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A realistic objective for drug education

The Lincolnshire Project to Combat the Misuse of Drugs, funded by the Education Support Grant, entered its fourth and final year in September 1989. Funding at the national level is ceasing in March 1990, although a new ESG Health Education Project is being set up nationally through the DES, beginning in April 1990.

In the past three years the drugs education project has not been limited to the high-profile drugs such as heroin, cocaine, and cannabis, but has promoted preventive education approaches to combat the misuse of tobacco, solvents, and any substances that are used as drugs. With the exception of alcohol and tobacco, specific substances have not been focussed upon in training and curriculum developments, bearing in mind the vast range of substances available to change the way that the body or mind works, it would be totally impracticable to attempt to deal with all of these. Indeed, drug use is a complex behaviour, involving many factors apart from the substance being used or misused!

SHOCK-HORROR

Drugs education must be comprehensive in its approach, and, above all, must not focus predominently on knowledge. The use of 'shock-horror' tactics is still considered by some to be the most effective way of changing behaviour, and audio-visual aids such as *Better Dead* and *The Adolescent Epidemic* still find their way into the classrooms — even when they are intended for use only with adults or professionals!

There is no evidence to prove that shock-horror strategies prevent people from experimenting with drugs in the first place, or make them stop using drugs if they have started, but there is some evidence to show that they are counter-productive. Often, young people have asked to be shown shocking images, and teachers should ask themselves — and their pupils — why they need or wish to be frightened.

Drug use involves *people + environment + drugs*, which adds up to *consequences*. These consequences can be good or bad, depending on variations in each of the three components. For example...

- *Is the user alone or in a group?*
- *Is the use experimental or regular?*
- *What is the mood of the user?*
- *The drug itself: what sort is it, how much of it is used, and how is it used?*

Drugs education may need to cater for the different levels of drug use, which are...

1. Abstention — avoiding any non-medical use of drugs.
2. Experimentation, first-time use.
3. Recreational or reasonably controlled regular use.
4. Problem use, dependency.

Therefore its objectives, at least for the first three levels, should include...

Developing a wide range of skills, from communication to coping, assertiveness, and decision-making.

The acquisition of accurate scientific information on drugs.

Enabling young people to become aware of the beliefs and attitudes of themselves and others, and the ways in which these may affect behaviour.

The development of positive self-concept and self-esteem, with increased empowerment for making self-determined healthy choices.

Many of the popular and preferred learning materials are fundamentally skills-based — for example the *My Body* and *Health for Life* projects (primary), *Skills for Adolescence* (11-13), the *Alcohol Education Syllabus* (11-19), and *Drugwise* (14+).

Drug use and misuse, as a health education issue, has been located quite prominently in the National Curriculum and has been placed initially within the programmes of study for science. It is to be developed through all four Key Stages, thereby reinforcing the long-supported principle that it should be part of a developmental programme.

Key Stage 1 states that children should develop a variety of communication skills; they should be finding out about themselves; they should be introduced to ideas about how to keep healthy and about personal safety, and they should recognise the role of drugs as medicines.

Responsible drinking in a 6th-form clubroom.

Key Stage 2 states that they should continue to develop and use communication skills; be introduced to the fact that while all medicines are drugs, not all drugs are medicines; and begin to be aware of the catastrophic effect on health resulting from an abuse of drugs.

LIFESTYLE

Key Stage 3 states that pupils should begin to make personal decisions and judgments based on their scientific knowledge of issues concerning personal health, well-being, and safety, and they should examine ways in which the healthy functioning of the human body may be promoted and disrupted by lifestyle. The use and abuse of medicines and drugs, and the physical and emotional factors necessary for people's well-being, should also be included.

Key Stage 4 includes the ability to communicate, to apply, to make informed judgments and decisions. Pupils should have opportunities to consider the effects of solvents, alcohol and other drugs on the way the human body functions.

Substance use has been included as part of the Statements of Attainment for Attainment Target 3 — 'Processes of Life'.

Level 2 'Safety, and the proper and safe use of medicines are important.'

Level 4 'Avoidance of harmful substances such as tobacco, alcohol, and other drugs.'

Level 6 'Understand the risks of alcohol, solvent, and drug abuse and how they affect body processes.'

Level 8 'Understand that... drugs can disrupt the normal functioning of the body, and how the body's natural defences may be enhanced by... the use of medicines.'

Many schools are already using teaching resources and programmes that enable them to deliver this part of the National Curriculum, as well as resources that have become available to them through a programme of in-service courses covering the last three years.

UNDER-AGE

Is this a realistic objective for education? Alcohol abuse is not just a teenage problem, but one which affects every age, occupation, and racial group in the UK. However, it has been much easier to focus on the drinking behaviour of teenagers and young adults, and we have been helped to do this. Several sources of research data confirm that there is a high level of under-age drinking (Schools Health Education Unit, OPCS surveys), while Home Office statistics show that alcohol is involved in many crimes, especially those of violence.

Regular use of alcohol is the norm for many, if not most, adolescents as young as 13, and since the law enables alcohol to be consumed by all but the under-5s, drinking by this age-group is endorsed on one hand and dis-

approved of on the other. The young are bombarded with subtle messages about drinking alcohol, so abstention is not only a very difficult route to take, but perhaps an unrealistic one to enforce.

Moderate use of alcohol can be harmless, and the public needs increasingly to be made aware of healthy levels of consumption. Education about the sensible use of medicines in 5-9 year olds is the groundwork for learning about — and practising — sensible drinking in youngsters of 11 and older.

SENSIBLE

Knowing your limit is not the same as being able to hold your drink! The former involves healthy and sensible behaviour, while the latter is a recipe for possible ill health. It is not the aim of alcohol education to encourage young people to drink, but to encourage them to drink wisely if they decide to do so, or to offer alternatives.

A survey of Lincolnshire 11-15 year olds carried out in 1988, involving over 3500 pupils, revealed that 48% of 11-12 year olds and 61% of 15 year olds consumed alcohol on a weekly basis. As might be expected, the amounts consumed increased with age, as did the frequency of drinking.

While general drug education must be a part of the social education of our young people, there is a strong case for focussing upon alcohol use — but within the context of the former process. Secondary-school resources such as the *Alcohol Education Syllabus*, *That's the Limit*, and various audio-visual and games materials should be available from Health Promotion Departments, with *All About Me*, *Think Well*, *Drugs Education and the Primary School Child*, and the *Health for Life Project* being suitable for primary schools.

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