**Viewpoint**

I read with interest the Viewpoint feature written by Phil Barnett in Education and Health Vol 13 No 4, which posed a number of questions relating to the effectiveness of DARE (Drug Abuse Resistance Education) and to the relevance of the evaluation of this programme within the United Kingdom — not least because I co-worked on obtaining the research data and wrote the subsequent evaluation report.

I am confident that Phil Barnett has not read the evaluation report, published in August 1994, and that he has based his analysis of the UK evaluation purely on a publicity-focused newsletter produced by DARE UK. This, in all probability, accounts for the lack of a conclusion to the seventh question posed, that is, How meaningful is the UK evaluation? The report I wrote identified a number of positive short-term outcomes based on the research which appeared attributable to DARE, and which Phil Barnett correctly identified in his article. He did, however, fail to report the numerous references to these findings that the evaluation clearly made. Indeed, we stated categorically that there were no generalised patterns that could be attributed to DARE.

**Wanted: resonance and conviction**

Moreover, there are various other points relating to the evaluation that Phil Barnett makes and which I could address. It is unfortunate that the evaluation he conducted was not undertaken. I referred to in your publication, and I feel it is certainly developing the very pertinent points he makes in his article. It may be of interest to note that North Nottinghamshire Health Promotion are currently conducting a longer-term analysis of DARE with a new cohort. This work has included the utilisation of pre- and post-test "draw and write" questionnaires, structured attitudinal questionnaires, focus group discussions, and individual interviews with a stratified sample of the cohort.

There is, however, an interesting area of debate raised within the article, which I feel needs wider debate and which Phil Barnett is raising within your publication. That is to say, any of the benefit of DARE from a teacher's perspective that can come across loud and clear in researching the programme is that teachers are not in a position to deliver drugs education to school children in a manner that is relevant or convincing as external agencies are able to.

**Credibility gap**

I have ascertainment two principal reasons for this. Firstly, many teachers report not having had life experiences that enable them to relate to the reality of drug use and 'drug cultures'. Secondly, teachers feel removed from contemporary drug-related cultures and the impinging nature of these upon mainstream youth cultures, and thus their opportunities for addressing the needs and issues of young people in the most appropriate way are hampered. As a result of day-to-day dealings with these very issues, other agencies are perceived by teachers as, if you like, more "street-wise", and consequently more able to deliver effective drug education.

While this credibility gap exists, whether it is real or perceived, there is going to be a dichotomy of view. On the one hand we shall have educators, who believe that teachers, for a variety of reasons, are best placed for the delivery of efficacious drug education within the classroom context. On the other, we shall have a variety of others (including many teachers) who believe that the best education is delivered from outside the school itself. If it is the latter argument that wins the day, then it is the longer-term, developmentally-orientated programmes such as DARE as opposed to one-off visits, that will prevail — and rightly so.

**Central, not peripheral**

My view, however, is that it should not be one or the other. If Phil Barnett perceives local authorities as grasping at "desperately trying to superimpose", then he must see DARE as colonising drug education in school. If external agencies colonise any part of the school curriculum, then this need for addressing, as a vacuum will inevitably be left once the package is removed or reaches a natural conclusion. However, David Scott's reply is not altogether objective. I think he is perfectly right to seek what teacher could not use a consistent visiting speaker to good effect?, but the context of the school's involvement in DARE in a purely consultative role, as described by David Scott, does not go far enough, and indeed provides ample ammunition for those who in the first instance are not well-disposed to programmes as DARE.

The question for this arena is not whether or not DARE works, but how drugs education is best delivered within the classroom. What is surely required then, is more pro-active from all parties concerned in the development of real and tangible classroom partnerships for the delivery of drug education programmes. Teachers need to be intrinsically involved in the development and delivery of drug education programmes led by outside agencies, rather than being involved only in an observational and feedback role at the periphery of the intervention. Outside agencies need to be utilised by schools in order to support, develop, consolidate, and actively contribute to the ability of schools in dealing with very real educational problems.

Partnerships in development and delivery can enhance a programme and result in the fortification of ideas, experiences, skill, and above all credibility.

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**Frances Hudson & Jackie West**

**Necessary to be heard: the young person's agenda**

Young People and Clinics: Providing for Sexual Health in Avon was a project involving Jackie West, Frances Hudson, Ruth Levitas and Will Guy. It was funded by Avon Health.

Family planning has expanded nationally in recent years to include clinic sessions specifically for young people seeking help and advice on sexual matters. The number of Brook Advisory Centres has also increased.

In the Avon area there are currently eight Young People's Clinics run by Healthcare Trusts, as well as the Brook Advisory Centre. Provision in the area is uneven, and the Brook in central Bristol is the only one offering services to young people six days a week, as opposed to one session a week at all the others. Only three are open on Mondays, of which the Brook is one.

Despite the Health of the Nation targets and research on consumer views, very little is known about teenagers' own views on sexual health provision for themselves, of the clinics they attend, or on factors influencing attendance and non-attendance. This, so doubt, reflects society's legal and moral confusion related to young people's sexuality and sexual activity. However, a number of recent local surveys (Ford 1991, Tully 1993, BASHH 1993, Evans 1995) indicate a need to tailor services more closely to the sexual health needs of young people.

**Discovering young people's views**

The project described here, which ran from mid-January to mid-June 1995, aimed at assessing young people's use and views of clinic provision in Avon, and their preferences.

Two methods of enquiry were used. One was to conduct 79 semi-structured indepth interviews, mostly paired, with 147 young people (89 female and 58 male). The sample, mainly aged 14–21, was drawn from schools, youth centres, and FE colleges in socially-representative areas in Avon: outer urban estates, the inner city, relatively affluent suburbs, and smaller towns. Ethnic minority interviewees constituted 10% of the sample.

The second was to ask those attending eight of the nine young people's clinics in Avon to fill in a questionnaire, a total of 403 being completed. The social class composition of the respondents corresponded very closely to that of the Avon population.

Although the two approaches were quite different, and were undertaken and analysed by different people, the findings both of the interviews and the clinic survey have given us in many respects very similar results. This "research triangulation" increases our confidence in the data.

The interviews, which are discussed here, lasted anything from 40–90 minutes, depending on the circumstances (school timetable, noisy youth centre, curious others, etc.) and the degree of interest and 'engagement' shown by the interviewees. Volunteers were gathered by means of a focus group exercise, where the researcher introduced the project, explaining its rationale and the importance of the young people's views. She opened up a discussion, often using wordboards to encourage participation. The researcher herself has a background in teaching, and worked for many years in a unit for schoolgirl mothers where sex and relationships education played a considerable part.

Most of the young people chose to be inter-
Many appreciated the attention and respect that the interview brought them.

The vocabulary of sex is problematical for the young.

As 'front of house' the receptionist is the vital link between clients and their continual wellbeing.

A need for anonymity on one hand, and openness, honesty, trust, and the opportunity to talk on the other.

Managing sexual relationships

The link between abstract knowledge about 'safer sex' and their personal lives is not being made, according to the young people interviewed.

Erratic use of condoms as well as of the contraceptive pill are examples of this. A typical young relationship, by admission, means that first intercourse would not be protected because 'it just happens'; then he will sometimes but not always use a condom, as he might not have one on him, then, as the relationship establishes itself into one that feels stable, he goes on the pill 'so he doesn’t have to use a condom any more'. Alcohol plays its part too: many admit to having unprotected sex under its influence, which is considered a pity but normal.

Embarrassment plays a large part in the management of sexual relationships. Few of our interviewees felt comfortable talking about sex and relationships with their partner. There is no suitable language for such talk with which young people are familiar. And without language it is difficult to discuss ideas and opinions and express wishes or needs assertively. For example, a girl is seen as accusing a boy of sleeping around if she asks him to use a condom for STD (including HIV) protection, while this is not the case if the object is to avoid pregnancy, which for the vast majority of the young people (male and female) is the real fear.

Discussion

Much of our research says little that is new, and is complemented by recent studies in the same area (for example Ford 1991, Phelps et al. 1992, Mellanby et al. 1995, Holland et al. 1990, Lee 1988, Ingham et al. 1992, Peckham 1993). However, several striking points emerge from these findings, and there are a number of issues arising from the interviews that are worthy of comment, for they are somewhat surprising. In this respect they offer new challenges, and could make providers aware of additional ways of tackling users' needs.

A key element in the findings is the conflict young people experience between their need for privacy, confidentiality, and anonymity on one hand, and the need for openness, honesty, trust, and the opportunity to talk on the other. In this respect, the creation of a local helpline would go some way towards meeting this need.

However, the main finding from the 79 transcripts of interviews with 147 young people aged between 13 and 23 is their lack of opportunity to talk freely and comfortably about issues concerning sex and relationships. In order...
to feel comfortable, a number of conditions must be met. The right person must be accessible; the place where they talk must feel safe; and there is need so that they do not feel they are being rushed or that concerns are being glossed over and not taken seriously.

Where sex education in schools aims to inform, at best it confuses and even perplexes. Where it aims to help, reassure, explain, and support, it is significantly fails. There is no guarantee that what is delivered in schools is absorbed, understood, or remembered, let alone put into practice at a personal level. Messages about safe sex and the means to internation are not always transmitted and do not therefore influence actual behaviour unless the links are made between abstract knowledge and personal responsibility in relationships. Much contraceptive practice is based on false logic arising from misremembered, misunderstood, unsuitable and ill-timed information.

Young people do not need a barrage of information on HIV at the expense of other STDs, and they would like the opportunity of talking about the emotional aspects of relationships, sexual or otherwise, as well as feelings and attitudes, which may not be related to sex at all. While they are being heavily encouraged to be sexually responsible, they are given no resources with which to discern, neither sufficient information nor the skills and language to negotiate relationships safely. The young people interviewed did not feel that the schools could comfortably explore these areas either during sex and relationship classes or at home with their parents.

Where sexual health services are available, they are very patchily geographically, and information about these services and their whereabouts appears to be deliberately withheld from young people. They detect a lack of respect and general disapproval among adults regarding their lives and at the same time they fear not being accepted for what they are. This makes it difficult for them to ask questions and embark on discussions. One of the few opportunities for opening up a discussion on sexual matters at home is, by common consent, a programme on television where HIV/AIDS features, whether it be a soap or a documentary. But such discussions are not always very satisfactory.

On the whole, the young men interviewed were more pleasantly surprised than the young women at how much they appreciated the opportunity the interview setting provided of talking freely. This illustrates the extent to which young men need special attention in this area if we are to encourage their interest, respect, and sense of responsibility. Their needs are greater than might appear, for they are often ignored: the sexual double standard in societycrypto them up into flippant camaraderie and invests them with a kind of power they neither really understand nor know how to handle. When it comes to creating and using a vocabulary for sex and feelings, language is a greater problem for males than for females. This is an area requiring extensive input.

Such input could be achieved if the young people's expressed need for a counsellor as part of the local clinic were taken up. The idea came directly from the interviewees, who felt that such a person could also take on some of the responsibility for sex and relationships education in the local school, as an established subject for small-group work in all years.

Many young people are anxious, shy, or worried; they may be feeling inadequate and ignorant. Their behaviour may appear defensive or evasive; they may be feeling confused, embarrassed, and lacking in confidence. All these emotions may well be exhibited as belligerence, rudeness, and an unwillingness to communicate. The way young people subsequently handle their responsibilities is not always the best way to address two of the recommendations, which have been treated at the initial encounter with the clinic at the reception desk. The first impression makes all the difference to their continued attendance and the reputation of the clinic's staff and services — and ultimately, in these times of scarce resources, to the clinic's continued existence.

From research to practice

Although this research has highlighted some issues of which we were already aware, there are also others that surprise and encourage us. The most surprising aspect is the extent to which the young men are aware of the opportunities for discussing matters of concern and interest in the interview. The young men we interviewed are aware of the openness of their sexual needs in particular, and the heartfelt desire for more attention and respect are, we feel, significant. There is a feeling that now we must stop researching and begin to put some of the recommendations into practice. For we raise expectations with research of this kind. We owe it to these young people the respect they deserve by following through some of our suggestions.

Generally, our recommendations include more comprehensive and systematic sex and relationships education in schools, starting at the beginning of their time there. The responsible staff should be specially trained, and share space and time between the clinic and the school, being available for small-group and individual work as well as class work. More openness, honest discussion, and respect for individual differences are required if young people are to become responsible, understanding, and considerate in all their relationships.

Specific recommendations include:
- Smaller groups in school PSE classes.
- The setting-up of a local helpline.
- Specific training for staff who undertake sex and relationships education, whether in school, clinic, or youth centre.
- Training for front-of-house staff (clinic receptionists), who can make or break the young person's confidence.
- More clinic sessions for young people at convenient times during the week.

Postscript: some action

Most encouragingly, the recommendations have been taken seriously by Avon Health Authority, which was responsible for the research. The report went to the Authority in July, 1995, and the following year, a series of workshops on the recommendations were held in November, 1995, therefore, the project researcher undertook two tasks: to plan and run courses for receptionists in family planning and young people's clinics in Avon, and to carry out a feasibility study for a sexual health telephone helpline for young people in the area. Three courses for receptionists and other administrative staff in sexual health clinics within the Authority area have been completed. Each course, of three half-day each, ran over a period of several weeks in order to give the participants time to relate their raised awareness to their own clinical practice. The courses addressed in particular understanding, empathizing, and responding appropriately to young people's sexual health needs. These needs can often be difficult to handle. A significant aspect of the course also involved looking at the work involved in clinic reception and administration, as well as the difficulties encountered.

Three courses for young people, representing 11 clinics (including the Genito-Urinary Medicine clinic) attended these courses, and the feedback on all three has been very encouraging, emphasising a strong desire for regular follow-up sessions.

Following the feasibility study for the young people's sexual health helpline, Avon Health has agreed to fund the setting-up and running of such a service for a six-month period, after which it will be reviewed in the light of use and performance. The Authority has also expressed its confidence and commitment to the project as essentially information and referral service as well as a 'short-listening' service. The launch is planned for November 1st this year. Bearing in mind that the young people interviewed wanted a counselling-type service in their local clinic for all sorts of worries and support, and not just for their sexual health, and bearing in mind also the lack of financial resources for extra health services, a helpline as a hub for all services for young people in the area seemed the best option.

References


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