressed the need for resources that promote and develop life skills, such as assertiveness. Secondary teachers, however, highlighted a need for teaching materials that help to place drug use in the context of other issues that shape young people's lives. The most popular requests were to cover links with sex and relationships (56%) and mental health (55%), coping with stressful situations (52%) and addressing social norms (47%) to counter myth that 'everyone does it'.

Figure 6: Participants' access to appropriate resources.



Local authority advisors provided support to 60% of schools in the sample, variously offering general advice, classroom materials, factual information and advice on school drug policy, although participants commented that this support was gradually being cut back or removed altogether. Open comments and follow-up interviews revealed that teachers lacked the confidence to deliver services which had previously been funded or provided directly by the local authority, such as drug education for primary pupils or workshops for parents. The PSHE Association, FRANK and the police were also mentioned as useful resources for factual information and, occasionally, more concerted support. However, significant numbers of respondents demanded more support to ensure good practice: 56% requested best practice guidance, 52% updates on policy and 52% case studies of good practice.

The data in *figure 6* reflect a lack of consistent external guidance and support for schools: many teachers admitted to using ‘informal knowledge’ and ‘local data’ to inform provision, due to a perceived lack of reliable, evidence-based information and teaching materials and a relative absence of external support from expert organisations. The fact that a high percentage of schools employ one-off external speakers (Ofsted, 2013) further supports the suggestion from survey data that teachers are not fully confident in their ability to deliver consistent drug education.

What makes an effective resource?

When asked to characterise an effective teaching resource, teachers prioritised material that both engages pupils’ interest (86%) and makes pupils think about their attitudes and values (86%). A smaller number thought that teaching resources should spark discussion among students (57%) or enable pupils to practise life skills (47%), suggesting that certain key elements of effective drug education – interactive teaching, life skills, social resistance skills – have not fully filtered down into practice. Moreover, a significant minority – three in ten teachers – continue to adopt widely discredited ‘scare tactics’, opining that drug education should contain ‘hard-hitting messages’. Survey data also revealed that fewer than half of respondents considered continuity and building on previous learning to be important factors in drug education; it is possible that this manifests in erratic teaching that diminishes student learning, a problem that was highlighted in the evaluation of the Blueprint Programme (Stead et al., 2007).

Key constraints for teachers

Participants outlined three key constraints in providing quality drug education:

1. *A lack of curriculum time.* The varying level of importance placed on PSHE, and consequently on drug education, impacts on the number of hours that teachers are able to devote to education around alcohol and other drugs. This often results in fragmented, topic-style teaching, rather than holistic, continuous learning.
2. *A lack of financial capacity.* Schools often relied on external providers to deliver classes. However, recent budget cuts to providers, such as local authorities, and a lack of financial capacity in schools has rendered many schools unable to secure ‘quality-assured’ external support.
3. *Non-specialist teaching.* Drug education is often delivered by non-specialist teachers with no specific teacher training on relevant topics and teaching methods. As a result, teachers display varying levels of confidence when approaching drug education.

ADEPIS

ADEPIS was established to address the gaps in support and to enable schools to improve the quality of drug education. The service produces high-quality information and advice for schools, based on the needs identified in Boddington et al.’s assessment of drug education in schools (2013) and in seminars and consultation with practitioners. A key output is the ‘Quality Standards for Effective Alcohol and Drug Education’ (Mentor-ADEPIS, 2014), a guidance document that informs schools on good practice for effective education and prevention. By enhancing practitioners’ confidence in delivering high quality drug education, ADEPIS also aims to evidence broader, long-term influences on school attendance, academic attainment, pupils’ attachment to school, and aggressive and disruptive behaviour.¹¹

Due to the open access nature of ADEPIS, it is hard to quantify its reach and impact. The website was visited 20000 times between May 2013 and September 2014, with over 4000 downloads by 2356 individual users (Rees & Bowles, forthcoming). However, with resources shared across

networks and hosted on other sites, these figures only offer an indication; and with opportunities for follow-up data limited, it is hard to ascertain the impact of resources in practice.

Despite these difficulties, a recent independent evaluation (Rees & Bowles, forthcoming) concluded that ADEPIS 'is making a positive and growing impact on the teaching of drug education in England'. Although the number of respondents was smaller than anticipated, partly due to the time in the school year that the survey was carried out, their response was overwhelmingly positive. 74% of teachers rated the quality of information as good or excellent; 76% agreed that the service provided much-needed resources, with material used to influence school policy and approaches to teaching, and as a reference point for up-to-date information.

These initial findings require further substantiation, with more focused follow up with service users, to determine the impact of ADEPIS. However, respondents provided further evidence of the need for the existence of ADEPIS and its value to practitioners. The report noted widespread concern that existing statutory guidance (DfES, 2004; DfE, 2012) was out of date, and a general lack of clarity about best practice. In this context, ADEPIS was welcomed as a valued source of information and advice on best practice. Overall, Rees and Bowles suggest that ADEPIS is 'beginning to "fill the gaps" as a trusted source of credible information and support'. There is an ongoing need to increase the capacity of the service and build greater awareness among schools; but thus far, it is beginning to demonstrate that, if provided with an authoritative source of information and guidance, schools are more confident and capable of improving the quality of drug education.

Discussion

Several themes were consistent across both teacher and student experiences of drug education. Both groups highlighted the low frequency of delivery: 48% of LYIP respondents received drug education once per year or less and, although ADEPIS's findings suggested slight improvement, the majority of schools provided less than two hours of drug education every twelve months. This was keenly felt by both research groups, with 38% of pupils believing it was 'not enough' and teachers labelling a lack of curriculum time as the major obstacle to providing quality drug education. This is a concern since such small time allocation barely allows for teachers to cover key topics (see *figure 4*), let alone encourage a change in attitudes towards alcohol and other drugs.¹²

Data from both sets of respondents suggested that drug education is often delivered too late. 22% of LYIP participants, the majority from Key Stages 2 and 3, had received no drug education whatsoever. ADEPIS research also revealed that more than a fifth of students in Key Stage 2 received no drug education, with primary schools struggling to provide relevant information around alcohol and other drugs. While schools tend to increase the time spent on drug education for older students (see *figure 5*), this may be too late (White & Pitts, 1997; Ofsted, 2013). The optimum age for exposure remains unclear (Martin et al., 2013), but several studies highlight the importance of delaying the onset of alcohol and drug use (Foxcroft & Tsertsvadze, 2011; UNODC, 2013). Although its role is educative rather than preventive, quality drug education can contribute to preventive outcomes; it appears critical, therefore, to deliver drug education at an early age, enabling young people to develop a holistic understanding of alcohol and other drugs before they begin to experiment.

Adherence to established evidence-based standards was patchy: three in ten teachers believed that drug education should contain 'hard-hitting' messages, and many schools utilised police officers and people with experience of substance abuse to deliver these messages (*figure 3*). Fear-based education is not only ineffective (Tobler, 2001) but may also have a negative impact by enhancing the status of drug-taking (Cragg, 1994; Ashton, 1999); further, police officers do not appear to offer additional credibility (O'Connor et al., 1999) and have been associated with negative outcomes

(UNODC, 2013). The use of external speakers in one-off sessions can also disrupt continuity, preventing teachers from building on previous learning (Stead et al., 2007; Boddington et al., 2013). There are real concerns, therefore, that a significant number of schools are adopting drug education practices that are ineffective or have negative outcomes for young people.

Most schools delivered a reasonable degree of factual information but were less proficient in other key areas. Despite the significance of social influence in predicting future drug-taking behaviour (Hansen & Graham, 1991; Donaldson et al., 1994; Dusenbury & Falco, 1995; White & Pitts, 1997), fewer than half of LYIP respondents recalled learning about how many young people use alcohol and illicit drugs, and only 47% of teachers recognised the importance of challenging the myth that 'everyone does it'. Furthermore, despite guidance that promotes interactive teaching (Dusenbury & Falco, 1995; Stead & Angus, 2004; McWhirter, 2009) and evidence that supports providing opportunities to develop and practise life skills (Faggiano et al., 2005), less than half of teachers believed this to be important.

The two pieces of research suggest that a significant number of schools are failing to deliver quality drug education, which supports existing evidence (Stothard, 2006; Ofsted, 2013). The studies have certain limitations, particularly in relation to the sample sizes; LYIP's (2013a) exclusive focus on London; and the recruitment of participants from the PSHE Association mailing list for the Boddington et al. (2013) study. It cannot be claimed that either sample is representative of the population as a whole; but nevertheless, both sets of respondents provide useful and indicative information about the status of drug education in England.

With only 68% of pupils agreeing that they 'trust the drug education [they] get in school', there is a clear need to re-establish best practice, to deliver more consistent messages (Stead et al., 2007; McWhirter, 2009), and to involve young people to ensure that drug education is relevant to their needs (White & Pitts, 1997; McWhirter, 2009). Despite intermittent national guidance documents of varying detail (Dusenbury & Falco, 1995; Butcher, 2004; DfES, 2004; McWhirter, 2009; DfE, 2012; DfE, 2013b; Boddington et al., 2014), a majority of teachers complained about the absence of clear guidelines and difficulty in accessing up-to-date information. Their uncertainty and lack of confidence supports the argument for the existence of ADEPIS, as a central, specialist repository of information and guidance on drug education.

The ADEPIS survey also highlighted several institutional constraints that prevent teachers from delivering quality drug education: a lack of curriculum time; a lack of financial capacity to secure relevant teaching materials, guidance and external support; and a lack of specialist training to deliver drug education. In order to raise the standard of drug education in schools, it is vital to address both teachers' capacity to deliver good practice and the structural constraints that, at times, prevent them from doing so.

Policy implications

The two studies reveal a number of obstacles to providing quality drug education, some of which may be allayed by the continuing development of ADEPIS. However, these challenges also have implications for national policy, as the three major obstacles identified by teachers are directly related to the non-statutory status of PSHE. Although drug education is considered an integral component of schools' statutory duty to promote the health and wellbeing of children and young people, and represents a key element of the UK government's drug prevention strategy (HM Government, 2013), there is a lack of centralised authoritative direction which contributes to the constraints outlined above: lack of curriculum time, lack of financial capacity and non-specialist teaching. With priority given to statutory subjects – especially in Ofsted inspections – schools afford relatively little time and

resources to drug education, often resulting in weak and inconsistent planning and the neglect of best practice (Boddington et al., 2013; Ofsted, 2013).

Currently, science is the only statutory subject that delivers drug education in schools, and this is largely confined to physical and biological understandings of drugs (DfE, 2013a). Schools are expected to cover other cardinal components of drug education – social norms, resilience to risk factors, social and emotional skills – within PSHE (DfES, 2004; DfE, 2012). However, the non-statutory status of PSHE often renders drug education neglected (Ofsted, 2013). Many schools convey information primarily within science curricula, missing the opportunity to provide the ‘structured learning opportunities’ that develop knowledge, skills and confidence, as advocated by the Department for Education and Skills (DfES, 2004).¹³ Further, although PSHE-related issues are implicitly assessed during inspections (Palmer, 2014), the lack of clarity and limited emphasis on PSHE in the Ofsted framework renders the topic a low priority. The decentralisation of education authority (Clark, 2012) and the increasing independence of state schools, and especially academies, have afforded schools ever more discretionary choice around PSHE, further increasing the potential for drug education to be marginalised. The House of Commons Education Committee (2015) recently advised that statutory status would encourage schools to allocate sufficient time to PSHE, thus enhancing the level of provision.

Similarly, the lack of statutory recognition correlates with the paucity of PSHE-specific teacher training. In 2011 the Department for Education reported that 90% of teachers delivering PSHE did not have a specialist qualification – a practice that would ‘rarely or never be applied to other subject specialisms’ (DfE, 2011). As a result, many professionals lack expertise and confidence when teaching PSHE (Ofsted, 2013), which has led to widespread calls for funding to be restored to the National PSHE CPD programme (House of Commons Education Committee, 2015). Making PSHE a statutory subject, assessed by Ofsted, could play a significant role in incentivising schools to both ensure sufficient curriculum time and equip teachers with specialist training, thus enhancing the overall quality of PSHE and drug education.

By producing quality, evidence-based information and guidance for schools, ADEPIS has mitigated some of the problems highlighted by the research discussed in this paper. Schools that engage with ADEPIS value the service and have enhanced the quality of drug education (Rees & Bowles, forthcoming). However, to ensure widespread evidence-based practice, there is a need for centralised guidance and support for drug education.

Notes

¹ ‘School-based alcohol and drug education’ is shortened to ‘drug education’.

² More evaluation is needed to discern exactly what works (Stothard, 2006).

³ This is partly due to the non-statutory status of PSHE, which offers little incentive to schools to invest in drug education. This is discussed in ‘Policy Implications’.

⁴ LYIP ran between 2010 and 2013; the research cited was conducted by young people, with support from Mentor. ADEPIS was launched in April 2013; it is funded by DfE and run in partnership with DrugScope and Adfam; both reports cited in this paper were commissioned and conducted by external professionals. Both authors are employed by Mentor and one of the authors manages the ADEPIS project.

⁵ For an evaluation of the methodology of LYIP, see LYIP, 2013b.

⁶ Some of the findings are presented in LYIP, 2013a.

⁷ 'Drop-down days' are days when students are taken out of timetabled classes to participate in workshops, often delivered by an external provider.

⁸ 25% 'Unsure', 7% 'Disagree'.

⁹ Pupil referral units provide education for children and young people who are excluded, sick, or otherwise unable to attend a mainstream school.

¹⁰ High intensity programmes and programmes with booster sessions appear to be more effective in terms of preventive outcomes (Dusenbury & Falco, 1995; Strøm et al., 2014).

¹¹ Ofsted (2013) linked social development programmes to wider benefits for schools and pupils; Dom & Murji (1992) similarly suggest broader education benefits.

¹² Adequate coverage and follow-up are key elements in preventive outcomes (Connell et al., 1985; Falco & Dusenbury, 1995; Strøm et al., 2014); the Blueprint Programme, for example, considered fifteen lessons the minimum requirement for an effective drug education programme (Stead et al., 2007).

¹³ DfES (2004) *Drugs: Guidance for Schools* has been archived and replaced by DfE (2012) *DfE and ACPO drug advice for schools*. The latter guidance is less detailed and does not address PSHE directly. DfES (2004) therefore is still used by schools as a reliable document for guidance on drug education.

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