School-based drug education and prevention: the impact of inspection and curriculum provision

Patrick Hargreaves

Patrick Hargreaves is based at Patrick Hargreaves Associates, Newcastle upon Tyne, UK.

Abstract

Purpose – *The purpose of this paper is to examine the links between school inspection requirements as represented by Ofsted and the provision of drug education programmes in schools.*

Design/methodology/approach – *An examination of relevant guidance from the Department of Education and the school inspection agency Ofsted; and reference to the research literature and evidence base around drug education.*

Findings – *The provision of drug education programmes in schools is influenced by the requirements of the national curriculum; and the frameworks used by Ofsted in its inspections. Recent reduction in emphasis on drug education in both sources has reduced the extent and quality of drug education in schools.*

Research limitations/implications – *The paper looks at national documentation and conclusions. It is not a quantitative study of school provision – some indication of this is provided by Ofsted reports.*

Practical implications – *The paper indicates that reports and conclusions from Ofsted and other bodies, e.g. House of Commons select committees and the ACMD, have in the recent past reported on rather than informed governmental action.*

Social implications – *The paper concludes that central government support and professional training and development are essential ingredients in the provision of universal drug education in schools.*

Originality/value – *The paper illustrates some of the factors involved in the provision of drug education; the contribution this can make to drug prevention, including harm reduction; and the seeming lack of understanding of education and prevention in the wider professional and political discussions about drugs and their use.*

Keywords *Curriculum, Schools, Inspection, Young people, Drug education, Personal social and health education*

Paper type *Technical paper*

Introduction

Measuring the effectiveness of educational interventions on health-related behaviour is something of a chimera. The wide range of confounding variables, together with the likelihood of incidental, unplanned or delayed factors, makes evaluation of such work extremely difficult. However, the difficulty of measuring impact does not mean it does not exist, an assumption non-educationalists are sometimes rather quick to make: "Most schools in the UK provide drug education programmes. Research indicates that these probably have little impact on future drug use. There should be a careful reassessment of the role of schools in drug misuse prevention. The emphasis should be on providing all pupils with accurate, credible and consistent information about the hazards of tobacco, alcohol and other drugs" (Advisory Council on the Misuse of Drugs, 2006)[1]. This view, proposed by a committee comprised of

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non-educationalists, ran counter to the thinking in the profession at the time. It heralded ten years of resource reduction, which still continues.

First, let us define our domain. Drug prevention aims to prevent substance use – it aims for behaviour change. Drug education informs people about facts and explores attitudes and contexts, behaviours and consequences. "The key aim of drug education is to enable children to make healthy informed choices" (Office for Standards in Education, 2005)[2]. Even if someone chooses to continue using substances, they may do so less dangerously and will have the tools to make an informed decision should they decide to change. It can also delay first use and in this way can be seen as having a harm-reduction outcome. Some drugs have the potential to cure cancer; they may also be lethal if misused. We do not seek to "prevent" their use but educate about it. Neither do we aim to "prevent" alcohol in our culture, much of which revolves around its consumption: we seek to reduce the harm which can result from its use.

Drug education considers all drugs, including medicines, volatile substances, alcohol and tobacco. This paper will concentrate on school-based drug education as part of Personal, Social Health and Economic education. However, drug education goes on in a wealth of settings – formal, informal and vicarious; in the family, through the media and among friends. Herein lies the first hurdle for evaluators to clear – that of trying to factor out a huge range of confounding variables whenever an assessment of the impact of an educational programme is attempted.

What is PSHE education?

"PSHE education is Personal, Social, Health and Economic education. It is a planned programme of learning opportunities and experiences that help children and young people grow and develop as individuals and as members of families and of social and economic communities" (PSHE Association, 2011). PSHE education is about the provision of information and the development of knowledge, skills and attitudes that enable young people to make effective choices which will help them to live happy, healthy, successful lives, now and in the future. It also provides an opportunity for them to reflect on issues which do not arise elsewhere as part of the formal curriculum, for example understanding themselves, their interests and needs, managing challenging relationships, understanding their personal response to risk and recognising the contribution they make to the wider community.

Evidence suggests that schools with successful PSHE education are more likely to have the following features: a coherent progressive curriculum across the full range of elements; core curriculum time; well-resourced delivery; and continuing professional development (CPD) opportunities. They are more likely to work in a context of clear support from senior leaders and motivated, rewarded PSHE education leaders. Rather than a peripheral add-on, it is central to the ethos of the school. Schools do have a responsibility to discuss the topics which form part of accepted PSHE curricula, ensuring that they are taught in an interactive way and that the skills of communication, negotiation, decision making and managing relationships and pressures are explored and promoted. An emphasis on these skills, topics and methodologies has consistently been shown to be the most effective way of adding to pupils' own repertoire of knowledge and skills.

It is important that drug education is taught as part of PSHE education as the range of issues need to be seen in context. Risk behaviour does not happen in a vacuum but in a socio-cultural context where the substance, the people and the situation are inextricably linked and of equal importance. "Pupils should have opportunities to consider how they will respond if they are in different real life situations […] give them space to rehearse some of these choices" (McWhirter, 2009). In 2011, the Department for Education (DfE) wrote: "The government recognises that children can benefit enormously from high-quality PSHE Education and that good PSHEE supports young people to make safe and informed choices about their lifestyles, health, careers and finances both now and as they prepare for the responsibilities of adulthood. Good schools understand the connections between pupils' physical and mental health, their safety and their educational attainment. Good schools will also be active promoters of health because healthy children with high-self-esteem learn and behave better at school" (Department for Education, 2011)

(incidentally this document was published when the programme supporting drug education in PSHE was being reduced).

Broadly, drug education programme delivery styles fall into three categories. Two are based on information and rational decision making, one of which also takes account of socio-cultural influences. The third is rather more complex.

Behavioural model

The most basic model of drug education is a behavioural one, the traditional but increasingly contested starting point for health promotion. Its premise is that we respond to a stimulus to change behaviour. The model assumes that we know and understand the benefits of change (e.g. giving up smoking) then make a rational decision based on costs and benefits. Key to the model is that we have an incentive to change; feel our present behaviour is disadvantageous; believe the benefits outweigh any costs; and feel competent to realise our aim. This model is the basis of many past educational approaches and informs the government's view today, following the ACMD findings cited earlier.

However, in practice, we know that knowledge alone is rarely enough to change our behaviour, so educational approaches based only on information will indeed be ineffective (Stead and Angus, 2004). Additionally, the "knowledge" proffered by teachers may be at variance with the "knowledge" students already have or are acquiring from their own experience. The statutory obligations on schools around drug education are minimal, meaning that it may merely be addressed, in passing, within the science curriculum, a knowledge-based programme. Fear arousal is also ineffective and may even impact negatively exaggeration breeding contempt for the overall health message (see e.g. Ashton, 1999).

Health-related decision making is very much more complex than a series of rational calculations based on factors over which the individual may have no immediate control. Changing behaviours already established is a less promising approach than that of prevention.

Normative education model

Normative education also sees health choices as rational choices but recognises our behaviour is determined too by our attitudes and intentions, moulded and reinforced by our social group. "Normative education is an important mediator of risk. Children (also young people and adults) often dramatically misperceive norms of behaviour" (Cuijpers, 2002). It is important to realise that perceived social norms are often informal. For example, young people may believe that most people in their age group regularly use alcohol. However, this norm may be influenced by a few prominent members of their social group, or by an exaggerated view generated by the media. Challenging perceived norms by providing feedback of prevalence data and encouraging discussion and reflection on the facts has been shown to be effective in several studies (e.g. Bruvold, 1993). "Peer norms about risky behaviours are grossly over-estimated. Peer influence is a major determinant of behaviour so these misperceptions should be addressed" (Perkins and Craig, 2006).

Clearly there are risks involved with the use of this model – the boomerang effect. A million ecstasy tablets used weekly, one in five young people in England say they have been drunk before the age of 13, one of the highest rates of drunkenness in Europe. Shocking? Yes, but might the statistics also serve to further normalise the behaviour in young people's eyes?

Interactive learning model

Interactive learning is arguably the most important aspect of effective drug education, providing a stimulus for young people through group investigation, simulation and role play to identify and avoid risky situations, develop skills to manage situations involving drugs, and be able to avoid particularly harmful misuse.

In interactive teaching the teacher becomes a facilitator, creating a safe and supportive environment where young people can consider new and challenging information and ideas.

Risk is explored, offering the opportunity to develop "risk competence" – the capacity to recognise, assess and manage risk and benefit in stimulating and challenging situations. Studies here have shown that young people with stronger social skills are more able to resist peer influence and abstain from misuse for longer. Evidence suggests that the use of different approaches, combined, will be more effective than focusing exclusively on one (Botvin, 2000; Flay, 2000; Gottfredson, 1997; Hansen, 1992; Lloyd *et al.*, 2000). "Multi component programmes (those which address several life issues by different means and in different settings) can help prevent drug use and/or drug problems" (McGrath *et al.*, 2006).

Evaluation – a cautionary note

We have already considered some of the difficulties facing programme evaluators. In addition to these, most programme evaluations are based on questionnaires regarding young people's risk behaviour. Such questionnaires are compromised by various issues e.g. the notorious inaccuracy of self-report data of offending/risky behaviour; young people responding how they think you want them to (or the opposite!); subtleties of behaviour change not measured, such as patterns, styles or frequency of behaviour or attitudinal change which young people (indeed adults) may find difficult or impossible to identify or verbalise; and the lack of good longitudinal data. "When you're working with 13 year olds, it can be 10 years before you see the impact you've had"[3].

However one typical, and widely shared, summary of evaluations states: "School-based intervention programmes can delay the onset of substance use by non-users and reduce by current users. Drama appears to be more effective at changing attitudes to drug use than traditional information dissemination approaches" (Canning *et al.*, 2004).

Where are we going?

Prior to the 2010 UK election, there was a move gathering pace to include PSHE in the statutory curriculum. Ultimately not only was this aim not achieved but the status of the subject was reduced still further when the Ofsted evaluation schedule dropped two key judgements – "Personal Development and Well Being" and "Care Guidance and Support". It was argued that these areas would be covered elsewhere in the schedule. Indeed, some are, but the inexorable devaluing of the provision of quality PSHE education has continued.

PSHE education subject inspections in which I was involved until about five years ago, when Ofsted responded to the PSHE education review (MacDonald, 2009) by demoting those judgements, were rigorous, reporting on all aspects of the subject; and were, in my experience, of great benefit to schools – they served a formative as well as summative purpose. In most current Ofsted reports, PSHE education is not mentioned and unless there is an inspector on the team with a particular interest in it, will barely be evaluated during the inspection. There are now few inspectors able to properly inspect and report on the quality of a PSHE programme; and little incentive for the school to improve it when the focus is on examination results in the statutory subjects.

The inevitable result is that investment in training teachers to deliver quality PSHE education has all but vanished. There is no incentive for schools to engage professionally trained PSHE education teachers to bring the standard of delivery into line with other subjects. Around a third of schools have one or more staff who have undertaken PSHE education CPD, for which it is now increasingly difficult to be released or funded. As many as 90 per cent of teachers teaching PSHE education have no specialist qualification, unthinkable in other subject areas. There is generally scant regard paid to PSHE education training in initial teacher training courses. Neither is there any incentive to address the staffing, time-tabling, programme planning, methodology and assessment of PSHE education because there is no systematic inspection of the subject. A growing number of secondary schools do not have a member of the senior leadership team or a governor charged with supporting PSHE.

In general PSHE enjoys higher status among leaders, staff and pupils in primary schools compared with secondary schools, largely due to the value placed on social and emotional

aspects of learning (SEAL), making clear connections between PSHE education and developing learning and standards. This conceals an assumption that adolescents "do not need" SEAL. But, put crudely, your achievement will be negatively affected if you are nursing a hangover.

In many secondary schools, PSHE is not timetabled but "covered" in assemblies, tutor time, perhaps by a quiz squashed in between registration and announcements, or on "drop down days" where students immerse themselves in sex, drugs, alcohol, crime and safety for a day. Such sessions typically involve a range of agencies sharing information on their area of expertise. The problem with such interventions is that they provide a huge overload of information which is rarely considered or debated properly. Further, after the session, the providers leave, so students cannot revisit with them questions they formulate over time. Finally, the student who is absent, possibly who needs it most, will have missed their PSHE education for the year: we know there are clear links between school non-attendance and risky or unhealthy behaviours.

This leads on to the use of outside visitors in general. Because of the lack of training referred to above, many teachers assigned to PSHE education delivery do not have the expertise and/or confidence to discuss sex or drug use with their students. They may then decide to enlist an agency to deliver sessions on these themes, an approach for which there is mixed evidence of effectiveness. While there may be value in involving community and health organisations and the police in PSHE programmes, it is of the utmost importance that the teacher leads the programme and that these contributors are just that – contributors, not sole providers. A very clear service-level agreement must be negotiated with agencies prior to their being engaged.

Negative approaches based on scaring children, often favoured by the police, should be avoided.

Some observers have hoped that negative approaches – such as showing young people what it is like to be in jail or enabling them to hear from and speak with ex-prisoners or recovering addicts – can scare them into better behaviour. However, a number of rigorous evaluations have assessed such "scared straight" approaches and found that they fail to deter juvenile crime or promote more positive behaviours (see e.g. Ashton, 1999). Such approaches have been found to have negative impacts – in some settings, participation in programmes using this approach has resulted in significantly higher recidivism rates or drug use. The recovering addict can reel off horror stories, but how is he now? (it usually is "he") – doing very well! – touring schools and youth clubs, inspiring awe in his audiences, being paid to do so … The medium is more powerful than the message.

There are a number of evangelical organisations and sects, including Scientologists, masquerading as drug and alcohol agencies, offering glossy programmes free to schools but with a pernicious hidden agenda. As well as training teachers and supporting schools with delivery, local authority drug and alcohol advisers (I was one for ten years before the post was frozen, as happened in most local authorities as a result of spending cuts) could quality-assure what was on offer.

Without properly trained teachers and without skilled local consultation preceding programme planning, content will never be guaranteed to be relevant to and engaging for young people. Most schools do not conduct full student consultation before planning programmes, although this has been recommended and supported: "A healthy school has mechanisms in place to ensure all pupils' views are reflected in curriculum planning, teaching and learning and the whole school environment" (Department for Education and Skills/Department of Health, 2005) (for one example of what this can look like in practice see Hargreaves and Watts, 2010). Until and unless the status of PSHE education is raised, along with an expectation of systematic inspection of the subject, this situation is unlikely to change, and content will continue to be hit and miss.

A strategy for drug and alcohol education

If we revisit the quotation at the beginning of this paper, we can see the progress that was made in the ACMD's understanding of these issues over the nine years since the publication of the Pathways to Problems report. This progress is exemplified by the cut and paste job done on it to inform the Advisory Council on the Misuse of Drugs (2010) response to the Drug Strategy consultation.

This said: "The emphasis should be on providing all pupils with accurate, credible and consistent information about the hazards of alcohol and other drugs". It continued: "However, the ACMD stresses that research has indicated that such programmes have little impact on drug use", a statement which could be caricatured as: "it's no good but it's what we know so we'll carry on anyway". It was this conclusion which prompted my resignation from the ACMD at that time after five years of doing everything I could to persuade them otherwise. A welcome indication of changing attitudes towards prevention is shown in the ACMD's Recovery Committee report published early in 2015 (Advisory Council on the Misuse of Drugs (ACMD), 2015).

The European quality standards study cited in the ACMD's response to the government's 2010 drug strategy consultation does not in fact agree that quality work in schools has little impact. Further, their response claimed consistency with World Health Organisation guidelines. Those recommendations in fact advocate a needs-led, young person centred, life skills approach. Evidence and evaluation from the United Nations Office on Drugs and Crime (2010, 2014), the Drug Education Forum, DrugScope, MentorUK, the PSHE Association, NSCoPSE, The National Children's Bureau and NIHCE all concur with this view. Incidentally, so do Ofsted, but do little to promote it. They also agree that PSHE education is "not yet good enough"! (Office for Standards in Education (Ofsted), 2013). The World Health Organisation reports that 73 per cent of European countries have a statutory obligation to include alcohol prevention in the school curriculum and over half have national guidelines for the prevention and reduction of alcohol-related harm in social settings (Anderson *et al.*, 2013). More recently, the *British Medical Journal* (Allen, 2014) has called for PSHE education to be a statutory part of the National Curriculum. Most recently, so too has a parliamentary Select Committee (Education Select Committee, 2015).

Educational interventions can and do deliver significant positive outcomes and there is, as indicated above, a wealth of nuanced evidence which demonstrates this. "Young people's attitudes towards drugs can change – over time and in response to the prevailing societal climate […] so programmes need to be in tune with the social cultures and attitudes among the target and general populations" (Coggans *et al.*, 2003). This is particularly so in the case of alcohol misuse, a major focus of current concern and one of Public Health England's key priorities (Public Health England, 2014). This is additionally welcome news in the light of the Drug Science Advisory Group's[4] "Drug harms in the UK" (Nutt *et al.*, 2010) multi-criteria decision analysis, considering a wide range of harms and clearly showing alcohol to be our most harmful drug overall.

Further, it is not only attitudes that change, but the substances themselves. The recent Channel 4 documentary "Drugs Live", amongst many other sources, clearly showed Skunk and traditional cannabis to be very different drugs, affecting different parts of the brain with differing intensity. "New" psychoactive substances (often misleadingly referred to as "legal highs") pose a highly significant risk to users precisely because of their unpredictability and confusing legal status for anyone trying to equate our Misuse of Drugs Act classification system to the actual risk of harm.

Prevalence data from various bodies must always be viewed with some circumspection. Police figures may reflect a change in emphasis in enforcement policy as much as a change in behaviour; health data only records those who come in to contact with health services. An apparent dip in either may just mean we are all getting smarter! However, over the ten years when schools enjoyed the advisory support noted above, the range of data does correlate interestingly, not, I would suggest co-incidentally.

While not wanting to fall into the trap of mono-causal outcomes, it seems clear that local authority drug and sex education advisory posts and the resultant school programmes played a significant part in a range of health improvements. National data tell us that smoking, drinking and drug use among young people all fell consistently year on year; and the rate of conceptions among 15-17 year olds (at 38.2 per 1,000) was the lowest for 30 years (NHS Information Centre, 2011). This was within an environment of increased availability and decreased price, a huge illicit tobacco and alcohol market, an exponential rise in new psychoactive substances available on the internet and a moral panic about the sexualisation of children. Together these issues impact disproportionately on the young. This shows not only that there is no room for complacency but also demonstrates the folly of an over-reliance on enforcement and tax hikes to influence behaviour without parallel input from education.

Discussion

Young people do not need information which emphasises the hazards of alcohol and other drugs but accurate, credible and consistent information about alcohol and drugs full stop. This information should not be the emphasis but the foundation, and by itself will indeed be ineffective if the intention is that behaviour is to be changed. Education must not be confused with information giving. It is simply inadequate to consider only behaviour and possible consequences, we also need to address motivators. Similarly, education should not be confused with prevention. It is realistic to expect schools, adequately supported, resourced and encouraged, to provide education programmes about drugs and other substances. It is not realistic to expect schools, by virtue of such programmes, to be prevention agencies. Education can contribute to prevention but the two are not synonymous and it is unrealistic to pretend that they are. Harm reduction – risky behaviour delayed or reflected on – is a realistic and worthy aim and outcome of school-based drug education (and other PSHE topics) but is hindered by the reluctance of government to use the term in its strategies. The real lesson about drug prevention, not yet acknowledged by many policy makers or politicians, is that the likelihood of substance use and other unhealthy or risky behaviours is reduced – but not stopped – when young people feel that are looked after, socially and emotionally, by their families and their institutions, above all schools. This "knowledge" has long been available but there seems to be a reluctance by many to recognise, accept and act on it. There are, too, questions here about school ethos; and the willingness to provide in-puts additional to the curriculum or disciplinary (see e.g. Resnick *et al.*, 1997; De Haes and Schuurman, 1975; Rowe and Stewart, 2009; Markham and Aveyard, 2003).

Young people must be encouraged to develop their decision making, risk analysis and life skills competences, from the nursery ages, within an appropriate spiralling curriculum throughout their educational careers. They need to discuss, debate and consider drugs and drug use in a socio-cultural context alongside health, sex, relationships, risk, bullying, offending and so on. "Life skills training has demonstrated a positive effect on reducing indicators of drug use. Programmes based on life skills were the most consistent at reducing drug use" (Faggiano *et al.*, 2005).

The range of issues young people are likely to face should be considered in context. We know that where young people are taking risks, they are often taking more than one. For example "early drunkenness is correlated with smoking, cannabis use, injuries, fights, low academic performance and unsafe or unwanted sexual intercourse" (Windle, 2003). The science curriculum alone is not an adequate vehicle for the delivery of such a programme. While Ofsted feels PSHE in English schools is "not yet good enough" (Ofsted, 2013), the current accountability system is inadequate. The potential of inspection systems for boosting all aspects of pupils' social development and educational achievement is reduced by the increased focus on academic achievement in approved core subjects, at the expense of wider SEAL and school activity.

The current guidance to schools on drugs and alcohol is explicit in saying it should not "focus on drug education" but on the bigger picture (Department for Education/Association of Chief Police Officers, 2012). Previous guidance from both organisations had extensive sections on the purpose and delivery of drug education. The current document presents a crime-prevention and disciplinary view of school responsibilities, not a pupil-centred one. Inspectors should once again be mandated to report on health and personal development, and the quality of PSHE education must be a limiting judgement for the achievement of outstanding status. The DfE is currently (March 2015) conducting an internal review to determine how it can support schools to improve the quality of all PSHE teaching, including drug education.

If the recent Select Committee recommendations sound familiar (Education Select Committee, 2015), they are. They are very similar to those suggested by the MacDonald report on PSHE, published in 2009 (MacDonald, 2009). A change of government ensued and the recommendations were ignored completely. Subsequent to the 2015 election, it is imperative that we continue to lobby hard for their adoption this time round. The 2015 Education Select Committee report on PSHE (Education Select Committee, 2015) recommended statutory status for PSHE, with funding for CPD – specifically, the PSHE Certificate course introduced as part of the Healthy Schools Programme in 2005; and the resumption of regular Ofsted subject surveys. The first two recommendations were rejected in the government's response to the Select

Committee report (Department for Education, 2015). The most recent Ofsted inspection guidelines (Office for Standards in Education, 2015) continue to include broad references to pupils' personal development. They contain no specific references to personal social and health education or to pastoral care.

Making use of the government approved term "recovery", the ACMD has finally acknowledged the value of drug and alcohol education, subsumed in a briefing report on recovery. "An increasing body of scientific research supports including drug prevention activities as part of wider strategies to promote healthy development and well being" (ACMD, 2015, covering letter to Home Secretary). Given that the ACMD is the government's advisory body on drugs policy, it will be interesting to see how government responds to this set of recommendations. Past experience has not been entirely encouraging, as those who recall the government's behaviour in the debate on cannabis reclassification when it announced policy contrary to that recommended in the report will remember, an experience repeated in the government's response to the 2013 recommendations on the scheduling of khat[5]. It is worth quoting at length from this year's ACMD report as it reinforces many of the points being made by educationalists and health promotion specialists: "There is no commonly accepted definition of 'drug prevention' or precisely what type of activities it describes. At a simple level, drug prevention may include any policy, programme or activity that is (at least partially) directly or indirectly aimed at preventing, delaying or reducing drug use, and/or its negative consequences such as health and social harm, or the development of problematic drug use. There are commonalities between preventative responses to illegal drugs, alcohol and tobacco and so these substances should also be considered part of this definition. This definition of drug prevention may also include some types of harm-reduction activities, although this is not generally accepted".

Drug prevention is differentiated from drug education as the latter aims to provide information and advice about drugs upon which individuals can base decisions. Unlike prevention, it is not the primary objective of drug education to change behaviour, although prevention activities may include prominent educational components" (ACMD, 2015, p. 12).

This enlightened documentation from the ACMD is to some extent qualified by concerns about corporate learning. My personal experience with the ACMD has been that although there have been periods when individuals with an understanding and expertise around substance use, young people and education and prevention, have been able to inform Council, this level of knowledge has not been sustained within the agencies once those individuals' terms of office have ended; or if governments persistently over-rule advice from their own advisory bodies. As with governments, changes in make-up and personnel seem to necessitate a process of "learning from scratch" rather than developmental and increased institutional knowledge and understanding. One commentator[6] has observed the way in which some members of the ACMD, chosen for their expertise in narrow specialist areas to collectively cover all aspects of drugs policy, seem to regard their membership of the Council as giving them the expertise and the right to speak out in fields where they have no knowledge, especially in the education and prevention field. This has led to ill-informed and inaccurate statements being made at public sessions of the Council.

We know that preventing drug and alcohol misuse among young people is a cost effective policy option. In total, 15 years ago, the government invested heavily in PSHE education with the appointment of drug education and sex and relationships education advisers in most local authorities. Schools valued and made use of the support and challenge they provided. Most of these posts have now gone as a result of spending cuts. This reflects the dissonance between rhetoric – ministerial statements about the importance of (amongst other areas of school activity) drug education in young people's lives; and reality – reduced resourcing, the ending of training programmes, in-service and initial, and the down-playing or disappearance of drug education in any meaningful sense as a curriculum requirement.

We need the DfE, Department of Health and the Home Office to develop, fund and implement a co-ordinated education programme based on a harm-reduction approach, including quality training in teaching and learning. Such programmes should be accompanied by an on-going evaluation process. We need Ofsted to report specifically on PSHE education and on the

personal development of and support for young people. And we need consistently funded longitudinal research into the use of all substances, to show trends, prevalence and the emergence of new substances, new patterns of use and new using-populations.

Afterword: March 2016

Since this paper was first written, there have been further changes in education policy which will impact significantly on the teaching of PSHE. In March 2016 the government announced that all schools must convert to academies, regardless of their wishes and those of their students and parents. Currently, schools maintaining a link with their local authority enjoy an effective conduit for information and guidance from health, social services and the police. The strength of this relationship is diluted when a school becomes an academy and leaves the authority.

On 11 February 2016, despite the recommendation of four House of Commons select committees (education, health, home affairs and business), the education minister announced that the government will not make PSHE a statutory part of the National Curriculum. Echoing the views of a wide range of agencies and MPs, Sarah Brennan, Chief Executive of Young Minds, said: "It is extremely disappointing that the government have decided not to make PSHE statutory. Teachers, parents and young people are all crying out for space in the curriculum to address the key issues of our time for young people like good mental health, online safety, body image issues and sexual pressures. Not committing to making PSHE statutory means schools can choose whether to cover these subjects at all. A very worrying prospect if we want children and young people to grow up resilient and able to successfully navigate the world around them".

The government has also introduced a new range of tests for four year olds. This reinforces the policy that an exam and test-driven curriculum is the future for all our schools. Because PSHE is the only non-statutory and non-examined school subject this will inevitably mean that it will be removed from the curriculum in even more schools. Even less money will be invested in training and even less time and fewer resources will be made available it.

Notes

1. ACMD is the UK's Advisory Council on the Misuse of Drugs. It was established as part of the Misuse of Drugs Act 1971 to advise government on drugs and drugs policy issues.
2. Ofsted is the Office for Standards in Education, an organisation which inspects school and other young people's provision and effectiveness.
3. Clare Checksfield, Chief Executive, Crime Concern, in a 2004 interview with Children and Young People Today.
4. Formerly the Independent Scientific Committee on Drugs.
5. In 2013 the ACMD recommended that khat, a stimulant used in countries in the Horn of Africa and the diaspora communities from that region in the UK and elsewhere, should not be included in the provision of the Misuse of Drugs Act, 1971. The recommendation was based on assessment of individual, community and social harms and benefits of the use of khat. The UK Home Secretary over-ruled this recommendation, criminalising khat supply, use and users.
6. Blaine Stothard, Prevention Specialist and Co-editor of Drugs and Alcohol Today, telephone conversation.

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About the author

Patrick Hargreaves is an Ofsted Inspector and Education Writer, Consultant and Trainer. Patrick Hargreaves can be contacted at: patrickhargreaves10@gmail.com