Better education and care

Drug education in schools

A report from the Office of Her Majesty's Chief Inspector of Schools

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Definition of key terms used in the report

In this report, the following terms are used in relation to drugs:

a) a drug is a substance people take to change the way they feel, think or behave

b) the term 'drugs' is used to refer to all drugs:

- illegal drugs (those controlled by the Misuse of Drugs Act 1971)
- legal drugs, including alcohol, tobacco and volatile substances
- all over-the-counter and prescription medicines

c) drug use is drug taking, for example consuming alcohol, taking medication or using illegal drugs

d) drug misuse is drug taking which leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence. It may be part of a wider spectrum of problematic or harmful behaviour.

Executive summary

The majority of young people of school-age have never used an illegal drug. Most will, at some stage, be occasional users of drugs for medicinal purposes and the majority will try tobacco or alcohol. Some will misuse illegal drugs but very few of those who experiment will go on to become problem drug users.

Every school, therefore, has a responsibility to consider its response to drugs. The key aim of drug education is to enable pupils to make healthy informed choices. As with most aspects of personal, social and health education (PSHE), expectations of the impact of drug education in our schools are high, far higher than they are for most subjects. The expectations of drug education are that, as well as increasing knowledge, changing attitudes and enhancing skills, the taught programme will also impact positively on pupils' behaviour. In isolation, a schools' drug education programme cannot achieve these targets.

The quality of provision for drug education in schools is improving. Since 1997, the last comprehensive Ofsted drug education report, there has been a marked improvement in the quality of planning of drug education programmes; achievement is higher at all key stages and most schools now have effective plans for dealing with drug-related incidents. The quality of teaching has improved at all key stages, but the continued involvement of secondary teachers who lack subject knowledge remains an issue for some schools. Though poor assessment practice remains the key weakness in many schools, developing a better understanding of the needs of the pupils is also an issue that requires attention. For example, we need to respond to pupils' requests for a greater emphasis to be placed on education regarding alcohol and tobacco as they see these as the drugs that pose the most significant health risks to them.

Though school drug education programmes provide opportunities for pupils to develop their knowledge of drugs and their effects, pupils also acquire knowledge from their friends and families. Most parents will make every effort to ensure their children's personal safety by providing the support and guidance they need. However, it cannot be taken for granted that they have the information and skills they need in order to successfully carry out this role. Setting expectations for their children, and being aware of and accepting responsibility for their behaviour, are major challenges for all parents and are ones that some are not meeting thus placing their own children as well as others at considerable risk.

The report is based on the evidence gathered from over 60 schools visited as part of the survey and from over 200 school inspection reports. Where percentages are referred to in the report it applies to this sample of schools.

Key findings

- Since the last comprehensive drug education report in 1997, pupils' achievement in terms of their knowledge and understanding of drugs and their effects has improved. The more effective lessons also challenge pupils' attitudes and help them to develop a range of skills such as those of decision making and being assertive.
- In both primary and secondary schools, the quality of teaching about drugs continues to improve. However, not all schools provide enough time for effective learning to take place and some teachers lack up to date specialist knowledge.
- Assessment remains poor in drug education as it does more generally in PSHE.
- There has been considerable progress in the development of policies and curriculum plans for drug education, but some primary schools in particular need to update their policies in line with recent guidance.
- Despite the good attempts being made by over half the schools to engage the pupils in a dialogue about drugs, the lack of understanding of their needs remains a problem.
- A minority of secondary schools do not provide pupils with access to adult support that the pupils feel meets their needs and/or maintains confidentiality.
- Pupils identify alcohol and tobacco, particularly the former, as the greatest threat to them in terms of the personal risks they might face. However, a significant number of young people regularly place themselves at risk by drinking to excess and in sexual activity, the latter often influenced by the former.
- Most schools have done all they can to involve parents in educating their children about drugs. Despite their concerns about the risks their children face from drugs, information and advice evenings have attracted little support from parents.
- Setting expectations for their children, and being aware of and accepting responsibility for their behaviour, are major challenges for all parents. Some are not meeting them well, thus placing their own children as well as others at considerable risk.
- Nearly all secondary schools and a majority of primary schools have a policy for dealing with drug-related incidents. Many of the policies are based on detailed frameworks that have been produced by national or local bodies.
- There has been little research to evaluate the outcomes of most drug education programmes, making it difficult to compare their effectiveness.

❒ The majority of schools have indicated that their approach to dealing with drugs will not involve either the use of drug (sniffer) dogs or random drug testing.

Recommendations

The following recommendations for schools arise from this survey.

❒ A significant minority of primary schools need to review and update their drug policies and their curriculum plans following the publication of the national guidance.

❒ In order to devise a curriculum to meet the needs of the pupils, schools should employ a variety of ways of gathering evidence of pupils' existing knowledge of drugs and attitudes towards them.

❒ Schools need to ensure that they give sufficient time to the teaching of drug education so that the provision meets pupils' needs.

❒ The overwhelming majority of young people regard tobacco and alcohol as the drugs that pose the most significant danger to them. This should be taken into consideration when determining the balance of time to be given to education about specific drugs and to solvent abuse.

❒ Links between drugs and themes such as sex and relationships education need to be more explicit so that pupils understand the links between drug use and risk-taking sexual behaviour.

❒ Some secondary schools should consider the benefits of specialist teaching about drugs with a view to raising the quality, consistency and coherence of the teaching.

❒ High quality training is essential for teachers and for external contributors to enable them to keep their subject knowledge up to date and to be flexible in their teaching methods in the light of pupil needs.

The following recommendation for national bodies involved in drug education arises from the report.

❒ There needs to be a comprehensive evaluation of the effectiveness of drug education programmes used in schools.

❒ There is a need to subject both drug-testing programmes and the use of drug (sniffer) dogs to rigorous and independent evaluation. To be effective this research will need to compare schools with different testing programmes with schools that do not test pupils.

❒ If parents are to play a greater role in advising and supporting their children, training programmes and resources will need to be made available to them, and they must be encouraged to make use of them.

Young people and drugs

1. While the concerns of many adults are about the involvement of young people with illegal drugs, the reality is that for the overwhelming majority of young people the greatest drug-related dangers they face are from tobacco and from alcohol.

Smoking and young people

2. Smoking is dangerous at any age, but the younger people start, the more likely they are to smoke for longer and to die early from smoking. A young person who starts smoking aged 15 is three times more likely to die of cancer due to smoking than someone who starts in their mid twenties.

3. Young people start to smoke for many reasons. Some smoke:
   - to show their independence
   - because their parents, brothers and sisters or friends do
   - because adults tell them not to
   - to follow the example of role models.

4. Most people know something about the health risks of smoking but young smokers do not see the risks as applying to them.

5. The *National survey of secondary pupils,* commissioned by the Department of Health shows that:[1]
   - the prevalence of regular smoking decreased from 10% in 2002 to 9% in 2003, but has remained stable at between 9% and 11% since 1998
   - there is a sharp increase in the prevalence of smoking with age
   - girls are more likely to be regular smokers than boys.

6. The survey *Young people in 2004* produced by the Schools Health Education Unit, Exeter reported that:[2]
   - between Year 8 and Year 10, the number of regular smokers more than triples; when asked how many cigarettes they had smoked in the last seven days, 5% of Year 8 boys and 9% of Year 8 girls had had at least one cigarette compared to 18% of Year 10 boys and 26% of Year 10 girls
   - shops were the source of the cigarettes for most Year 10 pupils
   - two thirds of smokers want to give up
   - young people are more likely to smoke if members of their family are smokers; girls are particularly influenced if their sister(s) smokes.

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[1] The Department of Health commissioned national survey of secondary schoolchildren aged 11–15 by the National Centre for Social Research and the National Foundation for Educational Research, 2003.

[2] The Schools Health Education Unit, Exeter. Survey report *'Young people in 2004'* is based on the Health Related Behaviour Questionnaire results for that year.

Alcohol and young people

7. New figures from the Department of Health reveal that nine children a day are admitted to hospital in England for alcohol-related problems.

8. The *National survey of secondary pupils* shows that:
   - the prevalence of drinking alcohol was 25%; this figure rose steadily to 27% in 1996 and has since fluctuated within this range
   - boys continue to be more likely than girls to have consumed alcohol in the last week
   - prevalence of drinking increases with age.

9. In terms of the amount of alcohol consumed, the average weekly consumption among secondary pupils increased from 5.3 units in 1990 to 9.9 units in 1998, and has fluctuated around this level since then. In 2003, the average weekly consumption was 9.5 units.

10. The survey *Young people in 2004* reported that:
    - when asked if they had had an alcoholic drink in the last seven days, 16% of Year 6 boys and 10% of Year 6 girls had had at least one drink compared to 42% of Year 10 boys and 45% of Year 10 girls; the Year 6 data suggests that the use of alcohol starts at an early age
    - wine and pre-mixed spirits are the most popular drink among girls and beer or lager is the most popular drink for boys
    - the off-licence is the most important source of purchased alcohol for Year 10 pupils
    - most 'drinkers' drank at home; while it is often observed that the home may be a safe and supportive environment in which to explore the use of alcohol, 16% of Year 10 boys and 18% of Year 10 girls who consume alcohol do so outside in a public place.

Illegal drugs and young people

11. In terms of the use of illegal drugs, some groups are more at risk than others. Vulnerable/at risk groups have been identified as:
    - children whose parents misuse drugs
    - young offenders
    - looked-after children
    - young homeless
    - those excluded from school and truants.

12. The *National survey of secondary pupils* shows that:
    - about one in five pupils had taken drugs in the last year, a similar figure to previous years
    - there was no significant difference between the proportion of boys and the proportion of girls who took drugs in the last year
    - cannabis remained the most likely drug to have been taken
    - 4% had taken Class A drugs in the last year
    - 42% had been offered one or more drugs

- overall, boys were more likely to have been offered drugs than girls
- cannabis was the drug most likely to have been offered
- 19% said that they had been offered volatile substances to inhale or sniff
- the likelihood of having been offered drugs increased sharply with age.

13. The survey *Young People in 2004* reported that:
- when asked what they know about drugs, as they get older, fewer think that cannabis will always be unsafe
- 28% of Year 8 and about 60% of Year 10 pupils were fairly sure or certain that they personally knew someone who took drugs
- a high proportion of Year 6 pupils also thought they knew someone who used drugs; as knowledge of other drug users is a key to obtaining drugs, the proportion of Year 6 pupils reporting that they think they know someone who uses a drug presents concern for the potential future behaviour of these young people
- nearly 20% of Year 10 pupils have taken drugs and alcohol on the same occasion; this behaviour suggests a less than cautious attitude to risk.

Evaluation

1. Provision of drug education in schools

Achievement

14. Since the last comprehensive drug education report in 1997, pupils' achievement in terms of their knowledge and understanding of drugs and their effects has improved in both primary and secondary schools.[3]

Primary schools

15. In primary schools, achievement is good in most lessons at Key Stage 1 and is good in four fifths of lessons at Key Stage 2. There is some under-achievement at Key Stage 2 where a contributory factor is the difficulty teachers have experienced in obtaining up-to-date information on drugs and their effects.

16. A key success for many primary schools has been their adoption of a broad definition of achievement that extends beyond knowledge to the acquisition of key skills and to challenging pupils' attitudes and behaviour.

17. By the end of Key Stage 1, most pupils:
    - are able to listen to others and take turns in class activity
    - can sustain involvement in class activity
    - recognise safe and unsafe situations
    - can recognise medicines
    - know that all household products, including medicines, can be harmful if not used properly
    - know rules for medicines such as only taking their own and keeping medicines locked away
    - can reflect on how their feelings and actions have an impact on others.

18. By the end of Key Stage 2, most pupils:
    - are able to listen to, and support others
    - respect other people's viewpoints and beliefs
    - know and understand the effects on the human body of tobacco, alcohol and other drugs, and how these relate to their personal health
    - are aware of the impact of drugs on individuals and families
    - know where individuals and families can find help
    - know about keeping themselves safe when involved with risky activities
    - know that their actions have consequences and are able to anticipate the results of them
    - can talk and write about their opinions, and explain their views, on issues that affect themselves and society, for example writing about banning smoking on school premises.

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[3] *Drug education in schools*, Ofsted, 1997

19. At Key Stage 2, pupils are less secure in their knowledge of the levels of drug misuse among their peers and on the laws relating to drugs.

20. Particularly at Key Stage 2, pupils are influenced by the opinions and behaviour of their friends. Remaining part of a group has far greater significance for them than becoming involved in risking taking behaviour. In the following example, the lesson provided the Year 6 pupils with the opportunities they needed to demonstrate their subject knowledge and to practise their decision making skills.

    The key objective was to develop strategies to cope with peer group pressure. Pupils could already identify common drugs and their effects and their attitudes towards drugs were negative. Role play was used in which pupils were asked to consider what avoidance strategies they could employ if offered drugs by their friends. Each group developed and gave a presentation, which was evaluated by the whole class to discuss the effectiveness of avoidance strategies, and any alternatives. Individual pupils decided which might best help them resist peer pressure. Throughout the lesson, pupils had the time to develop their ideas and to listen to those of others.

Secondary schools

21. In secondary schools, achievement, in terms of pupils' knowledge and understanding of drugs and their effects, is good in half the lessons at Key Stage 3 and in three quarters of lessons at Key Stage 4. At both key stages, achievement is unsatisfactory in one lesson in fifteen.

22. By the end of Key Stage 4, pupils have a good knowledge of drugs and are aware of, but do not always accept, the risks associated with their use. In particular, pupils are less likely to reduce their use of alcohol or tobacco in the light of evidence of their harmful effects. For example, many pupils spoke of knowing their safe limit for alcohol but were not basing this on their understanding of the alcohol levels in various drinks but on their experience of how much alcohol they needed to consume to get drunk. A significant minority of pupils did not recognise the physical risks they faced from drinking to excess. However, in about one lesson in ten, pupils did not have the opportunity to consider the social and emotional issues associated with drug misuse.

23. Most pupils have a good knowledge of the law as it relates to illegal drugs. To date, there is little evidence to support claims that reclassification of cannabis has given pupils any wrong messages: one study found that 95% of young people were clear about its status after reclassification. However, some pupils are, at times, less clear about the laws relating to alcohol.

24. The majority of pupils are aware of the prevalence and acceptability of drugs among their peers. By the end of Key Stage 4 they are less inclined to quote peer pressure as the reason why they might use a particular drug.

25. Opportunities for pupils to explore their attitudes towards drugs and to share their views with others are weak in one lesson in six. With few exceptions, use of illegal drugs is challenged but this is not always the case with alcohol. Here, teachers are acutely aware of the possibility of conflict with parents with the result that there is sometimes a blurring of what is safe or socially acceptable in relation to the consumption of alcohol.

26. In most lessons pupils are given opportunities to develop their decision making skills. They are aware of where they can find information and advice. A concern is the one lesson in five where pupils are not given opportunities to develop their decision making and resistance/assertiveness skills.

Planning for drug education

27. *Drugs: guidance for schools* (DfES, February 2004) states that all schools should have a drug education programme which:
    - *is developmental and appropriate to the age, maturity and ability of pupils*
    - *covers, as a minimum, the statutory elements included in the National Curriculum Order for Science for each Key Stage*
    - *is taught as part of PSHE and citizenship and, to be effective, is supported by a whole-school approach*
    - *covers all drugs and, when appropriate, should focus on drugs of particular significance to pupils such as alcohol, tobacco, cannabis, volatile substances and Class A drugs*
    - *is based on pupils' views and builds on their existing knowledge and understanding*
    - *is taught by skilled and confident teachers.*

28. The guidance also states that all schools should have a drug policy which sets out the school's role in relation to all drug matters: both the content and organisation of the drug education programme and the management of drugs within school boundaries.

29. Since the 1997 *Drug education in schools* report, there has been considerable progress in the development of policies and curriculum plans for drug education.

Primary schools

30. More than four fifths of primary schools now have a drug education policy compared to only two fifths of schools in 1997. The quality of the drug

policy and related curriculum planning are good in over half the schools but are unsatisfactory in almost one third. One of the unsatisfactory features of the planning is the failure to review the policy and the plans following the publication of local or national guidance: in one in eight schools the policy is out of date.

31. The extent to which the drug policy and the curriculum plan are based on the assessed needs of the pupils is good in over half the schools but is unsatisfactory in one quarter. Consultations with pupils about the drug education provision are improving but many schools are not recognising that lesson and topic evaluations and assessment data can yield important evidence that can guide future planning.

32. Some primary schools have used behavioural surveys to help them to plan the curriculum so that it meets the needs of the pupils. As a result, in these schools, increased time is being devoted at Key Stage 2 to education about alcohol and tobacco.

33. Where the quality of the curriculum plan is good, most have made use of local education authority (LEA) guidance as a planning framework. Key aspects of drug education from National Curriculum science and from the PSHE guidance from the Qualifications and Curriculum Authority (QCA) have also been used to good effect in developing the programme. Good drug policies and programmes also take due account of local circumstances.

34. Primary schools are particularly effective at teaching subjects such as drug education through more than one curriculum area. Many plan for the teaching about drugs through PSHE, science and RE. Such cross-curricular planning is good in two thirds of schools and satisfactory in the others.

35. When teaching is good, teachers make good use of the guidance in the schools' curriculum plan as the basis for planning their drug education lessons. In the following example, the co-ordinator advises teachers on the structure of a good drug education lesson.

The following teaching and learning approaches have been particularly successful for drug education. When planning for your class, consider whether the lesson should include time for:

- *individual reflection on the issue in hand*
- *small group discussions and decision making*
- *the sharing of ideas by the whole class*
- *opportunities for reporting back.*

36. One of the common factors in weak teaching and poor assessment practice is the failure of the teacher to share the lesson objectives with the pupils. Usually, this results from the curriculum and lesson plans paying little or no attention to the desired learning outcomes for the topic or for

the individual lesson. The identification of learning outcomes is good in one third of primary schools but unsatisfactory in a similar proportion.

Secondary schools

37. Over nine out of ten secondary schools now have a drug education policy compared to less than three quarters in 1997. The quality of the PSHE policy and curriculum planning is good in half the schools but unsatisfactory in a quarter. The majority of secondary schools have reviewed their policy since the publication of the drug education guidance by DfES in 2004.

38. The extent to which the policy is based on the assessed needs of the pupils is good in almost half the schools but unsatisfactory in a quarter. Where practice is good, teachers use a variety of ways of gathering evidence of the existing levels of pupils' knowledge of drugs and their effects. This includes:
- the use of questionnaires before teaching a new topic
- evidence from the evaluation of the teaching
- assessment data
- discussions with pupils
- discussions with the school council
- individual pupil interviews
- lifestyle questionnaires/surveys.

39. Despite the good attempts being made by over half of the schools to engage the pupils in a dialogue about drugs, the lack of understanding of their needs remains a problem. While the concerns of many teachers and parents are about the involvement of young people with illegal drugs, the reality is that the overwhelming majority of young people regard the greatest drug-related dangers they face as being from tobacco and alcohol. Such evidence has to be taken into consideration when determining the balance of time to be given to education about specific drugs.

40. In the overwhelming majority of schools, drug education forms part of the PSHE programme. In recent years, the PSHE curriculum has had to adapt to accommodate, for example, an expansion of careers education and guidance and work-related learning and, in some schools, the inclusion of parts or all of the National Curriculum programmes of study for citizenship. With no additional time provided for PSHE, this has had an immediate and negative impact on the time allocated to aspects of the provision such as drug education. This creates a tension for schools as intensive drug programmes, given a large amount of curriculum time, have been shown to be effective, although intensity alone does not necessarily ensure effectiveness.

41. Good schemes of work organise the teaching in a coherent way that ensures continuity and progression. The nature of drug education, with its particular emphasis on meeting the needs of pupils as they mature, requires that learning is revisited and extended throughout their school career. In the following example, the scheme provides teachers with guidance on the outline of the programme. It indicates the learning objectives, the key words to be developed and any cross-curricular links. It also indicates how assessment should take place.

The drug education scheme of work shows very good continuity and progression between year groups. The initial research with pupils has identified the most appropriate teaching time for all aspects of drug education. This research is conducted annually in order to detect and respond to changing priorities.

Drug education is also taught through National Curriculum subjects as well as being part of the PSHE programme. For example, the Year 8 PSHE programme teaches about illegal drugs, science addresses the effects on health of drugs while work in English relates to the role of the media and, in particular, to the topic of celebrities and drug misuse.

42. Too few drug education programmes make links to other PSHE themes such as sex and relationships education. As a result, the planning and subsequent lessons do not make any link between drug use and risk-taking sexual behaviour.

43. Some schools have sought to augment their programme of drug education lessons with different approaches, such as whole-school 'focus days', that have the potential to enrich programmes but not to replace them. Such focus days, as in the following example, require considerable organisation and the involvement of a range of external agencies to provide key inputs.

A focus day: Year 9 drugs awareness

The aims were to:

- *raise pupil awareness and understanding of the drug scene and to recognise the pressures on them to get involved*
- *help pupils to make informed and well considered decisions and understand the consequences of their actions*
- *explore coping strategies and provide information on where students can obtain support to help themselves or their friends should the need arise.*

The programme comprised:

Drugs and the law	*Police Youth Affairs Officer*
Consequences of drug taking	*Assistant County Coroner*

A focus on cannabis	*School Youth Worker*
Attitudes to drugs and where to obtain advice and support	*Youth Counsellor*
You as a risk taker	*Drugs Education Adviser*
The effect of drugs	*Nurse*

Each pupil was be given a booklet which provided a wealth of information about drugs, their effects, legal implications and support agencies as well as containing quizzes relating to the subject. Parents were asked to look through the booklet with their son/daughter and to discuss with them some of the issues it raised.

There were follow up lessons to the conference.

44. Overall, the day was well planned, pupils are well prepared, external inputs were well co-ordinated and the school effectively followed up and evaluated the event.

Teaching about drugs

Primary schools

45. In primary schools, the quality of teaching about drugs has shown steady improvement. In both Key Stages 1 and 2, teaching is good in four fifths of lessons.

46. The quality of teaching about drugs in primary schools is higher than in secondary schools. Perhaps the most significant factor in this is the higher level of contact that primary teachers have with their classes, giving them a greater knowledge of pupils' abilities and attitudes. As a result, effective drug education lessons provide an inclusive experience: high quality lesson planning ensures that all pupils are engaged in all aspects of the lesson. Good lessons set appropriate, high expectations and build on what pupils already know; teachers are very successful at both matching the teaching techniques employed to the lesson objectives and in ensuring that the lesson is delivered within a safe, secure and supportive learning environment. The consequence of all this for the pupils is that learning develops their understanding and skills through enquiry, learning and problem-solving and that the lessons are enjoyable and challenging experiences.

Secondary schools

47. The 1997 *Drug education in schools* report stated that teaching was good in three fifths of lessons but unsatisfactory in one lesson in seven. The quality of teaching has continued to improve and is now good in two

thirds of lessons at Key Stage 3 and in three quarters of lessons at Key Stage 4 with, overall, unsatisfactory teaching in one lesson in twenty. This improvement in teaching is the result of a number of changes.

48. The reduction in the proportion of unsatisfactory teaching has resulted principally from the increased deployment of teachers with both the required specialist knowledge of drugs and the necessary teaching skills. Other factors have been the quality of the lesson planning and the extent to which the resulting provision has been targeted at the identified needs of the pupils.

49. In some instances, however, the production of a detailed lesson plan may not lead to good teaching. In a significant minority of schools, particularly those where form tutors teach drug education, the co-ordinator has written detailed guidance for each lesson. Too many teachers do not use this as the basis for their own planning of the drug education lesson but instead they opt to teach the lesson directly from the guidance. On too many occasions this can result in poor teaching as insufficient thought is given to the existing levels of knowledge of the pupils or whether the teaching approach being used is appropriate, for example sufficiently differentiated, to the needs of the pupils.

50. Much has been written about the difference in quality of teaching about drugs by specialists and non-specialist tutors. The quality of teaching is unsatisfactory in twice as many lessons taught by tutors as by specialist teachers. Even so, some schools defend the use of tutors for teaching drug education on pragmatic or educational grounds. The pragmatic view is that it is much easier to timetable all tutors to teach drug education (as part of PSHE) at the same time each week than it is to create and timetable a specialist team. The educational view is that of making a link between the role of the tutor in the personal and social development of the pupils and the content of PSHE courses. In both cases the key issue is the variable level of subject knowledge and enthusiasm of the tutors that are quickly apparent to the pupils, who react negatively or are simply embarrassed by their tutor's reluctance to teach the subject. Schools should be monitoring and evaluating all aspects of provision including their drug education (PSHE) programme. If weaknesses in the teaching about drug education are identified remedial action, including training, should be put into place. If this fails to secure the necessary improvement in the quality of the teaching then the school should establish a specialist team or efficiently deploy specialist lead teachers to teach drug education.

51. When teaching is good:

- the teacher has an appropriate level of knowledge about drug education
- the lesson is well planned and has clear learning outcomes
- all pupils are challenged at levels appropriate to their ability
- ideas and initial thoughts from pupils are received positively and the teacher is skilled at asking open questions to further develop thinking

- pace is maintained
- a clear structure to the lesson supports the use of a range of teaching techniques and learning styles
- pupils are motivated and remain fully involved in the learning process
- the teacher provides a very good open forum where opinions can be shared and pupils are supported to explore their own ideas and reasons behind them
- the teacher gives a clear indication of ground rules
- pupils feel safe and secure to share experiences as well as ideas.

52. For some time, peer education has been successfully used in schools.

The peer educators in the project schools were trained by professionals from education and health. They were supported in their schools by a co-ordinating teacher. The project benefited the peer educators themselves, increasing their confidence and giving them more information about drugs and was well received by the young people who experienced the lessons, who felt very positive about the methods of delivery that were used. The successful teaching methods employed by the peer educators included discussion, role play and flipcharts, as these were interactive, participative methods. In all the classes there was an increase in students' levels of knowledge about drugs. In particular, students had a greater awareness of the social and psychological effects of alcohol on individuals and the impact on the community; clearer understanding of the effects of alcohol on the body; and increased knowledge about the more visible effects of smoking. The vast majority of students felt that teaching by the peer educators was good and liked the way the information was presented. [4]

53. Where teaching about drugs is less effective the common features are:
- weaknesses in the subject knowledge of the teacher
- planning that does not ensure all pupils are challenged at an appropriate level
- questioning that does not enable pupils to build on original thoughts
- the pace of learning is not maintained.

Assessment

54. Assessment remains an issue in drug education as it does more generally in PSHE.

Primary schools

55. In primary schools, the suitability of assessment is good in one quarter of schools and is unsatisfactory in a similar proportion. While assessment of

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[4] *Evaluation of the North Somerset Pilot Peer Education Drugs Project*, University of the West of England, 1998, J. Orme and F. Starkey.

pupils' knowledge is good in half the schools and unsatisfactory in very few, the recording of these assessments is unsatisfactory in half the schools. In half the schools teachers are making a good attempt to assess pupils' skills and attitudes but assessment is unsatisfactory in one in eight schools. A major concern is the half of schools who do not use their assessment data to inform future planning or to influence subsequent teaching.

56. However, the situation is not as bleak as it may seem. Most primary teachers do know a great deal about pupils' levels of subject knowledge and understanding and the extent to which they are developing key skills such as decision making and communication. What then is the problem? In part, it is the teachers' lack of understanding of what might constitute suitable assessment in drug education. In the majority of the lessons, learning outcomes are specified in the curriculum and in individual lesson plans. From observation of role play, group work and general discussions the teacher has a view of the extent to which pupils understand the issues under discussion. Over a period, they assess the extent to which pupils are developing and using key skills. However, relatively few teachers have systems for recording the progress being made by pupils. In the best of practice, teachers assess knowledge and understanding within each aspect of the work and take, quite appropriately, a longer term view to the assessment and recording of pupils' skills and attitudes. In one school, for example, prior knowledge is determined, learning is checked in lessons and use is made of pupils' self-assessment materials as well as baseline and end of topic assessments.

The school has a good approach to assessment. A formal system for recording progress towards outcomes is being developed by the PSHE coordinator. At present, lesson observations and work scrutiny clearly reflect good practice in assessment for learning. Learning is checked periodically in lessons, prior knowledge determined and use is made of pupils' self-assessment materials in topics using published materials. Teachers have a good knowledge of what their pupils can do. Use of cluster and mind-mapping tasks give the teachers good feedback on progress in the lessons. Some baseline and end of topic assessments are also carried out. Developments continue as the school trials different methods for topic assessments in order to make them more user friendly, to better fit the overall school assessment policy and to suit their particular drug education programme.

Secondary schools

57. In secondary schools, the assessment of pupils' knowledge is good in two fifths of schools and unsatisfactory in a similar proportion.

58. In one fifth of schools, teachers are making a good attempt to assess pupils' skills and attitudes but practice is unsatisfactory in one third of

schools. Half of the secondary schools do not use their assessment data to inform future planning or to influence subsequent teaching.

59. The report *PSHE in Secondary Schools* [5] stated that 'Assessment is the weakest aspect of teaching and is often either poor or entirely absent.' In too many schools, perceptions of achievement in drug education (PSHE) are narrow, relating only to pupils' progress in developing their subject knowledge and understanding. Where assessment practice is effective, it is used to determine pupils' existing levels of knowledge and understanding of a topic before new teaching takes place and is central to teaching and learning. Good assessment also involves the pupils through peer group and self assessment activities.

Opportunities for assessment of pupils' knowledge, understanding and skills are identified within drug (PSHE) lessons. Good use is made of short questionnaires to determine pupils' knowledge before and after teaching a topic. Appropriate skills are developed in drug education (PSHE) and in other subjects. For example, work on communication skills in English is assessed within that subject and relevant outcomes shared with the PSHE team. Similarly, work in mathematics on data analysis uses drug-related statistics. The quality of analysis of the data by the students is very good. Many pose searching questions that are followed up in subsequent drug education lessons. Such work has the double value of placing statistical analysis within a meaningful context but also presents good opportunities for the assessment of the skills of analysis.

The schools' comprehensive photographic records of pupils' achievements add considerably to the evidence profile for the subject.

Working with other agencies

60. While there is no evidence to suggest that any particular external contributor is more effective than any other in providing drug education, when working with teachers, external contributors often bring specialist knowledge and novelty, leading to high involvement and enjoyment for pupils.[6]

61. School nurses, police officers and Theatre in Education (TiE) groups are the most frequent contributors to drug education. In each case, if their contribution is planned as part of the overall drug education programme, they add value to the pupils' experiences.

[5] *PSHE in secondary schools*, Ofsted (website report), 2005

[6] White, D., Buckley, E. and Hassan, J., Centre for Health Psychology, Staffordshire University. Literature review on the role of external contributors in school drug, alcohol and tobacco education.

62. Programmes delivered by school nurses have been shown to produce short-term knowledge gains, and to have at least short-term effects on cannabis and alcohol use.

63. Police officers can also provide a valuable contribution to drug education when used in a supplementary role, but only when their expertise is linked effectively with the school's aims for drug education. For example, police officers have made particularly successful contributions to pupils' knowledge in relation to the laws about drugs.

64. A qualitative assessment of TiE delivered in eight schools suggests that the programme is effective in changing attitudes and in providing information. When most effective, the production is well matched to the needs of the pupils and is included as a part of the programme of drug education planned by the school rather than as a stand-alone session.

65. When external contributors make a significant contribution to the schools' drug education programme, the school has worked closely with them on the planning and co-ordination of the activities. They also ensure that the sessions led by the external contributor match with the curriculum, with preparatory and follow up work by the teachers increasing the effectiveness of the sessions.

66. Most external contributors make such positive contributions to drug education but where provision is less successful there are a number of contributory factors. Firstly, when the time for drug education has been reduced by a school they often require the police officer to cover the same range of issues in a much reduced time. This leads to frustrations for the police officer and for the pupils as the opportunities for raising questions and general discussion are often severely reduced or even eliminated. Secondly, a minority of schools regard such external contributions as sufficient in themselves to cover an aspect of drug education; this is not so.

67. Some LEAs and other organisations provide training for external contributors to prepare them to contribute to school drug education programmes. Currently, there is considerable variation in the quality of the training received by external contributors. For many contributors, their training is not sufficient to ensure that their lessons will allow the pupils' opportunities to develop their skills such as those associated with decision making nor does it enable the contributors to cope with the demands of working with a whole class.

68. Providing high quality training is essential for effective drug education. Training is required to enable external contributors to be flexible in their teaching methods and to modify their approach in the light of pupil needs. Both teachers and external contributors require an assessment of their training needs and need to be offered appropriate training.

Working with pupils and parents

Working with pupils

69. *Drugs: guidance for schools* (DfES), states that schools should ensure that pupils vulnerable to drug misuse are identified and receive appropriate support either from within the school or through referral to other services.

70. Good drug education lessons improve pupils' knowledge, challenge their attitudes and help them to develop a range of skills. Most lessons provide opportunities for pupils to ask questions but some issues are of a very personal nature so that the pupil concerned will want to raise the matter separately with a teacher or other adult. Currently, a minority of schools do not provide pupils with access to adult support that the pupils feel will either meet their needs or maintain confidentiality.

71. Successful schools are being creative in the way they engage key members of staff to work with pupils and their families. In the following example, the primary school has made very good use of the learning mentor.

The drug education programme has a strong emphasis on keeping safe and staying healthy. The learning mentor role is closely linked to the drug education programme.

The mentor works closely with the class teachers to address the needs of individual pupils and their families, providing information and a link to outside agencies for advice. The mentor provides advice and support to pupils through one to one counselling sessions, but also through the setting up of a buddy scheme. The approach is grounded in respect for one's body and what goes into it.

72. In one LEA, schools are able to call upon agencies whose advice and support is coordinated by the LEA Drug Adviser.

The LEA, the District Council and other local agencies help the schools to provide good support for pupils. The LEA Drug Education adviser is held in high regard by the schools and by other agencies. Both the adviser and the co-ordinator of the local Crime Disorder Partnership emphasise their role in developing work in primary schools and the links with secondary schools. There is a good local long term strategy for dealing with drug education. As part of the strategy, parents are made aware of what their children are doing in drug education. Most schools hold drug awareness evenings for parents. Local agencies, where necessary, have the facilities to support parents who are dependent on drugs.

73. An alternative source of advice for pupils may be a drop-in clinic at or near the school. Such school based drop-in centres address the major concerns of pupils who find it difficult to access GP services where they have

concerns about maintaining confidentiality, the timing of GP surgeries and GPs who will see young people under 16 only if a parent is present. The advantages of drop-in centres were stated in the *Sex and Relationships* report (Ofsted 2002).[7] Unfortunately, progress towards the establishment of such drop-in centres has been, at best, modest.

Working with parents

74. Most schools organise drug information evenings for parents. Despite the general concern among parents of the risks their children face from drugs, such events have attracted a variable and often small number of parents. Schools have identified hard to reach parents and these include:
  - those living in rural areas
  - fathers
  - those with special needs and
  - those who are drug users themselves.

75. In addition, schools have not always been able to identify the needs of particular community groups including black and minority ethnic groups.

76. Building on where the gaps are in engaging hard to reach parents and on what is already known, the 'Drug Education for Hard to Reach Parents Project' mapped the drug education provision for parents.[8] Among the outcomes of this exercise were the suggestions that:
  - schools and other bodies might use different venues as a means for providing drug education
  - different methods of delivery might be considered, including one-to-one sessions, parents evenings, literature and through parenting courses
  - schools work in partnership with other organisations to deliver drug education to all parents or to a target group.

77. This project confirmed the findings of other surveys about what parents wanted from drug education training. Most parents felt that drug training could not be successfully completed in one session and should include:
  - the provision of accurate, up-to-date information on all drugs and their effects with particular attention given to those drugs most frequently used by young people
  - advice on how to talk to their children about drugs
  - advice on how to access local sources of advice and information.

78. While some schools are working hard with parents and the community to address their needs, the general picture, though improving, indicates that more progress is needed. Currently, two fifths of primary schools and half of secondary schools are effective in engaging parents in discussing policies for drug education and for dealing with drug-related incidents.

[7] *Sex and Relationships* report, Ofsted, 2002
[8] *Drug education for hard to reach parents*, Drugscope, 2004

Practice is weak in one third of primary schools and in one fifth of secondary schools.

79. How do schools engage with the parents who do not attend such briefing meetings particularly those with children that the school considers to be at risk? At the point where a school has done everything it can, the responsibility for supporting and advising the children has to pass to the parents.

80. When parents are aware of the issues that are being taught in drug education, they can work together with the school to support their children. Evidence from discussions with pupils and from national surveys confirms that parents are now less regarded as the pupils' main source of advice on aspects of PSHE such as drugs. However, if asked who *should be* their main source of information and advice on such issues, many of them feel that their parents should take on this role. Most parents will make every effort to ensure their children’s personal safety by providing the support and guidance that their children need. However, it can not be taken for granted that they have the information they need in order to successfully carry out this role. For example, most parents believe that the greatest threat to their children is that from illegal drugs; yet this is the case for only a tiny proportion of young people.

81. What is the role for parents in such a situation, especially if they themselves drink alcohol? Do they recognise this as drug use and how aware are they of safe levels of use? Secondly, are they providing the advice and support their children need if they are to understand potential dangers, have the skills to cope with new experiences and know what expectations their parents have of them? Setting expectations for their children, and being aware of and accepting responsibility for their behaviour, are major challenges for all parents and are ones that some are not meeting thus placing their own children as well as others at considerable risk.

Leadership and management

82. The quality of management and leadership by drug (often also PSHE) co-ordinators has shown steady improvement. Currently, almost nine out of ten co-ordinators provide good management and leadership of their teams. Effective co-ordinators, supported by senior managers, ensure that:
    - schemes of work are regularly reviewed
    - effective approaches to teaching and learning are identified and used
    - there are clear policies and practices for assessing pupils’ progress
    - the achievement and progress of all groups of pupils are regularly monitored with the active contribution of the pupils themselves
    - all school staff receive drug awareness training, understand the school’s drug policy and their role in implementing it

- teachers have access to high-quality support and continuing professional development opportunities
- there is continuous monitoring and evaluation of teaching and learning.

83. Where leadership and management are good, it ensures that the provision is well matched to the identified needs of the pupils.

Drug education has high priority and status within this primary school. The governors are aware of the programme and give it their active support. The co-ordinator is highly effective and has produced clear schemes of work. Very good liaison between the co-ordinator and other subject co-ordinators ensures that the school provides a coherent drug education programme. There is a good programme of monitoring progress by scrutiny of pupils' folders and there is a planned programme of lesson observations.

84. The 1997 report on drug education stated that teachers in a quarter of schools had attended drug-related training in the previous year. Though prior to the training there was often no analysis of the needs of the teachers the quality of the training was often good. The key issue at that time related to weaknesses in the dissemination of the outcomes of the training to other teachers.

85. The DfES and the Department of Health are jointly funding the continuing professional development and training of teachers in aspects of PSHE. The most recent programme has involved about 1800 schools and is addressing many of the issues raised in previous Ofsted reports. Teachers' enthusiasm, confidence and knowledge of aspects of PSHE have improved and many feel they are in a better position to support colleagues. Pupils are benefiting from improved lesson planning, more creative lessons and from teachers' use of more varied and appropriate teaching styles.

86. An increasing number of schools and LEAs have also responded positively to the training needs of teachers.

All primary teachers and some of the governors have received drug education training from LEA advisers. The evaluations of the training sessions have been very positive. Teachers indicate that the training has been very successful in improving their understanding and knowledge about drugs and about drug education. As a consequence of the training, improvements to teaching have been observed with increased use being made of role play and discussion.

Drug related incidents

87. *Drugs: guidance for schools* (DfES) states that all schools should have agreed a range of responses and procedures for managing drug incidents,

which are understood by all members of the school community, and documented within the drug policy.

88. The 1997 drug education report indicated that three quarters of schools had a policy for dealing with drug-related incidents. In the remaining quarter of schools, and in some others where there was insufficient detail in the policy statements, there was often confusion as to how best to deal with drug-related incidents.

89. The situation is now much improved: nearly all secondary schools and a majority of primary schools have a policy for dealing with drug-related incidents. Many of the policies are based on detailed frameworks that have been produced by national or local bodies. The most effective policies have been adapted to meet the specific needs of the school and its pupils. Where policies are less effective they have not been tested and evaluated for effectiveness against potential drug incidents. The most effective policies clearly establish how staff should manage incidents with confidence, consistency and in the best interests of all those involved. They give a clear message to the school community that the possession, use or supply of illegal and other unauthorised drugs within school boundaries is unacceptable. A weakness in many policies is the absence of a definition of where and when they should apply. In particular the policies often fail to consider whether they should apply to incidents that take place outside the school premises and beyond the school day. Crucially, the more effective schools have also ensured that vulnerable pupils receive appropriate support through the curriculum, the schools' pastoral system and through referral to other services. They work closely with both the pupils concerned and their families.

90. A good school drug incident policy will:
- clarify the school's responsibilities and the legal requirements
- give a clear view on the use of drugs in school
- support the pupils
- explain the school's approach to drugs to the community
- provide consistency in the management of drug incidents
- ensure that the school's ethos and values are reflected in its responses to incidents
- create a framework for monitoring and evaluating the effectiveness of the policy in practice.

91. An example of effective practice is given below.

The school approach to dealing with drug-related incidents is excellent. It has been developed through co-operative working with the police liaison officer, parents, teachers and pupils.

Pupils found in possession of drugs, with their parents, meet with the staff and the police. An agreed course of action is determined. Pupils

receive advice and support and are referred to a counsellor if needed. With very few exceptions, the interventions have positive outcomes. Dealing drugs is not permitted. Pupils know they will be excluded: there have been no cases in the last ten years.

There has been very good involvement of the pupils in both developing and evaluating the programme. The key to the success of the programme has been flexibility and refusing to take action before all the evidence has been considered.

92. The majority of schools have indicated that their approach to dealing with drugs will not involve the use of drug (sniffer) dogs. However, some schools have trialled the use of drug dogs with pupils. To date the projects have been small scale and the outcomes have not yielded consistent evidence of their effectiveness. There is a need to exercise caution before the use of drug dogs in schools is increased.

Some Bedfordshire schools have been working with the police to involve the use of drugs dogs with pupils. The key question was: could the use of drug dogs in school events have a positive impact on the attitudes of pupils towards illicit drugs? The evaluation of the project indicated that the core elements of the events, such as presentations and demonstrations, had a positive impact on: [9]

- *pupils' knowledge of*
    - *the laws concerning drugs*
    - *the consequences of being caught with drugs*
    - *how the police detect drugs*
- *pupils' attitudes towards the police*
- *pupils' and parents' awareness of the police tackling drugs in the community*
- *partnership working between the police, parents and schools.*

However, the evaluation found that walking pupils past the dogs carried high costs and risks, but it added no value to the events. The research recommended that schools and police worked towards maximising the impact that the drugs dogs events through the presentations and demonstrations only.

93. A small number of schools is considering or has introduced random drug testing of pupils. The introduction of such testing raises a number of issues that might be resolved through national debate. Issues that might be considered include whether:

- such testing involves serious breaches of trust between parents and children and between schools and their pupils
- the inclusion of testing of teachers impinges on their civil liberties

[9] Matrix MHA, January 2004, *Evaluation of Drugs Dogs Events in Bedfordshire's Schools.*

- the tests do lead to the creation of 'drug free schools' when the tests detect a narrow range of drugs.

94. There is a need to subject drug-testing programmes to rigorous and independent evaluations. To be effective this research will need to compare schools running a range of testing programmes with schools that do not test pupils.

2. The impact of drug education in schools

95. The key aim of drug education is to enable pupils to make healthy informed choices. Expectations of the impact of effective drug education in our schools are high, far higher than they are for most subjects. The expectations of drug education are that it will increase pupils' knowledge, change their attitudes and enhance their skills as well as having an impact on their behaviour. It is intended that effective drug education will:
    - enable young people to make healthy choices
    - minimise the proportion of users who adopt particularly dangerous forms of misuse
    - persuade those who are experimenting with or misusing drugs to stop
    - enable any pupils who are misusing drugs or who have concerns about the misuse of drugs to seek help.

96. If we have these expectations of what a school drug education programme can achieve, what does research evidence tell us about impact?

97. Few curricular programmes, particularly those for primary pupils, have been fully evaluated.[10] Some research studies have shown the impact of drug education programmes on pupils' attitudes, knowledge and resistance skills, but very few have examined their impact on the long term behaviour of the pupils. However, a number of points about the effectiveness of drug education programmes can be made:
    - although the effects decrease with time, programmes can delay for a short time the start of substance misuse by non-users and temporarily reduce use by some current users[11]
    - prevention programmes designed to reach all pupils regardless of their risk of substance misuse appear to be more effective for lower-risk young pupils than those at higher risk[12]
    - life skill training is one of the few programmes that has been extensively evaluated and for which there is research evidence of a small but positive impact on drug use.[13]

98. Evidence suggests that interactive peer education programmes are more effective than non-interactive interventions in preventing drug misuse. In

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[10] Lloyd, C., Joyce, R., Hurry, J. and Ashton, M. (2000). The effectiveness of primary school drug education. *Drugs: Education, Prevention and Policy* 7.

[11] White, D. and Pitts, M. (1998). Educating young people about drugs: a systematic review, in *Addiction, 93* .

[12] Windle, M and Windle , R.C. (1999). Adolescent tobacco, alcohol and drug use: current findings. *Adolescent Medicine: state of the Art Reviews* 10 (1).

[13] Coggans, N., Cheyne, B., and McKellar, S. (2003). *The Life Skills Training Drug Education Programme: a review of research.* Scottish Executive Drug Misuse Research Programme, University of Strathclyde.

such peer-led interventions, the young person delivering the programme tends to benefit most from the experience.[14]

99. Information based programmes, including project DARE (Drug Abuse Resistance Education), led by police officers have not had much effect on substance misuse behaviour.[15]

100. Although more research is needed, a qualitative assessment of Theatre in Education delivered in eight schools suggests that the programme was effective in both changing attitudes and providing information.[16]

101. Parent programmes have not been adequately evaluated although there is an indication that such programmes are poorly attended. Attendance is even lower among parents who drink and smoke more heavily, suggesting that programmes might stigmatise these parents and so discourage high-risk families from attending.[17]

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[14] Parkin, S. and McKeganey, N. (2000). The rise and rise of peer education approaches. *Drugs: Education, Prevention and Policy* 7.

[15] How effective is drug abuse resistance education? A meta-analysis of project DARE outcome evaluations. *American Journel of Public Health* 84: 1394-1401. And Whelan, S., and Culver, J. (1997). Teaching young people how to say no. *Education and Health* 15 (3): 1475 -87

[16] Fine, D., and Durrant, K. (1996). Broken Angel a play by Lin Coghlan preformed by Roundabout Theatre Company as part of a drugs education programme. An evaluation of its effects as part of the 1994 European Drugs Prevention Week Initiative, by Sheffield Hallam University.

[17] Cohen, D. and Linton, K. (1995). Parent participation in an adolescent drug abuse prevention programme. *Journal of Drug Education* 25: 159-69

3. Background to the report

Drugs: Guidance for Schools

102. In 2004, Drugs: Guidance for Schools replaced the previous DfES guidance to schools, Circular 4/95: Drug Prevention and Schools and Protecting Young People: good practice in drug education in schools and the youth service (1998). The guidance provided guidance on all matters relating to drug education, the management of drugs within the school community, supporting the needs of pupils with regard to drugs and drug policy development.

103. The DfES commissioned Ofsted to conduct a survey of drug education in schools to assess the impact of its new guidance to schools and to determine the extent to which the quality of drug education in schools had improved since the last major survey by Ofsted in 1997.

104. Over 60 schools were visited as part of this survey. These schools were selected to provide a national sample of types and locations. Evidence was also gathered from over 200 school inspection reports. In addition there was a review of recent research evidence on drug education.

105. During the inspections, discussions took place with drug education/PSHE co-ordinators, subject teachers, senior managers and groups of pupils. Drug education lessons and those in other subjects contributing to the drug education provision were observed. Reference was made to drug policies and schemes of work. Pupils' work was scrutinised.