Alcohol education in South West England

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South West Alcohol Education Programme

An alcohol education project in the Tyne Tees area has led to a further study being carried out in the South West of England. A survey examining drinking-related behaviour was used as a preliminary to studying teaching attitudes and approaches. 'In most schools, the approach and priority given to alcohol education seemed to relate more to the personal attitude of teachers than to knowledge of drinking patterns.'

The South West Alcohol Education Programme (SWAEP) has been in existence since 1984, and is expected to run until March 1987. The programme has received funding from the Health Education Council as a development from their previous Tyne Tees Campaign (1). The philosophy of the programme was laid out in the Action Plan produced in Spring 1985 (2). This stressed the need for a 'social learning' approach, because this kind of approach recognises the individual's right to choose, the importance of participative forms of learning, and the need to locate alcohol issues within the broader questions of health and health promotion. The central concern of the programme was primary prevention, and the central aim was to encourage everyone to 'understand alcohol'. A central mechanism for achieving this would be through persuading a large range of professionals in the South West of the need to address such issues in their day-

to-day work with clients, patients, consumers and pupils.

The Action Plan listed two priority areas, namely *alcohol and the workplace,* and *alcohol and young people.* This second area led to the invitation of John Balding from the HEC Schools Health Education Unit, Exeter University, to join the Management Group of this programme. The Health Related Behaviour data bank was able to provide a range of information on alcohol-related behaviour, and some of this was reported in Vol. 3 No. 2 of *Education and Health.* Responses from 18,000 pupils in the 1st to 5th years were analysed and it was found that:

1. **Even at age 11, over half the boys and a third of the girls had an alcoholic drink on at least one day in the last week.**
2. **The percentage of 'drinkers' increases from 56.5% to 71.8% for boys, and from 35.4% to 62.1% for girls, from 1st to 5th years in this cross-sectional sample.**
3. **In all age groups, the majority of 'drinkers' had their drinks on only one or two days in the past week.**
4. **Overall, the frequency of drinking increases in the higher year groups. In Year 1, the average for the boys is 1.2 days per week, increasing to 1.9 days in Year 5; for girls the average frequency goes up from 0.6 of a day to 1.2 days (3).**

Four locality studies

The authors are members of a research team which is funded by the HEC to evaluate the impact of the South West Alcohol Education Programme. This has involved a range of activities, including four locality studies in which over 170 professionals have been asked about their day-to-day involvement in alcohol education and how this relates to organisational role, professional training, and perceptions of local drinking patterns and problems. The four areas chosen reflected something of the diversity of the South West, as can be seen below:

1. A market town together with a nearby tourist/fishing village.
2. A market town which was the administrative centre for its county.
3. A group of isolated villages.
4. A large inter-war council housing estate in a large urban conurbation.

These interviews included three social education Advisers and 20 teachers from 13 schools. Seven of these were Heads or deputy Heads, while the rest had some direct involvement in social, pastoral, or alcohol education. The full results of this research have just been written up (4).

The Advisers

There was a fair degree of agreement by the three Advisers about what should be the future direction of health education and social education. They believed health education should be integrated into a broad range of personal and social activities in schools: it should not be seen as esoteric and separate, although discrete content areas such as sex education needed to be addressed. Such an approach required an emphasis upon group work and participative learning. Two Advisers stressed that teachers found it difficult to accept this kind of approach, because it was not reflected in their training; this meant that teachers needed considerable support and in-service training. All the Advisers were faced with massive work loads. For example, one Adviser was also responsible for home economics, while the one not interviewed was also responsible for physical education.

An integrated approach

As one might expect, alcohol education in most of the schools did not reflect this type of approach. The main exception was a comprehensive school, where health education in the 4th year was organised by a biology teacher. She explained some of the exercises that were used. In *Run for your life,* the body was drawn and life support mechanisms listed. Dangers to these systems were listed, and one of these was alcohol and the liver. Under *Stereotypes,* attractive and unattractive forms of behaviour were discussed in small groups. One stereotype considered was the drunk; drunken men were far more acceptable to the pupils than drunken women. In *Free to Choose,* several sessions were organised around the BBC programmes on drinking.

However, much of the syllabus made no specific mention of drink. Children soon reacted against too much focus on one area. The course looked at how social rules, peer group pressures, and advertising pressures influenced lifestyle in areas such as diet and smoking. Pupils tended to be fascinated more by illegal than legal drugs. Throughout the health education work, a key component was the Health Related Behaviour Questionnaire. This is an instrument for describing the actual behaviour of pupils, and provided a pivotal point for small group and class discussions. It avoided the adoption of a prescriptive approach: the starting point was actual behaviour and attitudes, and the first question was *why*? The overall aim was to enable young people to make their own health and lifestyle decisions.

Health education and science

Most of the other schools seemed to take a far more varied and less coherent approach to health education in general, and to alcohol education in particular. For example, the Head of a boys' senior school said that alcohol education was part of the science programme given to 13-year-olds. A variety of health education subjects (including sex education) were introduced as part of both a broad science education programme and also within religious studies. Alcohol was addressed under *abuse of drugs,* and sessions looked at how alcohol was associated with mental or emotional problems.

The teacher responsible for the co-ordination of the health education syllabus in this school later explained that health education represented one third of the biology course during this year. Some health education issues might also be tackled in biology lessons in later years, but not all pupils took this subject. Religious studies was a person-centred curriculum, and so it was difficult to specify the extent to which health education issues were addressed. Both teachers agreed that it was difficult to know exactly what health education was received by which pupils; the situation was even less co-ordinated when the varying inputs on health education from their three feeder middle schools were considered.

A 'social education' approach

Another school appeared to have overcome these problems. The social education co-ordinator and a group of other staff had reviewed the social education syllabus two years ago. Every pupil now received one social education lesson per week. Previously, this kind of lesson had only been available to the 'less able', but it was felt this meant that the 'more able' were missing out.

The new syllabus has one general aim and seven underlying objectives. The general aim was *to develop pupils' knowledge and understanding of society and their present and future roles within it,* while the seven objectives included *to create a positive attitude towards leisure activities.* In the 1st year, the emphasis was on enabling pupils to settle down and feel confident at a secondary school. In the 2nd year, information was given on a variety of topics, but with a heavy focus on smoking. Possible careers were the main focus of the 3rd year, while the 4th-year syllabus looked at teenage development and the pressures and influences upon emerging lifestyles. The 5th year returned to the focus on careers work. Alcohol education was addressed in the 4th year under *abuses of health,* together with obesity, glue sniffing and anorexia.

Since teachers were allocated to such topics on the basis of both interest and availability, different approaches might be taken by different teachers: some were interested in the underlying objectives, while others were concerned only with the content of particular lessons. Some favoured a more shock/horror approach than others, and some teachers

refused to take alcohol education seriously at all. A further problem was that the careers input of the 5th year was now being started in the 4th year because it was seen as so essential; the time available to address health education issues was therefore being squeezed.

Teachers' attitudes to alcohol

In most schools, the approach and priority given to alcohol education seemed to relate more to the personal attitude to alcohol of teachers than to detailed knowledge of local drinking patterns or levels of under-age drinking. Some teachers had a very hostile attitude to drink and, therefore, any drinking by pupils caused them anxiety. Such teachers were prone to a prescriptive approach, which included guest speakers from Alcoholics Anonymous to warn of the dangers. Others viewed widespread under-age drinking in public houses as not necessarily a bad thing, if the environment was teaching them about 'sensible' rather than binge drinking; this was more seen as more likely to be the case with village pubs than public houses in large towns.

There was a discernible uncertainty in several teachers about what most pupils' drinking patterns were like. Should they interpret the occasional story in the local press, the discovery of a pupil found drunk in school hours, as signifying widespread abuse of alcohol by young people? Or could they comfortably dismiss these events as isolated incidents in the lives of 'problem' pupils, probably from a 'problem' family?

Implications for the SWAEP

This overall situation creates a major dilemma for the programme. Those schools in sympathy with its philosophy of experiential learning and the importance of being 'free to choose' may be unlikely to be attracted to a programme that is so clearly concerned with a specific health topic. Those schools more prone to concern about the specific issue of alcohol abuse may be likely to approach the subject with a narrow focus on the dangers of drink and treatment facilities for those labelled as 'alcoholic'. In both types of school, and in all Education Authorities, the present turbulent environment undermines the ability of nearly all teachers to respond positively.

A series of local co-ordinators have recently been appointed to the South West Alcohol Education Programme. These will be based in the health education units of District Health Authorities or in local councils on alcoholism. Some of these co-ordinators may well try to persuade the Education Authority to support a blanket coverage of secondary schools in their area with the Health Related Behaviour Questionnaire. This would open up the prospect of areas obtaining a much sounder understanding of alcohol consumption trends.

The Questionnaire can also offer an exciting way forward for individual schools. The low cost of the service will appeal to those searching for new resources: it helps to relate alcohol to other aspects of emerging lifestyles, and it generates discussion on the actual behaviour of young people. However, two schools in the sample have bought into the service but appeared to be making little use of it.

More thought may need to be given as to how schools and teachers can be trained to make maximum use of the Questionnaire along the line of the earlier 'good practice' example. This would need to include a mechanism by which teachers can address their own drinking careers, and how this relates to peer group pressure, work stress, and other relevant factors.

References

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