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mean ‘information’. Drug education from this perspective means giving young people lots of information and facts about drugs, often in association with mass-media campaigns. ‘Drugs’ tends to mean illegal drugs, and ‘facts’ usually means stressing all the negative and nasty effects that these drugs can have on young people who use them. They are not necessarily linked with the reality of many people’s experience.

This assumption that drug education often uses the ‘expert’ to reveal the facts. The police are often cast in this role of ‘fact-giver’ and can be a valuable resource for many splendid visual aids of a drug user’s equipment. Otherwise, one relies on video material or information leaflets about drugs to provide the facts.

It is easy to be cynical about this approach. It is a common belief that knowledge and information, on their own, will affect behaviour and that once ‘immunised’ with the ‘truth about drugs’ young people will not use them. It’s a bit like “Just say no!”. If only it were that simple!

However, it must be remembered that information and facts do have a role to play in developing knowledge. Some approaches seem to have altogether rejected the need to provide information. Both extremes have little hope of ‘success’ if real education is the objective.

Scare them to death

Much has been written about the inappropriateness of this approach to drug education. The general view of health and drug educators is that the shock-horror story or video ‘nasty’ about drugs and their effects is unlikely to be effective in the long term in reducing the likelihood of young people using drugs. Some argue it is likely to be counter-productive.

Despite this, it is still a common approach, particularly in smoking and alcohol education (part of drug education), and it is one that the young people often argue as being most effective. Those who argue that agendas and approaches to drug education should be set by young people might reflect on the approaches that many would request. Politicians argue for the positive impact of drink-drive campaigns with their tragic and shocking messages. The negative effects of this approach are difficult to argue against, and the research is not totally conclusive — or current.

However, it is difficult to justify this approach as ‘education’ in any pure definition of the term, and the ‘distancing’ it could never happen to me’ response is obviously common when faced with the shock-horror story. Nevertheless, in a different context and environment, and with the appropriate teacher, many would argue that certain material in this category may be useful.

“It happened to me — don’t let it happen to you.”

This approach centres around the use of the visitor or ‘expert’ to talk about how to be drug free. It is called the ‘ex-addict’ approach or the ‘student to student’ approach to offer a testimony on the problems of the drug user. It is the reformed addict who details his (usually his and not her) misery when using drugs and how he/ she eschews the younger takers to “stay clean”.

The claim for this approach is that it is ‘from the horse’s mouth’ — real people with experience talking to young people who will believe it comes from a real user with whom they can relate, and get the ‘truth’.

However, there are other messages to the young: you can take drugs, come off drugs, and achieve special status as a spokesperson on the subject. What about the ex-user’s other drug behaviour? For example, some ex-addicts smoke cigarettes. What happens if there is a relapse? “He doesn’t seem too bad on it,” was one response at an input I attended. It’s the same when the ‘star’ speaks of the dangers of drugs: “If I had their money I wouldn’t need to take drugs” is an understandable reaction.

Once again, it may be the need to know the ex-addict’s life and how far it is part of a more thorough drug education scheme in which avisitor responding to young people’s concerns may have a role where a lecture or testimony mingled with emotion or horror stories does not.

The visit to the theatre

A very popular approach is to ‘link the need for drug education with a visit to a high-tech input about how the body works and functions, encouraging young people to take care of their body and be responsible for their health and well-being by not taking drugs — all laudable aims.

It is an approach which is popular with politicians and lay people as it gives good photo opportunities, and is in line with the health message of the need to keep fit, to lose weight, and to be fit. However, such an approach is understandable popular with teachers and young people, too.

Certainly, technology needs to be exploited and be made accessible to education to help children learn and understand more readily. However, the danger is that it starts with the visit and stops with the visit. A ninety-minute ‘experience’ suddenly provides all there is to learn about drug education. It is the ‘easy answer to the complex questions’ approach epitomised and, sadly, if often seen and taken as the short-cut to ‘doing drug education’ rather than as a compliment or supplement for more thorough and comprehensive approaches. Scant financial resources are often poured into such ‘visual’ programmes.

There also has to be some question about the long-term value in terms of the effects of this approach on drug use behaviour. However, it has a contribution to make without being the complete answer.

KISS A VIP

The less visible but broader approach to drug education is the ‘KISS A VIP’ approach. It tends to see drug education within a broader context of health education and PSE, encompasses all drugs, and though it does have an input in specific content areas there are basic underlying concepts and issues that pervade this broad and comprehensive approach. These content areas are:

- Knowledge Information
- Social Skills
- Attitudes
- Values
- Influences (political, social and economic)
- Personal choice

This approach places a significant emphasis on drug education the individual’s self-esteem and ability to be in a position to make positive and healthy choices and decisions about lifestyle, including drug use. As such, there is also an emphasis on awareness-raising with regard to external influences within society that affect or even restrict choices and decisions that contribute to individual and group behaviour in certain ways often regarded as ‘unhealthy’.

The approach places an emphasis on everyone has the potential to act separately and collectively as agents who question, choose and can change their social situations. It is often portrayed as an ideal, but criticised for its attempts to take on too much within a real school environment.
A fresh approach . . . how to 'use safely', or with the least amount of risk or harm to self or others, rather than offer an unrealistic message of 'no use'.

where time and expertise for teaching with this philosophy and approach is not available.

It is also criticised for its lack of impact on specific health behaviours, including drug use, although evaluation work on this approach is not available. A major reason for this is that few schools have committed themselves to such a broad-based developmental programme, and, for those that have, the benefits may be long rather than short-term.

Certainly the approach is one that is as much to say about appropriate teacher methodology and style of learning, such as peer-led methods, as it has about content, with the requisite need for training support for those who become involved. However, it has an attraction to those idealists in education concerned with behaviour and not just drugs, but it has to take into account the realities of schools, teachers and timetables — as well as the National Curriculum!

They're going to do it anyway!

A fresh approach to drug education is now on the horizon. It is often labelled 'new', but that remains debatable. It arises from the powerful lobby for a 'harm minimisation' approach to drug education. Many would say that alcohol education has been such an approach for many years.

The basic theory is that the majority of young people will at some time in their lives experiment with or use drugs. Recognising this reality should mean that education should address the issue of how to 'use safely', or with the least amount of risk or harm to self or others, rather than offer an unrealistic message of 'no use'. The argument is quite convincing and has much to offer philosophically — indeed there are particular groups of young people, in more informal areas of education, where this approach is both advisable and possible.

However, there are certain political and legal realities that make such an approach very difficult for the majority of schools and teachers. Imagine, for example, the reaction of the media, parents, politicians and teachers if it became known that a school was suggesting that using drugs was a fact of life for most people — in fact, saying something that could be interpreted as conditioning drug use by teaching safe use or low-risk approaches for their use.

I think there are many practical problems connected with this approach that society is not ready to face. Whether one should teach 'safe use' of cigarettes is an interesting debate, even in its less emotive form of harm minimisation. The approach may have value for some, but will pose many problems for the reality facing most formal education institutions. Once again, however, there are elements of this approach that need to be considered seriously in devising a programme of drug education.

Cross-curricular, healthy lifestyles and all that jazz.

The developments with the National Curriculum and issues such as the 'whole curriculum', cross-curricular areas of study and the role of health and PSE offer another treatment of drug education. The 'Give us the facts, ma'am' approach is within the science curriculum, but these are to be supplemented by other approaches through other foundation subjects, areas, through cross-curricular but co-ordinated inputs of drug education, and through continued provision of PSE or health education courses.

The danger is that if it becomes too complex, it loses its identity. If it becomes too particular it is in danger of becoming too specialised and lacking time or demanding too much from too few teachers. If it becomes too fragmented, it is in danger of losing cohesion and meaning and provides a good excuse for doing nothing because of the difficulty of co-ordination.

Compromise?

At the end of the day I feel that drug education in schools has to be about compromise — a question of balance — recognising that there are horses for courses and that no one approach has all the answers or deals with all the questions.

Certainly the World Ministerial Summit, or at least politicians, may hold the key to as to which approach receives the best uptake, and that will not necessarily be the most effective approach. It will be the approach that receives the best financial support and political popularity and backing, and sadly that may mean more easy answers to complex questions.

Reference


Parents, schools, and health professionals could all do more

Margaret Jones
General Secretary of Brook Advisory Centres

Teenage pregnancies: who is responsible?

The headlines in the media herald the "teenage pregnancy crisis". We frequently hear of schoolgirl mums, but is there really a problem, and, if so, whose fault is it? As health professionals we can acknowledge some of the problems of teenage pregnancy — low birth weight for the babies, inadequate antenatal care for the mothers owing to late reporting — but are the teenagers themselves to blame?

If we take termination of pregnancy as an indicator of an unwanted pregnancy, the numbers that are terminated are considerably lower in the 16-19 age group (Table 1). This is to be expected, since they may not be as sexually active as the 20-24 year olds or 25-29 year olds; but we should always remember that many other women besides teenagers are having unwanted pregnancies, and maybe this says something about our service provision overall. Looking at the teenage conception rates, we find that after declining for many years they have been rising throughout the late 1980s, particularly as the provision of family planning clinic services has declined (Fig. 1).

Cut and difficulties

As readers probably know, Brook Advisory Centres run a contraceptive service for young people, predominantly under the age of 25. We see around 50,000 clients a year, of whom 35% are under 20 years of age and 4% under 16. Teenage too has suffered cuts in its services at Health Authority funding has been restricted, but through our enquiry service we are aware that many young people have great difficulties in gaining access to services, or have received insufficient sex education.

Brook is perceived as a friendly service and the queries we receive vary from young boys asking about body changes to young women requiring explanations concerning the use of the pill who ring up to check out how to take it once they have commenced their prescription.

A rising birth-rate

The rise in the conception statistics that has been continuing throughout the late 1980s has a number of possible explanations. Two of these I believe are (a) reduced access to services and (b) insufficient sex education. But who is responsible for providing the services and the education? Readers may have seen reports in the press that Brook Advisory Centres are trying to open a Centre in Belfast where the opposition state that there is too much sex education in schools, that this should be left to the parents, and that there is no need to provide a special service for young people.

But I think there are other areas where we can alleviate the problem of teenage pregnancies. There are three groups of people who can have