School-Based Drug Education in Northeast Scotland – Policy, Planning and Practice

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Happiness loves to see people at work. It loves sweat, weariness, self-sacrifice. It will not be found in palaces, but lurking in cornfields and factories and hovering over littered desks.

David Grayson

Abstract

This research utilised qualitative methods to gain a deeper insight into the policy, planning and practice of school-based drug education than had previously been achieved in Scotland. Semi-structured interviews were carried out with staff in nine Grampian secondary schools together with a case study of one school. The case study involved direct lesson observations as well as in-depth interviews and feedback sessions with stakeholders in drug education including staff and 48 pupils. In both parts of the study schools were selected by theoretical sampling, each interview was transcribed in full and all data were annotated and analysed with the aid of specialist computer software. Validity and reliability were enhanced by constant vigilance in data analysis and by various procedures including reactivity analysis, peer examination, triangulation and consideration of any potential bias on the part of the researcher. The highest standards of ethics were applied throughout the study.

Whereas previous studies have revealed the lack of impact of drug education on drug-taking behaviour in young people, this research is unique in attempting to explain this lack of impact. The research findings revealed that teaching and learning processes in drug education were below best practice as defined by the relevant research literature and national guidelines. Four key underlying issues were identified: (1) A lack of clarity and understanding about the goals of drug education; (2) A lack of time and support for researching, planning and reviewing drug education; (3) A low priority assigned to Personal and Social Education (PSE) in general; (4) A failure to recognise drug education as a broad and complex subject requiring considerable expertise to teach. Fundamental changes to how drug education is approached both locally and nationally would be required to resolve these issues in full. The nature of these changes is discussed in detail in the thesis.

Acknowledgements

One accumulates a lot of favours over three and a half years, and so I must acknowledge that this research has only been completed with the generous help, support and encouragement of many people. As a final favour, I request patience as I endeavour to thank each person and forgiveness should I omit anyone.

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Foreword from the Author

This thesis describes my work over the past three years or so, in which I have sought to gain a better understanding of how schools in north-east Scotland go about teaching their pupils about illegal drugs. In doing so, I have by necessity, built some skills in planning and managing research, in applying qualitative data collection and analysis techniques and in academic writing. Perhaps most importantly, I have grown in understanding of myself.

I came to this PhD in a somewhat roundabout fashion - looking around the pharmacy class of '97 in Trinity College, Dublin, I never imagined that I would be among those who went on to do post-graduate study, never mind a PhD. My attention span to my studies in fourth year was more akin to that of the proverbial goldfish than that of a budding doctoral candidate. This lack of diligence, along with a growing list of distractions, most notably my work with the European Pharmaceutical Students' Association (EPSA), meant that I was lucky to escape with an honours degree for my meagre efforts. It was my enthusiasm for my EPSA work that was to eventually lead me to this PhD however. In discussions about an EPSA project on drugs awareness which I had planned, it was suggested to me that I consider doing a PhD along similar lines. I was immediately interested in the idea and the more I thought about it, the more I became determined to do it. Twelve months later in October 1999, I began my studies at The Robert Gordon University in Aberdeen.

In this thesis, I aim to provide a readable and understandable text describing my research and the context in which I have carried it out. The first chapter introduces the issue of drug use in Scotland and discusses what is already known about drug education in schools in theory and in practice. The second chapter discusses the methods used in the study, why they were chosen and how each part of the research was carried out. Chapter 3 describes the results of interviews with teachers in nine schools that focused on how drug education was planned, developed and delivered in their school. Chapter 4 describes the results of an in-depth case study of the drug education that was delivered in one school over a four month period, and offers an insight into the perspectives of pupils and staff in that school. The fifth chapter discusses the validity and reliability of the research findings, and describes the ethical issues that arose over the course of the study.

Chapter 6 discusses the results of the research and the implications of the findings for schools and those who work in, attend or govern them. Finally, Chapter 7 provides a short summary of conclusions and recommendations. In addition, appendices are included to provide concrete examples of some of the documents referred to in the thesis and to give further explanation of particular areas or further evidence as required. I hope that readers will find my writing interesting and my findings useful.

Niamh Fitzgerald

July, 2002

Terminology

Definitions in this field are notoriously problematic as terms overlap, are ambiguous and are difficult to separate from the various value stances which underpin them (Lowden and Powney, 2000). In a qualitative study such as this where the statements and opinions of many people are central to the body of data the problem is confounded as the meaning of a particular term is likely to vary from speaker to speaker. Nonetheless, it is important to clarify the meaning of the most common terms at least as they are used by the author in the narrative.

Illegal Drug

In this thesis unless otherwise stated the term "illegal drug" is used to describe drugs controlled under the Misuse of Drugs Act, 1971 that are used illegally. This definition therefore includes many drugs which can also be used legally when prescribed for a medical reason (such as benzodiazepines, morphine etc.), but excludes alcohol, nicotine and volatile substances.

Drug Use

For clarity and specifically in order not to imply a judgement over the behaviour of people, the term "drug use", rather than "drug misuse" or "drug abuse" is used to describe the illegal use of drugs which are controlled under the Misuse of Drugs Act, 1971. The latter terms may appear in this thesis as part of quotations from respondents or other literature.

Drug Education

The term "drug education" is used in this thesis to refer to all lessons/activities which attempt to impact on the knowledge, attitudes or behaviour of the general pupil population in relation to illegal drugs. It is acknowledged that many drug education lessons may also include input related to alcohol, tobacco or solvent use, although these aspects were not specifically studied in this research project.

Other terms related to drug use (such as "problem drug use"), as well as a whole range of terms that are used in the field of qualitative research are discussed and/or defined at appropriate points in the main text of this thesis.

Chapter 1. Introduction

The focus of this research is the process by which secondary schools in Scotland plan, develop and deliver their drug education provision. To understand the issues surrounding this process, it is necessary to review the context which has led to the provision of drug education in the first place. Section 1.2 of this chapter provides a background to drug use in Scotland including the numbers of people who are using illegal drugs, which ones are most commonly used, how frequently they are used and a brief insight into the consequences of different levels of use. Section 1.3 discusses why people use illegal drugs in the first instance, and the factors that lead to problems with use.

The rest of the chapter deals specifically with school-based drug education. Section 1.4 describes the history of drug education in schools and discusses what is known about the relative effectiveness of different approaches to drug education by reviewing previous research on goals, content and delivery. A summary of good practice in drug education is provided at the end of the section. Section 1.5 describes the context of school drug education in Scotland and reviews existing guidelines available to schools. It describes what is currently known about the drug education that exists in Scottish secondary schools and the factors that affect its provision. Finally, section 1.6 discusses what is *not* known about drug education in Scottish schools and how this project seeks to fill some of those gaps.

Prior to any of this discussion however, section 1.1 outlines the strategy by which all of the above information was discovered and gathered.

1.1. Search Strategy

Initially, key review works in the field were identified (Coggans and Watson, 1995; Plant and Plant, 1999) and used as a source of further references. Each new document studied allowed the author to identify other relevant works and to become familiar with the journals relevant to the field. Table 1.1 (overleaf) contains a list of the titles found most useful. Where possible, the author arranged to receive electronic updates of the contents of these journals as new issues were published.

Key Publications	
Addiction (British Journal of Addiction)	Health Promotion Journal of Australia
Addictive Behaviours	International Journal of Drug Policy
Drug and Alcohol Review	International Journal of the Addictions
Drugs: Education, Prevention and Policy	Journal of Drug Education
Evaluation Review	Journal of Drug Issues
Health Education Research	Journal of School Health

Table 1.1: Key Publications

In addition, searches were carried out at regular intervals on the most relevant databases (SSCI; CINAHL; IBSS; ERIC; CAREDATA; ASSIA NET) using key words ("drug education" where permitted by the database search process). These searches elicited a large number of peer-reviewed papers of which the most relevant were ordered and studied, and again these referred to further published work. Over the course of the research, searches were also carried out on specific topics as they arose (e.g. "school management"; and "drugs and young people") where further understanding was needed. Finally, a number of publicly funded websites[i] maintain lists of relevant publications and these were also scanned regularly.

While published peer-reviewed work forms a very important part of the literature in this area, any review would be incomplete if it failed to consider the huge amount of "grey" literature on this topic, which has in many cases been written by leading researchers in the field and can be of a very high standard. This body of literature consists mainly of publicly commissioned reviews or research, official guidelines on health or drug education in schools and reports published by governmental and non-governmental bodies. These were identified by means of extensive searches of websites, references from published papers, and through contacts established over the course of the research.

[i] Health Education Board for Scotland: http://www.hebs.scot.nhs.uk/research/
Drug Misuse in Scotland Homepage: http://www.drugmisuse.isdscotland.org/index.shtml
National Institute on Drug Abuse (USA): http://www.nida.nih.gov/
National Drug Research Institute (Australia): http://www.curtin.edu.au/curtin/centre/ndri/

The search strategy used in this research project was not exhaustive, nor was it organised in such a way as to guarantee the inclusion or even the consideration of all the literature in the field, as would be the case in a systematic review. The enormous scope and breadth of the drug education literature militates against such systematic work, as does the limited timeframe of a PhD programme. Given the evolving nature of the research, literature was retrieved and read as was required to maintain an understanding of key issues at each stage of the project, and to ensure that no key papers were omitted. In total, over the course of the research, over 350 papers, books and reports were studied.

1.2. Drug Use in Scotland

In Scotland it is thought that at least one fifth of the adult population (aged 16-59) has used an illegal drug at some point in their life ("lifetime use"), (Fraser, 2002). This figure comes from the Scottish Crime Survey (n=2,886) and it is acknowledged that this may be an underestimation due to the reluctance of some respondents, especially younger ones, to admit an illegal activity in this kind of household survey. The Scottish figure is lower than that found in the equivalent survey in England and Wales and generally higher than in many other European countries (Ramsay et al., 2001; EMCDDA, 2001). The vast majority of those who have tried an illegal drug have used cannabis which is still, after alcohol, the main drug of use across the whole of Europe (EMCDDA, 2001). Lifetime use of amphetamines (including ecstasy) is also high in Scotland at about 6% of the adult population compared to the European average of 1 to 4% (ibid).

The Scottish Schools Adolescent Lifestyles and Substance Use Survey (SALSUS) 2002 (CAHRU, 2002; n=22,434) found that 24% of a sample of pupils in S2 and S4 had experimented with an illegal drug. Another study, also in Scotland, which included pupils from S1 to S5 (n=1,119) found that 23% of secondary school pupils had experimented with an illegal drug in their lifetime (Lowden and Powney, 2000). Similar figures for lifetime use of an illegal drug among teenagers have been found in smaller studies in rural Scotland (25% of 12-15 year olds, Barnard and Forsyth, 1998; n=765) and in independent secondary schools (26% of 11-18 year olds, Forsyth et al., 1998; n=557). Local figures for schoolchildren in Grampian are available from the Grampian Youth Lifestyle survey.

The 2001 survey targeted a 10% sample of all pupils from years 1 to 6 in all secondary schools in Grampian including independent schools. A total of 2,515 questionnaires were returned. 21% of the pupils who returned questionnaires had experimented with an illegal drug (NHS Grampian, 2002). Once again, in all of these studies cannabis was by far the most likely illegal drug to have been used: just 6% of pupils in the SALSUS study were found to have ever used any of the stimulant drugs (cocaine, crack, ecstasy, amphetamine or poppers).

Crucially, when the usage figures were split by age in the SALSUS study (CAHRU, 2002), it was found 37% of 15 year old pupils (n=10,443) had tried an illegal drug, compared to 13% of 13 year olds (n=11,991). In fact older teenagers and those in their twenties are most likely to have used an illegal drug over the course of their lifetime. Lifetime use of an illegal drug for 16-29 year olds in Scotland in the most recent Scottish Crime Survey was also found to be 37% (Fraser, 2002). Of respondents aged 20-24, as many as 15% reported lifetime use of amphetamines; 11% reported lifetime use of ecstasy; and 4% of females and 8% of males reported lifetime use of cocaine (not including crack cocaine) (ibid). These figures are based on a small sample size[ii] and again, they may represent an under-estimate. What is clear however, is that while most schoolchildren have not taken an illegal drug, on the basis of current figures nearly half of them will have done so by the age of thirty. Pupils are most likely to be offered or obtain illegal drugs by/from close friends or siblings and are most likely to use them outdoors, in a friend's house or at a party (Lowden and Powney, 2000; NHS Grampian, 2002).

Although most occasional use of illegal drugs is relatively problem-free, it is not without risk. The risk of formal legal sanction for cannabis possession seems likely to decrease following recent developments proposing reclassification of cannabis to Class C under the Misuse of Drugs Act, 1971 (Select Committee on Home Affairs, 2002; Blunkett, 2002). Despite this, it is acknowledged by a leading drug charity, DrugScope that occasional use still carries risks not unlike those associated with alcohol: short term memory loss; anxiety; increased risk of accidents and increased likelihood to participate in sexual activity that is later regretted, or to practice unsafe sex (DrugScope, 2002a).

[ii] The exact figure is not provided in this report.

Unlike alcohol however, the strength of cannabis is not controlled and there is evidence that the cannabis in the UK market has become increasingly potent in recent years (DrugScope, 2002b). This means that in addition to the above effects, some users may be more likely to hallucinate while under the influence of cannabis which may be experienced as a pleasant or disturbing episode. Although there is evidence that there may well be significant long term risks associated with regular cannabis use (see below), the vast majority of people who have used cannabis on an occasional basis only will experience no major adverse effect from the drug. This is also true of the occasional use of the other most commonly used illegal drugs, although for a tiny minority even occasional use can have tragic consequences. The legal sanctions imposed for illegal drugs other than cannabis also tend to be greater[iii]: amphetamines are to remain in Class B under the Misuse of Drugs Act, 1971, while despite the recommendation of the House of Commons Select Committee, ecstasy is to remain in Class A along with cocaine and LSD (Blunkett, 2002). Finally, it is worth noting that there is increasing concern about the numbers of traffic accidents that are caused by people driving while under the influence of illegal drugs (or indeed other medication) (Scottish Executive, 2002a; BBC News, 2002a; Lenton and Davidson, 1999). Given its widespread use, it is not surprising that cannabis has been found to be a significant contributor to this problem in a recent Scottish study (Neale, 2001).

In view of the high levels of lifetime use in young people as a whole, many commentators have reported that young people see illegal drugs as a normal part of life even though they themselves may not ever participate in use (Hirst and McCamley-Finney, 1994).

> Young people are aware of the presence of drugs in their social worlds and in the main they treat this matter of factly.
>
> [Hirst and McCamley-Finney, 1994]

Parker et al., describe illegal drug-taking as "common-place…in the social spaces which young people occupy" and as "integrated into 'official' youth culture" (1995).

[iii] For details of the maximum legal penalties for possession and supply of illegal drugs please refer to the HEBS website: http://www.hebs.com/services/drugs/law.htm

Measham et al., (1994) discuss the normalisation of drug use among young people, while Coffield and Gofton (1994) mention the "ubiquity of drugs among the young". These views are supported by studies that show that young people are very likely to be offered illegal drugs (National Statistics, 2001); high proportions of them have friends who use illegal drugs (Forsyth et al., 1998); and many report proximity to drug use (Barnard and Forsyth, 1998).

The widespread exposure to illegal drugs by pupils and apparently easy availability may mean that the presence of illegal drugs in the social networks of young people is something that comes as no surprise to them. It can still be argued however, that actual *use* of illegal drugs has not become a normal activity. Robertson's 1996 survey of young people in Scotland (n=9,496) indicates that most pupils do not consider illegal drug-taking to be a normal activity (Robertson, 1996). Shiner and Newburn (1997) report that even those who use illegal drugs do so within strict boundaries and that users display conservative attitudes towards any use of illegal drugs outside of these boundaries or where such drug use by siblings is considered. In fact rather than being considered normal, previous studies have found young people to be quite disapproving of drug use. In their study Lowden and Powney (2000) report that 91% of secondary pupils did not approve of drug use. Another study found that most young people did not approve of even occasional cannabis use (Cooke et al., 1997; n=837). It is possible that such attitudes grow more tolerant as use increases when young people leave school, but it is clear that for a large proportion of young people use of illegal drugs is not something in which they participate, or of which they approve.

This lack of interest in or approval for the taking of illegal drugs is evidenced by the fact that despite the large number of people who try an illegal drug, much lower proportions ever use them regularly. In the SALSUS (Scottish Schools Adolescent Lifestyles and Substance Use Survey) 37% of 15 year olds had tried illegal drugs, however only 23% had used one in the past month (CAHRU, 2002). In Grampian, while 19% of all respondents had used cannabis in their lifetime, more than half of those who had used it (10% of young people surveyed) had only done so once or twice in total. Less than 3% of pupils surveyed had ever tried the next most commonly used type of illegal drug, amphetamines, and far fewer, 0.525% (almost one in 200 pupils), used them once a week or more (NHS Grampian, 2002).

It is clear from the above figures that the vast majority of regular users of illegal drugs use cannabis and that most cannabis users do not regularly use any other illegal drug. This use is certainly not risk-free, however and it stands to reason that the more cannabis is used, the more often the user will be exposed to the risk of the short term adverse effects described above. According to DrugScope, there is no conclusive evidence that moderate, long term use of cannabis causes lasting damage to physical or mental health (DrugScope, 2002a). Nonetheless, it is fair to say that the body of research into the effects of cannabis on health is growing. In relation to cannabis and mental health, recent studies would suggest that evidence is mounting that cannabis use may increase the risk of schizophrenia or depression (Rey and Tennant, 2002). There is also some evidence that regular cannabis use may be associated with lung disease including emphysema and bronchitis, as well as changes in lung tissue that may be preliminary to the development of cancer (Henry et al., 2003; British Lung Foundation, 2002).

Cannabis is not thought to cause physical dependence however psychological dependence has been documented with some users having difficulties controlling use, experiencing withdrawal symptoms and a persistent desire to use the drug (Swift et al., 2001). However, it appears clear from drug use statistics, and from studies dating from as far back as 1974 (Brown et al., 1974) that the majority of cannabis users do not experience difficulty in reducing and ceasing use as they grow older and take on family and professional responsibilities. Overall, it is worth noting that studies into the effects of cannabis are highly contentious however; the British Lung Foundation report (2002) was not without its critics, and the evidence on long term effects is by no means clear-cut. This is exacerbated by the difficulties in separating the effects of cannabis from other substances taken by cannabis users, including tobacco which is normally smoked along with cannabis. The evolving nature of the research and evidence into the long-term effects of this drug is not unique to cannabis. Research into ecstasy, cocaine, amphetamine and other drugs has also yet to reach widely agreed conclusions. This complexity is not always reflected in information designed for the general public such as the DrugScope website, and this ought to be borne in mind in considering what is presented about the health effects of these other drugs through the rest of this section.

A much smaller proportion of people use illegal drugs other than cannabis regularly, as discussed above. Most amphetamine and ecstasy use, and increasing amounts of cocaine use are associated with dance music culture, in which a small sub-section of (mostly young) people are involved (DrugScope, 2002c; 2002d; 2002e). All three of these illegal drugs are stimulants. After use the body's energy stores become run down and feelings of anxiety, irritability and restlessness can commonly occur. Most of these effects last no more than a couple of days at the most, and the vast majority of regular users experience no major adverse effects from their use. Long-term, heavier use of these drugs can be linked with lack of sleep and appetite in the user, (sometimes anorexia nervosa, especially in women,) and lowered resistance to disease. Repeated snorting of cocaine damages the membranes which line the nose and both amphetamines and cocaine can be prepared for injection which carries serious additional risks (see below). Little is yet known about the effects of heavy, long term use of ecstasy but there are increasing concerns about the possibility of mental health problems, especially chronic depression and sustained memory loss. Studies of the dance music scene show that as well as using high doses of one particular drug, those who are heavily involved in the scene commonly use more than one illegal drug in addition to alcohol in the same session. A second drug is often taken to enhance or counteract the effects of the first (Winstock, et al., 2001; Sherlock and Conner, 1999; Hansen et al., 2001). The long term effects of such combinations, also sometimes known as "poly-drug use", are not yet known.

None of amphetamines, ecstasy or cocaine cause physical dependence in the same sense as an opiate, but it is possible to become psychologically addicted to the pleasant effects of the drugs and/or to the dance music scene if used regularly (DrugScope 2002c; 2002d; 2002e). Tolerance to the drugs can develop with regular use meaning that more is needed to get the same effect. Heavy users who try to stop taking them are likely to find it difficult, especially initially. They may feel anxious, depressed, lethargic, lacking in energy and incredibly hungry and may be tempted to keep using the drug to avoid these feelings. Normal work and domestic routines may be disturbed and users can suffer mood swings, or become aggressive. Cocaine can be particularly difficult to give up, as withdrawal is associated with extreme emotional and physical distress.

Despite these effects, the number of deaths related to the use of amphetamines, ecstasy and cocaine, though highly publicised, is very small. DrugScope report that over 90 young people have died from ecstasy use in the UK over the last 15 years. These deaths have been caused by heatstroke, excess fluid intake, or heart failure, however it is not known why these particular people have been affected in this way when it is estimated that over 500,000 people take ecstasy every weekend (DrugScope, 2002d; 2002f). Like ecstasy, the effects of amphetamine and cocaine can be particularly dangerous to people who have heart or blood pressure problems. There have been more deaths related to amphetamines than ecstasy (Shapiro, 2003) though fatalities are still very rare.

LSD (lysergic acid diethylamide) is also associated with the dance music scene, although as it is an hallucinogen, it is unlike the three illegal drugs discussed above. The Scottish Crime Survey found that approximately 4% of respondents aged 16-59 claimed to have used LSD in their lifetime (Fraser, 2002). There is no evidence of LSD use leading to physical dependence or fatal overdose, although people have died through accidents occurring under the influence of the drug. Some LSD users experience "flashbacks" which tend to be short lived but can be disturbing, especially if the user does not know that it can happen (DrugScope, 2002g).

While cannabis (and alcohol and tobacco) have been known as "gateway drugs", it is important to note that the regular use of cannabis, or indeed any drug, does not always lead to loss of control and self-destruction. While it is true that most illegal drug users who experience serious drug-related problems have used cannabis, it is also true that the vast majority of those who use cannabis, do not go on to develop serious problems with other drugs (DrugScope, 2002a). A recent Home Office study concluded that early soft drug use and later hard drug use may be joint expressions of the same underlying personal problem rather than a consequence of a causal influence of soft drug use on the subsequent desire for harder drugs. The apparent progression from soft to hard drugs may be just a consequence of the fact that soft drugs are easier to get and more affordable than hard drugs for the very young (Pudney, 2002). In fact, as Davies (1997) points out, the widely held belief that illegal drug use tends inexorably towards loss of control can become a dangerously self-fulfilling prophecy as users are taught to see themselves as helpless, problematic addicts. In fact most illegal drug use is controlled and such control is effected by (sub)culturally based social controls (rituals and rules)

which pattern the way a drug is used (Decorte, 2001; Maloff et al., 1979). Other studies support the idea that informal social sanctions and customs define acceptable drug use (Gamble and George, 1997; Zinberg et al., 1975; Grund et al., 1993). It is also true that the pattern of drug use throughout most users' lives is unlikely to be stable or even linear. As shall be seen in the next section, people use drugs for many different reasons, and they frequently go through phases of abstinence, occasional use, regular use or heavy use, according to what else is happening in their lives at that time.

According to Decorte (2001), patterns of use are dynamic in nature and a product of particular situations, contexts, events, time periods and drug use career transitions. This is true even of opiate use: Blackwell (1983) has shown that not all users become dependent. Some do not ever progress beyond casual, non-dependent use, others go through phases of dependence, controlled use and abstinence, and some "drift out" of dependent use altogether and emerge "relatively unscathed". Unfortunately, such "natural recovery" is not universal, and some users of illegal drugs develop serious problems as a result of their use. It is such use that is associated with many of problems linked to illegal drugs in society, and which poses the greatest risks to the users themselves.

Despite the impact of problem drug use on some communities, such users are relatively small in number when compared with the above figures and estimating them is particularly difficult. The term "problem drug use" is itself ambiguous and from some perspectives any illegal drug use might be described as problem use. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has defined problem drug use as "injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines" (EMCDDA, 2001). The EMCDDA points out that this definition excludes ecstasy and cannabis users and those who do not regularly use opiates, cocaine or amphetamines (ibid). On the basis of this definition, prevalence of problem drug use in Europe seems highest in the UK along with Italy, Luxembourg and Portugal (about five to eight problem drug users per thousand inhabitants aged 15-64) and lowest in Belgium, Germany and the Netherlands (about two to three per thousand) (ibid.)

In Scotland, a key recent study (Hay et al., 2001), defined problem drug use as misuse of opiates and/or benzodiazepines (including individuals taking opiates prescribed to them to treat their opiate addiction). This definition is narrower than the EMCDDA one, as it does not include those who may be injecting amphetamines or cocaine, or are dependent on any drugs other than opiates or benzodiazepines. Estimates were made based on a capture-recapture method, recommended by the EMCDDA, which allows the inclusion of problem users who are not in contact with health services. The report estimates that there were fifty-five thousand, eight hundred individuals misusing opiates and benzodiazepines in Scotland in the year 2000. This amounts to 2% of the population aged 15-54. Five thousand, four hundred, and fifteen users (or 1.8% of the population aged 15-54) were estimated for Grampian. Previously it had been estimated that there were thirty thousand problem drug users in Scotland (Scottish Executive, 2001a). Of the problem drug users known to treatment and primary care services, the majority report opiates as their "main drug", however Scottish figures continue to show an exceptionally high level of use of benzodiazepines with 5-9% of those reporting for treatment indicating that benzodiazepines are their main drug (ISD Scotland, 2000; ISD Scotland, 2002). This figure is two to three times that in England (DrugScope, 2000).

Whatever the definition, there is no doubt that the consequences of problem drug use can be serious for the individual, his/her family and for society in general. The UK drugs strategy reported research "suggesting that annual costs arising from the most serious drug misusers alone are well over £4 billion" (UK Anti-Drug Co-ordination Unit, 1998). The most immediate risk is that of overdose and even death. There were 332 (illegal-) drug-related deaths in Scotland in 2001, 46 of which occurred in Grampian (Jackson, 2002). In addition to the risks associated with long-term, heavy use of the drugs described above, injecting drug use carries serious risks. Apart from overdose, dangers of injecting include infection from non-sterile injection methods (including transmission of hepatitis or HIV through shared injecting equipment), and abscesses, gangrene or damage from adulterated drugs or the injection of dosage forms not intended for intravenous use (DrugScope, 2002h). In Scotland, injecting drug users made up 38% of all reports of HIV infection and the majority of cases of Hepatitis B and C infection in 2001/2002 (ISD Scotland, 2002). There was a strong link between "drug misuse" and psychiatric problems - for male patients with "a history of drug misuse", 16.8 per cent had also received a diagnosis of depression and 14.6 per cent one

of anxiety, compared to only 6.1 per cent and 5.6 per cent respectively of males without a drug misuse diagnosis (ibid). It is important to note that the psychiatric problems may have preceded any drug-related problems and/or may have contributed to the development of drug-related problems (Section 1.3).

The acquisition and consumption of sufficient drugs to sustain heavy use and the large amounts of money needed to pay for them, means that illegal drug use can become a full-time occupation and it becomes difficult for a heavy user to sustain employment or to meet family or social commitments. Recent research by McKeganey et al., (2002) describes the effect of parental heroin use on children according to their parents who were recovering heroin addicts. These parents described the material and emotional neglect of their children associated with their drug use, how the children were exposed to drug use and drug dealing and how they were at risk of violence, physical abuse, criminal behaviour and family break-up. There is no doubt that these social problems have a complex, wide-ranging and highly damaging effect on the drug user, his/her children and family and the community in which they live. In fact, when such drug use becomes endemic in a community, there is no easy way to separate it from other problems of social exclusion.

Such problems are described at the extreme by Quigley (2002) in his study of opiate dependent clients at an Irish community-based treatment service. Quigley notes that the service encountered deeply ingrained secondary and tertiary problems spanning a wide range of physical, psychological and social complications of addiction:

> The pattern of male unemployment, property crime, drug dealing and imprisonment is clearly illustrated in this client group, while problems of literacy, single parenthood and debt are typical of the women's experience.
>
> [Quigley, 2002]

This is in stark contrast to the problem drug use of cocaine-addicted celebrities, and it illustrates that drug use may be just one aspect of a whole range of deeply entrenched problems, particularly in socially excluded communities. At this extreme, discussion of causes and consequences of drug use becomes difficult, as inter-correlation is the rule rather than the exception (ibid). Nonetheless, there are factors which are associated with drug use at all levels of consumption, and these are discussed in the next section.

1.3. Aetiology of Drug Use

The aetiology or causes of drug use are complicated for a number of reasons. Spooner (1999) notes the distinction between risk factors, protective factors, factors that are associated with drug use (precede, follow or co-exist with but do not cause use), consequences of use and contributors to use. She also rightly points out that different factors may apply at different stages of life, and to different stages of drug use.

As reported by Spooner, Gorsuch (1980) reminds us that:

> [Researchers no longer] assume that initial drug use and drug addiction have the same causes...We found the evidence strong that many who do have an initial experience with a particular drug do not become continual users, and that many who become continual users do not become addicts. Hence the causes for each stage may be different and a set of stages is necessary.
>
> [Gorsuch, 1980]

A causal model to describe how many different forces alone and in combination with other instigators have an impact on drug taking during different stages of development has been developed by Huba and Bentler (1982). Their model reflects the complex relationships between different influences on drug taking and they conclude that:

> Drug taking is not a simple phenomenon; a complicated model must be formulated and validated before the dynamics of the drug-taking stages of initiation, continuation/maintenance, cessation and relapse are fully understood.
>
> [Huba and Bentler, 1982]

It is beyond the scope of this research to describe in detail the factors that apply to each of these stages, rather this section will provide an introduction to the decision-making process that accompanies drug use, discuss the relevance of factors often thought to be associated with drug use such as peer-pressure and low self-esteem, and provide an overview of risk and protective factors that relate to problem drug use.

Robertson (1996, n= 9,496) surveyed Scottish schoolchildren aged 11-17 on the question "why do young people take drugs?" The most popular answers among "non-regular users" (those who used drugs less than once a week) was "to keep in with their

friends" (28%) or "to act hard" (27%). In those who used drugs once a week or more, the most popular answer was much clearer – 50% indicated that young people use drugs "for a good feeling". Although this is a simplification of the reasons for drug use, there is no doubt that the pleasurable effects of drugs play a large part in most people's decision take to drugs. Johnston and O'Malley (1986) review reasons given in nine national surveys by American students, who had used an illegal drug or alcohol in the previous twelve months, for the initiation and continuation of use. They asked what had been the most important reasons taking each particular drug. Overall, the most frequently given reasons were:

> To have a good time with my friends (1)
> To experiment, see what its like (2)
> To feel good or get high (3)

In looking at specific drugs, there were some differences in the reasons given by those who had only used marijuana (cannabis) once or twice (experimenters) compared with heavier users. The experimenters were more likely to give the reason "to experiment, see what its like" than the heavier users, who were more likely to choose "to feel good, to get high" or "to have a good time with my friends". It is also apparent that heavier users were likely to select a whole range of reasons for their use.

This finding is consistent with the extensive work of Boys and her colleagues, who have carried out a number of primarily qualitative studies of decision-making in relation to drug use among young, regular, poly-drug users in the UK (Boys et al., 1999a; Boys et al., 1999b; Boys et al., 2000; Boys et al., 2001). They found eleven separate categories of influence on drug (and alcohol) related decisions, of which six were individual-level influences and the rest were social/contextual influences. These are summarised in Table 1.2 (overleaf). It is clear from these influences that "for many young people, the decision to use a drug is based on a rational appraisal process, rather than a passive reaction to the context in which a substance is available" (Boys, et al., 2001). The term function, as used in the table is intended to characterize the primary or multiple reasons for or purpose served by, the use of a particular substance in terms of the actual gains that the user perceives they will attain (ibid). Further study of these functions reveals interesting differences.

Influences on Drug and Alcohol-Related Decisions for Young Regular Drug Users
Individual-Level Influences:
Functions: The specific functions that the individual wanted their substance use to fulfil influenced their decisions, as different drugs served different functions.
Expectancies: The effect that an individual expected to obtain from a particular substance influenced choices. These expectancies became more sophisticated as the user became more experienced.
Current Physical or Psychological State: Individuals considered factors such as how tired they were, or what mood they were in, before deciding what drug, if any, to use.
Gender: There were indications that males and females preferred different types of substances.
Commitments: Some users made choices about which drug and what quantity to use, to reduce possible effects on work/study commitments
Boundaries: Drug users with similar experiences shared basic boundaries about what they would or would not use.
Social/Contextual Level Influences
Environment: Drug users commonly referred to needing to be in "the right sort of place" when using certain substances, particularly hallucinogens.
Availability: Lack of availability commonly prompted substitution of the drug of preference with another. This sometimes prompted initial use of a drug never previously used.
Finances: Users gave their social lives, including their substance use a high priority. However, they sometimes reduced use if they needed money for other things.
Social Influences: Young people tended to tailor their substance use to fit in with the norms of the particular group with whom they were socialising during a given night/time period.
Media Influences: High profile media stories about the dangers of particular drugs prompted some users to avoid those and to use others instead.

Table 1.2: Influences on Drug and Alcohol-Related Decisions for Young Regular Drug Users.
Derived from Boys et al., (2000; 1999a).

The five most common reasons for substance use overall (and the abbreviations used for them) were:

To help you to relax (to relax)
To just get really stoned or intoxicated (to become intoxicated)
To help you 'keep going' on a night out with friends (to keep going)
To enhance an activity such as listening to music or playing a game or sport (to enhance activity)
To make yourself feel better when down or depressed (to feel better)

[Boys et al., 2001]

Although it was one of the least popular reasons for use overall, almost a third of female participants in the study endorsed "to help you to lose weight" as a function of drug use. Females were also significantly more likely to report cocaine use in order to stay awake, lose inhibitions, stop worrying, to enjoy the company of friends or to enhance sex while males were more likely to report use in order to enhance the effects of another drug.

There were also age differences, with older respondents more likely to report use in order to feel elated or euphoric or to sleep and younger respondents more likely to use in order to stop worrying (Boys et al., 2001). Earlier work (Boys et al, 1999b) has suggested that the perceived functions served by the use of a drug predict the likelihood of future consumption, and so these differences may be important in determining those people who are vulnerable to longer-term problems. It is worth noting that peer pressure and low self-esteem do not feature strongly in any of these studies of reasons for drug use. In fact, there is little evidence to suggest that either of them are really a major causal influence on drug use in young people.

It is clear that most drug-using young people associate with drug-using peers, however, this is explained by Coggans and McKellar (1994) who have extensively reviewed the evidence for peer pressure as a cause of drug use. They conclude that peer factors associated with illicit drug use may be more appropriately interpreted as evidence for peer preference. This is described as the process by which adolescents sharing the same attitudes and beliefs tend to associate with each other. Subsequent drug use by a group member is more easily explained by these attitudes and beliefs than by the influence of the rest of the group. They refer to Jessor et al., (1973) who found that "social support" was a predictor of marijuana use and they note that "social support" is not the same thing as peer pressure. Support can be toleration, approval or encouragement. Encouragement comes closer to the popular interpretation of peer pressure than either approval or toleration but not so close as to constitute pressure to make someone do something they do not want to do. They quote Sheppard et al. who concluded:

> It does appear that it is not the group that goes after the young person, but rather that the person who wishes to experiment with or use drugs on a regular basis is more likely to seek out a drug-using group and thus be able to participate in what is normative behaviour for that group.
>
> [Sheppard et al., 1985]

Kandel (1980) concluded that peers select each other by preference, and that they are then influenced (though not pressured) by each other due to ongoing association. She reports that social and cultural factors explain initiation into drug use while psychological factors explain further involvement. She also notes that a person's perception of other people's use is more important than actual observations or measures of use in determining that person's behaviour.

The young people studied by Boys et al., (2000) recognised that peers had some influence over their behaviour, but maintained that their substance use was their choice. They also reported that other young people affected their use both in escalating it and in reducing it. Coffield and Gofton (1994) argue that informal peer influence could actually be used to positively affect drug use. They suggest that peers argue their case in a language readily understood by their listeners and without pressurising the "innocent". This influence could therefore be used positively in favour of harm reduction, by encouraging groups to be responsible for looking after their members who may be experimenting with drugs. May (1993) notes that peer group influence may equally act as a restraint on alcohol-related behaviours by reflecting a wider set of values. This is also the case with drug use. Gamble and George, (1997) found that the peer group members in her study alerted each other to their excessive or inappropriate drug use, becoming in fact guardians of each other. Similarly, Grund et al., (1993) found that peer-based rituals and regulations acted to control and regulate drug-taking and to prevent and manage drug-related problems.

In summary therefore; an individual who associates with drug using peers is more likely to be using drugs him/herself; however the person's inclination towards such drug use would seem to be the cause of the choice of friends, rather than the other way around. Once friendships are established, it is possible that peer influence may act to promote group norms, encouraging some use as well as acting as a restraint on use perceived by peers to be excessive or uncontrolled.

Schroeder et al., (1993) looked at whether there was a relationship between self-esteem and drug use and found that only a very small proportion of the variance in drug use is associated with self-esteem across a variety of definitions of self-esteem.

Self-esteem had not been conclusively defined and had been described as different things throughout the literature. They concluded that:

> The results of a large number of studies are at best mixed and strongly suggest no direct association between self-esteem and drug use.
>
> [Schroeder et al., 1993]

In fact, as found by Shedler and Block (1990), it is possible that those who experiment with drugs may be better adjusted emotionally and socially, than either those who abstain or use frequently. Again, it is clear that most young people who use drugs do so by choice because they want to try them initially; or having already tried them, because they enjoyed their effects. Such use generally does not result from any deficiencies of character. In the case of problem drug use however, the same may not be true. In fact, problem drug use is associated with a whole range of risk factors, including some personality variables that have been reviewed in detail by Hawkins et al., (1992) and more recently by Lloyd (1998) and Spooner (1999). These risk factors are not necessarily the causes of problem drug use, though some of them may be, rather it is a list of the factors which if present for an individual, mean that that individual is more likely to develop drug-related problems than another individual where none of the factors are present. The following list is an amalgamation of the factors found to be relevant by Hawkins et al., (1992); Lloyd, (1998) and Spooner, (1999). The reader is directed to these papers for further information and references on the findings discussed.

(i) Laws and norms favourable towards drug use

In relation to alcohol consumption, it has been shown that taxation (which impacts on the financial cost of use) laws affecting to whom alcohol may be sold and laws affecting how and where alcohol may be sold all affect consumption. This may be because such laws are generated on the basis of the social norms to which different ethnic groups adhere and/or because as availability decreases and price increases, people limit their consumption. It is considered likely that a similar relationship exists between laws and norms regarding illegal drugs and the prevalence of illegal drug use.

(ii) Availability

The availability of drugs is dependent in part on the laws and norms of society, however the availability of illegal drugs also depends on other factors such as law enforcement. It has been shown that drug availability in schools can influence the use of drugs beyond the influence of individual characteristics of pupils.

(iii) Extreme economic deprivation

The link between socio-economic status and drug use is not entirely clear and may be indirect, but it appears that extreme poverty, when it occurs alongside childhood behaviour problems (see factor 8), does increase risk of later drug problems.

(iv) Neighbourhood disorganisation

Neighbourhoods with high population density, lack of natural surveillance of public places, high residential mobility, physical deterioration, low levels of attachment and high rates of adult crime, also have high rates of juvenile crime and illegal drug trafficking. They are expected to produce higher rates of problem drug use than neighbourhoods which do not. Hawkins et al., (1992) note the need for more research on the importance of this factor.

(v) Physiological and genetic factors

There is evidence for a genetic predisposition as a contributing risk factor for alcoholism, and this is thought likely for illegal drugs also. In addition, sensation-seeking, low harm-avoidance and poor impulse control in individuals are associated with early-onset alcoholism.

(vi) Gender

Males are more likely to use illegal drugs, to engage in poly-drug use, to use illegal drugs at an earlier age and to use drugs to deal with problems than females. These factors mean that males may be at a higher risk of developing drug-related problems than females.

(vii) Family factors

Parental and sibling drug and alcohol use, criminal behaviour or tolerance of drug use, poor or inconsistent family management practice, family/parental conflict, lack of family closeness, lack of maternal involvement and negative communication patterns (blaming, criticism) are all associated with an increased risk of drug and alcohol problems.

(viii) Early and persistent problem behaviours

Anti-social behaviour, delinquency, conduct disorder, emotional distress and aggressiveness in early childhood have been associated with the development of drug "misuse" (rather than occasional or experimental use).

(ix) Traumatic life events

Children who have experienced traumatic life events (such as sexual, emotional or physical abuse, neglect or periods of life in refugee camps) are at a high risk of detrimental outcomes including problem drug use.

(x) School factors

Although there is little evidence to suggest a link between low intellectual ability and drug use, failure in school has been identified as a predictor of adolescent drug use. Poor school performance has been found to predict frequency and levels of use of illegal drugs. In addition, a low degree of commitment to education (absenteeism, dislike of school, low perception of relevance of course work, less time spent on homework, suspension) is also a risk factor.

(xi) Peer factors

Peer use of substances has consistently been found to be among the strongest predictors of substance use among youth. However, as described above, the influence is not simple. We are reminded:

> Drug-abusing peers do not suddenly appear in a child's life and 'pressure' that child to abuse drugs. It is more usually the case that children who are prone to problem behaviour tend to affiliate with like-minded peers and that affiliation with these peers tends to encourage and reinforce problem behaviours including drug abuse.
>
> [Spooner, 1999]

(xii) Alienation and rebelliousness

Alienation from the prevailing values of society, low religiosity, rebelliousness, high tolerance of deviance, low sense of social responsibility, a strong need for independence and normlessness, have all been linked with drug use.

(xiii) Knowledge, beliefs or attitudes favourable to drug use

There is a relationship between an individual's specific attitudes and beliefs regarding drug use, and their subsequent use of that drug. Those who hold values favourable to use or who believe that use is not harmful are more likely to initiate and continue drug use. It is possible that such beliefs develop from drug use experiences where no negative consequences have been perceived by the user. It is also apparent that drug users tend to be more knowledgeable about drugs than do non-users.

(xiv) Early onset of drug use

Early initiation into drug use has been identified with problem drug use in the later teens. The earlier the onset of any drug use (including legal drugs), the greater the likelihood of involvement in other drug use and greater frequency of use thus increasing risks.

(xv) Labelling

There is evidence that negative social sanctions for adolescent drug use, that label the individual as a "drug user" or "addict" can be a powerful predictor of increased drug use as it further alienates the individual from the prevailing values of society, and non-drug-using peers.

Other factors mentioned by Hawkins et al., (1992), Lloyd (1998) and Spooner (1999), including mental health problems, ethnicity, peer rejection, locus of control, and poor stress and coping mechanisms may all contribute to an individual's risk of developing drug problems later. According to these reviewers, the evidence for these is not as clear-cut as for those factors listed above. The more risk factors that are present, the greater the chance that a person may develop drug-related problems.

Protective or resilience factors are also important, as it is clear that only about one third of an "at-risk" child population experiences negative long-term outcomes; up to two thirds appear to survive without serious developmental harm (Newman and Blackburn, 2002). Such protective factors are in many respects the opposites of the risk factors described above and they are outlined in Table 1.3 (overleaf). In considering both risk and protective factors, it is important to recognise the dynamic nature of developments as noted by Glantz (1992):

> Vulnerability develops and in this sense it is not just a set of static predisposing antecedent factors but rather a dynamic process. A risk or protective factor is a contributive component in an interactive system that leads to emergent factors that in turn interact and evolve.
>
> [Glantz, 1992]

The Child	The Family	The Environment
Temperament (active, good-natured)	Warm, supportive parents	Supportive extended family
Female prior to and male during adolescence	Good parent-child relationships	Successful school experience
Age (being younger)	Parental harmony	Friendship networks
Higher IQ	Valued social role (e.g. care of siblings)	Valued social role (e.g. job, volunteering, helping neighbours)
Social skills	Close relationship with one parent	Close relationship with unrelated mentor
Personal awareness		Member of religious or faith community.
Feelings of empathy		
Internal locus of control		
Humour		
Attractiveness		

Table 1.3: Childhood Resilience Factors (Newman and Blackburn, 2002)

In summary therefore, it is clear that the vast majority of people who chose to use a drug do so because they expect to enjoy the experience. Those who use drugs regularly become sophisticated in their knowledge of the effects of different drugs on them, taking into account several different factors before deciding whether to use - and which drug to use - to achieve a desired outcome. Those outcomes range from relaxation, to pleasure, to energy enhancement, to sleep inducement, to weight loss.

Only a very small minority of users go on to develop serious drug-related problems and this happens as a result of a variety of complex circumstances and interdependent evolving risk factors.

1.4. Drug Education Theory and Practice

1.4.1. Historical Overview

Beck (1998) traces the evolution of drug education in the USA, noting that it dates much further back than the 1960's drug crisis to the temperance movement of the late 19th century. By 1901, every state and territory had passed legislation mandating some form of "temperance instruction" to be taught in the public schools. From its beginning, the purpose and practice of this education was largely determined by the dominant "no-substance-use" injunction. Throughout most of the 20th century, this no-use ethos dominated, with drug education largely based on presenting horrible scenarios as the inevitable consequences of drug use. In the 1970's, there was some movement towards education based on responsible decision-making, however this was superseded in the Reagan era when the "parent power" movement saw a return to zero-tolerance programmes (ibid).

In France, compulsory education on alcohol began in 1895 in response to the rapid rise in distilled spirits consumption. French students were encouraged to abstain from the use of distilled liquors, but when it came to fermented beverages such as wine, cider and beer, students were instructed to "use but don't abuse" and strive to drink in moderation (Gershman, 1987). As such the French system of temperance instruction appears to represent the first attempt by a government to enact formal "responsible use" or harm-reduction drug education.

Stears et al., (1995) note that health education in UK schools was transformed during the 1960's and early 1970's. They document the appearance of an official health education handbook from the Ministry of Education in the UK as early as 1957, the introduction of compulsory health education courses for teachers in initial training and reports from official bodies, expressing the importance of health education in schools.

The School Drug Safety Team (2000), reports that there were no significant initiatives on drug education in Scottish schools until the 1980s, although educational initiatives on alcohol and tobacco are more longstanding. One school health education report from 1939 recommends that:

> Opportunities should be taken by teachers of emphasising the physical and mental disadvantages of the cigarette habit, sometimes contracted by young boys.
>
> [Cited in School Drug Safety Team, 2000]

The same report gave considerable weight to problems associated with use of alcohol by young people. In 1985, the Scottish education department issued a circular to educational authorities on the role of the education service in combating drug misuse. This was accompanied by the development of in-service training and of curricular materials (Coggans et al., 1991) Since that time, drug education, and more broadly health education have become an intrinsic part of the curriculum in the vast majority of schools in Scotland (Scottish Executive, 2002b).

1.4.2. Goals of Drug Education

The goal of drug education, or what it should set out to achieve, is a highly contested topic on which the debate falls mainly into two camps. The most common goal of drug education is prevention of drug use, which has been attempted for many years by a huge number of programmes, using a wide variety of strategies. This approach to drug education has dominated particularly in the United States, where most of the research on drug education has been carried out. As a result, much of what we know about what "works" in school-based drug education is based on evaluations that measure whether or not a particular programme has brought about a reduction in drug use among the participants in the programme.

Much less common in schools is drug education which focuses on the reduction or minimisation of harm associated with drug use. Harm reduction has been explained as a process of development of strategies, both practical and philosophical, so that the outcomes of drug use are as safe as is situationally possible.

It involves the provision of actual information, resources, education, skills and the development of attitude change, in order that the consequences of drug use for the users, the community and the culture have minimal negative impact (Watson, 1991). Although abstinence can be considered a successful outcome of such an approach (in so far as it results in less harm for an individual), it is only one of a range of desirable outcomes in which harm is also reduced, although drug use may continue. The rejection of the idea that young people's drug use is abnormal or pathological behaviour, or that young people who use drugs must somehow be lacking in knowledge, skills or self-esteem, is central to the approach. Harm reduction drug education is based on the premise that most drug use is functional, has immediate benefits and is mostly experienced as pleasurable with only a small minority experiencing significant problems (Cohen, 1993; van de Wijngaart, 1989). O'Hare (1988) states that:

> Harm reduction drug education is secondary rather than primary prevention on the understanding that we cannot prevent drug use *per se* and that attempts to do so may counterproductive. It is education about rather than against drugs.
>
> [O'Hare, 1988]

Proponents of harm reduction drug education argue that traditional abstinence based methods have rarely been successful and promote negative attitudes towards drug users further marginalising those with problems. They claim that the refusal of traditional methods to accept or acknowledge that there are patterns of use in between the extremes of abstinence and addiction, disempowers users and inhibits the operation of social sanctions that promote "controlled" use (Zinberg et al., 1975). Moore and Saunders (1991) note that without the necessary information to minimise harm, beginning users have to learn safer practices by trial and (potentially costly) error.

On the other hand, those who oppose harm reduction in drug education, worry that any ambiguity in drugs education could "cross the line between providing accurate information and encouraging young people to take drugs" (Select Committee on Home Affairs, 2002). Cohen (1993) notes that:

> Many teachers feel that harm reduction drug education will be seen as 'condoning' drug use and that they must make it clear to students that they 'condemn' it.
>
> [Cohen, 1993]

This view is supported by the recent report of the Select Committee on Home Affairs who concluded that:

> All drugs education material should be based on the premise that any drug use can be harmful and should be discouraged.
>
> [Select Committee on Home Affairs, 2002]

Despite such stark differences in philosophy, both abstinence oriented drug education and harm-reduction based drug education make use of a variety of the content and delivery strategies described below, and there is much overlap between them.

A third approach to thinking about drug education is discussed by Evans (2002a). Rather than focusing on behavioural outcomes such as a reduction in drug use or drug-related harm, she argues for drug education to be judged by the degree to which it has *educated* its recipients.

> Imagine that I were to go into a classroom or youth group to impart information and promote discussion of the effects of drugs and attitudes, I would think it entirely reasonable for my success to be measured by the degree to which I had actually done those things.
>
> [Evans, 2002a]

According to Evans, the aim of drug education should not be about demand reduction at all – it should be part of a child's right to education, part of the comprehensive process of enabling them to learn about the world around them, and to analyse, understand and act within that world. Thus, the quality of drug education should be judged by how well it achieves this process, rather than by the "whims, desires and informed choices" of the young people who are taught.

Regardless of which approach is taken in drug education, it is important that goals are agreed and decided by all stakeholders in advance both for clarity of purpose and in order that the success of the programme can be evaluated (Pompidou Group, 1998). The Pompidou Group's handbook on substance use prevention provides a useful checklist for formulating the goals or aims of a drug education programme that is reproduced in Table 1.4.

Checklist – Formulating Aims

In formulating aims, bear in mind the following:

- The aim should state clearly to which group or groups the intervention is targeted.
- The wording used should specify how and to what extent the aim should be achieved.
- The aim should incorporate time and deadlines.
- If several aims are involved, they should be consistent with one another. Where possible, a synergetic effect should be aimed for.
- When formulating an aim, it is necessary to be receptive to and even provoke criticism of the result.
- The aim should be viable.
- The aim should be sufficiently specific and explicit and the question of whether the effect is measurable should be addressed.
- The scope and stability of the intended effect and the possibility of unintended effects should be considered.

Table 1.4: Checklist – Formulating Aims (Pompidou Group, 1998)

1.4.3. Content of Drug Education

1.4.3.a. Information Based Approaches

Early drug education efforts consisted mainly of attempts to shock or scare potential users into not using drugs. Evans (2002b) recalls her involvement in drug education talks in schools in the 1970's, and the films that accompanied them:

> After the talk came a film – undoubtedly the main attraction of what was often the graveyard slot of the day. The films were usually American, vintage army productions and intended to shock. The facts were presented in graphic detail, the voiceovers powerful exhortations of the dangers of experimentation. Drugs equalled death. Graveyards to the fore.
>
> [Evans, 2002b]

Such tactics often had more in common with wartime propaganda than education, and the information provided was most certainly unbalanced, highly exaggerated and in many cases even false (Cohen, 2002). These approaches have largely been superseded over the years by more factual drug education.

A wide range of different topics is included in information-based drug education - the origins and forms of the drugs, their pharmacological characteristics, their physiological and psychological effects, the legal and social consequences of drug use, their scientific and slang terminologies etc. (Goodstadt, 1975). These approaches are more balanced, however the goal of many programmes (or those who deliver them) is to prevent drug use and there may be a tendency for information to be presented selectively, or an emphasis on the information which seems most consistent with decisions not to use drugs (Dorn and Murji, 1992).

The impact of information based programmes which are delivered in schools has largely been found:

(i) to have been minimal (Goodstadt, 1978)

(ii) to have been ineffective in preventing drug use, while gains in knowledge or changes in attitude have been counter-productive and stimulated interest in drug experimentation (Berberian et al., 1976; Kinder et al., 1980)

(iii) to have mixed effects, with some programmes showing positive effects, some having no effect and/or some showing negative effects on drug use behaviours (Hansen, 1992; Tobler and Stratton, 1997)

(iv) to have increased knowledge but with minor effects on attitudes and behaviour (Schaps et al., 1981; Bangert-Drowns, 1988; Tobler, 1986)

In their study of drug education methods in Holland in the 1970's, De Haes and Schuurman found that both "warning" and information-based approaches led to increased correct answers in tests of drug knowledge in the short term. This increase disappeared after six months. There was also however an increase in the number of wrong answers after the drug education sessions – fewer pupils selected the "don't know" option. Thus, some pupils had misleading confidence in their own knowledge (De Haes and Schuurman, 1975). This illustrates a potential negative side effect of drug education sessions.

Information-based approaches find their theoretical origins in the basic assumption that people use drugs because they lack information that would prevent them from doing so. In fact, the relationship between knowledge and drug use is not clear as noted above: users are likely to hold beliefs and attitudes favourable to drug use and at the same time to have higher levels of accurate knowledge about drugs (Hawkins et al., 1992; Goodstadt, 1975). The drug education that they may receive is only one small aspect of a whole myriad of information and influences that lead to the formation of their beliefs. It is too simplistic to believe that increasing knowledge or changing attitudes will lead to changes in behaviour, as this ignores the other social and personal factors such as those described above in relation to problem drug use (Coggans et al., 1991).

In reality, the relationship between information and a person's beliefs, attitudes, intentions and behaviour is thought to be much more complex, as proposed in Fishbein and Ajzen's Theory of Reasoned Action: To gain new information a person may read books, observe events, interact with other people, watch television etc., and *all* of these activities [not just what a person is taught] provide the basis for the formation of beliefs. In a social interaction situation for example, a person's behaviour (and that of the other people involved) leads to the formation of *beliefs* about the attributes of objects in the environment, about the characteristics and reactions of other people, and about the consequences of the behaviour. These beliefs provide the basis for the formation of *attitudes* toward the objects in the situation, toward the other people, and toward the behaviour. *Subjective norms* about the behaviour are determined by beliefs that specific individuals or groups support or disapprove of the behaviour and how important those persons are to the individual. *Attitudes* toward the behaviour and *subjective norms* in turn determine the person's *intention* to perform the behaviour in the future, and the *intention* that exists immediately before performance or non-performance of the behaviour determines which happens (Fishbein and Ajzen, 1975; Ajzen, 1985). Thus, in this myriad of influence, it is not surprising that information given in drug education classes has only a limited influence on behaviour.

Despite information based programmes having been discredited in terms of their ability to prevent or decrease drug use, Hansen (1992) notes that virtually all drug education programmes include some element of information-giving as part of the curriculum.

The presence of this component suggests that the role of information and changes in perceived risks remain important and the ancillary benefits that these components provide is not known. Indeed, from the perspective of Evans (2002a), discussed in relation to the goals of drug education above, some of the information-based programmes are at least partly successful in that they do increase young peoples' knowledge about drugs which she sees as part of their right to education. In addition Dorn and Murji (1992) remind us that the effects of information-based programmes in relation to reducing drug-related harm are not known since programme evaluations have simply not addressed this as an issue.

1.4.3.b. Affective (Person-Centred) Approaches

Affective approaches to drug education are based on the assumption that individuals use drugs because of an underlying deficit in their development or skills. This deficit may be a lack of moral or personal development or values; a lack of development of social or interpersonal skills; or lack of strategic or coping skills. There are many programmes that include approaches based on this assumption using a combination of the content areas that are described below. Although drug education programmes based on affective approaches have in the past included no reference to drug use, most programmes now include information on drugs and some elements of other approaches. The following descriptions of content areas are adapted from Hansen (1992).

(i) Values Clarification

Values clarification programmes examine the relationship between individuals' values and the consequences of their behaviour. Individuals are encouraged to identify their existing values or select a set of positive values. Values clarification approaches are postulated to operate by placing an individual's values in a central position to influence life choices and by developing beliefs that drug use is inconsistent with an individual's overall life objectives.

(ii) Decision-making skills

Decision-making programmes teach a process for making rational decisions about substance use. They typically teach young people a strategy for identifying problems, creating solutions and making choices among alternatives.

(iii) Goal Setting

This approach involves the teaching of skills for setting and attaining goals and encourages the adoption of an achievement orientation. There is an emphasis on identifying drug and alcohol use as incongruent with these goals.

(iv) Pledges

Many drug education programmes encourage participants to adopt a personal commitment not to use substances. These programmes may emphasise the message that taking drugs or drinking alcohol is morally wrong, and often include the wearing of red ribbons, signing pledge cards or signing petitions. The aim is develop in the participants a strong personal commitment to stay drug or alcohol free.

(v) Self-esteem building

Self-esteem programmes focus on developing individual feelings of self-worth and value. Students are taught to accept and play down failings and difficulties. Self-labelling of failure is discouraged. An appreciation of one's natural or developed strengths and uniqueness is encouraged.

(vi) Stress Management

The stress management approach teaches skills for coping with and managing stress and psychologically difficult situations. Skills taught may include strategies to reduce stress and strategies to find alternatives to deal with stressful situations. There is usually an emphasis on relaxation techniques.

The outcomes of affective approaches alone or in combination with information-based approaches have generally been found to be neutral in terms of changing levels of drug use. Hansen (1992) found mixed results but concluded "nonetheless, affective approaches seem to be benign, generally having no impact on behaviour".

Dorn and Murji (1992) also report mixed results, noting that these approaches have yielded inconclusive but generally discouraging results in relation to drug consumption. Tobler and Stratton (1997) found that drug education programmes which included the above components were far more effective when a range of other elements – such as refusal skills, community involvement, normative education and information about drugs – were also included, and when an interactive teaching process (Section 1.4.4.b) was used.

This approach to drug education has its foundations in "Problem Behaviour Theory" (Jessor and Jessor, 1977). This theory conceptualises drug "abuse" as one of a range of "deviant" antisocial behaviours that may lead to problems in adolescence, including problems at school and early sexual activity. Evolving on the back of the Jessors' work is the notion that if generalised skills are imparted to the individual in a way that promoted positive relationships with themselves, their society and their environment, it may reduce their overall propensity towards problem behaviour (Plant and Plant, 1999). Most drug use however, is not part of a range of antisocial behaviours and most young people who use drugs are not "deviant". In fact, as discussed earlier, most people who use drugs do not do so because of deficits in values or skills but for functional reasons. It is not surprising therefore that no overall change in drug use is found among participants after delivery of these programmes.

Despite this, *problem* drug use does often occur in conjunction with a range of other problem behaviours (see Section 1.3) and it is possible that these approaches may be more effective in reducing or preventing problem drug use. Most evaluations of school drug education programmes have not sought to examine the effect of the programmes specifically on such use. Potential future problem drug users tend to be very small in number and so it would be very difficult to demonstrate significant effects. In addition, they may already have left or been excluded from school, or are frequently absent. Given this fact, along with the deep-seated nature and range of problems that such vulnerable young people face, it seems unlikely that a classroom-based initiative alone will be helpful.

1.4.3.c. Social Influence Approaches

Social influence approaches are based on the assumption that drug use occurs as a result of direct and indirect social pressures, and is reinforced by friends, family, media and community norms. Drug education based on social influence approaches generally includes a combination of drug information along with one or both of resistance skills training and normative education.

(i) Resistance Skills Training

Resistance skills training focuses on (a) identifying and labelling social influences and pressure situations and (b) developing behavioural skills to resist such influences (Dorn and Murji, 1992). The focus of instruction may be to develop skills to deal with pressure from peers as well as pressure from advertising, parents or siblings to use drugs (Hansen, 1992). Instruction can take several forms including films or discussions that demonstrate peer pressure, and discussions or role-plays about how to say no. Pupils observe others and practice their resistance strategies for example through role-playing to develop personal competency. Assertiveness training is also used.

(ii) Normative Education

Normative education is based on the premise that adolescents are prone to overestimating the acceptability and extent of drug use among their peers, and it aims to correct these misperceptions and to establish conservative group norms (Dorn and Murji, 1992; Hansen, 1992). Programmes that use this approach present credible feedback about rates of use and acceptance, e.g. the results of local surveys. These approaches may also include input from peer leaders (Section 1.4.4.a), to reinforce or define standards of group behaviour, emphasising that use is unacceptable.

As with the previous forms of drug education, the outcomes of social influence based programmes are mixed. Programmes that have focused primarily on resistance training have been especially criticised. Most notably, the Drug Abuse Resistance Education programme, which has been delivered to millions of pupils in the USA, has been shown to have little effect.

Drug Abuse Resistance Education (Project DARE) is the most widely disseminated school-based prevention programme in the United States. It has been administered in about 70% of US school districts reaching 25 million students in 1996 and has been adopted in 44 foreign countries (Rosenbaum and Hanson, 1998). DARE is a school-based primary drug prevention curriculum designed to be taught in the last year of American elementary school (average age 11-12 years). It involves the use of trained, uniformed police officers in the classroom to teach a highly structured drug prevention curriculum. Typically, DARE officers are given eighty hours of instructor training in classroom management, teaching strategies, communication skills, adolescent development, drug information and instruction of the DARE lessons (Rosenbaum et al., 1994). The DARE curriculum, like many other school-based curricula, combines aspects of information about drugs and their effects, peer pressure resistance skills, media influences, decision-making skills, normative education, enhancing self esteem, responsibility for one's own safety and avoiding gang involvement. Therefore, although primarily based on social influence theory, DARE also includes elements of the informational and affective approaches (Clayton et al., 1996).

While one follow up of DARE found a reduction in the use of harder drugs six years after the programme was delivered (Dukes et al., 1997), an overwhelming number of short and long-term follow up studies suggest no consistent beneficial effect. It is worth noting that none of the evaluations look at illegal drugs other than cannabis separately, because the prevalence of use is too small to be able to show an effect. As well as cannabis, most evaluations also consider the impact of DARE on alcohol and tobacco use. Rosenbaum et al., (1994) found that the DARE programme had no statistically significant overall impacts on students' substance use approximately one year after the completion of the programme. Other short-term evaluations concur with this (Becker et al., 1992; Harmon, 1993; and Ennett et al., 1994a).

Lynam et al., (1999); Rosenbaum and Hanson (1998); Clayton et al., (1996) and Ennett et al., (1994b) carried out ten, six, five and three year follow ups of DARE respectively and all concluded that drug use was little or no different in the pupils who had received the programme from those who had received normal classroom based health education. Ennett et al. concluded:

> Our analysis of DARE's results over three years provides only limited support for DARE's impact on students' drug use immediately following the intervention, and no support for either continued or emerging impact on drug use once subjects have made the transition to middle school.
>
> [Ennett et al., 1994b]

In the UK, DARE has been running in one police force (in Mansfield, Nottinghamshire) since 1994 and other forces have piloted the programme (Coggans et al., 1999). Evaluations of the programme are reported to be few and methodologically limited but there is some evidence to suggest that DARE Nottingham failed to prepare participants "for the reality of the drug offer situation" (Coggans et al., 1999).

Many commentators believe that DARE has failed because it is fundamentally, theoretically flawed in that it trains young people in how to refuse drugs should they be offered them (Coggans and Watson, 1995). In doing so, it assumes that young people do not want to take drugs, but lack the skills to resist direct and indirect pressure to do so. On the contrary, it seems that most drug use occurs as a voluntary choice as discussed above. Programmes such as DARE that seek to create a consensus of intolerance of drug use (and by extension drug users) may be inconsistent with attempts to make drugs services more available and accessible (Dorn and Murji, 1992) and may further alienate vulnerable individuals.

These reservations aside, some studies have shown social influence programmes to be effective, and much progress has been made on determining the intervening mechanisms by which this success is achieved. In other words, what individual aspects of content have been responsible for the success of particular programmes? MacKinnon et al., (1991) studied mediating mechanisms in a large school based drug prevention programme known as project STAR (Students Taught Awareness and Resistance), which had shown positive results (Pentz et al., 1989). This project is an example of a comprehensive programme such as those discussed below. There was evidence that the programmes effects on pupils' intentions to use substances and on their beliefs about the positive consequences of use may have been responsible for the positive effects of the programme. However, changes in perceptions of friends' tolerance of drug use were the most substantial mediator of the programmes effects (MacKinnon et al., 1991).

Donaldson et al., (1994) carried out a randomised, controlled trial involving 3,077 fifth grade students from 229 classrooms in 124 elementary schools in Los Angeles and San Diego County to study the impact of resistance skills training and normative education as drug education strategies. They found that both strategies worked in the way that was expected, that is for the most part, resistance training significantly improved resistance skills and normative education significantly reduced prevalence estimates and strengthened beliefs about the unacceptability of drug use. Furthermore, normative education not only affected prevalence estimates and beliefs about the unacceptability of drug use, but these mediators consistently predicted subsequent adolescent substance use (ibid). These findings imply that efforts to combat passive social pressures to use drugs (i.e. social modelling and overestimation of peer use), known collectively as normative education, are effective components of adolescent drug prevention curricula.

The same study however revealed that training adolescents to refuse explicit drug offers did not appear to be an effective method of drug prevention (ibid). This is because resistance skills alone do not significantly predict subsequent adolescent drug use. In fact, those participants who only received resistance training in the study (rather than normative education alone, or both approaches combined) actually had the highest prevalence estimates. The authors suggest that resistance training by itself may lead adolescents to believe that drug use among their peers is prevalent. They note however, that this "potentially harmful unintended outcome of resistance training does not appear to exist when normative education and resistance training curricula are delivered simultaneously" (ibid).

Hansen et al., (1992) carried out a review of forty-five substance use prevention studies published between 1980 and 1990 and grouped programmes into different types including social influence programmes as well as information-based programmes, affective education and comprehensive programmes. By reviewing the reported impact of these programmes, and analysing potential selection bias and the statistical power of each one, he concluded that comprehensive programmes which included the highest number of content areas tended to be the most effective. Interestingly, Hansen's classification placed project DARE in the comprehensive grouping as it included such a wide range of curriculum areas, however it was not noted as one of the programmes that contributed to the positive outcomes of the comprehensive group as a whole.

Overall, the social influence programmes had predominantly positive effects (63%) with few neutral effects (26%) or negative outcomes (11%) and came second only to the comprehensive programme category.

The question remains, therefore, as to whether social influence programmes are effective in reducing drug use. It seems that although the most popular social influence programme - DARE - is not effective, the strategy itself, especially when based on or including normative education, may be a good one. The reason for this may lie not in the content of the programme, but in the delivery method as discussed by Tobler and Stratton (1997). In their meta-analysis of the results of 120 school-based programmes, they found that where programmes similar to DARE were taught using an interactive, participative delivery method, they were significantly more effective than DARE's traditional, non-interactive, didactic fashion. The impact of delivery method is discussed further in Section 1.4.4.b.

1.4.3.d. Comprehensive and Other Approaches

Many drug education programmes that have evaluated positively in terms of reducing substance use consist of a very broad range of components including those described above, along with training on what are known as life skills[iv]. These are broad social skills including communication skills, human relations skills and skills for solving interpersonal conflict. In this approach, participants are taught skills that have a broader application than simply resisting offers to use drugs or skills to identify advertising pressure (Hansen et al., 1992). Life skills training conceptualises drug use as a socially learned, purposive and functional behaviour that is the result of a complex interplay of social and personal factors (Botvin et al., 1984). According to Botvin, this approach attempts to reduce intrapersonal pressure to use drugs by fostering the development of general personal competence as well as teaching students' tactics for resisting pro-use interpersonal pressure (ibid).

[iv] There is a specific drug education curriculum that has been developed by Gilbert Botvin and his colleagues (Botvin et al., 1984) that includes training on life skills, and is known as the "Life Skills Training" programme (LST). However, many other programmes also include training on life skills, and all of these programmes together are known as life skills training programmes. In this text, they can be distinguished by the use or absence of capitals.

The original Life Skills Training (LST) programme described by Botvin (see footnote[iv]) includes sessions on decision-making, independent thinking, self image, coping with anxiety, communication skills, social skills (such as overcoming shyness, and giving and receiving compliments), relationship skills (such as conversing with the opposite sex) and assertiveness (ibid.). One long-term follow-up of a randomised trial of LST involving 56 public schools involving a total of 3,597 individuals found that the programme significantly reduced cannabis use, even up to six years after delivery (Botvin et al., 1995). A recent major Scottish review of 44 published papers on LST found that it can have durable preventive effects on cannabis use if delivered relatively completely (Coggans et al., 2002). The full programme consists of a core curriculum of fifteen sessions in year one, with ten booster sessions in year two and another five booster sessions in year three. There was a greater tendency to find positive impact with young people who had received more than 60% of the programme. This review found that there was little evidence that the programme achieved its impact through factors such as self-esteem and social competence. It appears that the positive effects are more likely mediated by knowledge acquisition and influence on attitudes as well as by the interactive and participative delivery methods used in LST (Tobler et al., 1999; Coggans et al., 2002).

Botvin's Life Skills Training is only one of a number of more comprehensive drug education programmes that have also shown effectiveness in reducing drug use. Together, these have been found to be the most effective type of drug education programme in a number of reviews (Kumpfer, 1997; Hansen, 1992; Dusenbury et al., 1997; White and Pitts, 1998). This success may not be due to their inclusion of life skills training however, as Kumpfer (1997) notes that these programmes differ from other ineffective programmes in a number of respects. They have stronger curricula targeting a larger number of primary risk factors for drug use, improved fidelity in implementation, increased contact time, better training of implementers, more skills-based curricula and interactive teaching methods. White and Pitts (1998) carried out a systematic review of 1,486 studies potentially relating to reduction of drug use or drug-related harm. Of these, only ten programmes met strict inclusion criteria, were found to be effective and were considered methodologically sound. Eight of these ten included booster sessions to regularly reinforce messages and the majority were intense programmes with a large amount of curriculum time devoted to them.

Several programmes which have evaluated successfully (Perry et al., 1996; Pentz et al., 1989; Spoth et al., 1999) include components aimed at parents, families and communities such as: parent-child communication, community responses to substance use, promotion of family bonding, promotion of bonding with school and community organisations, promotion of positive parental attentiveness etc. Hawkins et al., (2002) has recently described a community-based prevention system that has evaluated successfully in separate in 25 communities in Washington State, and 35 communities in Oregon. In this programme (Communities that Care) classroom-based drug education is only one component of many and though a randomised controlled trial has still to be carried out, the intervention appears promising. These components directly address many of the risk and protective factors for problem drug use outlined above (Section 1.3). Outside of reducing drug use, these programmes operate partially by improving family relationships and bonding which are positive outcomes in themselves, and may prevent other problem behaviours which share similar risk factors (SAMHSA, 2002).

This involvement of family and community is also part of the ethos of the Health Promoting School initiative. This initiative emphasises the importance of environmental change and personal development in promoting health, as well as classroom-based activities. The twelve criteria developed by WHO for schools to work towards in order to become a "Health Promoting School" include the active promotion of the health and well-being of school staff, the provision of stimulating challenges for all pupils through a wide range of activities, and the development of good links between the school, the home and community (Parsons et al., 1996).

The UK joined the European Network of Health Promoting Schools in 1993. Participating schools may focus on just one (or more) of the twelve criteria and target one or several health needs. Thus there is considerable flexibility in the ways in which schools work towards becoming health-promoting schools. In Grampian, a range of support packs, including one on drugs, have been prepared to help schools (Health Promotions, 1998). While one UK study found positive effects on smoking uptake and drug use with a scheme designed to encourage schools to become health promoting (Moon et al., 1999), a recent extensive, systematic review of the health promoting school initiative found that there have been few quality evaluations carried out in participating schools (Lister-Sharp et al., 1999).

The authors of this review concluded that little is known about how effective the initiative may be in the long term. Further discussion on the health promoting school in practice and how the concept has been developed in Grampian can be found in Section 1.5.2.

1.4.4. Delivery of Drug Education

There are many factors in addition to curricular content that impact on the effectiveness of drug education. The characteristics of the person or persons who deliver the programme, the training they have received, the teaching methods used, the resources available, the priority given to drug education by the school, policies put in place, and the process of consultation used, are just some of the issues that may have an effect. In 1992, Hansen et al. noted that numerous intervening factors must be considered but reported that they found little research dealing with the issue. Since that time, there have been a small number of key studies that shed some light on the subject and these are reviewed below.

1.4.4.a. Teacher

The question of who best delivers school-based drug education has been the subject of much debate, but there is little rigorous research on the issue. McBride et al., (2002) have suggested that a number of factors, including the past health education and training experience of teachers, the subject area of expertise of teachers and the motivation and commitments of teachers may affect how the health education programmes are implemented in practice. In fact, drug education is likely to diversify significantly from what is described in the curriculum unless teachers are trained appropriately (Dane and Schneider, 1998; Ross et al., 1991; Perry et al., 1990). Methodologies, such as interactive teaching (see next section) which would not have been part of traditional teaching practice, are often required and training and supervision of teachers increases their preparedness and comfort for this role (Tortu and Botvin, 1989; Norland et al., 1995; Bosworth and Sailes, 1993). Adequate preparation may also help to convince them of a programme's utility and effectiveness and increase their commitment to the drug education.

It is important that teachers are comfortable and confident when teaching drug education, because if they appear nervous or unsure of their facts, they are unlikely to be seen as credible sources of information or influence by pupils. Credibility is not a well-defined concept in the literature, but it is suggested here that it may be thought of in this context as the extent to which a teacher appears to their audience to be knowledgeable, experienced, up to date and understanding of the audience's perspective. Many schools make use of external agencies to deliver part of their drug education programme. Former drug users, health professionals and police officers have all been used by schools in the past, as they are perceived to be or to have been "closer to the action" and therefore more credible. Tobler and Stratton (1997) found that drug education programmes led by mental health clinicians had exceptionally high effect sizes, because they were more likely to deliver programmes in an interactive way (see next section). Nonetheless, teachers who had received special training, including on interactive teaching methods, had also successfully implemented the programmes and the authors suggest that they may be preferable to outside professionals who are not available on a daily basis (ibid).

Coggans et al., (1999) have reviewed the involvement of the police service in drug education work in UK schools. Some police services are involved in formal programmes of drug education in the UK (similar to or developed from the DARE programme) however the evidence for their effectiveness is questionable (Williams and Keene, 1995; Coggans et al., 1999). According to Coggans et al., (1999), the credibility of the police as deliverers of drug education is also questionable, despite their first-hand knowledge of drugs issues. They refer to research by O'Connor et al., (1997) who found that the education provided by the police was generally valued by non-drug-using young people but generally not by those already experimenting with drugs. They also note research by Cragg, (1998) in which it was found (albeit with a small sample size) that secondary school children were markedly less likely to value the police contribution to their drug education than primary school children. Coggans et al., (1999) suggest that while the police may have high credibility in terms of being a source of knowledge and experience, they may not have the same credibility in terms of possessing values that would be seen as relevant or attractive to many of the young people targeted by drug education efforts.

It is this aspect of credibility (i.e. shared values) that is thought to be present in drug education initiatives involving young people themselves as the teachers. Such initiatives are described as "peer education" and are reviewed later in this section.

Coggans et al., (1999) recommend that the contribution of the police should be restricted to their particular areas of expertise, which they see as key knowledge of the law relating to drugs, and experience of the consequences of drug use/misuse to individuals, families and communities. They note however, that such experiences may present a distorted picture of the world of drugs to young people and that careful consideration must be given to the message received by the audience concerned. In addition, whatever the role of the police, Coggans et al. emphasise that teachers and schools should take prime responsibility for drug education as part of their educational responsibilities. They point out that if police take the lead role in drug education, this may prevent schools from taking real ownership and inhibit long term development and implementation. This concern is echoed by the advice of the school drug safety team set up by the Scottish Executive. They concluded that teachers should always be the main source of expertise for delivering any programme of health education and recommend that any other groups should be viewed as complementing the curriculum already in place, not as a substitute for the school's mainline provision. Other groups and individuals may contribute to a broader understanding of drug use but their contribution should meet certain minimum guidelines (School Drug Safety Team, 2000). These are summarised in Table 1.5[v] (overleaf).

As noted above, some drug education programmes have involved young people as teachers, in an effort to enhance the credibility of the messages presented. Although the term "peer education" is widely used to describe the education of young people by young people, Shiner (1999) notes that the term is best viewed as an umbrella term to describe a range of interventions in which the educators and the educated are seen to share something that creates an affinity between them. This "something" may be age, background, or a shared experience; and the educators may be involved in formal delivery of programmes of drug education, or in the informal passing on of knowledge and skills to those with whom they associate.

[v] Schools should refer to the complete set of recommendations which are available in the SDST report.

In schools, "peer education" usually refers to the formal delivery of education sessions/programmes by peer educators - pupils who are the same age, or older than the target pupils.

Involving External Agencies in School-Based Drug Education
1. Contributions to drug education by external agencies should...
• be given by individuals who are prepared to prove that they are drug free
• be evaluated in the light of references furnished by credible sources
• be an integral part of the programme already planned by the school
• allow teachers to build upon the learning experience in a planned way
• satisfy child protection requirements
• satisfy recommendations made under the rehabilitation of offenders legislation
2. The teacher should be present throughout the contribution.
3. A preliminary meeting should be held with the external agency to plan the event.
4. Papers and materials to be used in the presentation should be viewed by the head teacher in advance to ensure their suitability.
5. Parents should be informed and involved as appropriate.

Table 1.5: Guidelines on the Involvement of External Agencies in School-Based Drug Education (Summarised from the School Drug Safety Team, 2000)

Some early reviews of drug education found that programmes that involved young people as peer educators showed superior results than those led by classroom teachers (Schaps et al., 1981, Bangert-Drowns, 1988). One study, Botvin et al., (1984) assessed the effectiveness of a 20-session Life Skills Training programme comparing older peer leaders with regular classroom teachers. This four-month follow-up study found statistically significant differences between students receiving LST and control students on monthly and weekly measures of marijuana use, but only for the students whose LST lessons were implemented by peer leaders. The effect on marijuana use was not found for the teacher-led group. This difference was, however, likely to be due to the different levels of support and monitoring given to the two groups of educators.

> The peer leaders not only received considerably more training than the teachers, but almost every session conducted by the peer leaders was monitored by a member of the project staff. The teachers on the other hand were monitored only periodically throughout the programme. Thus while it can be stated with certainty that the programme was completely implemented by the peer leaders... it is very possible that the prevention programme may have been selectively or incompletely implemented by the regular classroom teachers.
>
> [Botvin et al., 1984]

A systematic and comprehensive review of drug education by Tobler and Stratton (1997) found that peer-led programmes were no better in terms of effectiveness than teacher-led programmes provided that the programmes involved interactive teaching methods. They concluded that (interactive) programmes were not dependent on peer leaders for success, but that most often the peer leader was used as a co-partner with an adult leader. This did not negate the importance of using peer leaders to set the stage, initiating dialogue and acting in supportive roles. As with external professionals however, the credentials of the leader were not as important as whether the leader could facilitate group interactions.

Although the use of young people as peer educators may be seen as relieving some of the "burden" of drug education from classroom teachers, it is far from an easy option. As with any other teachers, or perhaps to an even greater extent, peer educators require training to ensure that they are comfortable and confident and that they implement the programmes completely and effectively. The initial selection of peer educators is important although it varies depending on the goals of the programme. Some peer education programmes are focused at least as much on achieving positive outcomes for the peer educators as for those to whom they are delivering the education. Selection procedures are likely to reflect this. The support that is provided to the peer educators throughout the implementation of the programme is also important for success. These and other issues that should be considered when planning, implementing and delivering peer-led activities are described in Table 1.6 (overleaf).

Standards for the Development of Peer Education Programmes
1. Programme Start-Up
a. Decide on rationale, purpose, goals, procedures and ethical standards
b. Establish adequate administrative, community, advisory, and financial support
c. Ensure staff have adequate rapport with pupils, experience, knowledge of the programme and are adequately trained
d. Establish clear lines of authority, responsibility and communication
2. Selection and Training of Peers
a. Develop application and screening procedures for peer educators according to established criteria
b. Develop training programme that reflects nature and goals of programme and takes into account the age/stage of the peer educators
c. Training programme should include: demonstration, skill development, practice, critique, the role of the peer educator, confidentiality/liability issues, communication skills, problem solving skills, decision making strategies, and the specific content of the programme
d. Delivery by the peer educators should be supervised on a regular and ongoing basis
3. Maintenance
a. Plan for both process and outcome evaluations of the programme
b. Keep stakeholders (community, parents, media, funders) informed of the programme
c. Consider long-term issues such as peer ownership of the programme, ongoing staffing and funding arrangements

Table 1.6: Standards for the Development of Peer Education Programmes (Summarised from the National Peer Helpers Association, 2002)

In summary therefore, it seems that police, teachers and peer educators may effectively deliver drug education programmes, if trained and supported appropriately and if effective teaching methods are used (see below). However, in school-based drug education, it is considered best if teachers take prime responsibility for delivery, working in co-operation with external agencies and peer educators as appropriate, taking into account the focus and objectives of each section of the programme.

1.4.4.b. Teaching Method

Evidence from meta-analyses of drug education programmes carried out by Tobler and her colleagues (Tobler and Stratton, 1997, 143 drug education programmes analysed; Tobler et al., 1999, 37 programmes analysed) indicates that programmes which incorporate an interactive teaching method have higher effect sizes on drug use, than those which do not. In these studies, the authors classified the teaching method of each drug education programme according to four different types of group process based on the topology of Toseland and Rivas (1984). Those programmes which utilised group process A or B were classed as non-interactive. Of these, group A is the least interactive and corresponds to a traditional lecture or presentation with little or no feedback from participants. Group B also uses a structured lecture format, and although students may actively participate in teacher-led discussions, there is little focus on interactions between students.

Those programmes which utilised group process C or D were classed as interactive. These programmes use techniques to stimulate active participation of all students in the classroom activity, be it discussion, a brainstorming session or practice of new behaviours. Optimally, in group C, the interactions include everyone and are both *participatory* and *between peers* (Tobler and Stratton, 1997, original emphasis). Structured small group activities are used to introduce programme content and promote the acquisition of skills. The group leader (teacher or other) keeps the group on track by initiating appropriately timed, structured activities. The final group process, group D, is the least structured and is considered more appropriate for older adolescents (ibid). In both interactive group types, the leaders encourage everyone to participate, promote positive social interactions between the adolescents, and assume an authoritative role only when it is necessary to correct a misconception. The characteristics of each group process are summarised in Table 1.7 (overleaf).

Group Types		
Non-Interactive:	**Group A**	**Group B**
Aim:	To educate; knowledge gain	To educate; build intrapersonal competence; self-awareness; self-esteem; feelings, values, affective education
Methods	Didactic presentations	Didactic presentations, group discussions and individually oriented activities
Leadership	Leader as teacher	Leader as teacher and provider of group structure
Focus	Individual knowledge.	Individual growth.
Structure	Highly structured, passive participation	Structured. Passive and some active participation.
Communication	Leader to student, no self-disclosure	Leader to student; sometimes student to student in discussions; self-disclosure low.
Interactive:	**Group C**	**Group D**
Aim	To develop interpersonal skills; relationships with others; feelings of acceptance	To develop intrapersonal and/or interpersonal growth, identify students potentials and heighten self-awareness
Method	Structured exercises, role plays, interpersonal experiential activities	Discussion and dynamic group process
Leadership	Leader as facilitator of group activities and provider of structure for the group	Leader as facilitator and role model. Group members take responsibility for group direction.
Focus	Group serves as medium for interaction, involvement of all students	Either individual or group focus; individual growth through the group experience.
Structure	Structured, active participation	Limited structure, open ended, active participation.
Communication	Student to student; often represented in activity and non-verbal behaviour, self-disclosure moderate.	Highly interactive, students often take responsibility for communication in the groups, self-disclosure moderate to high.

Table 1.7: Group Types (Adapted from Tobler and Stratton, 1997)

In their meta-analysis, Tobler and Stratton (1997) found that the interactive programmes had statistically and clinically significant higher effect sizes for tobacco, alcohol, cannabis and illicit drug use and for all adolescents including minority populations. In another meta-analysis, the authors report that if interactive programmes replaced the non-interactive programmes found in the study, the relative increase in preventing cannabis use could potentially be almost 12 percent (Tobler et al., 1999).

In both studies, effectiveness decreased for larger programmes (that is those delivered to greater numbers of students), however the larger interactive programmes were still significantly superior to the larger non-interactive ones. The authors suggest that extra classroom leaders would be needed in the larger programmes to allow each adolescent his/her "air-time" (ibid). Such extra personnel are unlikely to have been hired due to the added cost involved. An essential ingredient of the interactive programmes is participation and communication by everyone, preferably in small groups. Without extra leaders to facilitate lots of small groups within larger classes, the chance to exchange ideas, get validation from peers and truly practice new interpersonal skills is perhaps missing.

Many of the most popular drug education programmes and packages (including DARE) achieve such popularity by means of intensive marketing to schools in the US, rather than on evidence of effectiveness (Dusenbury and Falco, 1995; Dusenbury et al., 1997). In fact, many of them are based on non-interactive group processes (ibid). On the other hand, many of the interactive programmes are not available in curriculum packages that are teacher-friendly and they require considerable teacher training (ibid). Without adequate supports in place, teachers may become uncomfortable or insecure with the ambiguities that can arise during open discussions and may abandon interactive strategies and use more teacher-centred, less interactive strategies such as lectures or individual work instead (Bosworth and Sailes, 1993). Tobler and Stratton (1997) question whether school boards and administrators are willing to provide the necessary money, class time, extra personnel and aggressive teacher training necessary to successfully implement interactive programmes. If such training is not provided, the positive effects of these programmes found in the literature, may not be realised in local classrooms (Bosworth and Sailes, 1993).

1.4.4.c. Other Factors Affecting Delivery

There are many other issues which affect how drug education programmes are implemented in practice. These issues may also mean that a programme which has been shown to be effective in experimental settings may not retain that effectiveness when implemented in schools on a broad scale. In a major qualitative study of health (rather than drug) education in the United States (n=607 schools, 1,040 health education teachers) utilising interviews and questionnaires, Pateman et al., (1999) found six recurring issues that facilitated or prevented the delivery of quality school health education programmes:

(i) The value placed on health education in the school curriculum

Respondents in the study wanted health education scheduled with the same priority as other subjects, but described challenges in making it a priority in their school. Many reported that it was treated as a filler at the end of the year or placed late in the day where it is often dropped or replaced by "more important things". Some teachers who were assigned to teach or administer health education did not value it and were not committed to teaching it.

(ii) Qualifications and opportunities for health educators

Respondents reported a lack of certification and professional development for health educators. They advocated the creation of school-level positions for health education that could only be filled by professionally prepared health education teachers. Only 4% of lead health education teachers (of a total sample of 1,040) majored in health education, with an additional 22% having majored in health and physical education.

(iii) Programmes, curricula and teaching methods

Respondents reported a lack of up to date curricula that used the experiential teaching strategies that they wanted to implement in the classroom. They felt bound by policies and curriculum manuals, even when they judged those materials to be outdated, unreasonable or unresponsive to students' needs.

(iv) Assessment, evaluation and accountability issues

Many respondents advocated student testing in health education. The pressure for students to do well in such tests means that tested subjects are prioritised for curriculum time. Others had reservations, stating that testing took up time that could be used to broaden what is taught. Respondents were supportive of programme evaluation and monitoring to ensure that schools comply with government mandates for health education.

(v) Resources and support

Respondents reported a number of problems with resources for health education including lack of classroom space, obsolete textbooks, large class sizes, lack of time, and lack of adequate funding for health education materials.

(vi) Communication and collaboration

Respondents expressed a desire for increased communication between the health service, the community, parents, teachers and the school. Others reported a need for collaboration between the various specialists who ought to work together in comprehensive school health programmes, and for greater public awareness of the need for programmes.

Of all of these factors, increasing the value and priority of health education in the school curriculum was the most pervasive need expressed by the respondents in this study. At all levels, respondents called for increased support for health education in word and in deed from education leaders (Pateman et al., 1999).

In their study of school drug education across Scotland, the Scottish Council for Research in Education (Lowden and Powney, 2000) found that the actual content and style of lessons in schools was influenced by a number of factors including:

(i) teachers' perceptions of the pupils' needs and abilities
(ii) teachers' attitudes/understanding concerning the aims of drug education
(iii) awareness and availability of resources and support
(iv) local authority policies
(v) staff skills and staff development opportunities.

An earlier study, by Coggans et al., (1991) also revealed that school policy and management structures significantly influenced the development and implementation of drug education. There are few studies of how the above issues impact on the actual delivery of drug education in the classroom, or on its effectiveness. It would seem sensible however, to include consideration of these issues as part of good practice in developing any drug education inputs.

Although not a formal research study, the role of schools in delivering drug education has been considered in detail by the School Drug Safety Team (SDST) set up by the Scottish Executive. Made up of representatives from a range of interest groups in health, education and social work, the team met on ten occasions and considered current publications as well as submissions by a number of invited organisations and individuals before finalising their report. Their findings are useful in that they offer further advice on some of the more controversial issues, and also on what should be done by the government to support the development of drug education (School Drug Safety Team, 2000).

The SDST report highlights the potential conflict between stances taken by official organisations (such as local authorities, health boards and the police) on drug misuse, and the view of some young people who do not perceive the "recreational" use of substances as necessarily constituting a problem. They recommend that effective drug education should take full account of the range of issues and viewpoints in modern society and the realities of drug use as viewed by young people themselves. They note the importance of providing teachers with clear, realistic aims and objectives for drug education which are regularly monitored and evaluated. They also emphasise the importance of responding to the individual circumstances of pupils, particularly those with special educational needs, already alienated from school, looked after by local authorities or coming from a family where the parents misuse drugs.

The School Drug Safety Team also examined current barriers to effective delivery of drug education in secondary schools. The difficulties identified were as outlined overleaf:

- Drug education is delivered often on a one period per week basis by subject specialists who may not be very interested in it, nor trained adequately in appropriate approaches and methods
- There is no defined career progression within schools for teachers of personal and social education (PSE) and health education. This tends to lower the importance ascribed to it and to staff development in this area.
- Good teachers tend to already be heavily engaged in raising standards within their subjects, making selection of staff for PSE difficult. Some PSE teachers may feel conscripted and ill-prepared for the challenge.
- There is a limited allocation of time for the co-ordinator of drug education to discharge this remit successfully. This causes significant difficulties for effective co-ordination of drug education.

To try to resolve some of these issues, the SDST recommended (among other actions) a review of the place of PSE within the school curriculum/structure which considers giving formal recognition to the status of PSE teaching and the development of an additional teacher qualification in PSE. They also recommended the development of key targets for drug education at the various ages and stages in school, and the production of a guide similar to "How Good is Our School?" specifically for drug education.

In 2001, the Scottish Executive Annual Report on Drug Misuse announced the allocation of £1 million per year for 2001/02, 2002/03 and 2003/04 to implement the SDST recommendations (Scottish Executive, 2001b). An enquiry by the author as to how this money was to be spent found out that most of the money had "been distributed to education authorities to help them ensure that every pupil receives drug education in line with national advice by 2002, and also to develop drug education generally in their areas" (Miller, 2001). It is not clear if any more specific conditions were outlined to local authorities on how the funding should be spent. The Executive was also looking at further teacher training in collaboration with Scotland Against Drugs and the other recommendations of the SDST would be developed "in future years" (ibid).

1.4.4.d. Meeting Pupils' Needs

It has been noted that in any drug education classroom there will be sub-groups of pupils with different motivations and experience with respect to drug use (Goodstadt, 1986). Young people in secondary schools receive conflicting messages about drug use and they have different levels of knowledge (Drugs Prevention Initiative, 1998a). In addition, factors such as age, development of personal and social competencies, attitudes, beliefs, culture, ethnic group and drug-related behaviour vary among pupils even in the same classroom (Coggans and Watson, 1995). All of these factors result in differing drug education needs.

> Drug users are not a homogeneous group and distinctions between normative use and problematic use are essential in developing effectively targeted interventions. Interventions must take into account the varying needs of these groups.
>
> [Coggans and Watson, 1995]

Although the importance of tailoring drug education to meet the needs of different pupils has been emphasised, there is little discussion in the literature of efforts to do this. White and Pitts (1998) noted that too few interventions consider the varying contexts in which drug use and drug use resistance occur and allow this information to inform programme design. Goodstadt (1986) reported that drug educators have failed to discriminate between alternative prevention objectives and target groups. This not only means that the needs of pupils may not be met, but failing to distinguish between subgroups may mean that evaluations of programmes are not sensitive enough to detect an effect. In fact, opposite effects on different sub-groups may cancel each other out. Coggans and Watson (1995) noted the need to develop variable and well-targeted interventions which address the needs of different groups; however they note the difficulty of establishing at an early age, to which group each pupil belongs. In addition, they report that there is as yet no consensus as to what combinations of educational interventions are likely to be most effective with which groups of young people.

In mainstream education, differentiation is the term used for attempts to cater for different needs in the classroom. Differentiation has been defined as follows:

> Differentiation is the identification of, and effective provision for a range of abilities in one classroom, such that pupils in a particular class need not study the same things at the same pace and in the same way at all times. Differentiated approaches should mean that the needs of the very able, and of children with learning difficulties, are discerned and met.
>
> [Simpson and Ure, 1994]

In their study of differentiation practices in Scottish schools, Simpson and Ure (1994) found that "good differentiators" used a range of strategies to meet the needs of their pupils. The strategies they identified were as follows:

(i) Sharing the management of learning with pupils by giving pupils responsibility for identifying their problems and difficulties, and by agreeing mutual responsibilities

(ii) Promoting the belief that attainment could improve

(iii) Using a wide range of sources of information about pupils needs from other staff, testing, observation and discussions with pupils

(iv) Identifying a range of needs for different learning strategies, extra explanations or special arrangements

(v) Responding to needs by agreeing targets, giving assistance, boosting confidence and using a variety of teaching methods

(vi) Giving and receiving continuous feedback and advice to and from pupils on pupil performance, from comments and discussions, formal and informal assessments, pupil attitudes etc.

(vii) Using a range of sources of support such as learning support staff, parents, older pupils and non-teaching staff.

For the most part, differentiation has been thought of as a means of meeting the needs of pupils with differing academic abilities, whereas in drug education the pupils own experiences, attitudes and behaviours may determine their needs, at least as much as their academic ability. Thus differentiation in drug education lessons may be a more complex issue and it is not known if similar strategies might be successfully employed or how such strategies might impact on the effectiveness of school-based drug education.

The Drugs Prevention Initiative (an organisation formerly responsible for co-ordinating community prevention activities in England) has noted that pupils can make an active and useful contribution to the development of school-based drug education programmes (Drugs Prevention Initiative, 1998b). They suggest that involving and consulting pupils offers the prospect of a greater degree of ownership and acceptance of programmes on their part, however it may also slow down the development process.

There is little discussion of pupil consultation or involvement in most of the drug education literature. Ives and Clements (1996) have suggested that one reason young people are so rarely asked what drug education they would like is because horror stories from former addicts are often requested but are unacceptable to most drugs educators. Pupils' views on drug education as they enter secondary school (in England) have been studied by Cole, (2000). The pupil focus groups in this qualitative study revealed that pupils were not receiving the messages that were being put across and that they harboured a number of misconceptions that should have been addressed by the drug education they had received. They often exaggerated the dangers of finding illicit drugs at secondary school and even thought people would be trying to force them to take them. This illustrates that consulting pupils may reveal interesting findings that might otherwise go undiscovered. She concludes that pupils' voices should not be excluded from dialogue on what is the best way to educate them about drugs, though she notes that "we should not be unduly swayed by the views of pupils, who are not always aware of all the issues".

The usefulness of pupil consultation is also illustrated by a major consultation with young people in California that was carried out by Brown and his colleagues (D'Emidio-Caston and Brown, 1998; Brown et al., 1997; Brown et al., 1995). The study involved in-depth interviews at over 50 school districts with school district personnel, questionnaires to more than 5,000 students and 40 focus groups with over 250 students. The consultation brought to light a number of issues, including an important indication of the effect of not taking student values and behaviour into account. As students got older, they increasingly identified inconsistencies between the messages that were being taught in school – that is that all substance use is abuse and has dangerous consequences – and what they observed outside school – people using a variety of substances at varying levels, in different social contexts and with different perceived outcomes.

This cognitive inconsistency meant that their dissatisfaction with drug education increased as they got older and it was often resolved by the students concluding that educators were lying to them about the information they provided or were not interested in helping those students that may have had a substance use problem.

Despite these findings, there have been few studies of how effective pupil consultation is in helping drug educators to identify the needs of different pupils compared to other possible strategies or what impact pupil consultation might have on the overall effectiveness of a drug education programme. In addition, little is known about what kinds of strategies may be useful in meeting the needs of different pupils and how they might be implemented in practice. In fact, there are fundamental difficulties with attempts to target high-risk young people for special interventions as counterproductive negative peer influences can arise (Williams, 2003). The practicalities of providing different interventions to different groups need further consideration.

1.4.4.e. Parental Consultation and Involvement

The role and involvement of parents in drug education is not routinely discussed in the drug education literature. There are a small number of studies that have focused specifically on parental involvement and many of the more successful drug education programmes have included components aimed at parents and families, as reviewed above. In general, commentators are agreed that parents are powerful figures influencing child behaviours and their involvement should therefore be a part of drug education activities (Young, 1992; Cohen and Linton, 1995; Daw and Joyce, 1996; Finnigan et al., 1997; Mallick et al., 1998; Plant and Plant, 1999).

A major study of parent involvement in drug education in the UK was carried out by Mallick et al., (1998) including questionnaires, interviews and focus groups with a total group of 947 parents. The results showed that parents were concerned about drugs in relation to their children, however they were often misinformed about the drug situation and they requested accurate and up-to-date information. Parents in the study were largely unaware of their children's school drug policies and programmes and they believed in their children being given the "Just Say No" message.

The authors point out that parents need to be informed of what messages are being given in schools and why, and educated about what that means for children's education. This is essential in order to avoid possible later misunderstandings among parents about the methods and motives of the drug education taught to their child. According to the authors, parents need drug education for themselves in order to play a role in the drug education of their children. This conclusion is supported by the work carried out in the Western Isles of Scotland in 1998 which found that many parents wished to play a greater role in relation to drug education for their school aged children, but that many also believed they needed further information to perform this task adequately (Plant et al., 1998).

Cohen and Linton (1995) studied levels of parent participation in a drug education programme targeted at them. The programme included surveys (completed by 1,263 students and 1,143 parents), an evening meeting for students and parents, and meetings for parents alone. They discovered that parents underestimated the number of their children's peers who used drugs and they note that this could be an important reason why parents do not attend meetings about drugs. In addition, parents who did not respond to invitations to attend meetings, had significantly higher levels of alcohol and tobacco use, based upon child reports. Cohen and Linton concluded that parental involvement should be re-conceptualised not as a separate one-shot extra-curricular programme (such as a parent evening) but as an integral part of the education process (ibid).

According to Cohen and Linton (1995), the current forces of society are not consistently conducive of family life therefore support systems and motivation for parental involvement must be created so that it becomes a norm, not an elective part of child education. They recommend that future research should explore maximizing parental involvement by implementing or improving workplace incentives, tax credits, media involvement, or other business and community based programs. Although the involvement of parents is a desirable, if not essential, part of successful drug education, involving parents from high-risk families can be very difficult. This is the difficulty that may arise with any drug education programme for parents – those that may be most in need, are the least likely to turn up.

In a study of drug education provision involving a postal survey and focused inspections in Scottish schools from 1996 to 1998, HM Inspectorate of Education (HMI, 1999; n=37 schools) found that although there were some improvements in the involvement of parents in drug education over the period, much still remained to be done. Most schools provided parents with information on school drug education programmes but few involved them in programme development. Some features of the most effective partnerships with parents included:

- Workshops to familiarise parents with selected activities and resources used.
- Leaflets outlining plans for pupils learning in each term, including homework and suggesting how parents might play a supporting role.
- Using parent helpers under the guidance of teachers to support small groups of pupils.
- Encouraging parents to identify their child's special needs for food or medication at admission to the school and before extra-curricular activities.
- Involving parents in working groups to develop aspects of the school's health education programme.

1.4.5. Monitoring and Evaluating Drug Education

Evaluation has been described as the systematic collection, analysis and interpretation of information on how a drug education programme operates and on the effects it might have (EMCDDA, 1998). The information collected should be used to decide on if a programme needs amendment, how it could be improved and whether to expand or discontinue it. The 1993 ACMD report "Drug Education in Schools" discusses the "complexity of evaluating school drug education programmes" and states that any evaluation which fails to take account of all the factors involved in education will provide misleading results. It lists the following considerations:

(i) The Audience

An educational programme may produce different results in relation to the age, characteristics, experience and social background of the individual pupil.

(ii) The Environment

The programme will have different results depending on the community in which the school is situated and the degree of availability of drugs in the community.

(iii) The Prevention Strategy

A school drug education programme will only be one of a number of factors influencing health behaviour. A programme which is supported by broader demand reduction strategies in the community may be expected to have more impact than a programme operating in isolation.

(iv) Level of Provision

The extent to which a programme is effective in implementation will depend on a number of factors such as the level of training provided to the teachers delivering it, the amount of resources and curriculum time devoted to the subject, the quality of delivery and the aims and commitment of all involved in the programme.

(v) Delivery of Education

Although there is some literature on outcomes of drug education, it is unclear what educational processes (i.e. the way the programme was carried out) led to these outcomes. Educational programmes as actually delivered may not always correspond to the programmes as actually planned. More attention should be paid to the evaluation of processes, as well as outcomes.

(vi) Behavioural Outcome

A given educational programme may be more effective in relation to one drug or type of drug than another (volatile substances, for example, may raise educational issues that call for specific evaluation). Furthermore it may discourage ever use, delay onset of use, decrease the quantity or frequency of use, discourage particularly harmful forms of use (e.g. injecting) or encourage cessation of use and/or seeking help. Any one programme may be more effective in achieving one or more of these outcomes than others.

Given the wide range of issues that ought to be considered it is perhaps not surprising that evaluation is not routine for school-based drug education programmes. In 1986, Goodstadt noted that the overwhelming majority of programmes had not been evaluated in any way. More recently, Dane and Schneider (1998) found that the majority of studies in the prevention literature contained no indications of the adequacy of programme delivery or of the number of subjects that participated in a satisfactory proportion of planned sessions. They note that the internal validity of much of the outcome research in this literature may be compromised by these omissions. In Scotland, Lowden and Powney (2000) reported that schools increasingly evaluating their drug education provision but that such evaluations were almost completely based on internal evaluations conducted by teachers involved with drug education and drew on day-to day teacher and pupil informal feedback. Outcome evaluations are particularly difficult as they require considerable expertise as well as large sample sizes to show any statistically significant effect.

Functions of Programme Evaluation
1. To determine to what degree, how fast and in what respect the aims have been realised.
2. To call attention to the strong and weak points of the programme in order to be able to decide upon a more definitive form and content
3. To verify that the programme has been carried out according to plan and to decide upon the mechanisms for quality determination and quality control
4. To determine whethert the programme is suitable for other groups
5. To raise the level of scientific knowledge
6. to form hypotheses for future research
7. To give account to the community and inland service
8. To support the expertise of the staff as far as planning, implementation and evaluation are concerned
9. To support a good relationship with and to be considerate to the general public
10. To honour contractual obligations, for example, from those who grant subsidies

Table 1.8: Functions of Programme Evaluation (Pompidou Group, 1998)

Despite the difficulties, comprehensive evaluations are useful in a number of important ways. Table 1.8 (on previous page) provides a summary of the functions of evaluation in the context of drug education.

1.4.6. Best Practice in Drug Education

Best practice in drug education requires careful planning and management to consider all of the elements described above and to ensure that programme development proceeds in a reasoned and structured way. Table 1.9 (overleaf) presents a guide to best practice and a summary of the factors that are likely to maximise the impact of drug education as discussed above. This table has been compiled by the author drawing on the literature referred to throughout Section 1.4 as well as advice on good practice devised by other authors in works not previously cited (DrugScope, 1999; Health Education Board for Scotland, 1997; Ogborne, 1988).

Best Practice in School-Based Drug Education
Policy and Planning: Goals, objectives, methods and the theory behind the programme should be agreed in advance by the school (including classroom teachers and senior staff), pupils, parents and the community, and expressed explicitly in a policy document open to all for inspection. Pupil knowledge, attitudes and behaviour should be established and considered in advance as well as social, developmental and cultural factors.
Development: A process of feedback, assessment and evaluation should be in place to allow continuous updating and development of the programme and to encourage a wider feeling of ownership of the programme. This process should include staff at all levels, parents, pupils and the community and should take account of national guidelines and initiatives. Evaluation should focus on whether, how, and why the original goals of the programme are being achieved or not.
Time and Resources: Adequate resources should be decided and secured in advance including curriculum and staff (or deliverer) time, external agency input, classroom materials, venues for parent and community involvement and funding for training of deliverers and evaluation of the programme.
Curriculum: To maximise impact on drug use, the curriculum should be intense and comprehensive including accurate, credible and unbiased information, normative education, skills development and components which involve families and the community. Although planned in advance, it should be sufficiently flexible and include specific strategies to ensure that the needs of different groups can be met. The programme should continue throughout each child's school career.
Delivery: Delivery should be led by carefully selected classroom teachers who are knowledgeable, comfortable and confident, complimented by the involvement of peer educators, the police service or other groups/ individuals as appropriate given their areas of expertise and experience. It should be primarily based on interactive teaching methods with pupil to pupil discussion of attitudes, views and experiences in small group settings. All deliverers should be comprehensively trained and receive ongoing support.
Environment: The programme should be integrated within a broader programme of personal, social and health education, supported by a positive school ethos emphasising honesty, trust and respect, within a safe, secure and stimulating environment that encourages the health and wellbeing of all. A clear and inclusive system should exist for pupils who need extra support, help or referral.

Table 1.9: Best Practice in School-Based Drug Education

1.5. Drug Education in Scotland

This first part of this section describes the official national guidelines for drug education in Scotland to which schools are asked to adhere. A brief summary of each guideline is provided and compared to the findings from the literature that are summarised in Table 1.9 above. A similar description of local Grampian guidelines is also provided. The second part of this section reviews what is currently known about drug education practice in Scottish schools from available research literature and government surveys.

1.5.1. National Guidelines for Drug Education

In Scotland the school curriculum is not prescribed by statute but it is set out in national guidelines developed through wide consultation. The responsibility for organising and delivering the curriculum rests with local authorities and school managers. According to the Scottish Executive (Scottish Executive, 2002b), current national advice on drug education is set out in the following four documents:

- How Good is our School? - Performance Indicator 1.2 - Quality of course or programme. HM Inspectorate of Education, 1996. (HMI, 2001 – See footnote[vi])
- A Route to Health Promotion (Aberdeen City Council, Health Education Board for Scotland, HMI Audit Unit, 1999).
- HELP UP-DATE on drug and nutrition education, LT Scotland Curriculum File No 9. (Learning and Teaching Scotland, 1998)
- 5-14 national guidelines on health education (Learning and Teaching Scotland, 2002a)

These documents are described in more detail in the following sections.

[vi] Although the 1996 version is still listed as one of the four national guidelines for drug education, this has now been superseded by a new edition. In the new edition (entitled the "2002 edition", although published in 2001), performance indicators are referred to as quality indicators. In keeping with the latest document, the latter term is also used in the remainder of this thesis, and it is the newer edition that is referred to at all times.

1.5.1.a. How Good is Our School? – Quality Indicator 1.2

The aim of this publication is to help schools to self-evaluate the quality of the education they provide. It is based around a set of quality indicators to help schools to recognise key strengths, identify areas where good quality needs to be maintained or improvement is needed, identify priorities for the school development plan and report on standards and quality in the school.

Quality indicator 1.2 refers to courses and programmes and is concerned with the following themes:

- breadth, balance and choice
- integration, continuity and progression
- support and guidance for teachers

In secondary schools, it refers to outcomes, components, aspects and subjects within curriculum areas including core skills in S1 and S2 and course elements in S3-S6. For each performance indicator, quality of provision in a school is evaluated at one of four levels as follows:

Level 1 = Unsatisfactory – major weaknesses
Level 2 = Fair – some important weaknesses
Level 3 = Good – strengths outweigh weaknesses
Level 4 = Very Good – major strengths

To achieve an evaluation at level 4 for this performance indicator a school would be expected to be broadly equivalent to the illustration below (continued overleaf).

- Courses or programmes have breadth and balance between the various elements. They give full consideration to national and local guidelines, and are fully in keeping with the school's aims. There are appropriate opportunities for pupil choice. Programmes contribute to a continuing interest in learning and self-development.

- The various elements of the courses or programmes are planned and taught in an appropriate sequence to meet the range of needs, abilities and aspirations of pupils, and to promote progression and continuity in pupils' learning. Productive links are made with other curriculum areas or subjects.
- Teachers receive comprehensive and helpful guidance on courses and programmes of work, learning and teaching, support for pupils and assessment and recording.

This guidance reflects what was found in the literature, particularly in relation to meeting the needs of pupils and supporting teachers adequately.

1.5.1.b. A Route to Health Promotion – Self-evaluation Using Performance Indicators.

Similar to the previous document but specifically relating to school health promotion, this publication is designed to help schools to strengthen their approach to promoting the health of their pupils. Based on the same evaluation levels as above, it provides guidance on how ten of the most relevant quality indicators from "How Good is Our School?" apply to health promotion. These indicators are described in Table 1.10 (overleaf).

For each of these indicators the document describes an illustration of performance equivalent to an award of level four and level two. It provides guidelines on how to assess the schools performance with respect to each quality indicator, features to look for, ways of finding out what level the school is at and suggested points for action. In this way, it is focused on helping schools to plan, develop and improve their drug education provision in a structured way. As such, it is therefore very much in keeping with advice from the research literature. More detailed information and critical commentary on each quality indicator is provided in Appendix 1.1 which includes summaries of the standard of practice needed to attain a level four rating. This is a good indication of what the guidance considers best practice for the field.

No	Quality Indicator	Themes
1.1	**Structure of the curriculum**	breadth and balance across elements of the curriculum, integration and permeation
1.2	**Quality of courses or programmes**	breadth, balance and choice; integration, continuity and progression; support and guidance for teachers
3.3	**Meeting pupils' needs**	choice of tasks, activities and resources; pace of learning to achieve appropriate targets for all pupils; relevance of the purposes and contexts of teaching to pupils' experiences and interests; where applicable, the contribution of learning support staff
4.1	**Pastoral care**	provision for the emotional, physical and social needs of individual pupils; provision of support for pupils
4.2	**Personal and social development**	Development in pupils of positive attitudes and personal and social skills; contribution of extra-curricular activities, syllabus inserts and special courses
5.1	**Ethos**	sense of identity and pride; equality and fairness; welcoming environment; pupil and staff morale and pupil/staff relationships; pupil and staff expectations and use of praise; pupils' behaviour and discipline
5.2	**Partnership with parents and the School Board**	encouragement to parents to be involved in their child's learning and the life of the school; responsiveness of the school to parents' views and enquiries; effectiveness of links between school and School Board
5.3	**Links with other schools and agencies, employers and the community**	range, purpose and effectiveness of contacts with other educational establishments; range, purpose and effectiveness of contacts with voluntary organisations, the wider community and employers; range, purpose and effectiveness of contacts with statutory organisations
6.1	**Provision of accommodation and facilities**	sufficiency, range and appropriateness
6.3	**Organisation and use of resources and space**	organisation and accessibility; use of resources; display and presentation of items of interest

Table 1.10: The Ten Quality Indicators Chosen as Most Relevant to Health Promotion

It is clear from the range and depth of the quality indicators that attempts to implement top quality drug education potentially impact on all areas of school life. The level four ratings for these indicators require continuous, careful attention to be given to a broad range of issues, and attaining such a rating seems likely to be by no means an easy task. Despite this, the guide provides a clear understanding of what is best practice and outlines a framework for achieving it.

1.5.1.c. Health Education for Living Project (HELP)

The Health Education for Living Project aims to provide advice to schools on the appropriate resources, teaching and planning needed to achieve a coherent health education curriculum from pre-school to S6. The 1998 update covers drug (and nutrition) education and is the only one of these four guidance documents that explicitly refers to some of the more difficult issues in drug education. In the initial introduction, it addresses the issue of the goals of drug education in schools:

> The aims of drug education in schools are prevention of drug misuse, the promotion of healthy life-styles, and the development of knowledge, skills and values to help young people make responsible health choices. These aims are constant but the emphasis changes to match young people's different needs at each stage of their development.
>
> [Learning and Teaching Scotland, 1998]

The clarity provided by the introduction is unfortunately muddied by the fact that terms such as "drug misuse" and "drug education" are not defined and it is not clear if illegal drugs are included as well as "commonly misused substances such as alcohol, medication, solvents and tobacco".

The introduction to this document emphasises the importance of an appropriate understanding of responsible uses of medicine and the impact of drugs on health and legal consequences of misuse for older pupils as well as strategies for dealing with stress and pain. It goes on to discuss the development of "the necessary sense of self-esteem which helps pupils to make responsible healthy choices instead of engaging in drug misuse". Given the evidence against self-esteem as a cause of drug use as reviewed above (Section 1.3), it seems somewhat naïve to suggest that raising self-esteem will have an impact.

Assertive skills "to avoid drug-related risks"; setting of health targets; and strategies for dealing with health risks, are also mentioned as important issues for drug education. This implies that young people take drug-related risks because they lack the assertive skills or strategies to do otherwise and again is theoretically on shaky ground (Section 1.4.3.c). Finally, it is emphasised that drug education should involve young people in exploring issues and expressing concerns within a context in which they feel valued. This touches on the theory of interactive teaching methods discussed in Section 1.4.4.b above.

The resource emphasises prevention and protection as approaches to action for all pupils along with "responsible decision-making for healthy life-styles without drug misuse" for older pupils. Harm reduction and harm minimisation approaches are recommended only for "habitual drug misusers in specialised settings". The omission of definitions of "drug", "drug misuse", "harm minimisation" etc. again prevents clear interpretation of this advice. For example, what if any, level of use of any substance (whether legal or not) is included in a "healthy life-style without drug misuse"? Equally, it is not clear if harm minimisation education, for alcohol for example, is to be taught in classroom settings. Unfortunately, further advice does not clarify this.

It is stated that schools can never condone drug misuse, however it does recommend helping pupils to develop "an informed understanding of...how to prevent the harm caused by drug misuse".

> A secure place has therefore to be found in drug education programmes for older pupils to learn how to recognise the danger signs of drug misuse and how to take emergency action to protect themselves and others.
>
> [Learning and Teaching Scotland, 1998]

It is not clear exactly what lesson content is proposed here. Is emergency action to be taught to pupils to help those who suffer the harms of drug misuse but not information to prevent that harm occurring? Or is it recommending that pupils be given information on less risky means of drug use? If, as the research indicates, some pupils are using drugs right through their teens, when and how should they develop an informed understanding of how to "prevent harm"? After they have already used drugs many times? Or before they ever try them?

Although the advice and principles of drug education given in this document are much more specific than in the other national guidelines, there are still difficult questions which are neglected. With regard to planning and evaluation procedures, however, the advice is very clear:

> To be credible, effective drug education has to be both up-to-date and to start from pupils' actual needs. This requires systematic assessment of pupils' prior knowledge, experience and attitudes and subsequently of the learning gains made as a result of the drug education programme.
>
> [Learning and Teaching Scotland, 1998]

The advice on the involvement of external agencies is similar to that described previously (Section 1.4.4.a) noting that contributions from external agencies can help teachers provide credible well-informed drug education. The school is held responsible for selecting, planning, evaluating and building on such contributions however. Particular attention is drawn to concerns about the use of ex-addicts in drug education, though their involvement in carefully planned interventions for some older pupils is not ruled out. Finally, the document refers to the need to take account of local community needs, involve parents and the wider community in developing policies including ones for dealing with specific incidents of drug misuse. These issues are not discussed in detail.

Learning outcomes for health education are outlined for each stage of education. Those for secondary school pupils focus on developing understanding and skills across a broad range of issues including "looking after oneself", relationships, and health and safety in the environment. Specific mention of drugs occurs only in the context of learning the relative risk to health of activities and situations such as smoking, drinking alcohol, solvent abuse, drug use and how to minimise levels of risk in risky situations. Much of the HELP resource consists of help sheets for teachers with suggested activities and appropriate opportunities for assessment. Further helpful suggestions are made on resources, timing, national advice, and potential partnerships with parents/other groups.

The final part of this resource consists of three advice sheets for school managers on drug and nutrition education, promoting healthy eating and managing drug incidents. The checklist on drug and nutrition education is summarised in Table 1.11 (overleaf).

HELP Checklist on Drug (and Nutrition) Education for School Managers

1. **School arrangements should:** include clear and shared expectations, effective co-ordination and partnerships with parents and the wider community.
2. **The school health education programme should:** include drug education for all pupils within a balanced programme and identify times to teach, reinforce and progress key learning.
3. **Teaching plans should:** have clear learning outcomes for each age and stage, take account of prior learning and current learning needs and ensure teaching approaches and timing are well-matched to planned learning.
4. **Resources should:** include regular updating of drug education resources particularly videos.
5. **Assessment should include:**
    - **Pre-topic assessment** to establish how much pupils already know, can do and apply; find out their interests and concerns about health issues; decide allocation of time for teaching and reinforcing lessons, and to establish how much support/challenge is needed for individuals/groups
    - **End of topic assessment** to measure learning gain, give feedback to pupils, plan next learning and to involve pupils in self-assessing their learning about health and in identifying future learning needs
    - **A range of assessment approaches** to include age-matched techniques, pupil surveys and records of achievement, health action plans and transfer of information between sectors.
6. **Partnerships with parents and other agencies should:** include consultation with parents on sensitive issues and parent involvement with homework, contributions from non-teaching staff, parents and others as appropriate, and Health Board surveys of local lifestyles to identify local health risks and health education needs e.g. type of drug misuse and age-group involved.
7. **Quality assurance should:** include monitoring of and systematic feedback on planned learning and use of resources. Programme planners should work alongside colleagues to evaluate learning and teaching against agreed criteria and assessment information should be used to evaluate pupils' progress and the effectiveness of programmes.
8. **Special needs: safety.** Arrangements should include compliance with education authority and national advice on child protection and safety, admission and recording arrangements for individual health needs, and guidelines for staff on managing issues of disclosure, confidentiality, referral and support in relation to drug misuse.

Table 1.11: HELP Checklist for Drug (and Nutrition) Education for School Managers (adapted from Learning and Teaching Scotland, 1998)

When taken together with the rest of the resource, it is clear that the HELP guidance is similar in many ways to the summary of best practice for effective school-based drug education presented in Table 1.9. Key differences are perhaps that there is less emphasis in the HELP advice on normative education, involvement of pupils, parents and the community in planning and development (rather than consultation alone), and training and support for deliverers of drug education.

1.5.1.d. 5-14 Guidelines on Health Education

The 5-14 guidelines on health education were published following an extensive consultation by Learning and Teaching Scotland with schools, teacher education institutions, local authorities, professional associations and interest groups. They mainly cover primary school pupils but also extend to pupils in S1 and S2. They are designed to provide a clear framework within which individual schools and teachers can develop programmes responding to the health education needs of young people. The preface to the guidelines states that they will enable teachers to plan, teach and assess health education in a coherent way and adds:

> It is essential to establish what it is young people know and understand and to base health education programmes on these needs. The reality of young people living in today's society must be a fundamental part of planning these programmes.
>
> [Learning and Teaching Scotland, 2002]

The aims of health education for five to fourteen year olds are clearly stated:

> Health education should aim to enable young people to explore and clarify their beliefs, attitudes and values, develop personal and interpersonal skills, and increase their knowledge and understanding of a range of health issues.
>
> [Learning and Teaching Scotland, 2002]

They differ from (but do not contradict) the HELP guidelines in that there is more emphasis on exploring the beliefs and values that young people hold rather than just knowledge and skills. In aiming for this, it is pointed out that there is a need to provide opportunities for young people to explore their feelings and emotions, to share experiences, and to discuss issues which are relevant to them in a secure and comfortable environment.

According to this document, schools can provide this supportive and encouraging climate through the use of interactive learning and teaching approaches. The importance of meeting the needs of young people and consideration of social, cultural and religious influences are also mentioned.

The central theme of the guidelines and principal attainment outcome for health education is "taking responsibility for health", and three interrelated strands are used to organise the scope of the outcome. *Physical health* is concerned with the knowledge, skills and attitudes that are needed to understand physical factors in relation to our health. *Emotional health* deals with the knowledge, skills and attitudes that are required to understand emotions and feelings and how they affect us. Finally, *social health* develops an understanding of the interplay of knowledge, skills and attitudes that are needed to understand the interaction of the individual, the community and the environment in relation to health. The document divides attainment targets into six levels: of these, level E should be attainable by some pupils in P7 to S1 and certainly by most in S2, and level F should be attainable in part by some pupils and completed by a few pupils in the course of P7 to S2. It is clearly stated that the framework provided by the 5-14 guidelines is a way of describing the curriculum and of identifying the desired outcomes of learning: it does not prescribe a particular approach to teaching.

In considering how to plan for health education and health promotion, this document focuses on developing a strategic whole-school approach. It notes that health promoting schools are characterised by the high value they place on the good health of staff and pupils, resulting in concern for people as individuals and in the provision of stimulating, safe and healthy conditions for the life and work of the whole-school community. In addition to an emphasis on ethos and progression, the characteristics of good practice in the whole-school approach are outlined as follows (continued overleaf):

- a clear statement of the shared aims and whole-school expectations concerning health education and health promotion
- the involvement of staff, pupils and parents in developing provision for health education
- balance and continuity in learning
- planned coverage of issues, including misuse of drugs

- planned response to specific incidents and to the concerns of particular pupils
- clear guidance on resources and on learning and teaching approaches
- systematic arrangements for assessment that involve pupils recording their health education needs and their level of understanding
- efficient management that encourages consultation, co-ordinated provision, ongoing audit, evaluation and staff development

Teaching, learning and assessing health education are singled out for further consideration by this document. In particular the guidelines emphasise teaching and learning experiences that are interactive and encourage critical thinking, and that promote responsibility and reflection on the part of the learner. They suggest the use of brainstorming, case studies, games, simulation and role play. Schools should ensure that classroom activities are supported by appropriate resources, that teachers are comfortable and confident with the content, methodologies and resources and that programmes are regularly monitored and evaluated. It is noted that within any class, pupils have different levels of maturity, confidence, experience, physical condition and ability and that teaching and learning must take account of these needs through:

- sensitivity and respect for individual differences
- exploring pupils' pre-existing knowledge and beliefs as a basis for further learning and teaching
- adapting tasks, pace, resources and pupil groupings to pupil needs
- incorporating sufficient opportunities for taking responsibility through reflecting and through working with others
- using assessment to plan and monitor progress and provide appropriate challenge
- taking account of pupil and staff views on the relevance of the programme
- working in partnership with parents and the wider community and using their input to develop shared approaches to specific aspects including drug education.

These strategies are in many ways similar to the good differentiation practices described in Section 1.4.4.d. Consultation with pupils, involving parents in discussion, and taking account of the school environment and local and national research findings are recommended and the importance of creating a climate between staff and pupils that will encourage honest discussion and a feeling of trust is emphasised. Assessment is highlighted as necessary to identify pupils' strengths, attainments and development needs and to allow effective feedback to pupils and to others. According to these guidelines, assessment should be based on what pupils say, write and do and should be clearly recorded and reported appropriately whether to pupils, parents or other teachers. Attainment targets for the three strands of health at levels E and F are summarised in Appendix 1.2. Finally, further guidance is provided on developing partnerships with other agencies, parents, and health professionals, liaison with other schools, staff development, appropriate language and confidentiality.

The 5-14 guidelines on health education are supported by a comprehensive guide for teachers and managers (Learning and Teaching Scotland, 2002b). It provides detailed guidelines on planning, teaching and learning methods including group work, assessment activities, evaluation, detailed attainment targets for drug education, links with other topics, and advice for local authorities.

In a similar way to the document "A Route to Health Promotion", these 5-14 guides form a useful tool for planning drug education. In addition, they provide comprehensive help and advice on assessing pupil progress throughout any programme. In both of these aspects, they are in tune with key research findings.

1.5.2. Local Guidelines and Initiatives

In addition to the national documents described in the previous section, the health promotion department of Grampian Health Board has developed curriculum guidance packs to help schools become health promoting schools, including one specifically related to drugs (Health Promotions, 1998). One core pack sets out a seven stage process which forms a logical progression towards becoming a health promoting school. These are illustrated in Figure 1.1. (overleaf).

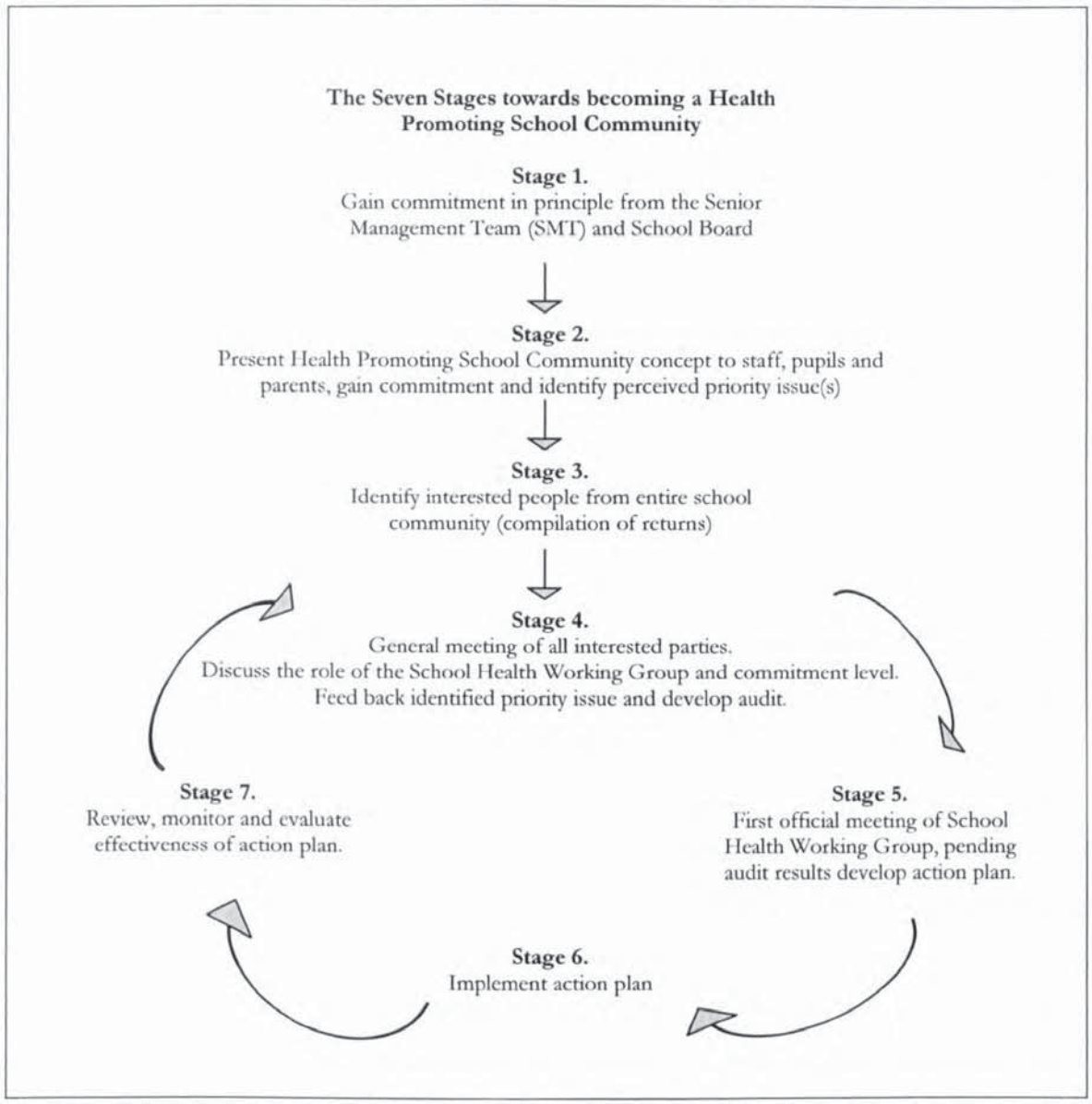

Figure 1.1. Stages towards becoming a Health Promoting School Community (From Health Promotions, 1998)

The drugs pack was written by Health Promotions in conjunction with representatives from nursery, primary, secondary and community education across the three local authority areas. Firstly, it provides guidance on carrying out an audit of provision specific to drugs including distributing questionnaires to staff and pupils, identifying any gaps, selecting appropriate resources, and assigning responsibility for audit tasks. Then the main aim of drug education for a health promoting school community is outlined as follows:

> To prevent drug misuse among young people and to reduce the harm caused through existing drug misuse.
>
> [Health Promotions, 1998]

Within this, the resource advises that the remit of schools is to provide information, advice and the necessary life skills for young people to remain or become drug-free. Harm minimisation approaches are only recommended for community education settings. Key messages for drug education are outlined as follows:

(i) It is important to look after yourself and keep yourself safe.
(ii) Some drugs are used to fight illnesses (medicines).
(iii) All drugs and medicines can be harmful.
(iv) The effects of drugs can be unpredictable.

The pack is divided into three sections. The first part, entitled "The Formal Curriculum" outlines teaching points for each age/stage, associated resources and provides basic information on definitions, life skills, drugs, and the history of drugs. The second part, "The Informal Curriculum" addresses confidentiality, children's rights, sources of leaflets, pastoral care and policies and procedures. The final part, "Links with the Community" discusses how to develop partnerships with parents and the wider community, the use of outside agencies and useful local contacts. Overall, this resource is focused primarily on planning for a whole-school approach to the issue of drugs as this is the ethos of the health promoting school initiative. In this sense, it is in tune with research that indicates that comprehensive approaches involving the community are more likely to be effective in reducing drug use (Section 1.4.3.d).

Allott et al., (1999) describe a collaborative effort between police officers and classroom teachers that has been developed in Grampian by police and the education authority. Funded by a private sponsor, a teacher was engaged by Grampian Police to design, implement and deliver training on a resource for teachers and police officers. "The Police Box – Learning for Life" (Grampian Police, 1995) was the original card-based resource produced and the learning was further extended by the development of two interactive CD ROMs – Learning for Life Volumes One and Two (Grampian Police, 1999; 2000). The resources address five subject areas: bullying, vandalism, drugs sense, safety and law and order. Rather than delivering the programme unilaterally, uniformed police officers (known as Police School Liaison Officers) support teachers in delivering the packs, on the request of the teacher or school.

The resources are designed to fit in with the 5-14 curriculum guidelines for Scotland and are based on a life skills approach to drug education.

The drugs sections of the resources suggest the involvement of a wide range of external specialists including pharmacists, doctors, school nurses and customs officials, as well as the police. Activities for pupils to complete at home are also suggested in some lessons, but the pack does not in itself discuss parental or community interventions led by the schools. Although there have been a number of reviews and evaluations of the Police Box, there has not been a longitudinal study of the effect of the resources. There have been a number of reviews and evaluations but there has not been a longitudinal study of the effect of the resources. Grampian Police have also produced The Buzz - a resource pack aimed at secondary school pupils, designed by young people for young people (Grampian Police, 2001). The Buzz pack is discussed further in Section 4.8.1.d.

Overall, it is clear that there is an extensive armament of guidelines and advice available both nationally and locally to assist schools in developing best practice in their drug education provision. Taking these into account, along with the research literature, indicates that drug education of the highest quality requires extensive planning, consultation, assessment, evaluation and follow-up, and impacts on a whole range of areas of school life. The next section considers what is known about current practice in drug education in Scottish secondary schools, and how closely it reflects these high standards.

1.5.3. Current Practice

At present, information on current practice in drug education in Scottish secondary schools comes from the following published sources (overleaf):

(i) In the late 1980's, Coggans et al., (1991) carried out a national evaluation of drug education in Scotland. This was a wide-ranging study that compared groups of pupils who differed in their exposure to drug education and teachers who had different levels of in-service training. As part of this study, 106 secondary schools, and pupils from a total of 20 schools took part in surveys to assess the impact of drug education. The research also involved group discussions about drug education with pupils, and case studies of four schools.

(ii) A more recent study of drug education in Scottish schools is that of the Scottish Council for Research in Education (SCRE) which was published in March, 2000 (Lowden and Powney, 2000). This project had two main quantitative data collection phases, in 1997 and 1999. Each phase entailed:

- A census of secondary and primary schools (284 primary and 318 secondary covered in 1999)
- A pupil survey of a representative sample of P6, S1, S3 and S5 year groups, approximately 4,400 in all, of whom 1,119 remained to complete the second phase.

Interviews and focus groups were also arranged in two primary and four secondary schools to provide insights into the views of teachers and pupils.

(iii) HM Inspectorate of Education carried out a study of drug education provision involving a postal survey and focused inspections in 37 Scottish schools chosen by the education authorities as having effective approaches to drug and nutrition education. The study, which took place from 1996 to 1998 is also based on returns and discussions from officers in all education authorities (as existed at that time) and evidence drawn from general school inspections (HMI, 1999).

(iv) Finally, the Scottish Executive Education Department (Scottish Executive, 2002b) carries out an annual survey of drug education in schools, the most recent of which was published in 2002. This survey is based on figures returned to the Scottish Executive by each local authority, compiled from individual school responses.

Lowden and Powney (2000) found that specific drug education was taught in 99% of secondary schools for at least one year group, and that schools shared the same overall aim for drug education: to provide accurate information on drugs to promote pupils' decision-making skills. In response to the SEED survey, 92% of all schools (primary, secondary and special) reported that they provided drug education "in line with current national advice" (Scottish Executive, 2002b). In Grampian, 89% of schools in Aberdeen City, 100% of schools in Moray and 90% of schools in Aberdeenshire were reported as providing drug education in line with current national advice. For secondary schools only, the national figure was 94% (ibid).

A variety of drug education materials were found to be available in schools. Coggans et al., (1991) reported that the packages that were in use included emphasis on the social and personal consequences of drug use; knowledge and awareness; and social and life skills such as decision-making skills, "rejection" skills, and "dissuasion" skills. They highlighted a number of issues in relation to these packages including:

- In some instances, misleading assertions about drugs and opinions were presented as fact.
- Certain aspects of the packages were more about decision-implementation rather than decision-making, the decision being implicit or explicit in the content. The authors suggested that this directive aspect could be counterproductive if perceived by the pupil as being simply moralistic and opinion-based.

In the more recent study, Lowden and Powney (2000) reported that most school-based drug education was resource driven rather than based on clear theories or approaches. Most commonly used were the DrugWise series and TACADE resources which were then "heavily customised" with parts of other materials.

Most schools valued input from external agencies, the police being the most commonly used, followed by local health boards and drugs agencies.

Both of these two studies included an outcome evaluation of drug education. Coggans et al., (1991) found an effect on only two of their outcome variables, both of which were aspects of drug-related knowledge. Participation in drug education lessons had no effect on pupil perceptions, attitudes or self-reported drug use. Lowden and Powney (2000) found no association between quality of drug education - "based on guidelines for good practice and rated against criteria identified in the literature as desirable in quality drug education" - and any of the other outcomes - pupil alcohol, smoking and illegal drug behaviours, attitudes and knowledge. When the variables were looked at individually however, an association was found between participative teaching methods and a reduction in pupils' reported alcohol consumption.

Pupils' views on drug education were also investigated by the SCRE study. Most pupils valued the drug education they were receiving although older pupils and those who were using illegal drugs were more critical. They were more likely to be bored and frustrated with drug education on the grounds that it was often repetitive and did not reflect their perceived needs. Despite these criticisms, around 66% of those who claimed to use illegal drugs reported that drug education had had a positive impact on their drug use, ranging from reducing the risks associated with use to reducing the amount used or helping them to stop altogether. These reductions were not found in the overall outcome evaluation.

Coggans et al., (1991) reported that, between May 1986 and May 1988, nineteen first level drug education courses had been organised by education authorities throughout Scotland. They found that most education authorities had trained at least as many staff as they had secondary schools, though some staff may have attended more than one course. Only two authorities had no trained teaching staff. Lowden and Powney (2000) found that while most teachers valued drug education training, the majority had not received such training in the previous two years. Training about appropriate and effective approaches was in greatest demand.

The HMI (1999) evaluation found that most education authorities were still developing their policy and practice on health education and promotion. Policy expectations were unclear in some authorities and in some cases the inspectorate judged that health education policy had been delegated to too low a level of responsibility. This resulted in a limited capacity to co-ordinate and evaluate provision effectively. This is worrying, given that Lowden and Powney (2000) found that schools with formal written policies on drug education were more likely to provide training for teachers to enhance their skills and to conduct active evaluation of drug education. Although an increasing number of schools were monitoring pupils' satisfaction and needs concerning drug and health education over the course of the SCRE study, the HMI report found scope for improvement. Health issues could have been given more priority within school development plans, national advice on development planning and quality assurance could have been implemented more quickly, and development action well-targeted on identified health education needs was required. In addition, as reported earlier, they found that much remained to be done on involving parents in drug education (Section 1.4.4.e).

Lowden and Powney (2000) highlighted a number of issues that were raised by their study. Differences in values espoused at school, in pupils' own cultures and in their families became especially apparent in drug education and underlined the need to tailor approaches to pupils' needs. They reported that many teachers felt they lacked knowledge and experience in the area of illegal drugs and they noted that there was scope for increased teacher-pupil communication concerning pupil needs and strategies. Coggans and his colleagues (1991) also highlighted issues needing to be addressed in the future. These included the concept of informed choice, the social, cultural and historical context in which drug use takes place, the various interactive roles that different professional groups have in determining society's response to drug use, and the need for a system approach to the whole drug issue.

In summary therefore, it is clear from a number of sources that the vast majority of schools provide some form of drug education to pupils. Previous studies of drug education in Scotland have identified some issues in relation to drug education including teacher training, the appropriateness of messages for different individuals and groups, parent involvement and the importance of clear policies.

There are however, many issues that have not been investigated in full by previous work and these are outlined in the next section.

1.6. Rationale and Objectives for the Research

Section 1.4 of this introduction considers best practice in drug education according to the research literature, focusing on what is known about the factors that are most likely to impact on actual levels of drug use. Section 1.5 includes an outline of the various national and local guidelines that have been developed to advise schools in Scotland. Although very different in terms of format and origin, these two sources of guidance do not differ enormously, and it is likely that drug education which reflected the highest level of practice according to current national advice would not be dissimilar to that recommended by the literature.

Most schools already claim to provide drug education in line with current national advice but this information is based on self-reports by schools to local authorities, and on self-reports from local-authorities to the Scottish Executive (Scottish Executive, 2002b). Elsewhere, similar self-report mechanisms have proved an unreliable method of assessing actual practice in relation to school drug prevention, as schools or authorities may feel under pressure to make improvements on their figures each year (Ashton, 1999; Chen, 1997). In addition, while the four documents that make up "current national advice" are named in the notes of the press release, it is not clear if they were named in the surveys to schools or if further information was provided. Schools' understanding of the details of this advice is therefore not clear, nor is how they interpret such advice and put it into practice.

Previous studies of drug education in Scotland have been primarily outcome oriented, and have not focused on the processes of drug education planning and delivery in schools or on how or why schools make particular decisions about drug education. Coggans et al., (1991) recognised this and recommended further research to assess what distinguishes a more effective school from a less effective one in relation to drug education.

Lowden and Powney (2000) found that current approaches to drug education and the quality of such education varied widely between schools and even between individual teachers in the same school. They recommended further investigation of the impact of factors such as school ethos and the influence of school management. They also reported a lack of complex and focused studies that could account for the contextual processes that affect drug education. There are other unknowns. Where school provision does not match the criteria or guidelines described above it is not known why this is the case, or how willing, prepared or able schools are to change what is done. In other words, despite the huge amount of information that is already available, there are still questions about drug education practice in Scotland that remain to be answered.

To answer these questions, at least in part, drug education in secondary schools in the Grampian region of north-east Scotland was examined under three headings: policy, planning and practice. Thus, the overall aim was:

> To carry out an in-depth study of policy, planning and practice of drug education in secondary schools in Grampian, Scotland.

While this broad aim was identified in advance of any fieldwork, more specific research questions continually emerged and changed throughout the period of research. This process of emergence of the focus of the research is discussed further in Chapter 2, as it is a recognised feature of the methods used in this study. In the interests of clarity however, Table 1.12 is presented overleaf as a useful conceptualisation of the main issues investigated and as an insight into the aspects of policy, planning and practice that were considered.

Research Issues
General
How does drug education compare to the criteria laid out in research findings (Section 1.4) and in national and local guidelines (Section 1.5)?
What facilitates and hinders best practice in drug education?
At what levels of drug education is there any parent, family, or community involvement?
Policy
What policies exist at school and local level for drug education and how are they developed?
Who and what influences school decisions on drug education?
How do such policies and influences affect ongoing drug education practice?
Planning
How is drug education planned and organised both at programme and individual lesson level?
How do schools identify and/or take into account pupil needs and experiences?
What do schools and staff identify as the goals of drug education?
How is drug education monitored or evaluated by schools?
What feedback mechanisms are in place in relation to drug education?
Practice
To what extent is drug education delivered as planned?
What approaches, messages, lesson content and resources are used in drug education?
Who delivers drug education in schools and what training do they receive?
How does delivery vary between different deliverers, pupils and schools?
What teaching methods and group processes are used in drug education?
What level of openness and confidentiality exists in classrooms when discussing drug use issues?

Table 1.12: Issues Considered in this Research.

Chapter 2. Methodology

The purpose of this chapter is to explain and describe the methodology used in this study. It begins with a brief introduction to qualitative research, its philosophical underpinnings and key features. The chapter continues with a discussion of the selection of the particular research methods used in the study and concludes with a detailed description of how the interview study and case study were designed, developed and implemented. The decisions described throughout this chapter are further discussed in Chapter 5 with particular reference to their relevance to validity, reliability and ethics.

2.1. The Tradition of Qualitative Research

The term "qualitative research" is used to describe research that produces findings not arrived at by means of statistical procedures or other means of quantification (Strauss and Corbin, 1990). Murphy et al., (1998) note that the origins of qualitative research are as old as human civilisation itself, in that our ancient ancestors would have studied the world around them using their native senses in precisely the same way as we do today. We engage in qualitative enquiry each time we use our eyes and ears to watch and to listen and our voices to ask questions, in order to find out about a person, place or phenomenon.

Qualitative research can be found in all the social sciences, including anthropology, psychology, sociology, economics, geography, politics, education and law. It is a highly contested field in which there are extensive disagreements about the nature, purpose, status and practice of its methods. To attempt to describe these issues in any way comprehensively would require scholarly activity far beyond both the scope and purpose of this text. This section is an attempt, rather, to provide an introduction to the nature, purpose and methods of qualitative research that are most relevant to the work reported here. It is therefore, necessarily, a selective representation of qualitative research that seeks to be functional rather than comprehensive. Those who wish to consult a more comprehensive review are directed to the wide range of excellent general texts on the topic. For beginning qualitative researchers, Creswell (1990), and Cohen and Manion (1994), are recommended.

2.1.1. Philosophical Basis

Debates about qualitative research often refer to the ontological and epistemological assumptions that underpin the field. Ontology refers to assumptions about the form and nature of "reality" - whether it is external to the individual or the product of an individual's consciousness. Epistemology refers to claims as to how knowledge about reality may be gained; it considers the form and nature of knowledge. Epistemology is therefore defined by ontology, and both influence choices about methodology (Norton, 1999)

Simply put, there are two broad ontological approaches to social enquiry which are described as realist and constructivist (Blaikie, 1993). Realist ontology sees social reality as independent of the researcher. It assumes that reality is ordered and that it is possible to observe and explain uniformities in it. Stemming from this is the tradition of positivism on which natural sciences rely, where knowledge is seen as hard, objective and tangible. Positivist research assumes that a researcher may study an object without being influenced by it and without that object being affected by the researcher. Experimental hypotheses are stated in advance and bias is controlled methodologically. The assumption is that it is possible to state objective truths about the material world (Norton, 1999).

In contrast, in the constructivist paradigm, reality and knowledge are constructed by individuals or groups rather than discovered. While most qualitative researchers accept that there is an objective material world, as do realists, they contend that what matters in social sciences is what people perceive or believe rather than what might ultimately be true (Murphy et al., 1998). As Creswell explains:

> Knowledge is within the meanings people make of it; knowledge is gained through people talking about their meanings; knowledge is laced with personal biases and values; knowledge is written in a personal, up-close way; and knowledge evolves, emerges and is inextricably linked to the context in which it is studied.
>
> [Creswell, 1998]

Thus, in the constructivist view there can be multiple realities as people perceive things differently, not just through ignorance but because meanings are determined partly by experience (Stake, 1995).

Social realities are inseparable from context, as well as from the researchers who investigate them, not least because each individual researcher observes and constructs reality while influenced by their own personal characteristics and experiences.

2.1.2. Key Features of Qualitative Research

Qualitative researchers sometimes refer to data generation, rather than collection, to encompass the constructivist view that knowledge about the social world is not a single, fixed objective phenomenon waiting to be discovered, observed and measured by the astute researcher (Merriam, 1988). Rather, data are generated and the nature and detail of resulting knowledge depends on the process and contexts of this generation. In qualitative research, data generation most commonly involves the use of interviews and observation; however documents, books, artefacts and visual materials are also analysed in many studies.

Qualitative research varies in the extent to which hypotheses and even methods are decided upon in advance of data generation. Traditionally, the design of a qualitative study begins by planning a *general* approach to a problem or research issue which one would like to investigate. Creswell explains:

> To study the topic, we ask open-ended research questions, wanting to listen to the participants we are studying and shaping the questions after we "explore" and we refrain from assuming the role of the expert researcher with the "best" questions. *Our questions change during the process of research to reflect an increased understanding of the problem.*
>
> [Creswell, 1998; emphasis added]

Thus, qualitative research is inductive in nature: the researcher generally does not try to form theories or hypotheses in advance of data collection (or fieldwork) but rather induces such theories from the data that are generated. The design of a qualitative study is often described as "emergent" because the phenomenon of interest emerges over the course of data generation and the researcher must be flexible enough to respond appropriately.

While quantitative research often aims to isolate causal relationships from the contexts in which they occur, qualitative research emphasises the importance of understanding the phenomenon of interest holistically and in context. Much qualitative research is concerned with detailed description of exactly what is going on in a given situation. The setting under study, the participants, and the activity therein are carefully described thus allowing examination of routine assumptions about seemingly familiar social settings. Quantitative data may be capable of establishing whether or not a given input leads to a given output, however if one wishes to understand how this process occurs or why it occurs in one situation but not in another, then qualitative research comes into its own.

Some researchers choose to use qualitative methods based on experience of a particular discipline, such as anthropology, or adherence to a philosophical orientation, such as phenomenology, both of which traditionally advocate the use of qualitative methods. It is becoming increasingly common however, for qualitative methods to be considered in fields as diverse as marketing and medicine, where the nature of the research question dictates it. Some areas of study naturally lend themselves to qualitative types of research, for instance, studies of social interaction or people's experiences of a phenomenon such as illness or religion.

Strauss and Corbin (1990) recommend the use of qualitative methods to uncover and understand what lies behind any phenomenon or to gain novel and fresh slants on things about which quite a bit is already known. Creswell (1998) recommends qualitative methods for when research questions begin with "how" or "what" so that initial forays into the topic describe what is going on. There are research questions which cannot be answered adequately using numbers or statistics, but require the depth and rich description characteristic of qualitative research.

2.2. Choice of Research Methods

The overall focus of this research project, as identified in Section 1.6 was to investigate drug education policy, planning and practice in secondary schools in Grampian.

Previous studies of drug education in Scotland (Section 1.5.3) primarily used survey methods (Coggans et al., 1991; Lowden and Powney, 2000) and while they provided a valuable overview, the authors noted that the level of detailed information that they were able to gather in such survey-based work was limited. In particular, surveys are of limited value in situations where meanings are unclear or not universally shared. Accordingly, a survey method was considered unlikely to illuminate the complex processes and social realities that were the focus of the current study.

In contrast, the issues under investigation were believed to naturally lend themselves to qualitative research, which would allow the answers sought to be conveyed in context, with rich description and depth rather than with numerical data. To use an example, the first focus of this study was school policy on drug education. The research did not aim to find out what percentage of schools had a policy on drug education, but rather sought to elucidate the nature and content of school policy, how it was developed and agreed upon, and how it was used and reflected in the drug education practice of the school. A simple "yes" or "no" answer, or a "tick-box" questionnaire would not illuminate this sufficiently and open-ended survey questions would make unrealistic demands of any respondent if a comprehensive answer was to be provided. This conclusion was supported by the recommendations of Lowden and Powney (2000) who noted that schools in the UK are increasingly being surveyed by various organisations, especially on health-related projects. This has led to growing research fatigue and falling response rates for surveys. Resnicow et al., (1998) also found that classroom observation was a more valid method for measuring the implementation of school health curricula than teacher questionnaires.

Thus for both epistemological and practical reasons, it was decided that qualitative, rather than quantitative, methods of social inquiry, would be most appropriate for investigating the research issues identified in this study.

A two-part design was decided upon.

Firstly, qualitative interviews would be used in a number of selected Grampian secondary schools to gain insight into drug education policies, planning and practice in the schools. Qualitative interviews - as well as involving face to face interaction thus building rapport - allow in-depth consideration of issues and are flexible enough to be adapted to any school circumstances. The issue of rapport is crucial to the quality of this kind of study, and is discussed further in Chapter Five. Secondly, one school would be selected as the focus of a case study, to allow first-hand observation of drug education as it is delivered over a period of time in the school. It would also allow in-depth interviews to be carried out with a wider range of stakeholders in drug education – pupils, staff and the rector.

These two classic qualitative methods complement each other in that the interview study would allow the researcher to gain insight into a broad range of schools of different sizes and locations while maintaining a depth not found in survey methods. The case study would look deeper still, not simply asking respondents what they (think they) do and why but actually examining what happens in the school, how different teachers approach drug education, how pupils react to different teaching methods, and how staff and pupils view the drug education.

Thus, the combination of methods would not only provide a broad sense of perspective on the research issues across a number of schools but would also allow them to be explored in great depth, all within the given timeframe. Therefore, again for reasons both epistemological and practical, this combined approach was felt to be an appropriate choice for this study.

2.3. Permissions for Study and Ethical Approval

A letter (Appendix 2.1) was sent to the directors of education in each of the three local authorities in the region outlining the background and aims of the study, and requesting permission to carry out the fieldwork. All three responded positively to the research and gave permission for the researcher to contact schools directly.

The regional ethics committee were contacted with a view to gaining formal ethical approval for the research. It was indicated, however, that as the study did not involve work with NHS patients or staff, or take place on NHS sites, formal ethical approval was not required. Notwithstanding this, the study was planned and carried out to the highest ethical standards as discussed in Section 5.4.

2.4. INTERVIEW STUDY

2.4.1. Initial Focus

As the first part of the two part research design discussed in Section 2.2, the objective of the interview study was identified as:

> To carry out in-depth, semi-structured interviews with appropriate staff on drug education policy, planning and practice, in a broad range of secondary schools in the Grampian region.

This broad objective formed the basis of the interview study, however more specific questions and areas of interest emerged both in advance of fieldwork (via the literature) and over the course of the study as the interviews and data analysis progressed. Perhaps common in doctoral research generally due to the evolving nature of the researcher's expertise, this constant evolution of the focus of investigation is a well-recognised feature of qualitative research, as discussed in Section 2.1. In fact, it is crucial to the quality of the research that the researcher does not make too many presumptions about the topic in advance of speaking with respondents. This issue is considered further in Chapter 5. The initial specific areas of interest, identified from extensive study of the drug education literature as requiring further investigation and research are summarised in Table 2.1. Each of these areas was considered in terms of how feasible it would be to include within the constraints and timeframe of PhD research, how relevant and useful each option would be to practitioners and the field of drug education research, and the researcher's own personal inclination towards researching the topics.

Areas of Interest
1. The impact of particular teaching approaches on the effectiveness of drug education
2. How/if schools tailor drug education to meet the needs of individual pupils
3. The effectiveness of drug education training available to teachers
4. The influence of school ethos and management on drug education processes in schools
5. How the teaching of drug education differs from/compares to that of traditional school subjects
6. How drug education is assessed and evaluated by schools

Table 2.1: Areas of Interest

After such consideration and consultation with other researchers, it was decided that it would be most feasible, useful and personally interesting for the researcher to focus initially on the second area identified above – how/if schools tailor drug education to meet the needs of individual pupils. In addition, given the overlapping nature of the research options, it was apparent that insight would also be gained into topics four and six – ethos and management, and assessment and evaluation. Thus having established a broad aim and specific areas of interest, early drafting of an interview guide began.

2.4.2. Initial Development of Interview Guide

Initial drafts of the interview guide were developed by means of subdividing the overall objective of the research into more specific mini-research questions as recommended by Mason (1996) and incorporating the above areas of interest. Each version of the interview guide was examined and re-drafted to improve its relevance, clarity and practicality. As the questions began to take shape, they were grouped into relevant sections and ordered in a logical sequence. A summary of the interview guide, as it was used for the expert consultation and pilot interviews, is illustrated in Table 2.2 (overleaf). The full draft guide can be found in Appendix 2.2.

Summary of Interview Guide Prior to Pilot Study
Introduction
• Aims, background to research and interview topics.
• Data management and feedback procedures of the research project
• Confidentiality guarantee for respondent
Section I – Background Information
• Respondents' role in drug education
• Discussion of prevalence of substance misuse locally and among pupils
Section II – Drug Education Policy Development
• School policy on drug education and how it was developed
• Pupil involvement in development
• Future plans for policy development and pupil involvement
Section III – Pupil-Centred Drug Education
• How the drug education policy is applied in the classroom
• Resources (in-house or other) used by the school in teaching drug education
• Use of prevalence information in lesson planning
• Involvement of pupils in lesson planning
• Tailoring of drug education to different pupils and pupil choice
• Harm reduction in drug education
• Openness in drug education lessons
• Use of interactive teaching methods in drug education lessons
• Peer education and peer support
Section IV – Conclusions
• Pupil satisfaction
• Any additional comments

Table 2.2: Summary of Early Draft of Interview Guide

2.4.3. Expert Consultation

A number of "independent experts" with a range of relevant experience were identified and were sent the draft interview guide for review as recommended by Appleton (1995). They were also provided with a flowchart of the topics for the interview, a document outlining the objectives of the interview and the planned procedures and a form for their feedback (Appendices 2.3, 2.4, 2.5, respectively). The individuals who were invited to comment held the following positions:

- Research Officer/Project Manager, Scottish Council for Research in Education
- Lecturer, School of Applied Social Studies, The Robert Gordon University
- Lecturer, National Addiction Centre, King's College, London
- Health Promotion Specialist (Schools), Health Promotions, Grampian Health Board
- Reader, Health Services Research Unit, The Robert Gordon University
- Professor, Department of Psychology, University of Aberdeen

The documents were also reviewed by members of the research supervisory team. Consulting independent experts in this way allowed the researcher to draw on their knowledge and experience of research methods of this kind and of drug education both nationally and locally. This helped to minimise the effect of any personal bias on her part. Comments on the interview guide and plans were received in various formats from these reviewers and are summarised here:

(i) Length of Interview

The reviewers commented that the interview guide was quite long, and therefore the interview would probably also be lengthy. They suggested merging some questions, and informing respondents in advance of the length of the interview to avoid any misunderstandings during the actual field work.

(ii) Structure and Order of Questions

Some of the reviewers suggested a change in the order of questions, the wording of parts of the interview guide and/or a simplification of the directions for the interviewer.

(iii) Suggestions for Additional Questions

Additional questions were suggested on teacher training, the use of outside speakers, differentiation according to educational capabilities, and the impact of national drug education policy.

(iv) Procedures for Arranging the Interviews

The reviewers suggested interviewing teachers as well as the health education co-ordinators, advising the respondents of the topics in advance and approaching the head teacher before any individual teachers.

(v) General Advice

Finally, the reviewers cautioned about the nature of qualitative research and offered a reminder to emphasise the experiences as well as the opinions of respondents, and that a standardised interview guide might not be appropriate for all schools.

All of the comments received were considered carefully and were used along with the feedback of the pilot respondents (see below) to amend the interview guide and the procedures used for arranging and carrying out the interviews. These amendments are described below in Section 2.4.5.

2.4.4. Pilot Interviews

Before approaching schools in Grampian, pilot interviews were carried out in a convenience sample of three schools outside of the region in September 2000. In this way, the procedures and questions used in the interview could be tested in advance of any interviews in the targeted region and the researcher could gain insight into the Scottish secondary school setting. A profile of each of the pilot schools is included in Table 2.3 (overleaf).

Profile of Pilot Schools			
	School 1.	**School 2.**	**School 3.**
Local Authority	West Dunbartonshire	East Dunbartonshire	East Dunbartonshire
Respondent's Position:	Principal Teacher of Guidance	Health Education Co-ordinator	Assistant Head Teacher
New Community School?	No.	Yes.	Yes.

Table 2.3: Profile of Pilot Schools

A general enquiry was made with personal contacts in each school to identify a potential respondent and this person was then contacted by telephone to request an interview and if possible, arrange a suitable time. All three potential respondents agreed to be interviewed and were then sent further details by facsimile including:

- a letter confirming the time and date of the interview
- a document outlining the objectives of the work and the topics that would be covered in the interview
- a list of documents that would be reviewed or of which copies would be required, if available
- a draft of a letter that would be used to contact respondents prior to interview

The pilot respondents were asked to look over the list of topics and discuss them with colleagues if necessary. They were also asked to gather together any relevant documents if time permitted them to do so. Finally, in relation to the draft letter, they were asked to read over it with a view to giving their opinion on its content, tone and suitability.

The procedures for the pilot interviews were broadly the same as for the main Grampian study that are described below. Each interview was semi-structured with the (draft) interview guide being used only as a reminder to the interviewer as to potential issues of interest. The introduction to the interview was explained orally, again using the prepared script only as a guide and subsequent topics were covered in a fluid fashion, as they were introduced by the respondent. As a result, the order of topics was unique to each interview.

The interviews were audio-taped, transcribed, stored and analysed in a similar way to that described in Sections 2.4.8 and 2.4.9 below. After each pilot interview, the respondents were asked to give their impressions of the interview, the style of questioning used and the procedure proposed for the organisation of the main study interviews. The comments received are summarised below.

(i) Technique and Rapport

Asked what they thought of how the interview was conducted and the questions asked, none of the three pilot respondents suggested any changes, although one did comment that some respondents might be defensive about questions on drug education policy if their school did not have a policy at that time. Overall, the pilot respondents were very positive in their assessment of the actual interview process and how it was managed by the researcher.

> I thought the questions were good. I thought your questioning technique was excellent.
>
> Health Education Co-ordinator, pilot school 2.

(ii) Procedures for Arranging the Interviews

One pilot respondent suggested including a timeframe in the initial letter sent to the schools. He also commented that the offer to make respondents aware of the results of the study for the area was a valuable incentive that would have ensured his positive response to an initial letter. Another respondent confirmed that an initial letter followed by a phone call would be the most appropriate way to approach schools.

(iii) Other

One of the pilot respondents noted that he was more comfortable answering questions about policy than he was about the exact content of the lessons. He noted:

> You would have perhaps got more detail from one of the PSE teachers who is directly involved in teaching the lessons...Because I'm not directly involved in delivering the courses, there may be inaccuracies, which if it had been something for real [not a pilot], I would have ensured I had more checking done.
>
> Health Education Co-ordinator, Pilot School 2

The amendments made to the procedures used for arranging the interviews and the interview guide itself as a result of the pilot study are described in the next section. The pilot interviews also served an important purpose in helping the researcher to build rapport with respondents, gain in understanding of relevant issues and build confidence in conducting qualitative interviews of this kind. Sections 5.1.3 and 5.3.1 include further discussion of the motivation for using pilot interviews in terms of their value to the quality of the research as a whole. Appendix 2.6 summarises the issues that emerged following analysis of the pilot study data.

2.4.5. Further Development of Procedures and Interview Guide

After the expert consultation and pilot interviews, the procedures for arranging and carrying out the interviews were reviewed and adjusted. It was decided that it would be most appropriate if head teachers were the first point of contact for each school. The initial letter to head teachers would ask them to identify an appropriate person for interview, who would then be contacted to arrange a time and date. In an effort to curb the time required for the interview and the resultant burden of transcription, this request to head teachers did not suggest interviewing more than one respondent; however two respondents were interviewed when this was suggested by a school. Once the interview had been arranged, respondents were sent a facsimile to confirm the arrangements for the interview which also informed them that it would take approximately one hour, and that if they were unable to be present for that time, they should contact the researcher to re-schedule. Samples of the letter to head teachers and the confirmation fax for respondents are included in Appendices 2.7 and 2.8 respectively.

At this stage, the interview guide was once again examined and re-drafted, bearing in mind the comments of both the independent experts and the pilot respondents. As in the pilot study, the interview guide was not used as a verbatim "tool" for "collection" of information. This meant that changes to individual words or the order of particular questions in the guide would have little impact on how they were asked during the actual interview. Nonetheless, the use of the interview guide in this flexible way requires the interviewer to monitor what has been asked and answered, what has still to be covered, and the time remaining in the interview while always remaining attentive and interested in the continuing conversation.

Failure to do this competently could have adversely impacted on reactivity issues such as emotional valence and the sense of importance attached to the interaction. These issues are discussed further in Section 5.1.3. It is vital therefore that, to aid the interviewer, the guide is as clearly and logically structured as possible and the amendments that were made reflect this.

The new interview guide covered the same broad topics, along with a general request for a description of the school and an additional question on teacher training. General open-ended questions were introduced at beginning of each section, to allow the respondent to speak freely. Subsequent specific questions could then be skipped if they had already been answered by the respondent. The division of the guide into sections was also slightly changed. The section on "pupil-centred drug education" was removed and the questions in it were placed in two new more general sections on drug education planning and lessons. This was an important change as it allowed respondents to describe the planning and lessons of the school's drug education in their own terms without it being framed within a description and concept imposed by the interview guide. The respondents' own descriptions could then be analysed in due course to allow the data to suggest the level of "pupil-centring" that existed. Table 2.4 (overleaf) provides an overview of the interview guide following this work. This guide was used in the first interviews in Grampian schools and the full text is available in Appendix 2.9.

Over the course of the main study interviews, the interview guide was continually amended and re-drafted as the data were analysed and the research issues evolved. It would neither be interesting nor useful for the purposes of this text to describe all the changes that were made and the reasoning behind them and so this is not attempted here.

Summary of Interview Guide Post Pilot
Section I – Introduction
• Aims, background to research and interview topics
• Data management and feedback procedures of the research project
• Confidentiality guarantee for respondent
• Description of school, locality, pupil profile
• Respondents' role in drug education
• Discussion of local prevalence of substance misuse
Section II - Policy Development
• School policy on drug education and how it was developed
• Pupil involvement in development
• Priority topics for personal and social education in the school
Section III - Planning of Drug Education
• Planning and organisation of drug education in the school
• Involvement of pupils in planning
• Monitoring and evaluation of drug education
Section IV - Drug Education Lessons
• Teaching methods and activities in drug education lessons
• Practice, skills and training of teachers
• Tailoring of drug education to different pupils and pupil choice
• Harm reduction and openness in drug education
• Openness in drug education lessons
• Peer education
Section V – Conclusions
• Effectiveness
• Pupil satisfaction
• Any other issues

Table 2.4: Summary of Interview Guide Post Pilot

The very last of these drafts which was prepared after seven main study interviews is available in Appendix 2.10. It is important to note however, that while the researcher had clearly identified areas of interest in order to develop initial drafts of the interview guide (as discussed in Section 2.4.1), each new draft became more general and less focused on these areas. This is reflected in the changes described above and continued to be the case as the main study interviews progressed. Once again, this illustrates how in a qualitative study it is initially the respondents rather than the researcher who highlight the relevant issues as they are better placed than the researcher to identify (at least from their perspective) the important issues for *their* school. Of course, this makes the careful selection of respondents even more crucial to the success of the research.

2.4.6. Selection of Schools

Initially, schools were selected for the interview study by theoretical sampling for maximum variation, that is, schools were purposely chosen in a way most likely to shed light on the research questions and to provide a comprehensive range of perspectives. Key contacts in the advisory services at each of the three local authorities in Grampian were asked to identify a range of schools in their region. They were asked to nominate some schools that they considered to be innovative in their drug education provision, some that they considered to be less innovative and some they considered to have average provision. From these nominations, a range of schools from the most to the least active in drug education and varying in terms of location and size were contacted. After interviews had been carried out with willing schools from this initial sample, it became clear that the research issues would be further illuminated by the selection of the most progressive schools in terms of drug education, as they had experience of overcoming some of the issues and difficulties identified by the less innovative schools. Although this might have biased the data towards a more favourable picture of current practice in drug education, thus affecting transferability to other schools, it was felt that it was important to study the leading edge of change in the field (Section 5.3.1). It also became clear that rural schools were somewhat under-represented in the data. The same key contacts were then asked to nominate further schools in accordance with these criteria.

A summary of the schools in which interviews were carried out is shown in Table 2.5. The interview transcripts were continuously analysed and further interviews arranged until the analyses resulted in few new key themes emerging and the resultant descriptions and explanations of drug education in schools were considered by the researcher to be sufficiently detailed to address the research questions.

Profile of Schools for Main Study Interviews

	Local Authority	Location/Description	Size*	Respondent, Position *(All names have been changed.)*
School 1	Aberdeenshire	Rural town	Large	Mary, PT** Guidance
School 2	Aberdeen City	Suburban	Large	Angela, PT Guidance Bob, AHT***
School 3	Moray	Rural village	Small	Paul, PT Social and Vocational Education
School 4	Aberdeen City	Suburban	Medium	Doug, AHT
School 5	Aberdeen City	Suburban, deprived area	Small	Fiona, AHT
School 6	Aberdeenshire	Rural town	Large	Robert, PT Guidance
School 7	Aberdeenshire	Urban town	Medium	Tom, PT Guidance Karen, AHT
School 8	Moray	Rural village	Medium	James, Scott, PTs Guidance
School 9	Aberdeenshire	Rural town, new community school.	Large	Calum, Simon, PTs Guidance

* In this table: >1000 pupils = Large; >500 pupils = Medium; 500 pupils or less = Small

** PT = Principal Teacher

*** AHT = Assistant Head Teacher

Table 2.5: Profile of Schools for Main Study Interviews

2.4.7. Selection of Respondents and Procedures for Interviews

In each school, the head teacher was initially contacted by post to inform him/her of the study and to request permission to interview staff. The head teacher was then phoned to confirm receipt of the letter and to find out if permission had been granted. If so, the head teacher was asked to identify the person(s) in the school who would be best able to discuss the topics of the interview.

Of the twelve schools approached, three refused to take part on the grounds of lack of time and the implications of this are discussed further in Section 5.3.1. When the interview had been arranged with selected staff, they were faxed confirmation of the time and date and a short guide listing both the topics to be discussed and any documents that would be helpful to the research. On the day of the interviews, the background, aims and purpose of the study, how the data would be recorded and used and arrangements to protect the identity of the respondents were discussed prior to any questions being asked. A consent form was developed which the respondents were asked to sign, stating their understanding of the research and the above arrangements. The consent form is reproduced in Appendix 2.11. Interviews for the main study were carried out between November, 2000 and May, 2001.

2.4.8. Data Management

Each of the interviews, which lasted between one and two hours, was audio taped and subsequently carefully transcribed in full. The transcripts were then "tidied" to remove redundant words and phrases, though the content was maintained in the vernacular and no attempt was made to "correct" the language. Efforts to protect the confidentiality of the information included the secure storage of original tapes and paperwork, and the protection of electronically stored documents with passwords. A second "anonymised" version of each transcript was prepared, with all identifying information (except for a code number) removed. Careful data management procedures are central to ensuring reliability in qualitative studies (Section 5.2).

2.4.9. Data Analysis

Where possible the interviews and data analysis were carried out in what Creswell (1998) has described as a "zigzag" process. This process involves the researcher carrying out an interview, analysing data and how it contributes to themes and then going back to the field for another interview to develop the themes further. Thus, the interview, and therefore the interview guide (and interviewer), continue to adapt to the themes that are emerging. The transcripts and any accompanying documentation were initially analysed using a variation on the procedures used in grounded theory research (Strauss and Corbin, 1990; Glaser, 1992).

Each transcript was read several times as recommended by Agar (1980) "to immerse [the researcher] in the details, trying to get a sense of the interview as a whole before breaking it into parts". As this reading was done, annotations were placed in the margins of the document or in later interviews directly into the transcript using a different colour from the text (blue). These annotations consisted of short phrases, ideas or key concepts that occurred to the researcher. Given the quantity of data generated from even one interview (typically thirty pages of transcribed text), this process of reflection, annotation and thought was a lengthy one and very much human one which is largely unaided by any technological advances. Where technology did help however was in the use of the computer software for qualitative data analysis NUD*IST VIVO (QSR International Pty. Ltd., 2000), more commonly known as "NVivo", to ease the task of categorising and then reviewing all segments of text relating to each particular theme. Initially, a project file was created into which all transcripts were loaded. As the transcripts and notes were subsequently re-read, phrases and sentences were highlighted (in red) in the N-Vivo based documents where they discussed various themes. Appendix 2.12 contains an extract from one analysed transcript that illustrates the colour coding. These phrases and sentences were later grouped together under broader headings or categories using the nodes function of the software. This allowed the researcher to select any theme and produce a document containing all the interview quotes relevant to that theme. An extract from one such document is included as an example in Appendix 2.13. These categories were developed into a framework of themes and sub-themes, which went on to form the basis of the results of the study. A full list of nodes (categories) for both the interview study and the case study is provided in Appendix 2.14. A detailed discussion of how NVivo is used as an aid to data analysis is provided in Richards (2000) and Fraser (2000).

2.5. Case Study

2.5.1. Objectives

As the interview study drew nearer to completion, the focus of the research turned to the planning of a case study of one of the secondary schools in the region. As discussed in Section 2.2, the case study was designed to complement and expand on the understanding of drug education already gained in the interview study.

In particular, the objectives of the case study were:

(i) To participate in drug education lessons as a primarily passive observer and record the interaction and content of those lessons

(ii) To investigate the views of teachers and pupils on observed drug education lessons and drug education in general.

(iii) To observe and investigate the implementation and delivery of a drug education curriculum over the course of a few months in a school under normal conditions[vii], including relevant documentation.

2.5.2. Selection of Case Study School

During the interview study, the representatives of each school were questioned about the possibility of the school being involved in further research on drug education as the focus of the planned case study. All of the respondents reacted positively to the possibility resulting in a total of nine schools that were considered for selection as the "case study school". The final decision was made on the basis of the following criteria:

(i) Distance from Aberdeen

Some of the schools where the interviews were carried out were up to two hours driving distance from Aberdeen city where the researcher was based. It was not considered possible financially or practically to carry out the case study in those schools. This distance in effect ruled out four of the nine schools from the selection process.

(ii) Major Upheavals

One school was involved in merger talks with another school. It was felt that any data collected on the drug education at such a turbulent time might not be reflective of "normal conditions" at the school (see footnote). This left a choice of four schools.

[vii] The issues of whether any state that could be considered "normal conditions" actually exists and if so, what would constitute such "normality" are open to debate, however in this context, it was intended to exclude from the case study any school in which extraordinary or major upheaval was taking place. Such major upheavals would include events such as a merger with other schools, move to new premises or an outbreak of disease. Other changes such as curriculum development or change of staff responsibilities were considered to be part of the "normal" school cycle and as such, did not preclude a school from selection as the case study school.

(iii) Innovative or Progressive drug education.

Of the four remaining schools, two were considered to be of particular interest. One had a well-established programme of peer-led drug education, in which sixth year pupils were trained to deliver drug education lessons to each second year class. The second school of interest had large numbers of pupils considered at risk for drug misuse and high levels of drug and alcohol use among pupils and their families. Both the issue of peer education and of dealing with vulnerable pupils have been widely discussed in the literature and have been considered as meriting close attention. Thus, the final choice of case study school was narrowed to these two schools.

(iv) Rapport with existing contacts in the school.

The rapport that existed between the researcher and the respondents who had already been interviewed in each school was expected to be crucial to the success of the case study (Section 5.1.3). It was considered likely that the interview respondent in the school would act as "gatekeeper" for the case study school, arranging introductions to other drug education staff and making arrangements for the fieldwork in the school. Though rapport had been good with both of the respondents in the remaining schools, the school in which provision included a peer-led drug education programme, had been visited twice and the respondent had been particularly accommodating. That respondent was considered to be more likely to facilitate the researcher in observing lessons and accessing pupils for feedback and it was therefore decided to approach her with a view to carrying out the case study research in that school.

The advantages of using these selection criteria are discussed in Chapter 5, along with consideration of any disadvantages.

2.5.3. Preparation and Access

Once the school had been selected, two meetings were arranged with the interview respondent in the school. As predicted, she took on the role of gatekeeper, arranged permission from the rector, and informed other relevant staff.

Initial visits to the school were arranged around a weekly guidance team meeting at which all six of the principal teachers of guidance (who, apart from outside speakers, delivered all of the drug education in the school) were present. The first visits allowed timetables both of individual teachers and of the drug education curriculum for each year group to be collected. As the study progressed, each visit to the school was planned and negotiated in advance using these timetables.

In addition, over the first few visits a document was drawn up detailing the background, aims and methods of the case study and outlining the ethical commitments of the researcher (and also partly of the participants). The content of this document was negotiated and agreed with the guidance team. A letter was prepared to inform parents of the research which was distributed to all pupils in the school. The ethical agreement and letter for parents are reproduced in Appendices 2.15 and 2.16 respectively. Finally, a short notice was placed in the school bulletin to let all staff know about the research.

2.5.4. Data Generation

This case study generated data from four main sources: (1) General Observations, (2) Lesson Observations, (3) Pupil Feedback, and (4) Staff Feedback. These data were generated over the course of twenty-five days spent in the school between August 2001 and January 2002.

2.5.4.a. General Observations

While in the school, the researcher was given access to a desk in the office shared by two of the guidance team and was provided with a key to this office. This location allowed her to observe these two teachers in their daily work. The researcher also attended seven of the weekly guidance team meetings. These allowed her to update the teachers on her research, but also allowed her to observe the team dealing with issues as they arose both in relation to drug education and many other topics. Finally, the researcher spent some time with each member of the guidance team over the course of the fieldwork, chatting informally on the way to or from lessons or during break and other free times. An extract from the researcher's general observation notes can be found in Appendix 2.1.7.

2.5.4.b. Lesson Observations

The selection of drug education lessons for observation was a complex task, involving intensive study of each timetable, planning and time management. In the end, the lessons were selected to ensure that the broadest range was observed over the course of the case study. Most of the lessons observed involved second and third year classes as the bulk of the drug education curriculum of the school was delivered at those stages. Two peer-led sessions of the second year drug education programme, led by two different groups of sixth year leaders were observed, as were the sessions in the second year programme delivered by the schools' police liaison officer. Within the third year programme, lessons were selected to ensure that no part of the curriculum was omitted from observation. In addition, the whole sequence of lessons was observed with one class and teacher ("3L") while they went through the complete third year drug education curriculum as planned by the school. All of the guidance teachers were observed at least once and a smaller number of lessons were observed in fourth and fifth year. This care was taken to minimise any bias that could have arisen from the method of selection of lessons. The implications of the selection are discussed further in Section 5.3.2.

Table 2.6 (overleaf) provides a profile of the drug education lessons that were observed over the course of the study. Also observed as part of the data generation were training sessions that were provided to the sixth years who had volunteered to participate in the school's peer-led drug education programme. These are also shown in Table 2.6.

During classroom observation, the researcher typically took a seat to the side or the rear of the room and did not attempt to participate in the lesson unless asked to do so. On some occasions during the lessons, the teachers themselves referred to the researcher, either to confirm facts or to request help with the provision of certain factual information. The researcher answered the questions politely, but did not attempt to maintain any involvement in the lesson. During small group work it became necessary for the researcher to take a slightly more active role in order to observe the interaction of the groups. Depending on the situation, she moved from group to group, listening, and occasionally asking the pupils what they were doing. During this time, the pupils sometimes asked her questions on the topics which they were discussing. An extract from the researcher's lesson observation notes can be found in Appendix 2.18.

	Date	Class	Delivered By[viii]	Focus of Lesson
Second Year	01/11/01	2C	Constable Gordon Schools Police Liaison Officer	Police Talk on Drugs
	2/11/01	2D	Constable Gordon	Police Talk on Drugs
	13/11/01	2L	Michael, Helena, Steven Sixth Year Peer Educators	Peer-led Drugs Session I&II
	15/11/01	2C	Rachel, Andrew, Alan Sixth Year Peer Educators	Peer-led Drugs Session II
	23/11/01	2A	Sandra, Justin, Rachel Sixth Year Peer Educators	Peer-led Drugs Session II
Third Year	01/11/01	3E	David Kerr	DrugWise Session I
	02/11/01	3L	Tony Morrison	DrugWise Session I
	23/11/01	3L	Tony Morrison	DrugWise Session II
	05/12/01	3A	Ruth Mackay	DrugWise Session II
	06/12/01	3F	Jim Cameron	DrugWise Session IV
	07/12/01	3J	Catherine Baxter	Drugs in Society
	13/12/01	3H	Ann Brown	Worksheet based
	14/12/01	3L	Tony Morrison	DrugWise Session III
	11/01/02	3L	Tony Morrison	DrugWise Session IV
Fourth Year	06/09/01	4K	Jim Cameron	Sorted Video
	13/09/01	4L,M	Tony Morrison, Ruth Mackay	Sorted Video
	18/09/01	4G	Ann Brown	Sorted Video
Fifth Year	22/10/01	5D	Catherine Baxter	Danny's Story Video
	29/10/01	5G	Jim Cameron	Danny's Story Video
Sixth Year	18/09/01	6th Yr	PT Guidance[ix]	Peer Educator Training
	20/09/01	6th Yr	Constable Gordon	Peer Educator Training
	23/09/01	6th Yr	Constable Gordon	Peer Educator Training

Table 2.6 Summary of Lessons Observed

[viii] The names (which have been changed) refer to principal teachers of guidance unless otherwise stated.
[ix] The pseudonym of the PT guidance in this case is not used, as only one teacher was responsible for training the sixth year peer educators and the pseudonym would then no longer protect the identity of that teacher when used for reporting other general or lesson observations.

2.5.4.c. Pupil Feedback

Table 2.7 (overleaf) provides a profile of the pupils who were interviewed during this case study. These pupils were selected in a number of different ways. Most commonly after a drug education lesson, the teacher would ask specific pupils if they were willing to spend part of their next lesson speaking to the researcher about the drug education that they had received. If the teacher enquired as to which pupils the researcher would like to interview, the researcher asked him/her to select those who the teacher felt had contributed to the lesson or would be interesting for the researcher to speak to. In other cases, the researcher was given the opportunity to ask pupils herself if they were willing to participate. In these cases the researcher sought to choose a range of pupils, in terms of gender, and how outspoken they had been in class. Finally, some of the pupils were selected by volunteering, by lottery or by a combination of these methods. The choice of selection method was left to the discretion of the guidance teacher in charge of the class. It is not known exactly what the implications of this mixture of selection methods may have had on the resultant data, but possibilities are discussed in Section 5.3.2. In all cases, it was made clear to pupils before they agreed to be involved that they were free to choose not to participate for any reason.

Most of the pupil interviews took place in groups of two or three pupils in an interview room adjacent to the guidance office where the researcher was based in the school. At the beginning of the interviews the pupils were reminded of the aims and background of the research, the arrangements to ensure confidentiality and their freedom to decline to answer any question or to withdraw their participation at any time without repercussion. The pupils were asked six main questions:

- What do you think of the drug education that you have received in this school?
- Which teaching methods do you think work best in school drug education?
- With which persons teaching it does drug education work best (teachers, sixth year pupils, outside speakers)?
- What level of substance use do you think exists among school pupils?
- Why do you think people take drugs?
- What do you think of harm reduction education?

In addition to these questions the sixth year peer educators were also asked:

- How did the peer-led drugs sessions in which you were involved in go?
- What do you think of the training you received?
- What, if anything, do you think should be done differently in the peer-led drugs programme?

Summary of Pupil Feedback			
	Date	**Class**	**Group Profile**
Second Year	13/11/01	2L	3 pupils, gender not recorded
	15/11/01	2C	3 pupils, gender not recorded
	14/12/01	2A	1 female, 2 males
Third Year	02/11/01	3E	1 female
	02/11/01	3E	1 female, 1 male
	06/11/01	3F	1 female, 2 males
	23/11/01	3L	3 pupils, gender not recorded
	05/12/01	3A	2 females, 1 male
	07/12/01	3J	1 female, 1 male
	13/12/01	3H	3 females
	14/12/01	3L	1 female, 2 males
	11/01/02	3L	2 females, 1 male
Fourth Year	13/09/01	4L, 4M	1 female, 2 males
Fifth Year	22/10/01	5D	2 females
	02/11/01	5G	2 females, 1 male
Sixth Year	20/09/01	Peer Educators	Clare, Justin, David
	27/09/01	Peer Educators	Rachel, Sandra, Helena
	02/11/01	Peer Educators	Helena, Michael
	13/11/01	Peer Educators	Helena, Michael
	15/11/01	Peer Educators	Rachel, Andrew
Total: 20 group interviews with 48 different pupils.			

Table 2.7: Summary of Pupil Feedback

An extract from notes arising from one pupil feedback session is available in Appendix 2.19.

2.5.4.d. Staff Feedback

As the fieldwork drew to a close, each principal teacher of guidance, the rector and the Police School Liaison Officer were interviewed individually by the researcher. The interviews were arranged in advance and each lasted between 20 and 45 minutes. The interviews were based on brief semi-structured interview guides which are summarised in Tables 2.8, 2.9 and 2.10 (on this page and the next). These interview guides were based on the core research question and the issues which arose over the course of the case study. An extract from the interview with the rector is provided in Appendix 2.20.

Summary of Interview Guide for Guidance Teacher Interviews
1. What do you see as the purpose of drug education?
2. Do you think that drug education works?
3. What helps/hinders the achievement of the purpose of drug education?
4. How would you like to see the drug education developing?
5. How are priority topics in personal and social education (PSE) decided?
6. What effect has the move to all-guidance delivery of PSE had?
7. What level of drug/alcohol/tobacco use would you say exists among pupils?
8. How do you try to present a balance of viewpoints when delivering drug education?
9. How easy is it to get active and open discussion going in the classroom about drugs?
10. What do you think about giving pupils harm reduction type information?
11. What effect, if any, will any change in cannabis classification have on drug education?
12. What do you think about involving pupils in planning or developing drug education?
13. What kind of training have you received or would you like to receive?
14. How do you think the McCrone report will affect the delivery of PSE and drug education?
15. Have you got anything to add?

Table 2.8: Summary of Interview Guide for Guidance Teacher Interviews

Summary of Interview Guide for Police School Liaison Officer Interview
1. What do you see as the role of the police (your role) in drug education in schools?
2. What do you see as the purpose of drug education?
3. Do you think that it works? How/why?
4. What helps/hinders the achievement of that purpose?
5. How do you try to present a balance of viewpoints in drug education?
6. What's your thinking behind the level of detail provided in some of your lessons?
7. Are you aware of cocaine and diazepam being commonly used in the area of the case study school? If so, why are these drugs not covered in more detail in lessons?
8. What is your opinion on the action that needs to be taken by teachers if pupils reveal occasional "recreational" drug use in a classroom situation?
9. How happy are you with the training that you have received in relation to drug education?
10. Have you got anything to add?

Table 2.9: Interview Guide for Police School Liaison Officer Interview

Summary of Interview Guide for Rector Interview
1. What is your vision for the school in terms of PSE broadly and drug education?
2. What do you see as the purpose of drug education?
3. Do you think that drug education works?
4. What do you see as your role in the development of PSE/drug education?
5. What defines/influences your decisions/those of the school in relation to drug education?
6. What's your impression of the level of substance use among pupils?
7. What do you think about providing harm reduction information to pupils?
8. What do you think about evaluating/certificating PSE and drug education?
9. What are the issues surrounding the move to all guidance delivery of PSE?
10. What do you think about involving pupils more in discussing/planning/developing PSE and drug education?

Table 2.10: Interview Guide for Rector Interview

2.5.5. Data Management

During general observations, lesson observations and the pupil feedback sessions, the researcher made handwritten notes of the conversation or interaction. These notes were fleshed out from memory and typed up as soon as possible after each day of fieldwork. This allowed the initial notes to be expanded upon or clarified and also allowed the researcher to add her own comments or create memos about the data. Each of the staff interviews was audio taped and subsequently carefully transcribed in full. As during the interview study, the transcripts were then "tidied" to remove redundant words and phrases and were anonymised. All of the data that emerged during the case study was stored in the NVivo project created previously (see Section 2.4.9) which was password protected. All names were changed and code numbers applied to each guidance class so that no individual would be directly identified in any reports emanating from the research and as before, both handwritten and typewritten notes as well as tapes were stored securely to protect the confidentiality of the data.

2.5.6. Data Analysis

All of the data analysis for the case study was carried out within the framework provided by the qualitative data analysis software NUD*IST Vivo. The mammoth task of reflecting on and analysing the hundreds of pages of data generated by the case study began while the case study was still underway and continued for many months afterwards. Each document was read and re-read, and the researcher reflected on the data, notes and memos were added to discuss the various themes and issues that arose. Once again, NVivo was valuable in helping the researcher to organise and maintain control of the analysis process. Phrases and sentences were highlighted in documents where particular themes were referred to and a "node" was created for each theme. All segments of data that related to that theme were then coded at that node. Later, related nodes were grouped together under broader categories known as "tree nodes". The nodes and their content were developed and refined, as data analysis continued, and the tree nodes were re-structured to form a logical framework of themes and sub-themes, which became the basis of the results of the study. As mentioned previously, a detailed discussion of how NVivo is used as an aid to data analysis is provided in Richards (2000) and Fraser (2000).

Chapter 3. Interview Study Results

This chapter describes the information that was generated by the research techniques used in the interview study as described in the previous chapter. The interview study results are presented here without comment as they are considered and discussed in detail in Chapter 6. The themes are organised according to the headings used in Table 1.9 to allow easy comparison with features of best practice in drug education. For each theme, a short outline is provided of what was found in the study, and a general indication is given of whether the theme was found in only one school or in most of the schools in this study. Following this outline, one or more extracts from the interviews are presented that best illustrate the theme and the common or opposing reports of different respondents.

The selection of extracts follows the guidance of Wolcott (1990) on writing up qualitative research. He notes the "misguided tendency among qualitative researchers to let informants rattle on in the written account, just as they may have done during their interviews" and advises that "brief quotes are more effective than lengthy ones especially when multiple speakers are being quoted on the same issue". In this text, the author has sought to use multiple quotes only when additional ones add something new or different to the discussion, rather than repetitiously illustrate the same point. It is important for the reader to remember that the number of quotes on each theme is not a reflection therefore, of how frequently the theme came up in the interviews, but rather how many different situations or opinions were reported in relation to that theme. The advice of Wolcott to writers of qualitative research was borne in mind:

> Most of us see and hear our informants as we enter their words onto a manuscript. We forget that our readers cannot do that; for them, the words remain lifeless on the page, and the repetition of materials that are virtually identical becomes tedious.
>
> [Wolcott, 1990]

This section of the study was based on interviews in nine schools throughout Grampian, as described in the previous chapter. The schools and respondents are described in Table 2.5, which is reproduced here for easy reference.

Profile of Schools for Main Study Interviews				
	Local Authority	**Location/Description**	**Size***	**Respondent, Position** *(All names have been changed)*
School 1	Aberdeenshire	Rural town	Large	Mary, PT** Guidance
School 2	Aberdeen City	Suburban	Large	Angela, PT Guidance Bob, AHT***
School 3	Moray	Rural village	Small	Paul, PT Social and Vocational Education
School 4	Aberdeen City	Suburban	Medium	Doug, AHT
School 5	Aberdeen City	Suburban, deprived area	Small	Fiona, AHT
School 6	Aberdeenshire	Rural town	Large	Robert, PT Guidance
School 7	Aberdeenshire	Urban town	Medium	Tom, PT Guidance Karen, AHT
School 8	Moray	Rural village	Medium	James, Scott, PTs Guidance
School 9	Aberdeenshire	Rural town, new community school.	Large	Calum, Simon, PTs Guidance

* In this table: >1000 pupils = Large; >500 pupils = Medium; 500 pupils or less = Small

** PT = Principal Teacher

*** AHT = Assistant Head Teacher

Table 3.1: Profile of Schools for Main Study Interviews

3.1. POLICY

In each interview, the respondents were asked if there was a written drug education policy outlining the philosophy of, and commitments to drug education in the school. All of the respondents were able to outline what they saw as the core messages (Section 3.4.2), although few schools had prepared a written policy. Many of the respondents indicated that they followed local authority guidelines; however these were more related to dealing with incidents of drug misuse in the school, rather than the drug education itself.

> We're obliged to follow policies of [the local authority][x]. They give guidelines. The current guidelines talk about what to do if children are found in possession of drugs. There isn't a policy document issued by [the local authority], there are guidelines but no policy document which says what you must and mustn't teach...[xi]And so certainly it has been my understanding that it is up to each school to provide their own education plan.
>
> *Mary, PT Guidance, School 1.*

> We're still using what was the Grampian policy...that was sort of 1995...And based on that we had a school policy and that really hasn't changed very much at all because it's pretty standard... That's sort of, sorry, yeah, that is to do with dealing with incidents rather than drugs education.
>
> *Karen, AHT, School 7.*

Two of the schools indicated that the Health Promoting School packs (described in Section 1.5.2) formed the basis of their drug education and overcame any need for a further written policy.

> I would have thought if the authority wanted a policy [on drug education], they would go to that pack [the health promoting school pack] and say this is the kind of stuff we want. They're nae gonnae sit there and make it up. You know they're only gonnae reinvent the wheel.
>
> *Simon, PT Guidance, School 9.*

> [The] health promoting school is our main focus at the moment and that's the route we want to take. We haven't produced a policy statement at all... I feel that personally, getting the programme up and running is more important than creating a document that we can show someone.
>
> *Paul, PT Social and Vocational Education, School 3.*

Paul's sentiments were reiterated by Karen, who also felt that their policy was subsumed into the programme of PSE that they delivered, not just for drug education but across all topics.

> I suppose any kind of policy on drugs education is really kind of part and parcel of PSE. We don't have a specific kind of policy because the same factors, the progression and all the rest of it are what we aim to have across all of the topics that we cover in SE.
>
> *Karen, AHT, School 7.*

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[x] In presenting quotations square brackets [ ] are used to indicate words which were not actually spoken by the respondent. They are used to replace pronouns or acronyms for clarity, proper nouns for confidentiality, or to replace descriptions or superfluous words stated by the respondent, for succinctness.

[xi] In presenting quotations, "..." is used to indicate that in the original interview transcript, the two extracts divided by the "..." did not follow on directly from each other but were separated by other words or dialogue which is not reproduced in the quotation.

Despite this Karen and others were supportive of the idea of a local authority-wide policy. It was felt that it might offer some protection to staff and schools, particularly in relation to difficult issues like harm reduction (see Section 3.4.4). It was important, however, that it was neither "too restrictive" nor "insulting to your professional judgement" and it was generally thought unlikely to have much impact on what would happen in practice.

> It would provide a protection I think for teachers, for individual schools...I think it would ensure that schools weren't kind of being picked off and you know I think there would be some merit in it...Unless they came up with something extraordinary I don't think we would be likely to change very much.
>
> *Karen, AHT, School 7.*

> I wouldn't want to be too restrictive, but I think it [a policy] would be good for protection.
>
> *Tom, PT Guidance, School 7.*

In School 8, James was less positive. He seemed to feel that there were too many policies being issued to schools, and indicated that they were in place just so that if something were to go wrong, there would be someone to blame.

> A policy document just says if you havnae done this you get it in the neck because you havnae followed this procedure... There's a procedure in truanting, there's a procedure in child abuse, there's a procedure in handling drug incidents, procedure in this, procedure in how to go to the toilet shortly!
>
> *James, PT Guidance, School 8.*

Very few of the respondents mentioned any of the documents outlined in Section 1.5.1 that constitute the national guidelines on drug education according to the Scottish Executive (2002b). Two respondents stated that the 5-14 guidelines had been helpful to them in planning the drug education programme, although one noted that beyond the age of 14, they had to use their own resources.

> We go by the, what was the yellow book[xii]...That was the book that was published as a guideline for how the curriculum should be balanced, and the five to fourteen initiatives have an effect on that.
>
> *Mary, PT Guidance, School 1.*

> Really, the main document I'm talking about is the 5-14 guidelines. They were really helpful. It tends to be when you get beyond that, that you're looking at your own resources and deciding what works really well.
>
> *Bob, AHT, School 2.*

In addition, Karen referred to the How Good is Our School documents which they used to help determine their priorities for PSE provision in School 7.

School 2 was the only one of the schools in which a written drug education policy had been developed. This outlined the commitments of the school in relation to drug education and details of messages and resources included for each year group (Table 3.2).

Extract from Drug Education Policy, School 2. [Outline of school commitments]
The policy for Drugs Education features in both the Health Education Policy and the Guidance/PSE policy of the Academy. The school will:
(1) Ensure that our pupils engage actively in a developmental programme of PSE to assist them to develop the knowledge, understanding and skills which will enable them to make decisions relating to drug use and misuse
(2) Use in-service training opportunities to maintain and develop effective drug education through PSE programmes
(3) Work with relevant support agencies
(4) Promote PTA activities relevant to drugs education
(5) Ensure that staff are aware of their legal responsibilities as outlined in this policy document

Table 3.2: Extract from Drug Education Policy of School 2.

[xii] The "yellow book" to which Mary referred was not available at the time of the interview. However, following consultation with Learning and Teaching Scotland (LTS), it is thought that she is referring to a book entitled "Curriculum Design for the Secondary Stages", which was known colloquially as "the yellow peril". This was published by the Scottish Consultative Council on the Curriculum, as LTS were then known. It was updated in September, 1999 by a white book of the same name.

Bob explained the motivation for this:

> We have an active policy which I've actually just rewritten. Its part and parcel of our care and welfare package because we felt that we had a lot of documentation but we now know that HMI can come in off the street and do a care and welfare inspection so we wanted to make sure we were structured and organised so that I could just go and take this off the shelf and say "Well, that's where we stand in this school here in terms of how we care for the youngsters in the school".
>
> *Bob, AHT, School 2.*

Although they didn't have a policy as such, School 3 had developed their own curricular guides for drug education, as described in Section 3.4.3.

3.2. PLANNING AND DEVELOPMENT

3.2.1. "Constant Evolution"

The overriding theme that emerged from questions related to the planning and development of drug education was one of constant, loosely structured evolution. In each school, the programme of drug education that was delivered changed from year to year and from teacher to teacher. Topics were added in, extra events (such as a talk from an outside speaker) were arranged and sections were omitted, deleted or altered. This happened frequently, as lessons were planned and delivered, either at school or individual teacher level. As a result, most schools were unable to present detailed, written plans of drug education provision, and when they were, they pointed out that the plans were not always closely adhered to.

> You'll see that [the programme outline] says "week two", "week three", and [the drug education lessons are] only a period a week, but that's only a rough skeleton. I mean, we do deviate from it, and if something new and interesting comes up, we'll take that on board and jettison something else. So it's a constantly evolving thing. It's not set in stone.
>
> *Fiona, AHT, School 5.*

> You can never run the programme two years running and say at the end "this is a good thing". There are always changes...
>
> *Mary, School 1.*

The programmes that were delivered were frequently amended both by programme co-ordinators and individual teachers, sometimes in an admittedly haphazard way. No one class (even in the same year of school) would receive the same programme of drug education as any other.

> [The health education programme has] been developed I think, on an ad-hoc basis...We've got existing material and we keep changing...[It's] constantly in a state of flux.
>
> *Paul, PT Social and Vocational Education, School 3.*

> Fairly arbitrary decisions [are made] about what goes in [to the programme] and what doesn't.
>
> *Robert, PT Guidance, School 6.*

Further discussion of variation between the lessons taught by different teachers can be found in Section 3.5.2.a.

3.2.2. Curriculum Review

The drug education provided by schools was reviewed by staff quite regularly, although the amount of curriculum and staff time given to such reviews varied considerably. In some schools, whole days were set aside once a year or so for reviews of personal and social education (PSE) provision, in which drug education would also be discussed; other schools held shorter, more frequent meetings with those delivering the education and some schools did both.

> We have a guidance meeting each week because we're all responsible for our own year group. I mean, I'll sometimes say at the end of a topic "Do you think that was okay? Is there anything you didn't like?"
>
> *Angela, PT Guidance, School 2.*

> We've a policy in school that X number of development days are given, so maybe a couple of times a year, three guidance staff will get a day each and they'll take that day out of classes etc. and they'll sit down and look at their priorities.
>
> *Fiona, AHT, School 5.*

> We've got our weekly team meetings and around this time of year when we start to look at our development plan, and when we start to be thinking about next year, we often have sort of sessions whereby we kind of do a blitz on something and we say "we really need to look at what we're offering first year" or "does anybody have any ideas for this?" and often this is the term where either we'll get together or somebody will say "look I'll go off and have a look at that and see what we can do" and then it's pulled together. It's maybe just passed around and everybody says "that's fine" or we actually get together again.
>
> *Karen, AHT, School 7.*

Again, the situation described is not one of regular, structured, comprehensive reviews of the relevance and value of each aspect of the programme. On the contrary, reviews were often informal and loosely planned. The language used is one of possibility in relation to carrying out a review ("I'll *sometimes* say"; "It's *maybe* just passed around"), rather than certainty.

It can also be seen from these comments that, in general, reviews were based on teachers' impressions or perceptions of how well the lessons had gone during the year, rather than any concrete evaluations. The implication is that as educators, the teachers can judge the quality of course content by the reaction and interest of the pupils. This is also expressed by Bob and James.

> We try to respond to how our perception is as, well, guidance teachers - how kids have responded to the material. Material dates very quickly and that's the point at which you say, "Well, that didn't seem to go as well this year"...so you've to try and keep updating.
>
> *Bob, AHT, School 2.*

> We'd be speaking about it informally. "Well, that worked" or "This was rubbish". You know, "I didn't like that too much, but this one was okay".
>
> *James, PT Guidance, School 8.*

In each school, the responsibility for reviewing drug education was divided up in different ways. One school had established a discrete department for social and vocational education (in addition to, and separate from the guidance department), with its own principal teacher. This principal teacher was responsible for all of the development of the drug education programme and he used informal feedback from the tutors who were delivering the lessons to help with this task.

> I've a meeting with all tutors at the beginning of the session and if it's the tutors I've had the session before, we look at the changes I've made in the light of what they've fed back to me.
>
> *Paul, PT Social and Vocational Education, School 3*

This situation was not repeated in any of the other schools in this group. In fact, Paul indicated that as far as he was aware, the school was unique nationally, in having a discrete department for the management and delivery of personal and social education. In most schools, personal and social education was managed by the guidance department. Responsibilities were divided up so that one or more people were responsible for the programme for each single year-group. Alternatively, or occasionally in addition to this, one or more people might be dedicated to each particular topic within the programme.

> I've got a senior teacher who is responsible for health education and two of the guidance team are delegated health education. It's their part of the programme. So whenever there are in-services or resources that come in, those three ladies are looking at that on behalf of the team, if you like.
>
> *Bob, AHT, School 2.*

> There's six years so each of us has a year, okay, and we've got responsibility for developing the lessons for our year group...Calum is doing all the second year SE [social education], I'm doing all the first year SE and so on and we liaise with each other to make sure there's nae duplication or overlap.
>
> *Simon, PT Guidance, School 9.*

> Each member of the team is actually responsible for that year-groups social education programme but within that kind of set-up, one member of the team has got overall responsibility for certain topics across. So there's a lot of liaison and a lot of communication about ensuring that what starts off is kind of built on, and you've really got two people with a sense of where things are at.
>
> *Karen, PT Guidance, School 7.*

Finally, in one school, the respondent was unable to describe any system or allocation of responsibility for carrying out reviews, although it was something that might be seen as desirable.

> We might [review the drug education] informally. I am sure we would like to have a regular review where we would say "Well, we'll chuck that out and bring that in". I don't think I have time to commit to that at the moment.
>
> *Mary, PT Guidance, School 1.*

3.2.3. Programme Evaluation

When asked if and how they evaluated their drug education programmes, most respondents indicated that the content of each unit of drug education was sometimes discussed with pupils after it had been delivered. Again, the language used to describe these discussions was uncertain ("I ask the kids sometimes"; "we tend to") and any consultation was done in an informal way, to get an impression of how satisfied the pupils were with the programme. Some respondents felt that a questionnaire or written evaluation was not necessary to know how well the lesson had gone.

> We tend to do evaluations of the course and ask the pupils opinions and then you fine-tune things... [It is based on] discussion. We don't do an awful lot of paper questionnaires...So I suppose our research isn't very scientific. But we certainly ask. And the one great thing about our kids is that they're very honest. There's no inhibitions. If they thought the lesson was crap, they will tell you so. So yeah, we get good feedback from them.
>
> *Fiona, AHT, School 5.*

> A lot of the feedback we get is very instant. I mean you don't need a questionnaire to know that youngsters think it was the pits or really enjoyed that or whatever. I mean, our youngsters are really good at being upfront and saying "ugh, not this again"...I mean they're really quite vocal. So you know I think often although it's not maybe written down or whatever, we have got a very clear sense of how it went.
>
> *Karen, AHT, School 7.*

> No, [we don't carry out evaluations], not formally, in the sense that I could nae produce a bit of paper saying now that the first year said this and this and this, but we do tend to by asking them and going over [it], so there's a kind of informal, kind of thing.
>
> *James, PT Guidance, School 8.*

> I ask the kids sometimes, "what was that lesson like?"..."is that relevant?", "does that mean anything to you?"
>
> *Calum, PT Guidance, School 9.*

In a few schools, written evaluations were used. An example of the questions asked in one such evaluation is illustrated in Table 3.3.

Text of a Pupil Evaluation Form used after the S3 Drugs Education Unit in School 1

It is helpful to your teachers to know what you think about the course you have just completed. This course was in five Sections: (a) learning about the names and effects of drugs; (b) effects of drugs on health; (c) the social consequences of using drugs; (d) drugs and the law; (e) resisting drugs.

Please complete the following sentences to show your opinions.

9. In Section (a), I learned that...

10. Section (b) made me think about...

11. One thing I hadn't thought about before studying Section (c) was...

12. After finding out more about drugs and the law I was interested/surprised to discover that...

13. My attitude to drug use is...

****

(i). The best thing about the course was...

(ii). One thing I did not like about the course was...

(iii). This unit of work has been...

(iv). In a future drugs unit I would like to find out more about...

Give the unit a score out of 10 for **enjoyment.**

Give the unit a score out of 10 for how much you think you have **learned.**

(v). **Other comments...**

Table 3.3: An evaluation form given to pupils in S3 after their drugs unit. Text extracted from papers provided by School 1.

In one school, such evaluations were used after every unit; in another, different aspects of the programme were selected each year. It is not clear, however, how much impact the results of the questionnaires had on programme development.

> We do an evaluation at the end of each of the courses to see what they've learnt and what they'd like to know more about. And while I wouldn't say that what they've said has made a great difference to what we've been doing, we do try and use those opinions.
>
> *Mary, PT Guidance, School 1.*

> Well, it varies from year to year. We all evaluate at least two things [from the PSE programme] within the year...It's just that we feel that there is so much happening that you can't do the whole thing.
>
> *Robert, PT Guidance, School 6.*

> We have a thing, it's an end of drugs topic review, you know to see the questions they can do. It's designed at one particular age-group. You could amend that and use it at any age-group.
>
> *James, PT Guidance, School 8.*

Respondents reported that the feedback received from pupils both in written or informal evaluations, was mostly positive. According to these respondents, pupils were generally satisfied, but as they got older were more likely to indicate that they were already familiar with, and possibly bored with, the topic of drugs.

> [The comments are] really quite positive. Again, we get "yes, this was fine, but we know this already" as you get further up, but that's why we've tended to back off and get outside agencies involved. That's always the feedback..."yeah, this is fine, more of this, but not you".
>
> *Paul, PT Social and Vocational Education, School 3*

> They would say themselves that they think it should be harder-hitting; should be more scary. And they tend to like the discussion; they don't like to do written work. You might get "oh, I didn't like fillin' in that sheet" etc.
>
> *Fiona, AHT, School 5.*

> What you don't want to do is go down the line of having something they've actually done before. You know "This is boring". They switch off... We generally get very positive feedback, but basically that's because the courses are so flexible that they go along with what they want to hear.
>
> *Doug, AHT, School 4.*

3.2.4. Pupil Involvement

Most schools did not involve pupils in planning the drug education programme. In the rest, the involvement was very informal and minimal, taking the form of brief discussions at the beginning of a drug education unit. These discussions focused on what topics the pupils would like covered in the programme and more commonly involved senior pupils.

> We tend to [consult] senior students: 4, 5 and 6. In the fifth and sixth year programme there's an element of choice within their PSE programme: "what would you like us to cover within the area of health education?"...They suggest [a topic], they say "I want to know more about such and such". And you usually find "yeah, we'd like to find out more about drugs but not from you".
>
> *Paul, PT Social and Vocational Education, School 3.*

> Some of them say, when you ask them what they would like to know more about when you next come back, that they would like to see the drugs...Some of them say they would like to hear someone who has used drugs, drug users.
>
> *Mary, PT Guidance, School 1.*

It can be seen from these comments that the suggestions given by the pupils were as informal as the way in which their opinions were sought. None of the schools had any formal pupil consultation arrangements in place for drug education and there were mixed feelings about this. In some of the schools, the feeling was that it could be done "if the will was there", but that it had never really been considered.

> I suppose it could be done, it's just never been thought about, Niamh.
>
> *Angela, PT Guidance, School 2.*

> Well, I suppose if there's a will to do it, I suppose you can try and find most things. But at the moment what we're using is evaluation sheets.
>
> *Mary, PT Guidance, School 1.*

Many respondents expressed doubts about pupils' abilities to contribute constructively to the planning and development of drug education programmes, particularly the younger pupils.

> Second year would be far too young [to involve pupils formally]. Fourth year, I suppose some of them could maybe cope with that, but again fourth year can be a difficult time just because of their maturity level. Some of them maybe could handle [it].
>
> *Angela, PT Guidance, School 2.*

> We did ask fifth year...and they couldn't come up with anything. "Well, can we use this period to do our homework?" They cannae come up with anything, even if they're given the opportunity...They've been through four years of social education, and they feel it's irrelevant and they can't even say why.
>
> *James, PT Guidance, School 8.*

Karen noted that the inability of pupils to comment may be explained by their lack of awareness of alternatives or possibilities for their learning.

> One of the things I was going to say is consulting with them [pupils] is, they don't always know what they need to know. They're not always aware of what's out there that they should be learning about and whatever.
>
> *Karen, AHT, School 7.*

Other potential barriers to formal pupil consultation included doubts about pupils' willingness to give up their own time to take part in formal consultations and a feeling that the kinds of pupils who would volunteer to be involved might not be representative of those pupils most in need of drug education. Many doubted that there would be enough time to get pupils involved.

> It's utopia, that's utopia you're speakin' about there. Can you imagine kids sayin' I'll give you up my time to come and [take part in a consultation group]? … And the ones who would volunteer to do that might nae be the people who would offer the solutions, the good solutions for the masses… I think it would be really hard to get pupils involved in that.
>
> *Simon, PT Guidance, School 9.*

> Actually, there isn't time within the week's timetable to take pupils and say "Now what would you like?" Well one of the questions in the evaluation sheet would be "what do you think you need to know more about?" But that would be the way we would approach getting pupils' opinions.
>
> *Mary, PT Guidance, School 1.*

> I've got no objections in principal [to involving pupils in planning] but it's the timing and the logistics and the practicalities of knowing what's happening. As a guidance group the six of us get together and we're about to have a major rethink of our SE [social education] courses…By the time if you ask other people, they tend to say "oh, we could do this and this and this and this and this" and it burgeons out of control.
>
> *Robert, PT Guidance, School 6.*

Despite their doubts, most recognised the scope for something more than was currently in place and some acknowledged that it could be a good thing. Another respondent pointed out that he saw a trend nationally towards increased pupil involvement.

> I think this is the way things are going in national circulars and government guidelines and so on. It's going to be pupil involvement and ownership.
>
> *Scott, PT Guidance, School 8.*

Many of the schools had pupil councils in which pupils could draw attention to and seek action on issues which affected them. Existing councils tended to deal with "bread and butter" issues however respondents agreed that they could possibly be used for consultation on more educational issues though that hadn't been given much thought.

> We now have a school council and that was set up last year. We had a tutor or a year council basically which didn't do a great deal, that the pupils would all be saying "yeah, I want more soap in the toilets" or "I want more toilet roll" or lockers, that kind of thing. Now they're getting down to real issues. As part of their role in supporting the work of the school, [involvement in consultation on drug education] is a possibility. Again, its something I don't think we've thought a great deal about.
>
> *Paul, PT Social and Vocational Education, School 3.*

> I think their concerns are at an altogether different level from where we'd like them to be...things like "why do we have to pay an extra five pence for a sachet of sauce on chips?"..."why are the toilets dirty?" and queues at lunchtime, it's all these kinds of things.
>
> *Tom, PT Guidance, School 7.*

Two schools had structures in place that could provide successful models for pupil consultation on drug education, although they were not currently being used for this purpose. In fact, despite Tom's last comment above, Karen, the AHT in School 7, reported that they had a model in place for pupil consultation that had worked very well. The model that was used, allowed the consultation to be structured in a way that facilitated pupil feedback, in order to overcome the worries expressed above. The quality of the feedback had "amazed" the respondents, and demonstrated to them that the pupils in this school were in fact capable of "that level of thought" (overleaf).

> What we're doing now is giving them a chance to speak in a very controlled way and it's amazing what's coming back...We've got what we call a pupil forum and we set the agenda. We say: "here are things to do with learning and your part in school. We've got our own values, we've got these values and expectations". We've tried to link everything so far to these values and expectations. The last one was not quite that – we were recently inspected so we said "here's what the inspectors thought was good, do you agree? Why do you agree or why do you disagree? Why don't you know?" So we're in control, but we're giving them a voice. We're asking them to comment on certain things. And it's amazing what they're coming back with...so I think we're seeing that they're capable of that level of thought or whatever, but it does need to be directed.
>
> *Karen, AHT, School 7.*

This model had been successfully used in school 7 for feedback both on school inspection reports and on bullying issues and it could possibly be altered for consultation on drug education, though this had not really been considered yet.

> We hadn't really thought about [using it to develop PSE]...Maybe we could start thinking about the pupil forum in different ways
>
> *Karen, AHT, School 7.*

In School 6, a health group was being set up, and although its composition had not yet been decided, there was scope to include pupil representatives on it. This group would organise themed days in the school on particular topics and one of the topics they were considering was drug education.

3.2.5. Pupil Assessment

Formal assessment of pupils in drug education courses or other more formal means of auditing drug education provision were topics which came up in a small number of the interviews. Among the three respondents with whom they were discussed, there was no clear consensus and many doubts. Some felt that it was difficult to measure the quality of a course by testing pupils or filling out an audit questionnaire.

> What we're hoping for really, as we've said is, the kids are building up skill and ability and confidence themselves to maybe make decisions and are competent in that. And I don't think you get that on a piece of paper at the end of the day...
>
> *James, PT Guidance, School 8.*

> I mean the process is, to audit what you're doing you need to tick a box. Where does that tell about quality?
>
> *Bob, AHT, School 2.*

Robert suggested that pupils did not take their social education very seriously and that might be improved if they were assessed in some way. James did not share this view however, as he was concerned that assessment was hard on the "poorer" pupils.

> If you spoke to the children here, they would say, or a lot of them would say that their social education was a waste of time...If you get something at the end of the day, perhaps you put more effort into it and you do regard it slightly more seriously.
>
> *Robert, PT Guidance, School 6.*

> We've tended to avoid assessment in PSE [Personal and Social Education] programmes, they're [the pupils are] assessed all the way through the school. And one of the things is that the poorer kids are no been told they're scoring high in this. Now you could have assessment that doesn't necessarily show that but at least they come in and they know they're not gonna be gettin' points out of ten.
>
> *James, PT Guidance, School 8.*

The difficulty of evaluating any kind of long-term outcomes of drug education was pointed out by Robert.

> I think you can pick out good practice. You can pick out things that work well and you can encourage other people to do it. Evaluating it is very, very difficult, I mean what is success? How do you know that what you're saying, you know it may have an effect ten years on. You don't know that so and so took cannabis at the weekend and because of what I said on a Tuesday, they're never going to take it again
>
> *Robert, PT Guidance, School 6.*

3.2.6. Parent Involvement

None of the schools reported any involvement of pupils' parents in the process of planning the drug education programmes that were delivered. It was not clear why this was the case, although in one school the respondent pointed out that no parent had ever complained about the programme.

> To be honest we're never really involved the parents in any o' the things that we've developed so far. I mean we've never had any complaints about it either and I don't think that there's any grounds for complaint.
>
> *James, PT Guidance, School 8.*

Communication with parents about drug education tended to be through events such as parents' evenings which were organised by most schools every few years on topics such as drugs and alcohol awareness. Many respondents reported difficulties in getting parents to attend these events however. In addition, some schools informed parents in writing if there were major changes to the personal and social education programme and invited them to contact the school if they had any questions.

> Turnouts for our parents' evenings were traditionally not very good...We had a parents night maybe two years ago, where the police were launching their drugs video which you may have seen...The turnout for that was abysmal. It was really embarrassing. There was only about half a dozen parents, other than staff.
>
> *Fiona, AHT, School 5.*

> With any health education unit, we inform parents and we're starting our sexual health unit 7th February... We're in the process of changing it, so a letter has gone out to parents informing them [that] this is happening and [telling them] "contact the school if you want more details".
>
> *Paul, PT Social and Vocational Education, School 3.*

> One of the things the inspectors told us was that we should have closer partnerships with parents. And we were a bit upset about that because there's a lot of communication goes out to parents, every major event in the school, parents are told about it. They get a newsletter once a term.
>
> *Fiona, AHT, School 5.*

In school 9, the event for parents took a conference-like approach, with various stalls and workshops laid out in the school. The turn-out for this event was very high and the respondents reported that it was used as a model for other schools.

> We had thirty different stalls, set up within an area and people could go and visit all the different things that were looking at and you were doing something on "coming to a street near you" - something like that. All the dangers, where drugs could be sold and things like that. And I was doing something on parents: "how do you become aware that your child has a drug problem, what are you looking for?"
>
> *Calum, PT Guidance, School 9.*

3.2.7. Community Involvement

Community participation in the drug education programme took the form of outside agencies (most commonly the local health promotion department or the police) being involved in delivering sections of the programme to the pupils. Participation or involvement of representatives of the local community in the development or delivery of drug education in the school or in any joint initiatives was not reported by the respondents, and they seemed unfamiliar with the idea. This is illustrated by some of the responses to questions about community involvement in the development of drug education programmes:

> We've got a local bobby, Constable Gordon. He's the community policeman. We see him fairly regularly. The kids are used to seeing him about school.
>
> *Robert, PT Guidance, School 6.*

> In terms of involving the community, we [have] involved community agencies a bit more than involved the community.
>
> *Tom, PT Guidance, School 7.*

> We've liaised with social work obviously, but that's agencies obviously rather than the local community. Were you thinking differently than that?
>
> *James, PT Guidance, School 8.*

Further discussion of the use of outside agencies in the delivery of drug education programmes is included in Section 3.5.3.

3.2.8. The Influence of Experience

Many of the respondents highlighted how experienced the team of guidance staff in their school was. There was a sense that the teachers had been teaching for years, and were comfortable with what they were doing. The programmes of drug education had been developed by or had evolved with those teachers over a long period of time. This experience was what led, at least partly, to the uncertainty about the value of any consultations or evaluations. They were experienced teachers and could quite easily judge what worked and what didn't with the pupils.

> I mean everybody, there is a prescriptive way of teaching it, that lesson thing that I showed at the beginning but as I say, everybody has been teaching for a long time in guidance. I'm the newest member. So they're into their way of doing it.
>
> *Angela, PT Guidance, School 2.*

> Having once started we go with what we've got and work on it. In our experience if this works well, and if it doesn't then we'll drop it and try something else.
>
> *Mary, PT Guidance, School 1.*

This perception of their team as being very experienced may have led some respondents to be a little complacent. However, when discussing this in the interviews, some respondents were aware of the risk of complacency developing.

> I mean, the longer you're at the job, the comfier you get with a particular style and you probably need to work on parts like that. I'm bein' honest here, [you get] comfortable doing what you're doing.
>
> *Simon, PT Guidance, School 9.*

> I mean, I've been 18 years in the job now, Scott has been longer than me, we're a pretty experienced team, we're fairly competent and we've done it for a long time...But part of this is we've kind of developed it as we're going, so maybe if I look at the guidelines-
>
> *James, PT Guidance, School 8.*

3.2.9. Entertainment Value

As described above, teachers relied on their own impressions of how a lesson had gone, rather than any formal evaluations, to judge whether the lesson had been a success or not. Perhaps because of this, when describing what they clearly considered to be very successful lessons or inputs, respondents tended to emphasise how much "the pupils loved it" or that it "really held the pupils' attention".

> [Paul Betts] was in [another school] and spoke to, I believe, a whole year group for three hours. If he kept the kids attention for three hours, I mean, he's doing a marvellous job...
>
> *Mary, PT Guidance, School 1.*

> We recently had a lady who had been a user herself [in the school] and her daughter had become addicted and her daughter had died. And you know the kids are so intently listening to this and to me, that's the best message they can get.
>
> *Bob, AHT, School 2.*

> [The "Junk" video] is excellent, it's well worth watching. And certainly our fourth years really enjoy it.
>
> *Doug, AHT, School 4.*

Fiona expressed her concerns about why pupils seemed to enjoy drug education.

> They quite like drugs education, I have to say. I just hope it's for the right reasons. I worry sometimes, I remember teaching health education myself in another area altogether and all the kids wanted to do the research on drugs and I just wondered you know, was it because they felt this fascination and this pull? And it's a difficult one to suss.
>
> *Fiona, AHT, School 5.*

3.3. TIME AND RESOURCES

Respondents generally felt well-resourced in terms of materials and facilities however many of them reported a lack of time and/or staff.

> I think we are fairly well-resourced…[but] we never have enough time. We never have enough staff!
>
> *Fiona, AHT, School 5.*

Time constraints were cited by Mary as the reason why they did not carry out any formal reviews of drug education (Section 3.2.2); by Robert when explaining that they did not evaluate all aspects of the PSE programme every year (Section 3.2.3); also by Robert and Mary as a reason why they did not consult pupils in any formal way and by Bob in describing why he can't carry out more quality assurance of lessons (Section 3.5.2.b). The origins and effects of these constraints, both on staff and curriculum time, are discussed over the rest of Section 3.3.

3.3.1. An Ever-Increasing Set of Topics

Many respondents spoke about the ever-increasing number of topics which they felt they were expected to cover in social education, and how it was a struggle to find enough curriculum time to cover them and staff time to develop them. Some of the teachers observed that many of these issues would previously have been expected to have been covered by parents with their children, and they seemed a little frustrated as teachers to have to fill the gap when parents did not do this.

> I suppose it's a by-product of social inclusion, more and more things that the government seems to think that schools should be teaching, you know things that you would automatically assume that the parents would teach, like personal hygiene, road safety, you know. There's more and more of that and we're being expected to deliver.
>
> *Fiona, AHT, School 5.*

> If in a community, let's say, two children are killed on the road on the way to school over a, maybe a three year period, councils will hold up their hands and some pressure group will say, "well, here's a six week lesson on road safety, why can't the schools get that going?" And really if we had to, I mean I've heard about heaps of these different kinds of things over the past ten years or so, we would need to have the kids in for fifteen days a week!
>
> *Tom, PT Guidance, School 7.*

> I think politically, we're the fall guys in school these days. Everything that goes wrong in society the response now is "Oh, it's the schools should be doing it, teachers should be doing it". I'd like to see a society where parents are doing a lot more. Where parents have values and get those values into their kids. Parents should be teachers.
>
> *Bob, AHT, School 2.*

The pressure on curriculum time was one of the reasons why the provision of PSE kept evolving and changing: because it was not possible to include everything, topics were added and removed as priorities changed. Sometimes removed topics were covered in other curriculum areas or just set aside and possibly revived at a later date.

> At times you're fire-fighting, you know its like saying, we've got to make whatever was in that priority more focused on that, and obviously some things have got to go on the back burner for a while.
>
> *Scott, PT Guidance, School 8.*

3.3.2. A Changing Role for Teachers

As well as trying to include more topics in the PSE programme, a number of the respondents noted that their role as assistant heads or guidance teachers had changed from an educational role to more of a social work or counselling role. They did not feel adequately trained or prepared personally to deal with this change.

> Our role has altered. We've become much more social workers for some of the pupils and basically we don't have the qualifications to do that.
>
> *Robert, PT Guidance, School 6.*

> This inclusion policy that we have. It means everybody has access to mainstream education. I can't physically and mentally cope with all the demands that are placed on me to handle all of these contexts. I'm not trained to help some of the kids I'm now getting in schools. It's not because I don't want to do it but I begin to see myself much more as a social worker than a teacher now...I just feel I'm being asked to do more and more and more.
>
> *Bob, AHT, School 2.*

Respondents reported that schools were not resourced adequately to deal with the range of needs of the pupils who were now in mainstream education. Bob and Fiona (both of whom were assistant head teachers) pointed out a need for more specialist or staff provision to cope with this.

> I just think [we need] more adult bodies in school to help you to cope with the needs of these kids with all their disparate needs. No matter what the level of disability, because they have special needs, they need special treatment, so I need special time to give that special treatment.
>
> *Bob, AHT, School 2.*

> My wish would be that we could have much more in the way of specialist provision both in and outside school for kids who are not coping...social work, counsellors, psychiatric counsellors...I don't have the training, I don't have the expertise, I don't have the time to devote to a lot of these kids.
>
> *Fiona, AHT, School 5.*

According to Bob, these time constraints made it increasingly difficult to monitor the quality of lesson delivery by teachers.

> There's probably less time being spent on quality assurance of learning and teaching because you're having to spend the times with the individuals, with kids, sorting out kids...I don't have a lot of time to visit classes now to monitor the quality of what's going on. I don't have the time to sit down with young staff and give them advice about how to improve their job performance.
>
> *Bob, AHT, School 2.*

3.3.3. Is More Curriculum Time Needed?

Mary reported that the social education time in the week had actually increased in recent years in School 1, and Robert explained that timetable changes were being discussed in School 6 that would give more time to PSE. On the other hand, Doug (School 4) was happy with curriculum time for PSE except perhaps in fifth and sixth year. In his school, they adjusted what was done in every year, to gradually squeeze things in at earlier stages in the school.

> I think all we've done is adjusted what we cover in each year...Second year in the past was a bitty year, in terms of second year PSE, there were lots of little areas we covered little bits of, and what we've really done is gradually squeeze things down so you know topics we used to cover in third year, we now cover in second year...I don't think [more time for PSE] would be appropriate, I think that the time we have at the moment is good.
>
> *Doug, AHT, School 4.*

Despite the already tight timetable, Robert (School 6) reported that social education tended to be cancelled in favour of meetings or events, as it was not always given the same importance in practice as was sometimes portrayed.

> It's one period a week. If we've got meetings to have, it tends to happen in that period, because it's a convenient period to get the whole year together and this sort of thing. So [the pupils] do get mixed messages about [the importance of social education]. I mean we're trying to say that social education in all aspects is important: it's not always followed through in practice.
>
> *Robert, PT Guidance, School 6.*

Not withstanding these constraints on time, many of the respondents expressed a desire to include more topics in PSE which they were not already covering or not covering sufficiently at that time. These included mental health (including bereavement, relationship breakdown), bullying, study support and parenting. The situation was best summed up by Robert (School 6) who said (overleaf):

> You know anyone will tell you, the more time you've got, the more you can put in.
>
> *Robert, PT Guidance, School 6.*

3.3.4. Setting Priorities

Having described the constraints on curriculum time and the number of topics that they were expected to cover in that time, respondents were asked how they decided which topics to prioritise. The answers given illustrate that a whole range of inter-related national and local factors influence these decisions, including "hot" political and media topics, local authority priorities and any school or local incidents.

> Some of it is really kind of traditional and some of it is in a way prescriptive – there are certain things that happen in terms of the general PSE course within a child's development or certainly their life in school that means that particular things just become part and parcel of that and then there are other things where we just feel, I suppose again, we're back to Grampian's guidance guidelines, where there is a sense that these things should be part and parcel and the "How Good is Your School" materials and the effective guidance provisions. So I mean, I think its mostly kind of national direction plus a little bit of, you know, what our own needs are.
>
> *Karen, AHT, School 7.*

> It depends on the school and what the senior management team and the head teacher sees as the priorities I think. But obviously driven by exterior forces as well – like the Scottish Executive, the SQA, the local authority.
>
> *Paul, PT Social and Vocational Education, School 3.*

Schools are very conscious of how what they teach in drug education can provoke negative reactions from parents, if they are not very careful. It is clear from what Doug says, that he is concerned not only about action that parents might take in contacting the school, but also that they might contact the local media, resulting in bad press for the school.

> You know we're not giving [the pupils] anything that they don't know already. But you've got to be wary of pupils going home and saying "this is what we did today". And the parents on the phone to their teacher or on the phone to the press saying "Did you know this is what they're doing in school?"... and [the press] would jump on that.
>
> *Doug, AHT, School 4.*

He was not the only respondent to comment on the tendency of the media to pick up on incidents or aspects of the curriculum and to blow them out of proportion.

> There's been quite a lot of publicity recently in one of the Scottish newspapers about a sex education teaching pack and you know the press, they'll pick out the things in it that are totally unacceptable.
>
> *Tom, PT Guidance, School 7.*

> If you got a bad incident in school you can rest assured the press would get hold of it.
>
> *James, PT Guidance, School 8.*

The media also contributed to many respondents' sense of what was a "hot topic" that they felt they ought to be concentrating on. National government priorities filtered down to schools and this filtering down was facilitated by the media as well as by the local authorities.

> The pressures, social pressures, local pressures because of the increase in drugs [mean] that we're forced to bring that in...Politicians say "schools must do this" so unless you're going to have a big protest and complain about that, you've got to do it and something else has to make room for it.
>
> *Mary, PT Guidance, School 1.*

> I would say [drug education] is very high in [our] priorities because of the national profile of it. You can't ignore what you're being instructed to do nationally.
>
> *Bob, AHT, School 2.*

> Sex education was being flogged at one time, that was high profile. It's kind of dipped and then it comes up again. If you've got some government figures saying there's X numbers of teenage pregnancies you can rest assured there'll be things comin' in...There's a degree of citizenship in the programme which is not written in as citizenship, which you know will be another thing that will be comin' in.
>
> *James, PT Guidance, School 8.*

James' comment highlights another interesting possibility that sometimes a change in priority at national level, might not lead to any real change in the content of the curriculum, just a re-packaging of previous content. Nonetheless, it seemed that when something became a national priority, non-action was not an option for these respondents.

It is not clear how exactly the pressure described above was brought to bear or what the consequences would be if they were not to take any action, however, Her Majesty's Inspectorate of Schools (HMI) was mentioned by a number of respondents.

> We had Her Majesty's Inspectorate in two years ago and they had their input about how the curriculum should be developed and how much time was available.
>
> *Mary, PT Guidance, School 1.*

3.4. CURRICULUM

3.4.1. Timetable

The frequency and duration of drug education provision varied between different schools. In general, specific drug education was delivered in most years of secondary school, from forty to one hundred and ten minutes per week for between three and ten weeks per year. Other PSE topics, including self-esteem building, assertiveness and decision-making were taught in addition to this, without specific reference to drugs. Furthermore, many schools reported that the topic of drugs was covered in different ways by many subjects outside of PSE. In some schools, health or conference days were held which included workshops on drug-related topics. Exact details of the frequency and duration of provision were not sought during these interviews, however a summary of what was reported by respondents is presented in Table 3.4. This table is provided only as an indication of provision; it is not intended to be a complete or definitive record. For example, drug education may have occurred in many other subjects in addition to RME in School 1, however other subjects were not highlighted by the respondent. In addition, as we heard earlier from Fiona (Section 3.2.1) and is reiterated by James and Doug, the timetables in each school were usually flexible and not "set in stone".

> It's flexible. One of the things that we would like to think in devising the programme is that we can actively respond to something if something comes up, you know we can switch to a lesson fairly easily. You know, say solvent abuse became a problem we could switch a lesson fairly quickly. So it has that benefit of being a wee bit flexible.
>
> *James, PT Guidance, School 8.*

> The courses are so flexible... And it depends you know, some drug education programmes will last four weeks, of a six or eight week, depending on how the kids work. You know if their knowledge is pretty good then they'll do it much quicker.
>
> *Doug, AHT, School 4.*

Summary of Drug Education Provision			
	PSE Programme Provision	**Proportion of PSE devoted to Drug Education**	**Provision in Other Subjects**
School 1.	2 x 40 mins per week in all years.	Not known.	RME[xiii].
School 2.	1 class per week.	5 or 6 weeks per year. Mostly in S2, S4 and S5.	RME, Drama, English
School 3.	1 session per week.	5 weeks per year.	
School 4.	40 mins per week in S1, S2. 2 x 40 mins per week in S3, S4. Conference days for S5, S6.	Not known.	
School 5.	1 period per week. Health days.	"A few weeks per year". Mostly in S2, S3 and S6.	Science, history, maths, home economics.
School 6.	55 mins per week (1 period) from S1-S5.	3 weeks in S2; 8-10 weeks in S3; 2-3 weeks S4.	Science, maths.
School 7.	1 lesson per week in all years.	Not known.	
School 8.	55 mins per week in S1, S2; 110 mins per week in S3, S4, S5.	Not known.	
School 9.	2 x 40 mins per week.	3-4 weeks in each year	

Table 3.4: Summary of Drug Education Provision

3.4.2. Key Messages

Most commonly, respondents stated that the focus of the drug education programme in their school was to provide pupils with factual information to help them to make decisions about drugs.

[xiii] Religious and Moral Education

Within this broad aim, however, there were differences in emphasis between schools. Some focused mainly on provision of information, with little reference to teaching any life skills.

> [Our focus is] to educate. To give them the information so that they can make their own choices based on fact rather than based on stories they've heard.
>
> *Doug, AHT, School 4.*

> To identify the variety of drugs which are available...and what the effect on people the use of these drugs is...As they get a little older, looking to more the long-term health risks of the use of drugs, the social risks, and the legal risks that they put themselves under by using...So that hopefully by being better informed, they'll be better able to make choices in the long run. I mean that's the underlying theme, I suppose.
>
> *Mary, PT Guidance, School 1.*

> We're giving them the facts and we ask them if they have questions but we don't stand and say "you will not do this" because that just doesn't work with young people. We try to be more fact-giving and put it over in a very decision-making way and that they themselves have to read the facts and decide what they want.
>
> *Angela, PT Guidance, School 2.*

Some of the schools emphasised development of confidence, assertiveness, self-esteem and scenario practice as much as or even more than information provision.

> It's being able to develop the confidence in yourself that "I'm okay without that". But knowing full well that part of growing up is wanting to try things, and wanting to buck the system, let's try that.
>
> *Paul, PT Social and Vocational Education, School 3.*

> We put a heavy emphasis on S1 and 2 on issues around self-esteem and making sensible choices and we see that as very much as part and parcel of drugs education as well. You know just kind of feeling good about yourself, being confident enough to say no...
>
> *Karen, AHT, School 7.*

> It's information giving and decision-making and it is proactive rather than reactive...Likely scenarios and assertiveness, building assertiveness skills. Thinking of who's likely to offer them.
>
> *James, PT Guidance, School 8.*

Although informed decision-making was central to provision in most schools, some respondents pointed out that the emphasis tended to be on one decision only – that is not to use drugs. This was expressed clearly by Robert.

> I think the philosophy, the message is definitely is a "don't use", but we do try and do it by providing information and allowing them to make an informed choice. I think that's one of the reasons why teachers find it so difficult, because you provide information; you do want them to make an informed choice; but actually you want them to make the choice you want.
>
> *Robert, PT Guidance, School 6.*

In some cases, the dilemma expressed by Robert resulted in schools emphasising what they saw as the negative consequences of drug use, in the hope that pupils would "say no" to drugs. In one school, the negative side was emphasised to the point of trying to scare the pupils into not using drugs. This was explained by Doug as showing the pupils the reality of what will happen if they make the wrong choices.

.....

Passage from School 4 Interview

> Doug: We hit them with the facts, we try and scare them, we want to encourage them not to.
>
> Interviewer: So there is a certain amount of scare tactics?
>
> Doug: Yeah, I think that is the approach that we ought to take. They have to be very aware that this is the reality; this is what will happen to you if you go down this line.

.....

He explained the logic behind the scare tactics:

> You can't scare them with the law...But you know scaring them with situations - you know we have ex-pupils who have died from overdose - you know telling them about these things because they all know somebody who knows the person. That gets through to them because they then wake up and think "Oh yeah. Okay. You know that was somebody who came to the school, that's somebody who was just like me."
>
> *Doug, AHT, School 4.*

Doug's emphasis on what he sees as the reality of the situation was echoed by Bob, when he was speaking about involving representatives of Narcotics Anonymous in the drug education programme:

> I think it gives [the pupils] a better understanding of what the extreme consequences can be. You know people coming in to talk about death, talk about prison, talk about misery squalor, talk about being homeless. That's reality. And the kids can definitely relate to that.
>
> *Bob, AHT, School 2.*

The core message of the drug education in School 5 was described somewhat differently than in the other schools. While again, the emphasis was on giving information to make informed choices, the respondent also emphasised keeping people safe. This was necessary because according to the respondent, the pupils were quite likely to be offered drugs in their community.

> We really have, well, yeah, there's the choice-making but we really have to get the message across that this is not a good idea and obviously legally we have to have zero tolerance in the school. But you know we do try and give them a balanced view...
>
> *Fiona, AHT, School 5.*

> The philosophy of it is to try and keep people safe, keep them informed so that they'll go [informed] into a situation where they are offered drugs; that will be quite likely in this community because there are a lot of drugs dealers in the community, our parents are drugs dealers. We've got a number of kids who are living with the consequences of that.
>
> *Fiona, AHT, School 5.*

3.4.3. "Dipping In"

Most of the drug education programmes were based on commercially available packages or resources, although the packages were rarely used from start to finish as published. The overriding theme in relation to the planning of lessons, was one in which schools "dipped" into a range of packages, using elements of more than one to make up their drug education programme. The packages mentioned by respondents in the interviews are illustrated in Table 3.5, however, again, these are presented only as an indication of the range of packages in use.

From this it appears that the most popular resources for this group of secondary schools were DrugWise materials, various TACADE materials and the Sorted video (which is known also as "the Leah Betts video")[xiv]. Some respondents also mentioned "big expensive" or "commercially produced" packages without specifically naming all of them that were in use.

Resources:	Format:	School and Year(s) in which the Resources is Used (if known):
DrugWise, Drug Free; DrugWise Too; General DrugWise materials.	Packs	School 2; School 4 (S3); School 5; School 6 (S3); School 8
TACADE materials: Skills for Adolescence World of Drugs - Skills for Life	Packs	School 2 (S2); School 3; School 5; School 8; School 9
Interactive CD ROMs	CD ROM	
Sorted	Video	School 1 (various); School 6 (S4); School 7; School 8
The Buzz	Video & Pack	School 5; School 7; School 8
Off Limits: Talking about Drugs	Pack	School 1 (S3, S4); School 6
A is for alcohol, B is for... E is for ecstasy	Videos	School 6 (S5); School 8
Taking Drugs Seriously	Pack	School 2 (older pupils)
Truths	Pack & Video	School 3 (S4)
Drink Talking	Pack (alcohol)	School 3
Junk	Video	School 4 (S4)
Psst	Video (alcohol)	School 5
It's My Life	Pack	School 8.

Table 3.5: Summary of Packages Used

[xiv] TACADE materials are available from www.tacadc.com. Drugwise Drug Free was produced originally by Strathclyde regional education authority. It is not known if it or the Sorted video are still available. All of the materials should be available to borrow from Health Promotions in Aberdeen.

Many of the respondents described how these packs were used to plan individual drug education lessons. These comments clearly illustrate the theme of "dipping in".

> This is Skills for Adolescence. We use this in first year and second year. We're now quite used to this book. When it first came out it was like the bible but now we've selected the bits that we like...This is Drugwise Too which we use...there is a video that goes along with this so we combine...There is a prescriptive way of teaching it...but as I say, everybody has been teaching for a long time in guidance...So they're into their way of doing it. So we dip into Drugwise Too and we dip into Skills for Adolescence.
>
> *Angela, PT Guidance, School 2.*

> Skills for Life has replaced [Skills for Adolescence] and we've been using elements, dipping into, massive expensive packages. We've actually got three. Again, these were free, we wouldn't have bought them.
>
> *Paul, PT Social and Vocational Education, School 3.*

> It's fair to say we're all in a wee state of flux just now in terms of the packs of material, the whole school approach which has come in from Health Promotions, we're looking at that...Basically, we've been dipping into all [the health promoting school packs]...We've extracted things from sex education, drug education, alcohol education and smoking.
>
> *Calum, PT Guidance, School 9.*

In School 3, Paul, the principal teacher of social and vocational education had compiled packs of drug education materials specifically for his school. Copies of the teacher's guides developed by him for S1 and S2 were provided to the researcher, and included two drugs units entitled: Good Health S1 – the World of Drugs; and Good Health S2 – Drugs Unit. Each guide outlined in detail the messages and activities to be completed for three lessons, with some element of choice included for a few of the described activities. The unit packs also contain pages that can be copied for use as overhead transparencies, master copies of information from other resources for tutors and/or to distribute to pupils, and master copies of tools from various resources such as quizzes and activity sheets.

3.4.4. Harm Reduction

In each interview, when an opportunity arose, the respondents were asked whether their school provided any information to pupils aimed at reducing harms that might result from drug use. The appropriateness of the provision of that sort of information in schools was discussed and the respondents' opinions were sought. A great deal of uncertainty existed about the appropriateness and acceptability of providing harm reduction information. It's clearly a "difficult" area for the teachers, this word came up again and again, throughout the discussion.

> Harm reduction's a real grey area for us. We're not really at liberty to say "If you're going to take this, then make sure you do this in conjunction with it and you'll be okay"...It's a difficult one, we can't be seen to be condoning anything...We've got to be very careful. It's not exactly quite on eggshells but we've got to be very careful.
>
> *Doug, AHT, School 4.*

> It's difficult, because you can't really stand up in front of a class and say "Well, if you're going to inhale solvents, don't squirt it directly to the back of your throat, squirt it to the side of your throat" but you have to make sure that if they are, they will, if you see what I mean...You don't bring it up essentially and you certainly don't bring it up to promote it.
>
> *Robert, PT Guidance, School 6.*

> It's a difficult line to get across...It couldn't be done in a normal classroom situation, I don't think it could be done in schools at all.
>
> *Tom, PT Guidance, School 7.*

The reasons for this uncertainty were varied. Some respondents were concerned that parents would not think it was a good idea to teach about harm reduction: they felt that parents expected teachers to take teach kids to "say no".

> I would be very surprised if parents would think it was a good idea for us to try to make a lot of the risk minimisation. Parents expect teachers and schools to say "No. Don't do it."
>
> *Mary, PT Guidance, School 1.*

> You've got to be wary of pupils going home and saying this is what we did today. And the parents on the phone to their teacher or on the phone to the press saying, "Did you know this is what they're doing in school?"
>
> *Doug, AHT, School 4.*

> I think most, if you were to ask most parents just now, they probably say, teach them about drugs, that drugs are wrong, rather than teachin' that you can use them safely. Or "this is how to reduce danger".
>
> *Calum, PT Guidance, School 9.*

Other respondents felt that provision of that kind of information was not suitable for a classroom setting, but that it might be suitable for provision to pupils on an individual basis, either by the guidance team or by another agency altogether.

> I wouldn't necessarily do it in a full classroom situation, but if I had somebody who was showing signs of interest, I would perhaps see them individually and talk to them more individually and do it that way.
>
> *Robert, PT Guidance, School 6.*

> If for example a group of youngsters was identified, perhaps as using drugs, then perhaps community ed. [education] or something could do that.
>
> *Tom, PT Guidance, School 7.*

> I think the counselling agencies and addiction services, I think fine if they're workin' with people, I think that's okay. I would still be pretty wary about, I don't know what it is, I just feel uncomfortable about [harm reduction].
>
> *James, PT Guidance, School 8.*

Some of the respondents stated that they did not feel they had enough information about harm reduction to be able to discuss it with pupils, or that their own experiences did not equip them to do this.

> Dealing with any drugs situation hasn't been my personal experience. I could give a text-book kind of answer but it wouldn't be from the heart.
>
> *Mary, PT Guidance, School 1.*

> In terms of harm reduction, I would need to be in-serviced on that anyway. I mean, apart from the needles thing and drinking water and that, I really don't know enough about harm reduction.
>
> *Calum, PT Guidance, School 9.*

> Dealing with [harm reduction for] drugs is difficult because depending what they've taken, I'm not sure I would know what to do.
>
> *James, PT Guidance, School 8.*

Angela felt that the strength of her own personal feelings against drug use meant that she wouldn't be able to provide that kind of information.

> I would find it difficult to stand there and tell a class about ecstasy, to stand and say if you do this. I don't feel I could do that, because I am so against drugs...the harm reduction is a bit of a difficult one.
>
> *Angela, PT Guidance, School 2.*

Related to a lack of knowledge about harm reduction, was a real doubt among respondents about the information that currently existed about how to reduce risks. They felt that even if a pupil followed the information you provided to them, they might still come to harm and that no-one was really sure what advice to give.

> I would also emphasise to them that the harm reduction aspects, I don't think anybody is really terribly sure because if you've got, who was that girl who died of ecstasy? Leah Betts. She seemed to do everything properly. She took water but they don't seem, the medics don't seem to be totally sure how the body reacts to things.
>
> *Tom, PT Guidance, School 7.*

> There is conflictin' [advice]...The guidelines are really difficult... A few years ago we got things on solvent abuse "tell 'em the right way to use it and reduce the risk". Now the current swing is dinnae use it at all because there's worry over how many of 'em are dying possibly on first experience...So that's my worry about harm reduction is that you could give honest advice and it might backfire.
>
> *James, PT Guidance, School 8.*

Only Karen explained her reluctance to provide harm reduction information by outlining the effect she felt it might have on the pupils' usage of drugs. She felt that information on safer use might encourage a number of pupils to experiment (overleaf).

> It's a difficult line to get across because...you've got such a mixed group in front of you. You've got the youngsters who you know with absolute certainty would never, ever [take drugs] for various reasons, it would just not be something that they would be interested in. You've got this middle group who say "no, no" but might and just hearing that maybe you could do it safely might just tip them over the edge and then you've got the real group who are full of bravado, and who have been there who look at you rather smugly and think "well, what do you know"...And okay, there are the ones who need that message of "well if you're going to do it for goodness sake, here's how to go about it", but your worry is that you scare the ones at the bottom end because you're suggesting how to do it and you also give the middle group a sense of "well, I could try that then, if that's how you do it safely, I'll give it a bash... So it's really, really difficult.
>
> *Karen, AHT, School 7.*

The "difficult" nature of harm reduction as an issue for schools is emphasised again in these latter two quotes from Karen and James.

Despite all of the doubts expressed by respondents, harm reduction information was provided in many of the schools, although the model of provision varied quite significantly. In school 5, it was provided as a matter of course to older pupils.

> I think its done in the 14-18 Drugwise and also it would be done with the sixth years. You know you stress that if they're taking ecstasy, if you've got to be that daft, you keep your fluids up.
>
> *Fiona, AHT, School 5.*

Some of the respondents stated that harm reduction information was provided by external agencies who came into the school to deliver drug education. This was done either in the classroom (School 3) or at lunch breaks (School 4). Again, in school 3, it was provided for older pupils only (fifth and sixth years), and was done indirectly by reference to third parties.

> I think when we're dealing with senior students we're looking at "what if?" and we try to put it in the third party; "you're out with a group and its someone else that this has happened to, how would you react to that?" And that's why we use Health- Health Promotions is using that approach. And that's the way we have to deliver it...I think it's important that its third party.
>
> *Paul, PT Social and Vocational Education, School 3.*

> The way we get around it is to bring in other people because they can say what they like. You know, community workers can talk about harm reduction. We have very good links with various community organisations, they come in and do lunchtime workshops in the social areas on a variety of topics, drugs...and they can give that kind of information.
>
> *Doug, AHT, School 4.*

Many of the responses in relation to harm reduction education were confused, and it seemed that respondents were not quite sure about whether it was covered or not. On being first asked this question, Mary (School 1), Robert (School 6) and Tom and Karen (School 7) stated that they did not think they would provide this kind of information at all, or certainly not in a classroom setting (see previous quotes in this section).

After further discussion however, they indicated that they would give the facts if it came up in a discussion or if they were asked a question about it, although that might depend on how it came up.

> That kind of topic would perhaps come up in discussion...I don't think certainly with the younger ones we'd set out to be doing that. But if a question from a pupil came up in the class, [and] made that a relevant topic to cover, then we would do so.
>
> *Mary, PT Guidance, School 1.*

> If we're asked questions as guidance staff in particular, we would answer questions...If it comes up, you answer questions...You don't bring it up essentially and you certainly don't bring it up to promote it. But to maintain your credibility as a teacher if you are asked questions, you can't look embarrassed and you have to be prepared to actually speak about things.
>
> *Robert, PT Guidance, School 6.*

> I think [how we would respond in relation to harm reduction] would depend on the question.
>
> *Tom, PT Guidance, School 7.*

> Well, it would [depend on the question] and who was askin' as well to an extent, and what age group, and what your sense was of why the question was being asked, and yeah, I think there would be a number of factors.
>
> *Karen, AHT, School 7.*

When asked about harm reduction education in relation to alcohol, respondents were able to give more definite answers. In fact, Robert (School 6) indicated that provision of harm reduction information in relation to alcohol, also allowed coverage of "the disco scene", which indirectly related to drugs.

> We do give harm reduction information directly [for alcohol]. You know, along the lines of "don't drink alone", "don't drink in parks and collapse under benches". Binge drinking we do, fluids. We would, I suppose, the disco scene type things we do give directly, the "take plenty of water, keep cool" message, which is sort of directly related to other things without making it an issue.
>
> *Robert, PT Guidance, School 6.*

> Aye, well we do [cover responsible drinking]. There's a programme in there, it's on binge drinking and the consequences of binge drinking, so we do try to express that, the dangers.
>
> *James, PT Guidance, School 8.*

Given the difficulty and confusion surrounding the existence, appropriateness and practicalities of harm reduction education, many of the respondents were supportive of the idea of a policy being devised by the local authority to guide them in relation to the issue.

> [Catering for pupils with different drug experiences] we find difficult, and that's why we would be pushing quite strongly for an authority policy on how we deliver, if you're looking at a damage limitation approach.
>
> *Paul, PT Social and Vocational Education, School 3.*

> I'm quite surprised that there isn't [a policy on drug education including guidance on harm reduction], that we're not really quite strictly bound...I wouldn't want it to be too restrictive but I think it would be good for protection.
>
> *Tom, PT Guidance, School 7.*

> If it was an official policy for you to fall back on, I think yeah, then the authority is taking responsibility for it, it would take the onus off the school. I would still have my worries about harm reduction to be honest with you, but within boundaries.
>
> *James, PT Guidance, School 8.*

3.4.5. Classroom Discussions

In relation to classroom discussion about drugs, respondents were asked how open the pupils could be in discussing their own attitudes and/or behaviours in relation to drugs in the classroom setting. Many respondents felt that the pupils were quite open, however this was not always in relation to their own drug use, and it was much more common for pupils to be open about alcohol use or smoking.

> It's incredible how open they are. You know a girl will sit and tell you "My dad spent three years in prison for dealing drugs".
>
> *Doug, AHT, School 4.*

> I would say when we talk to the kids about what they do, the kids are dead happy to tell you that they smoke. They willnae keep that a secret... And alcohol is the same. They'll tell you if they're taking alcohol as well. We wouldn't even ask them if they're takin' drugs because they wouldnae tell us.
>
> *Simon, PT Guidance, School 9.*

> They might admit [drug use] if challenged in private...but its never really come up as an issue [in class], which would surprise you. The alcohol, yes, that has come up as an issue a few times...We know its common, we discuss it. They don't seem to think there's any taboo in that, whereas the actual illegal drugs...they won't really say.
>
> *Fiona, AHT, School 5.*

Some of the respondents described how discussions in drug education developed with age, so that in the later years, teachers could be more upfront with the pupils and ask them directly about what their experiences were and the pupils were less likely to give the answers they felt were expected of them.

> If you're talking about fifth year, you're talking an entirely different level because you know I think they're more mature at that stage that they can present their arguments better.
>
> *James, PT Guidance, School 8.*

> Pupils are remarkably open, you'd be surprised about how open in terms of things going on...It varies, the seniors I think, yes, there is much more give and take and there is much more honesty. Lower down the school, they tell you what you want to hear, I think.
>
> *Robert, PT Guidance, School 6.*

Some respondents mentioned that pupils were not encouraged to discuss the specific behaviour of themselves or of named others, but were advised to speak in the third party in the classroom. Where a pupil might disclose their own drug use, some respondents indicated that they would be suspicious about the genuineness of such a disclosure in the class setting. However, pupils were encouraged to speak to teachers on a one-to-one basis, if they wanted to do so.

> They're encouraged, well, within a class situation, they're encouraged to talk about "for instances" rather than specific incidents. Now that doesn't mean to say we don't want to talk to them about specific incidents but it has to be done more confidentially than that.
>
> *Bob, AHT, School 2.*

> I would be surprised if a pupil would admit to drug use in a classroom situation and in any case if they did, it would be their friend that did it. I think you would just sort of, you might in your mind, raise your eyebrows at what was said, and perhaps choose an opportunity to discuss it on a one to one later.
>
> *Mary, PT Guidance, School 1.*

On the other hand, Mary described how pupils would be encouraged to be open and honest as far as they felt comfortable.

> One of the things we want to do is encourage the youngsters to express themselves and to be as open as they feel they can be, knowing that the teacher is not going to go out of the room and say "Oh, such and such a body is into taking this drug or that".
>
> *Mary, PT Guidance, School 1.*

In addition to discussing how open the pupils were in the classroom, respondents were asked to what extent they were open with the pupils in discussing the enjoyable aspects of drug use. In other words, did they present "both sides of the story" and if so, how did they approach that? Both Robert and Fiona reported that they felt that legally teachers were expected to present a "zero tolerance" approach, but that as guidance teachers they would be flexible and try to give a balanced view.

> [The legal situation] isn't very clear at all. I suspect, legally, we probably are obliged to say no, [however] most guidance teachers will be fairly flexible.
>
> *Robert, PT Guidance, School 6.*

> Well, yeah, there's the choice-making but we really have to get the message across that this is not a good idea and obviously legally we have to have zero tolerance in the school. But you know we do try and give them a balanced view. You know we would say "you know ecstasy might well be okay" but we show them the Leah Betts video and we also use the "Boy called David", the one about solvent abuse so you know they do get a lot of fairly negative [input].
>
> *Fiona, AHT, School 5.*

Most of the respondents stated that they did try to explain the reasons why people use drugs, in terms of the pleasurable short-term effects, but that they emphasised the long-term negative effects to the pupils.

> We certainly discuss the reasons why people decide to take drugs. And I would certainly try to be balanced. I try not to be alarmist because apart from anything else I don't think that to say "no" and to create a big issue about how dreadful it all is, is a very satisfactory way of doing it.
>
> *Mary, PT Guidance, School 1.*

> I'll be saying "the effects of, right, this is the effect of [a particular drug]". And that is the main reason say a lot of people take alcohol, because "it makes me feel more comfortable"; "I feel happy in a crowd"; "I feel high, light-headed"...So it's the fact, the idea that drugs affect different people in different ways and that the high might not last very long and...there are risks long-term and the fact that you may come to a stage where you're taking the drug just to be normal, you need to keep taking it just to be normal and is it worth it?
>
> *Paul, PT Social and Vocational Education, School 3.*

> "It's good, they're enjoyin' it, they're getting' a buzz"...I would say [the reasons why people take drugs] in language the kids can understand. I think you've got to take it beyond that and say you know fine, but with pleasure comes a consequence and you've got to weigh that, you know, is it a good thing in the long term or is it a bad thing?
>
> *James, PT Guidance, School 8.*

Although decision-making was emphasised (see Section 3.4.2), there was no doubt that in some, if not all of the schools, the choice was already made for the pupils (i.e. not to use drugs) and this was the decision that was actively promoted (see passages overleaf).

.....

Passage from School 2 Interview

Interviewer: There has been some criticism of drug education in schools as saying that its promoting decision-making but at the same time telling [the pupils] what the right decision is. How would you feel about that?

Bob: Well, I think that's quite important in what we do and that's the premise on which we bring in people like Narcotics Anonymous [who] talk about the misery [drugs] have brought to their lives.

.....

.....

Passage from School 6 Interview

Interviewer: Do you find that while you're trying to teach decision-making particularly in the area of alcohol and drugs, that you're in a way trying to teach the right decision, rather than genuinely being objective?

Robert: Well, I think that's almost inevitable. That does happen. You know, you try not to... And certainly if I'm asked questions, I will answer questions as fairly as I possibly can. You have to be credible...You know lots and lots of people take drugs.

.....

3.5. DELIVERY

3.5.1. Teaching Method

The respondents described a variety of teaching methods that were used in drug education in their schools, and again it was clear that lessons varied considerably. Activities, discussions, brainstorming, written work, information provision and project work were all mentioned. A number of the respondents explained that they sometimes showed videos to the class as a stimulus for discussion.

> We'd vary it a wee bit. I think it depends on, you know, what you're doing, who the class is...I don't think there's one lesson that we do. You might want them working in groups, you might want them working individual, you might want to use a video just to encourage discussion.
>
> *James, PT Guidance, School 8.*

> We do do some just straight sort of group discussion type work on drugs, but often with drugs in particular, we'll use a trigger. We'll use a video as a trigger and then we'll go into discussion.
>
> *Robert, PT Guidance, School 6.*

> We use videos generally. We use the Leah Betts video. We use videos that we've taken from television programmes. We do actually ask the kids to name two or three drugs and write what they know about them under different categories.
>
> *Mary, PT Guidance, School 1.*

Doug (School 4) described getting the pupils involved in activities such as research, preparing posters or group activities. Paul (School 3) described how they were trying to increase pupils' involvement in co-operative learning activities. He explained this as being work in small groups where each person was assigned a different task. Each person in the group had to complete their own task in order for the whole group to complete the activity.

> At the end of the year we get them to design say, poster or wall displays or whatever, make leaflets. We have them researching different areas...And at that point they can go down the alcohol route, they can go down the harm reduction route, they can go down the "say no" approach. Basically find out whatever they want from their angle.
>
> *Doug, AHT, School 4.*

> It does vary...sometimes there might be an icebreaker depending, just getting the group or if you're splitting the group up into groups, the tutor group, it might be some kind of icebreaker just to get it moving around. Some kind of icebreaker, sitting down, start normally with circle time, introduce activities, feeding back. We're beginning to introduce co-operative learning methods as well. And then again the lesson will finish again back in circle time and reviewing what's been learned. So it tends to take that course.
>
> *Paul, PT Social and Vocational Education, School 3.*

In general, the respondents emphasised that lessons included a lot of discussion, including some small group discussion. As well as following a video or activity, discussion might also follow a session on factual information relating to drugs, as described by Fiona and Mary (overleaf).

> There's a lot of discussion. I don't teach the PSE myself but I have been involved observing, you know going in. There's a lot of, the lessons would start with a fair bit of factual information. The kids would be told exactly what the various drugs were.
>
> *Fiona, AHT, School 5.*

> When you're going over the answers [to a quiz-type activity] and any comments the kids want to make, my kids anyway, I would welcome discussion.
>
> *Mary, PT Guidance, School 1.*

Further ways of stimulating discussion that were used by respondents included "playing devil's advocate" and the use of brainstorming activities as part of the lessons.

> Well, I sometimes play devil's advocate, depending on the viewpoints you're getting from them just to have an openness of debate. I often say things in these lessons that I don't necessarily believe but it will make them think and make them argue their point... As an early exercise in drug education we say that, we often have a brainstormin' session for reasons why you take, why people take drugs. And you tell them why people take drugs.
>
> *Scott, PT Guidance, School 8.*

> You know they break into groups and they brainstorm in groups and write their things on bits of paper and collate their answers.
>
> *Simon, PT Guidance, School 9.*

It is clear that lessons varied considerably, and two of the respondents explained that the activities carried out in a lesson depended to some extent on who delivered it. Outside agencies were able to use more people and could do more varied activities (Section 3.5.3), while some teachers might not be comfortable with discussion, and would prefer to lead the class "from the front".

> Teaching methods are varied. Sometimes it depends, as well, who the guidance teacher is because not everybody is comfortable with that style. Some people are more comfortable with the stand-in-front-of-the-class approach.
>
> *Calum, PT Guidance, School 9.*

The lack of curriculum time described in Section 3.3 not only caused problems in terms of trying to fit topics in, but it also affected the teaching methods that could be used, particularly where each guidance teacher did not have their own classroom to work from.

> It's nice to be able to have youngsters work in groups to discuss topics and give feedback much as you would do in an adult sort of training session. What I find hinders that to some extent is, one the time that is available to you. In this school we're not in our own classrooms, so you can't be there to have tables arranged the way you want them to have them sit in groups. And when you're going to someone else's classroom and you've got to be out again in 35-40 minutes, you know there's only so much time where it is practical to rearrange and put them all back.
>
> *Mary, PT Guidance, School 1.*

As well as describing a variety of teaching methods, respondents outlined the efforts made to meet the needs (both developmental and behavioural) of the variety of pupils that were present in any one class. There is no doubt that this caused considerable difficulty for those respondents who were conscious of addressing this issue, as pupils could differ by up to two years in age, and more developmentally. Small groups were used to try to address this issue, perhaps with a mix of abilities in each group, in which case the more "able kids" were the ones who got involved in discussion and kept it going.

> The education problem is made worse, because of the huge developmental age gap that you can have in classes as well as the chronological. I mean the classes are a year chronologically spread, and five years developmentally?...Our register classes are only 20 so you can sort of subdivide groups within there...but it raises the question of whether you let them make their own groups or whether you do the groups yourself and try to get a mix in each group...
>
> *Robert, PT Guidance, School 6.*

> Broadly, the lessons are just really pitched as a mixed ability class lesson would be...The rule really would be to promote discussion. So you can have 'em in groups so that's compensated a wee bit wi' able and less able [pupils] in your groups or workin' in pairs or just as a whole class and bring it in as a discussion and just get the whole thing going from there. Cause your more able kids are going to carry the discussion anyway.
>
> *James, PT Guidance, School 8.*

Some respondents described particular concerns in relation to catering for pupils with special education needs.

> It's difficult... we have a special unit and we do try and integrate special unit children but they are obviously pretty low in developmental age...It isn't just the health side where the discrepancy is a problem, you do try and give differentiated material.
>
> *Robert, PT Guidance, School 6.*

> The lessons are really sort of broad-based, one of the areas where we have a concern is we sometimes have kiddies who have almost special education needs and we've felt that that's something we've got to look at. And in some cases, it's probably nae appropriate really to have them in the lessons because its flying straight over their heads and they're completely lost. That's true in other things, but I'll be looking at that because we feel we've got to try and address that.
>
> *James, PT Guidance, School 8.*

As well as coping with pupils at different developmental stages, respondents were asked in particular, how they ensured that drug education catered equally well for pupils who might have experimented extensively with drugs, as for those in the same class who might not even have tried alcohol. Although most of the respondents were asked this question, many responded by describing how they coped with the developmental gap, as quoted above. Mary (School 1) and Simon (School 9) did answer the question however, and explained that they did not differentiate in this way.

> [You're asking] if its differentiated? We would probably all want to work through the same basic theme but I haven't used what we would call really project work because of the time involved. But we've done, like the thing that I did, asking them about advice which nominated different drugs, there was a difference in there, but that's not really what you mean.
>
> *Mary, PT Guidance, School 1.*

> You've no idea who they are [the pupils who have experimented with drugs or those who have not] so you cannae differentiate. The message is for all. Basically.
>
> *Simon, PT Guidance, School 9.*

Mary was keen to think about this and to try to be "more imaginative" in coming up with activities for the pupils and she hoped that the variety of lessons and opinions would mean that they "hit the mark some way".

> Hopefully, a variety of opinions will help and what's a good teacher for one might not be not be for another, it depends on the way they learn and their own experiences. So hopefully with one or other of the approaches, we'll hit the mark some way.
>
> *Mary, PT Guidance, School 1.*

3.5.2. Teacher

Each interview also included discussion of who delivered drug education lessons and what impact if any, that might have on the quality or success of school-based drug education programmes. Respondents described the differences between different teachers in the school, the training that teachers received and the arrangements made within the school to deliver drug education.

3.5.3.a. Variation

One of the major themes to emerge from discussion with teachers of drug education, was the enormous variation that exists between different teachers in the same school, between lessons to different classes (even with the same teacher), and between lessons at different times of the week. As summarised by Tom:

> There are probably some teachers who could make an absolute mess of any lesson and there are other teachers who can make a fantastic lesson out of absolutely nothing. I think there's always going to be variety... There's bound to be variation and there'll be variation between two different periods with the same teacher...Also because of the timing...if I've got two second year classes, one of them might be first period on a Tuesday morning and the other one might be last period on a Thursday and they're going to be different. And also the timing in the session of lessons can be quite important...You know there are particular emotions that a lot of kids have round about Christmas with absent parents and disappointments and God knows what!
>
> *Tom, PT Guidance, School 7.*

Others were also in no doubt that 100% consistency was impossible to achieve, and that the individual strengths and personalities of different teachers meant that lessons varied hugely.

> I've got six guidance teachers who've all got different strengths, different personalities. And they've all approached the topic in a different way and managing that situation is immensely difficult. You never achieve 100% consistency in a course because folk are different...in terms of the terminology, the vocabulary that people are prepared to use...
>
> *Bob, AHT, School 2.*

> It varies so much. There are so many variables. The teacher, the material, the information that the kids have to begin with and the group of children. You know, some groups knit and are very responsible and are very adult and some groups knit and it goes the other way, they become incredibly silly and childish over it. There's a lot of variables...Sometimes it is older teachers because when they came into teaching that was what teaching was about. Things have changed. But there are some younger teachers who are just not comfortable with personal issues and things.
>
> *Robert, PT Guidance, School 6.*

Mary (School 1) described how she personally had felt earlier in her career that she lacked credibility with pupils because she had no first-hand experience of drugs. This gave an insight into one of the sources of discomfort that might affect a teacher's confidence in delivering drug education.

> If they ask about tobacco and alcohol, I tell them what my experience is but you know some of them "you've never even had a joint" and I have to say "no" and I think "Oh well". You know, that's my street cred gone right down the tubes...I felt it might make someone more credible if they could relate their own accounts. I don't feel like that now.
>
> *Mary, PT Guidance, School 1.*

3.5.3.b. Dedicated Guidance Delivery Versus FLGT Delivery

An issue which was brought up by many of the respondents was that of who should deliver social education (or PSE) in secondary schools. Respondents described the delivery of PSE by first level guidance teachers (FLGTs, sometimes referred to as register teachers) and compared the quality of provision involving FLGTs with that of programmes delivered solely by full-time guidance staff. Ideally, any delivery of PSE by non-guidance staff would rely on volunteers as described by Angela.

> Any staff can be asked [to be a first level guidance teacher] but some teachers can say "I don't really fancy helping to deliver the PSE programme", so they wouldn't be given a first or second year class. So it has to be a teaching member that would like to participate...
>
> *Angela, PT Guidance, School 2.*

However, it is clear from Paul and another guidance teacher's descriptions that teachers cannot always opt out of delivering PSE lessons.

While the programme is ostensibly delivered by volunteers, they might be "conscripted volunteers" as the second teacher put it[xv]. Both of them described significant problems that arose in their schools because some staff were not willing or able tutors for PSE.

> [Drug education] was difficult at the time because it was being delivered- because a number of the first and second year tutees, they were secondees, basically, or press-ganged into, you've got a spare period in your timetable, would you like to be involved in personal and social education?.. You go through the process without really thinking about what you're delivering.
>
> *Paul, PT Social and Vocational Education, School 3.*

> Our first level guidance teachers were volunteers to deliver social education but it, in the way of these things, they were conscripted volunteers in some cases. We weren't very happy that all children were getting equal opportunities. The way we have delivered the course is that each of us [guidance staff members] is responsible for a single year's social education and we produce the course in its entirety with lesson plans and give it out to the first level guidance teachers and even so they weren't making the best of it.
>
> *PT Guidance*

James also described his doubts about delivery of PSE outside of an established guidance structure.

> I think a lot of schools where you dinnae have an established guidance structure or PSE programme, where you maybe get people recruited in to do this lesson and someone else to do that lesson, I'm quite sure it isn't credible at all and kids just treat it in that fashion.
>
> *James, PT Guidance, School 8.*

Because of the problems described above, a decision had been taken in one school, to stop having FLGTs deliver PSE and to move to a system where all PSE lessons were delivered by one of the team of six guidance teachers. The respondent from this school felt that this would resolve some of the problems of lack of interest and discomfort that they found with some first level guidance staff. In particular, the huge variation in quality of delivery should lessen.

[xv] The school in which the decision was made to move from FLGT-led to dedicated guidance team delivery was eventually selected as the case study school and it is therefore not identified here to protect the identity of this respondent. Quotes from this respondent are referenced simply as "PT Guidance" in this section.]

> Lessons vary hugely. This has been a particular problem here because of the delivery by first level guidance staff. Some of them are interested and comfortable. Some of them are interested but aren't comfortable. Some of them are neither interested nor comfortable. And the message kids get does vary from person to person... There are some staff who wouldn't dream of referring to harm reduction.
>
> *PT Guidance.*

Although variation may be reduced by the change described, the respondent was in no doubt that some variation was inevitable. As Bob put it however, variation is not a problem in itself, provided that the knowledge and understanding, and "all the areas" are covered.

> I don't think I want everybody to approach [a particular situation] in the same way. As long as I was guaranteed that everybody is conveying the knowledge and the understanding, when it gets down to opinions and those aspects that can vary, I think we have to live with that. In the same way as I wouldn't say to nine English teachers "You ought to teach the literature aspect of your course the same way". As long as its communicating and it covers all the areas.
>
> *Bob, AHT, School 2.*

3.5.3.c. Training

Respondents were asked about the training that had been received either by them, or by the teachers of drug education in their school. The picture portrayed by the respondents varied quite a bit in relation to training. Fiona and James were reasonably satisfied with the level of training that staff from their schools had access to or had achieved.

> Well, [the guidance teachers], they've all been to the various Health Promotions courses on drugs awareness and so on, alcohol awareness. You know we always try to keep up to date with the new packs...They go [on training] on a voluntary basis. I think there's just a very small token fee but its not much. The big issue for us is covering people to go out, but we have a fairly health staff development budget so it's financed out of that.
>
> *Fiona, AHT, School 5.*

> I've been sent on two national in-services in terms of training. Every other member of the team is trained to an extent in drugs education...So from that point of view we're competent. We're certainly not outstanding, but we're certainly competent.
>
> *James, PT Guidance, School 8.*

James went on to explain that while he would like more training, he had already been on the basic courses. He was open to the idea of further training or collaboration with other guidance teachers.

> The difficulty you come up with is if you look at in-service training...you find what's offered is a beginner's course. Well, I've already done that and...although it could be quite useful if the information is changin'... [it would be useful to] look at what's going on and how to maybe reinvent.
>
> *James, PT Guidance, School 8.*

In other schools, respondents acknowledged the need for further training for staff but felt that training had not been offered locally in the recent past, or that there was little/no funding available to support staff to attend training.

> I think so [it would be good to have skills training] aye. I mean the longer you're at the job, the comfier you get with a particular style and you probably need to work on parts like that.
>
> *Simon, PT Guidance, School 9.*

> Staff are worried about drug education because they feel they don't know enough because its so quickly changing and so on. So there is a training issue for staff...You used to be able to do the Health Promotions courses and things and get time off school and because of financial and time constraints, you can't do that. You have to do it in your own time these days, but it does happen.
>
> *Robert, PT Guidance, School 6.*

> I can't remember when I was last on a drugs education course, can you? [to other respondent]. I don't think there's been any locally here, in this region for a long time...It's more difficult to do now because of cutbacks. These courses aren't so easy to get onto.
>
> *Calum, PT Guidance, School 9.*

3.5.3. Use of External Agencies

As well as considering the varying abilities and strengths of teachers within this school in delivering drug education, respondents described the external agencies that were used in each school as part of the drug education programme. Table 3.6 illustrates the agencies referred to and the schools by whom they were mentioned. Most of these references were in relation to past use of the agency in work with pupils, although there were some other uses, as described below.

A wide range of agencies or individuals (nine in total) were involved in school work in the schools in this study, and four of them were widely used. The use of these four agencies is discussed in further detail below. The involvement of the school nurse in drug education is included in the table for comparison and is discussed in the next section (3.5.4).

External Agency:	School:
Health Promotions (NHS Grampian)	Schools 1, 3, 6, 7, 8, 9
Grampian Police	Schools 1, 2, 3, 6, 9
School Nurse	Schools 3, 5, 6, 9.
Calton Athletic	Schools 3, 4, 5, 9
Paul Betts	Schools 1, 6, 8, 9
Aberdeen Drugs Action	Schools 1, 4
Narcotics Anonymous	School 2
LiveWire Theatre Company	School 5
Fast Forward	School 8
Al-Anon	School 9

Table 3.6: External Agencies Referred to by Respondents.

External agencies were used for a variety of reasons – to deal with difficult issues like harm reduction as discussed above, to enhance the perceived credibility of the drug education or simply to add variety to the message.

> Things that we do in school on the whole get a better press from pupils if we have visiting speakers.
>
> *Robert, PT Guidance, School 6.*

> I think further up the school you begin to get a sense of "we've done this before" particularly if it's the guidance teacher [who] delivers the SE, so that one person has delivered it in S1, S2 and S3...I think we kind of consciously feel there's a need to break the mould a wee bit...to hear it from somebody else.
>
> *Karen, AHT, School 7.*

> [Calton Athletic] can say and do things which we could never ever do.
>
> *Doug, AHT, School 4.*

3.5.3.a. Health Promotions

Health Promotions is the name by which the health promotion section of the public health service of NHS Grampian was known. They offered direct services to secondary schools as described in the following quote from their website:

> Our aim is to complement the in-house health education programmes at every school in Grampian. We target the 13-16 age group because research shows that health education has the greatest impact at this age. Health Promotions input is flexible, although the most effective option usually is to do a whole year induction day(s) (or part days)...We can also do a series of PSE classes over a number of weeks.
>
> [Health Promotions, 2002]

In general, schools were satisfied with the input they had from Health Promotions, with both Mary (School 1) and Paul (School 3) noting that they would discuss and plan the content of the sessions with Health Promotions before any delivery. Karen and Tom described how Health Promotions had more staff and could use a greater variety of approaches than the classroom teacher.

> We have Health Promotions in, certainly for drugs sex and rock n roll, that workshop set that they do and that goes down quite well and we do that with our fourth years...its more credible for the students if its not school staff and Health Promotions are not bound in the same way.
>
> *Robert, PT Guidance, School 6.*

> People like Health Promotions and other agencies...they can come in with maybe half a dozen or eight or ten people and they take half a year group and they can do all sorts of different things.
>
> *Tom, PT Guidance, School 7.*

In School 8 however, there was some concern over some of the language that had apparently been used by Health Promotions in some sex education input, and the reported fact that school staff were not allowed to be present during the sessions.

.....

Passage from School 8 Interview

Interviewer: Do you get to see the materials [that they use] or anything?

James: No. Well, they left some booklets and stuff that they used and they're available every[where] but they-

Interviewer: But they don't give you a lesson plan or run you through it?

James: No, we give them a free hand to do it because we felt it was, they come in and do it...but to be fair I think they would if we approached them, and tailor it to what we want. They will tailor it.

Scott: I am very suspicious of people that come in and will not disclose what they're going to do and don't want you there. They must have something to hide.

.....

Despite their expressed concerns, it seems that this school did not make any attempt to preview the content of any sessions; rather Health Promotions were given a "free hand" by the school to plan both the sex and drug education lessons as they wished. These concerns were not echoed by any other school.

3.5.3.b. Grampian Police

Many of the schools had input from representatives of Grampian Police, as each area in Grampian is served by one of twelve police school liaison officers, employed by the police force. These were involved in a number of different ways with schools, and offered direct input to pupils. Most commonly, respondents mentioned that the police representative in their school used a set of plastic boxes containing replica drugs (samples box) when working with pupils in order to show them what different drugs look like. None of those that mentioned police involvement expressed any dissatisfaction.

> The police have for several years now, come in and spoken to first years, for a forty minute period. And usually what he brings in is a box of, they're all fake, but it looks very convincing, samples of drugs and needles and all the rest of it. And the kids get an opportunity to, they come and look at them, they're made of plastic containers and they pass them around the kids. And of course the policeman tells them entertaining tales, all true of course, but it's a different voice from the teacher and it's the real thing when the policeman tells you.
>
> *Mary, PT Guidance, School 1.*

> And the police are quite good, our educational liaison officer is excellent...and they've used footage from Aberdeen, the police cameras in Aberdeen, Saturday night in Union Street in Aberdeen and some situations inside clubs and so on and things that will, that could happen.
>
> *Paul, PT Social and Vocational Education, School 3.*

> Constable Gordon is with the police force but he is actually concerned directly in drugs education and we do see him a lot. He speaks to our sixth years. He speaks to our second years... He has a samples suitcase which he brings... He uses the box much more with the sixth years [the peer educators] for training.
>
> *Robert, PT Guidance, School 6.*

Further details of the involvement of Grampian Police in drug education are available from their website (Grampian Police, 2003).

3.5.3.c. Calton Athletic

Calton Athletic, also known as Calton Athletic recovery group is a Glasgow-based charity that involves "rehabilitated" drug users in drug treatment and prevention activities. One of their stated aims is:

> To provide and manage unique projects dedicated to drugs prevention and awareness, providing a range of services for schools, communities, prisons, social services and other organisations throughout the United Kingdom
>
> [Charities Direct, 2002]

There was considerable disagreement among respondents over whether or not Calton Athletic were an appropriate group for working with pupils in schools. Of the schools that mentioned them (Table 3.6), three (schools 4, 5 and 9) had used them for delivery of sessions with pupils and were very pleased with their input.

Doug especially liked Calton, as their presentation fitted in with his focus on presenting to his pupils what he sees as the hard-hitting reality of drugs (Section 3.4.2).

> We had Calton Athletic in on Friday morning... Their presentation is wonderful...They do their three workshops – "From cannabis to chaos" is the first one. The second one is "The life of a drug addict". The third workshop is "The effect on the family" and each workshop as they call it is just one individual telling their story...and [the pupils] are able to ask questions afterwards and so on... A lot of local authorities don't agree with their approach because it is very hard-hitting. You know its just in your face reality.
>
> *Doug, AHT, School 4.*

> I quite like the Calton Athletic folk because they do not glamorise it at all. They present it as a very nasty done deed. You know this is what happens to you, kind of thing, there's no great glamour or excitement about it at all.
>
> *Fiona, AHT, School 5.*

In School 2, a former drug user from Narcotics Anonymous had delivered a session to pupils and this had been well-received, according to Bob.

> What has worked particularly well is, we bring into the fifth year, Narcotics Anonymous and we have an hour session at a whole year group assembly, cause we can't take them in eight, nine times. And that elicits a great response from the kids because we're bringing in users who can talk from experience. We recently had one, a lady who had been a user herself and her daughter had become addicted and her daughter had died. And you know the kids are so intently listening to this and to me that's the best message they can get.
>
> *Bob, AHT, School 2.*

Paul (School 4) mentioned that he had considered having Calton Athletic in, but had some reservations. Robert (School 6) also expressed reservations in general about the value of ex-user groups working with pupils.

> We've toyed with the idea of Calton Athletic and I was at the point of saying "yes" but I've always backed off. I don't know why. I feel it's a sort of a, quite aggressive approach to take...with Calton Athletic I would be, feeling a loss of control in some way.
>
> *Paul, PT Social and Vocational Education, School 3.*

> We have had in, cured addicts, not talking to children in fact, but talking to guidance staff and to teachers and we haven't gone down the line of using them with pupils. I'm not quite sure why. I have certain concerns. First of all, I think cured addicts perhaps give the wrong message and you miss the ones who've died on the way and the ones who've sunk deeper and deeper into the slough of despond...[Cured addicts] are the ones who have tried it, who may have become addicted, who have recovered and who are confident and things have worked well.
>
> *Robert, PT Guidance, School 6.*

3.5.3.d. Paul Betts

Paul Betts is the father of Leah Betts who died in 1995 after taking an ecstasy tablet. Since that time her parents have delivered drug education sessions in many schools both in England and in Scotland. They moved to Grampian in 1999. The respondents from Schools 6 and 9 were very pleased with Paul Betts' input into their drug education programme and Mary (School 1) felt it was very important to organise some input from him as soon as possible.

> We had Paul Betts in to talk, just as a one-off... He was very, very good. He was able to sort of wind them up almost to a point of silliness about it, and then drop them right back down with some serious thing. We were really very, very pleased with him.
>
> *Robert, PT Guidance, School 6.*

> Paul came in, yeah, that went down very, very well... Strong message from Paul, it's a very strong "anti" message. Paul doesn't speak a lot about harm reduction, does he?... He tells it as it is. Paul Betts will be back in [this] academy.
>
> *Calum, PT Guidance, School 9.*

> [Paul Betts] was in [another school] and spoke to, I believe, a whole year group for three hours. If he kept the kids attention for three hours, I mean, he's doing a marvellous job...I think to have Mr. Betts come and speak to pupils, I'm sure, I really feel we should get that organised as quickly as possible. I think its important.
>
> *Mary, PT Guidance, School 1.*

Despite such positive feedback from elsewhere, detailed questions were raised about his approach and the content of his input after he had delivered a session in one of the schools. The language used by Paul Betts and the relevance of the information that he presented to pupils were questioned as well as the appropriateness of some of his comments about teachers and the accuracy of his stated predictions.

I wouldnae question the mans sincerity and he has a good tongue. He's worked on something, he delivers it and he holds an audience and he held the kids attention but I mean he uses language that we wouldnae use and I don't think that's good. You know, a couple of statements he came up with, he said "teachers know nothin'" which annoyed me, because I've done a couple of national in-services which I'm not brilliant at so I dinnae, I'm not brilliant, I've got some knowledge and I wouldn't like to be portrayed as someone who doesnae know anything.

PT Guidance[xvi].

He's talkin' about - Is it TCH in cannabis? I always forget that - saying well, it's now up to 60%. Well, in a sense, that's irrelevent. It's how much you use and abuse it in a sense. It doesnae matter if it's sixty or thirty.

PT Guidance.

He certainly has their attention and he's certainly "dinnae use drugs". He didnae want them usin' drugs and to that I'll gie him credit you know. But he uses the slide, this is me ten years ago, his head up his bum. With kids, we'd no put that in front of them as an image. He was usin' a lot of language of the coarse sort, which of course the kids are quite delighted but we're not gonna stand... I could go into class and I could entertain the troops no problem, with twenty-odd years experience by being flamboyant and throwin a bit and havin a great laugh and you know it's magic...

PT Guidance.

It's easy for him to come in and entertain them, he's not in front of them every week. I mean he was crude and rude and I don't think it's the place. If he's got to do that to get their attention I think it's rather sad...

PT Guidance.

3.5.3.e. Other Groups

In addition to the above groups Bob (School 2) and Fiona (School 5) both mentioned that they had used or were planning to involve drama groups as an adjunct to their drug education programme. Bob, who had used them in the past, felt that it added an important variety to the programme (see quotes overleaf).

[xvi] The respondent who made these comments and his/her school are not directly identified here due to their potentially sensitive nature.

> We've also used some of the drama groups that go around the country. They've done a variety of things for us. They've done drugs, use of narcotics. They've done alcohol. And that kind of message is better than what's taught. It's a different kind of approach. You've got to be factual but you've got to have the interactive approach as well, try and have a variety of all of these things.
>
> *Bob, AHT, School 2.*

> There's quite a lot of independent companies doing drama workshops on these topics so we're currently looking to book one to do a thing, "LiveWire"... They have an assembly in the morning where the whole issue is discussed. A small chosen group of pupils are taken away by the company for the day to work on a play and then we have another assembly last period again when the group come together and they actually perform it for other kids
>
> *Fiona, AHT, School 5.*

3.5.4. School Nurse Input

The school nurse was used in a number of the schools as an additional resource for the provision of health education, in particular sex education but also drug education. Of the four respondents that mentioned using their school nurse, they were generally pleased or very pleased with his/her input.

> We've a very good school nurse. She's really proactive and she's quite happy to play an active part in PSE and she gets involved in the programme...
>
> *Fiona, AHT, School 5.*

> Our school nurse is very good... Her confidentiality rules are slightly different from teachers and from education. So she can guarantee confidentiality in things where we can't always. So we, I use her a lot. Not just for drugs but for all things within school.
>
> *Robert, PT Guidance, School 6.*

3.5.5. Peer-Led Drug Education

Although many of the schools had some programmes of peer support in place, where older pupils helped younger ones with reading, or as part of a "buddy system", only the school that was eventually selected as the case study school had an established programme of peer-led drug education. This programme is described in full in Chapter 4.

3.6. CONCLUSION

It is clear from the results presented in this chapter that there was considerable variation in provision and practices both within and between individual schools. Nonetheless, some themes and issues were identified as being common to a number of schools and these are highlighted above. The validity and reliability of these results are discussed further in Chapter 5 while their implications for current and future practice are discussed in Chapter 6.

Chapter 4. Case Study Results

This chapter describes the information that was generated by the research techniques used in the case study as described in Chapter 2. As in the previous chapter, the results are presented here but considered and discussed in detail in Chapter five. Although no detailed discussion is presented in this chapter, issues and questions that occurred to the researcher during the fieldwork or observations were recorded in her case study notes, and therefore make up part of the body of material that constitutes this case study. These notes were used as an additional data source in compiling the descriptions of the content and delivery of lessons. The results of the case study are presented within a framework that is broadly based on the headings used in Table 1.9 to allow easy comparison with features of best practice in drug education. This part of the research was less focused on the planning or development process for drug education and was more focused on what was delivered in practice in the school. The division of the chapter reflects that focus.

The case study was based on general observations, lesson observations (Table 2.6), pupil interviews (Table 2.7) and staff interviews (Section 2.5.4.d) in the selected school over a period of four months as described in the Chapter 2. Again, the selection of vignettes, extracts from observation notes, or quotations from documents and interviews follows the guidance of Wolcott (1990) in that repetition has been avoided as far as possible (see page 115). Throughout the chapter, the origin of each extract or quotation is coded in square brackets [ ] and the breakdown of each code is described in Table 4.1 overleaf.

Prior to presentation of the results in this chapter, the selected school and the community in which it was based are described in as much detail as can be given while still maintaining an acceptable level of anonymity (Section 5.4). To protect the identity of the participants in the case study, the town and school have been given fictitious names: Allandon and Allandon Academy respectively. Staff were also given fictitious names as outlined as shown in Table 4.2 below. In addition, detailed references for the information given below cannot be included as they would reveal the location and identity of the school, and therefore the respondents. In these cases, a short description of the source of the data is given where possible, and extracts are marked as "not referenced" to avoid any ambiguity.

Codes for Origin of Extracts and Quotations.		
Extract Type:	**Example:**	**Explanation of Code:**
Guidance Interview	[GI3, 108]	Guidance Interview Number 3, Paragraph 108.
Pupil Feedback	[2A1, 56-64] or [4LM, 34]	Class 2A (second year class A), Feedback Session 1, Paragraphs 56-64. One specific feedback session with Class 4L and 4M (fourth year class L and M combined), Paragraph 34.
Peer Educator Feedback	[S62, 34, 46]	S6 Pupils, Feedback Session 2, Paragraphs 34, 46
Lesson Observations	[L3L4, 78-90] or [L4LM, 56-60]	Lesson Observation with Class 3L (third year class L), Number 4 (fourth lesson observed with this class), Paragraphs 78-90. One specific lesson observation with classes 4L and 4M combined, Paragraphs 56-60.
General Observations	[GN1, 12]	General Observation, Notes 1, Paragraph 12.
Teacher Feedback	[TF3, 10]	Teacher Feedback (other than guidance interviews), Notes 3, Paragraph 10.
Rector Interview	[RI, 34]	Rector Interview, Paragraph 34.

Table 4.1: Explanation of Origin Codes for Extracts and Quotations

4.1. ALLANDON TOWN

Allandon town is in a predominantly rural area, surrounded by scenic and varied countryside, and with good links to the nearest city. The town has a long history being mentioned as far back as the twelfth century and boasting evidence of prehistoric settlement. Although it profited from earlier industrial development, it remained small compared to today until the coming of the oil industry to the region in the 1970s. Nowadays, it is an important administrative and service area with a population in 2001 of approximately 11,000 people. It has grown rapidly in the past 30 years and is the location of a number of important employers as well as being an important commuter centre for people working in the nearest city. Approximately 30% of the working population of Allandon commute to the city. This information and that of the next paragraph is extracted from the website of a local alliance of public authorities in the region (not referenced).

Allandon is a prosperous town with very low levels of unemployment: 1.3% in January 2002, compared to a regional average of 2.1% and a national Scottish average of 4.5%. Tourism is an increasingly important industry with numbers having grown significantly since 1997. The average house price in the town is approximately £65,000 and hospital discharge figures show that levels of ill-health are below the average for the region. In addition, the percentage of school leavers in Allandon who go on to further or higher education is 59%, well above the Scottish average. The population of Allandon is older than the regional average, with less people under the age of 14 and a higher proportion over the age of 65.

> On the whole, it's a reasonably well off catchment area. Some very poor kids but they are very definitely the minority.
>
> *Ruth Mackay, PT Guidance, [GI1: 8]*

4.2. ALLANDON ACADEMY

Allandon Academy's website states that the school was founded in the early 20th century in keeping with the town's growing importance as an industrial centre. Initially a granite building, the premises expanded massively in the fifties and sixties, and the buildings completed in that era reflect the flat-roofed and concrete architecture of the time. The current catchment area of the school extends to a number of communities outside the town. The school is a six-year comprehensive school with over eighty teaching staff and over a thousand pupils. Ruth Mackay, a principal teacher of guidance at Allandon, explained that the academy has a growing and mixed roll:

> It's a growing roll. Half of our pupils are within [Allandon] itself and we bus in a further six hundred pupils...It's a good school. I mean if you were looking for a genuine comprehensive school, this is probably quite close to being [one], because we have some incomers through the oil and we have the local teuchters[xvii]. It is a fairly good mix.
>
> *Ruth Mackay, PT Guidance, [GI1: 16]*

[xvii] It is not easy to find a definitive explanation of the word "teuchter". Pronounced "choochter" this was (is) a (sometimes contemptuous) name given by lowland Scots to someone from the Scottish highlands or islands. [See http://www.scotsmagazine.com/words.htm for a definition]. It is not in any way used disparagingly in this context.

The school website describes the aims of Allandon Academy as being based on the "belief that the individual needs, abilities and aspirations of all young people should be respected".

> Our priority is to equip pupils with the basic skills they need for life. In order to do this we aim to provide the kind of interesting and stimulating environment which will enable pupils to realise their learning potential and lead to life-long learning.
>
> [Extract from School Website, not referenced]

The school is described as focusing on instilling in pupils social attitudes and awareness of others, confidence and the ability to adapt to change among other characteristics.

> We encourage honesty, self-reliance, self-control, consideration, and courtesy as well as pride and neatness in person and work.
>
> [Extract from School Website, not referenced]

Pupils at Allandon "are regarded as individuals with individual needs" and those needs are catered for through the guidance system and the special educational needs team. There are six principal teachers of guidance (PTs Guidance) who together make up the guidance team at the school (Table 4.2).

The Guidance Team: Six Principal Teachers of Guidance (PTs Guidance)	
Catherine Baxter	David Kerr
Ann Brown	Ruth Mackay
Jim Cameron	Tony Morrison
All names have been changed.	

Table 4.2: The Guidance Team at Allandon Academy

As well as being responsible for delivery of personal and social education (see below), each principal teacher in the team holds pastoral responsibility for about 200 pupils divided vertically across every year of school. The schools' most recent inspection report (not referenced) praised the atmosphere that had been established between teachers and pupils at the academy.

> Overall, the school had a good ethos. Staff had established a welcoming environment for pupils and visitors. Pupils and staff identified strongly with the school. Relationships between teachers and pupils were very good.
>
> [HMI, 1999, not referenced]

The school website also states that a working partnership between parents, teachers and pupils is sought at the school. This description was supported by the HMI report, at least in relation to parents. The report stated that the school had developed a strong partnership with parents by being responsive to their concerns, adopting a welcoming attitude to parents, offering information evenings and providing good quality homework diaries and regular reports on pupils' progress. In terms of health education, it was stated that:

> A good quality health education programme was provided at all stages through personal and social education lessons and coursework in a number of subject departments.
>
> [HMI, 1999, not referenced]

No further details or comment on the health education programme were available in the HMI report.

4.3. Prevalence of Drug Use

The Grampian Youth Lifestyle survey of 1998 allows a comparison between individual school figures relating to drug use by pupils at Allandon Academy and the general figures for young people across Grampian. In Grampian at that time, 40% of young people had been offered illegal drugs and a total of 21% of respondents had tried illegal drugs. Of the drugs listed, cannabis was by far the most widely used – it had been taken by 91% of those who had used an illegal drug (Health Promotions, 1998a). This survey was also broken down to individual school level and figures obtained directly from the Allandon Academy report indicate that 45% pupils had been offered illegal drugs (not referenced). The proportions of respondents who had used cannabis (~22%) and magic mushrooms (~5%) were similar in the academy sample and in Grampian as a whole; however, in Grampian 1.4% of respondents had tried cocaine, whereas in Allandon Academy, the figure was 4.6% (ibid). The Allandon Academy youth lifestyle survey report does not indicate whether these differences are statistically significant.

Over the course of the case study, pupils were asked during feedback sessions with the researcher what they knew about drug use in the area and which drugs they were aware of people using. The answers received were very varied, however almost all of the respondents at all ages were aware of other pupils who had used or regularly used cannabis. As one pupil indicated, it was seen as a drug that a person would be more likely to use than all "the other drugs".

> I know people who are doing drugs...the marijuana, you hear people doing that all the time.
>
> *S2 Pupil [2A1: 108]*

> The only thing I know some people take is dope...And they don't do it very often. Once a month. They don't have enough money. They don't have jobs or anything. [They are third years]. There are some first and second years [who take dope] because their older brothers or sisters influence them.
>
> *S3 Pupil [3H1: 162, 165]*

> I would say that maybe with cannabis if I was in a situation where folk I knew well and respected were all smoking cannabis and offered me some, then I might. I'm not totally sure about that one. But I don't think I will change my mind about any of the other drugs.
>
> *S5 Pupil [5D1: 110]*

Virtually all the pupils agreed that cannabis was the most commonly used of the illegal drugs, although some were aware of people using other drugs, including ecstasy, amphetamines and cocaine. The pupils' awareness of drugs in their neighbourhood or school community was not uniform: some were more aware of ecstasy use, while others mentioned speed or cocaine.

> Dope is the most common. In fourth year and maybe some in our year would maybe take something stronger, maybe speed. You hear things; they're getting bored of this so they try something new.
>
> *S3 Pupil [3F1: 194]*

.....

[xviii]Helena, S6 Peer Educator: There's an awful lot of cannabis. I mean I don't live here, but from being in school here, I can tell you there's an awful lot of cannabis.

Rachel, S6 Peer Educator: There's a lot of ecstasy.

Helena: A lot of ecstasy.

Rachel: And Valium

Helena: You don't really see much LSD, there's a little bit of coke, but not heroin...In [Allandon], there's quite a few on coke, but E, there's far more - its more social."

Extract from Peer Educator Feedback [S62: 100-108, 114]

.....

Justin, S6 Peer Educator: Ecstasy is not really very widely used in Allandon. Cannabis and speed are the most popular drugs. And cocaine, that's a lot more widely used now.

Researcher: By people in school? By pupils?

Justin: Yes. It's seen as glamorous, as though its only used by famous people.

Extract from Peer Educator Feedback [S61: 22]

.....

The use of benzodiazepines, specifically diazepam ("vallies") was mentioned by quite a number of pupils who agreed that it was not unusual. Worryingly, one pupil indicated that "vallies" were usually taken with alcohol.

I've heard a lot about Valium and stuff, tranquillisers – people taking them.

S5 Pupil [5D1: 84]

[xviii] Extracts from conversations with staff or pupils are presented as they were originally typed up by the researcher. Although this means that various different formats are used, this was thought preferable to altering or editing the original notes as far as possible.

.....

Gary then explained that ecstasy was not really the drug that was common in school. It was more likely to be dope or vallies.

"Are they popular?" I [the researcher] asked.

"Dope is" replied Anna.

One of the boys confirmed that "yeah, they are, dope is popular. Vallies are popular. The whole of [an adjoining area] is on them."

"I don't even know what vallies are, what are they?" asked Anna.

I [the researcher] explained that vallies is a name for Valium, which is a tranquilliser...I told them that they're very dangerous especially if you mix them with alcohol.

"That's what they do" said Gary.

Extract from Pupil Feedback [4LM: 23]

.....

Although guidance teachers in Allandon Academy were unsure of how widespread drug use was, it is clear from discussions with them that drug-related incidents are not unusual.

I think the general perception of the youngsters is that it's rife. Now whether or not it's a small group who've got a high profile so that youngsters think that there's an awful lot of drugs going on in the area in parks and in side streets...I don't know.

David Kerr, PT Guidance [GI7: 162]

.....

After the guidance meeting I [the researcher] went back to [the guidance office] with Ruth [PT Guidance]. She told me that they have a problem just now, there is a suspected drugs issue. "There is a girl coming in, in the afternoons and throwing up. Her hands are shaking, and things are not right. She hangs around with a group behind the community centre who are skateboarders, they're not academic. It's most likely to be cannabis, but I don't think we'll get it out of her".

Extract from General Observation Notes [GN6: 2]

Drug incidents were also an issue in the Special Educational Needs unit of the school.

> As I [the researcher] was leaving the office I met Elizabeth Wilson who is a Special Educational Needs (SEN) base teacher. Ruth [PT Guidance] suggested that she would be a good contact as some of the issues that the SEN deal with would also be relevant to me. Elizabeth commented that they had an incident with drugs recently. "We thought we didn't have a drugs issue, but how wrong we were". She didn't elaborate.
>
> *Extract from General Observation Notes [GN1: 14]*

In addition to the above comments about drug-related incidents, Ruth Mackay described a serious incident involving supply of illegal drugs that had taken place on the school grounds eighteen months previous.

> We do have drug incidents...We had a major problem eighteen months ago, a case that made the papers, where we had a fourth year who had a fresh start and a fourth year who was excluded and there was a court case and things...There was a supply system set up which involved one of the lanes outside school. It was adults as well as our fourth year pupils. As soon as we knew about it, the rector is our point of contact, and we enforce the [local authority] drugs education policy. The boys were isolated, the boys were spoken to, the police were involved, the parents were involved. We just went through the normal, the full statutory procedure...It was cannabis initially [that was being supplied] but in fact, without knowing any details and I don't know any details, the rumour was that there was more than that involved and that it was very much high finance. We were talking you know, lots of money.
>
> *Ruth Mackay, PT Guidance, [GI1: 60-68].*

4.4. Policy, Planning and Development

Allandon Academy had not prepared a specific document outlining the school's policy on drug education. In relation to drug incidents, as is clear from the section above, the local authority policy and procedures were used.

At a strategic level, the Personal and Social Education (PSE) programme for the school was managed by the member of the senior management team responsible for the guidance team. The rector explained that he did not get involved in the planning process for the PSE programme, but delegated it to this person (see quote overleaf).

> It's delegated to the person who manages the guidance team to be honest, but I would certainly hope that the guidance team would have a major input into suggesting what they would like to see and that the job of the senior manager is perhaps to point out the strategic decisions that have been made by the school, to link it in with national advice and local developments such as the health promoting school.
>
> *George Hunt, Rector [RI1: 109]*

As he had not been in post long, and the school had had a positive HMI inspection just a few years previously, the rector reported that he would not take a really good look at the PSE programme for two or three years.

> I have only been here two years and I haven't at this stage made any real – I haven't had a really good look at the guidance provision. Partially because it was inspected just before I came here and was felt to be very good, I mean it was commented on by the inspectors as being very good. So it's on a plan and I think it's...in year three or year four that we want to do that, so we're still another couple of years away from having a look at the PSE programme and just getting the balance right.
>
> *George Hunt, Rector [RI1: 109]*

In the meantime, the programme of drug education was planned and the lessons prepared by the guidance team, with one principal teacher of guidance taking responsibility for provision for a single year group.

> The way we deliver the course is that each of us is responsible for a single year's social education and we produce the course [for that year] in its entirety with lesson plans and give it out to the first level guidance teachers.
>
> *Ruth Mackay, PT Guidance, [GI1: 35].*

Allandon Academy had decided to change their system of PSE delivery starting from the 2001/02 academic year so that by the time of the case study it was no longer being delivered by first level guidance teachers (FLGTs). Instead, the principal teachers of guidance delivered all the PSE lessons (see also Section 4.8.2.a). To a certain extent this meant that further development of the course had been postponed until after the guidance team had had a chance to deliver the programme.

> What we decided was with this big change this year, the course as it stands was made up for FLGTs to deliver and sort of straight-forward, you know, routine. Not always a lot of discussion...minimum of preparation. So we decided, well, let's run with that this year and then maybe try and make changes. So what we've got to try and do now is especially when it comes nearer exam time is just set ourselves time to sit down and make these changes.
>
> *Ann Brown, PT Guidance [GI6: 354]*

The new system of delivery allowed the guidance teachers to see for themselves how the courses they had designed actually ran in practice, something that they had not actually experienced before. It was clear that delivering the programmes stimulated a certain amount of reflection on the part of some of the guidance team that perhaps would not have been present in previous years when weren't involved in delivery. One principal teacher of guidance wanted to give more time for drug education in third year, another felt that the continuity of the courses needed to be looked at, as well as some of the resources that were in the school but maybe hadn't been used before. All the guidance team were in agreement that the programme would have to be reviewed in depth over one or more days at the end of the year.

> I think it's a case that at the end of the year, probably in study time in May, that we're going to have to sit down and think what works? What doesn't? ...It's a case of just sitting down the six of us and deciding where do we think the priorities lie?
>
> *Tony Morrison, PT Guidance [GI3: 69]*

> I think the situation we have this year is an experimental situation...We've got the review, we haven't done that yet – as a guidance group we'll look at the programmes from S1-S4.
>
> *Jim Cameron, PT Guidance [GI4: 27]*

As in other schools (see Section 3.2), the staff envisaged that the review of the programme would rely primarily on the guidance teachers' impressions of how well the planned lessons and programme had worked with their classes, rather than direct pupil consultation or involvement. What goes in in a specific year would be decided by one person after general discussions, or where differences of opinion arose, the majority would make the decision. Although evaluation forms were given out to pupils at the end of the block of drugs education in third year, these were not very helpful, according to Tony, who was responsible for planning the S3 programme. Catherine noted that it had also been difficult to evaluate in the past because the programmes were being delivered by so many different teachers.

> There were questionnaires given to pupils but well, again, I suppose it depends from year to year but I tended to find there was never a hard message. Again, that's because it was just "here's a form – fill out the form", I don't know how much discussion went into the evaluation and then some kids just went through and say "I found this course worthwhile" or some said "it didn't tell me anything new" so all that really told me was yes, there are kids who had huge, wide different levels of knowledge.
>
> *Tony Morrison, PT Guidance [GI3: 81]*

> I would say that [evaluation] might be done in the future because guidance staff are now doing [the delivery]...It was difficult to evaluate [in the past] because different classes were given different length input.
>
> *Catherine Baxter, PT Guidance [GI5: 189]*

Tony also noted that having observed how the pupils were interviewed as part of the case study research, he felt that that might be a more useful way of getting their input on the drug education programme than a questionnaire. This was something that he was considering for future pupil consultation.

> You know I quite like the idea that you have, of taking a few kids and sitting down and seeing what they say. Because I think there are some pupils who will be very upfront and honest and I don't think that's a bad thing...I think we can learn a lot from what you've done because I think the wee small group interviews is a good way rather than blanketing the whole year with an evaluation.
>
> *Tony Morrison, PT Guidance [GI3: 85, 181]*

The school did have a pupil council but it was not used in reviewing any aspects of the curriculum, but focused on more basic issues as in other schools. One of the pupils who was interviewed, who sat on the school council, was asked about whether he felt it would be appropriate for the council to be involved in reviewing drug education within the school.

.....

Researcher: Is there any consultation about what you're taught, to ask your opinions of lessons?

S3 Pupil A: Not really, no.

Researcher: What about the school council?

S3 Pupil B: They talk about litter and gift vouchers.

Researcher: Is the school council for students?

S3 Pupil B: Yes, there's two from each year and the S6 House Captains. But we tend to stick to one topic.

Researcher: Do you think that the school council could also look at drug education or is that unrealistic?

S3 Pupil B: I don't think it's unrealistic. If there's a problem in school then we should have to deal with it.

Extract from Pupil Feedback [3L1: 177-191]

.....

As in the other schools studied (see sections 3.2.6 and 3.2.7), no attempts were made to involve pupils' families or community representatives in the planning or development process for the PSE programme.

4.5. TIMETABLE

The PSE programme timetable allocation in Allandon Academy consisted of one 55 minute lesson per week in each of the forty weeks of the school year across S1 to S5 inclusive. Topics were planned for each week of the PSE programme, and the topics relevant to drug education are summarised in Table 4.3. It can be seen from this table that in addition to those lessons that were timetabled as drug education, there were a number of other topics that may have consisted of or included elements of the life skills approach to drug education. There were also sections of the timetable that focused specifically on legal drugs.

As neither the life skills lessons nor the lessons on "legal" drugs were observed as part of this case study, the exact content of these lessons, nor how they reflect the content of Botvin's Life Skills Education (Section 1.4.3.d) is not known.

	Drug Education Provision	Content of Drug Education Lessons	Possible Life Skills Provision Out With Drug Education
S1	Smoking – 2 lessons.	Not known.	Assertiveness – 3 lessons. Anti-bullying – 3 lessons.
S2	Drugs – 3 lessons.	2 lessons led by S6 peer educators. 1 lesson led by the police school liaison officer.	Choices and Decisions – 3 lessons.
	Alcohol – 2 lessons.	Not known.	
S3	Drugs – 5 lessons.	4 lessons on Drugwise Drug Free programme. 1 lesson of Channel 4 video.	Relationships – 4 weeks.
S4	Drugs – 1 lesson. Alcohol – 2 lessons.	"Sorted" video. Not known.	Lifelines (life skills programme) – 3 lessons. Personal Safety – 4 lessons.
S5	Drugs – 1 lesson.	Video "E" – Danny's Story.	None.

Table 4.3: Summary of Timetabled Drug Education Provision in Allandon Academy

Table 4.3 was constructed from the written timetables that were provided to the researcher during the case study. It is interesting to note that while the timetable for the third year PSE programme outlines five lessons to be dedicated to drug education, these lessons were not scheduled to be delivered as a block. In fact, in seven of the thirteen classes who received drug education in third year, the five lessons were spread out across ten weeks. This resulted in gaps of up to four weeks between lessons in the timetable, and in practice these gaps could be even longer due to other disruptions as described below. The end result was that the drug education programme in third year at least, was somewhat "disjointed" and neither the pupils nor the teacher could be sure what point had been reached in previous lessons.

> When Tony (Morrison, PT Guidance) had gotten the video to work he introduced the lesson: "The past few lessons have been a bit disjointed but we've been talking about drugs, we spoke about bulking drugs, cutting them."
>
> *Extract from Lesson Observation Notes [L3L4: 15]*

> Jim Cameron (PT Guidance) then asked the class if they had already seen the video right through previously. One boy told him "yeah, they were at the police station". Other pupils weren't sure. Jim said "Okay, so some people saw it at the police station". He explained that he would show the video from the start and that they would discuss it afterwards.
>
> *Extract from Lesson Observation Notes [L3F1: 7]*

The issue of continuity was highlighted by Jim Cameron, as one that needed to be looked at for future delivery.

> What I would really want to do in the future if we were reviewing this is to try and get perhaps a look at the continuity because as you knew the Drugwise thing was split up between the exam review and all the rest of it... We've got to block it in some way, we've got to just block it...We've got to tie in with the school calendar of course.
>
> *Jim Cameron, PT Guidance [GI4: 22, 51]*

In addition to scheduled gaps in the programme, during the case study it became apparent that lessons were frequently re-planned, cancelled or changed as immediate circumstances at the time of the lesson dictated. Video equipment was required for all or parts of the S2, S3, S4 and S5 drug education lessons and it quickly became apparent that the availability (or lack of) of the equipment was the source of a significant portion of the disruption to the programme.

The explanation of how the video issue came to be a problem had been given by Jim Cameron in the course of general discussions with him.

> He explained that when senior management changed the system so that all the PSE classes would be delivered by the guidance team and not by tutors, the [guidance] team had agreed, only on the condition that they would be provided with TV/video facilities in each of their own rooms and that they would have a base room from which to work... However when they came to start this year, the equipment was not there.
>
> *Extract from Teacher Feedback [TF3: 7]*

It was not clear if the TV/video equipment had actually been promised or was due to arrive at a later stage, in fact, the system for procuring new resources such as these or indeed computers, was by no means clear, and in some cases bizarre:

> I [the researcher] met Tony Morrison in his guidance office and we went to the classroom together. When we arrived he motioned to the TV and video and said "this is the TV that we got from the RE department for the sum of four bibles". When I asked him to explain he said, "the RE department had two TVs. Somehow they got a second TV. [The RE principal teacher] said we could buy the TV off them but I said "we don't have much money". Then David Kerr (PT Guidance) said "we'll get you some bibles" and I was laughing but we got it for four bibles. Mind you they probably got it for free and charged us for it!"
>
> *Extract from Lesson Observation Notes [L3L2: 4]*

The lack of equipment caused a certain amount of disquiet among members of the guidance team. This was explained by Jim Cameron:

> [Jim Cameron told me that] the school was in a transitional period, where there was a lot of tension between staff and management: "the guidance team submitted their development plan, which included requests for certain resources - i.e. computers, TV/videos etc. We are then left submitting memos to request things, which should have been provided under the plan. We will then get a scolding from [our senior manager] in relation to pushing for these things. It's just the internal politics of the place."
>
> *Extract from Teacher Feedback [TF4: 21]*

This sense of "tension" was apparent at one of the guidance team meetings. Tony Morrison had been explaining to the team the latest situation in relation to equipment that they had ordered including computers and TVs/Videos:

> First Tony Morrison updated the meeting about the video machine situation. The school had ordered additional ones but they were pre-booked for folk. The TV and video in huts [prefabricated classrooms] one and two are for [another department], but they are going to Huts 11 and 12 later today. The school is going to order a new TV and video for huts 13 and 14, and in the meantime the one in 11/12 will have to be swapped around between 11, 12, 13 and 14 [i.e. the four guidance team classrooms]. Today the video was double booked already.
>
> *Extract from Guidance Meeting Notes [GM2: 5]*

> One person noted that there didn't seem to be any priority attached to PSE, that despite having the whole school IT suite, it was not available to them at any time for [the careers programme done in S3 PSE]. [The computers] were all booked. "They just haven't thought this through at all". "We always seem to be the poor relations". "Some huts have two videos".
>
> *Extract from Guidance Meeting Notes [GM2: 7]*

The impact of the lack of TV/video equipment in each room in which PSE was delivered caused widespread disruption to lessons, as there didn't seem to be a clear (or very effective) system for booking the equipment.

.....

On arrival at the door of the classroom, a grey, prefabricated building, we intercepted two adults dressed in lab-coats who were pushing a trolley with a TV and video on it out of the hut. Jim [Cameron] enquired as to where they were taking it and they said that they had been told to move it to [another classroom].

"That's okay," Jim said, "but I need it now. Could you leave it here just now and move it later? Am I messing up your day?"

"No problem, no. You're not messing up our day at all! It's a good job you caught us".

So Jim repossessed the trolley and made his way with it, in the door of the classroom.

"That could have been a total disaster!" he said to me as he set things up.

[L4K1: 3]

.....

I [the researcher] phoned the school and got through to Catherine Baxter immediately. Her class has been moved to the huts [prefabricated classrooms] and there is no provision for them to show videos in the huts. She was supposed to show the Leah Betts video to her other fourth year group today and because of the video problem she had to 'shelve' that and do something else from the list.

[TF6: 6]

Jim Cameron described how his lessons went today. He was to show the Leah Betts video to his class and then realised that [another guidance teacher] had her class in the same room. According to him, it was okay though, they showed it to both classes at the same time and then split the class in two for discussion purposes because forty would not be a number conducive to discussion.

[TF3: 22]

The situation with the TV and video equipment was the not the only thing to disrupt the drug education programme and cause it to deviate from the planned timetable. Sometimes the classroom in which the lesson was to take place had to be changed at the last minute – and there was not always proper equipment in the new location.

> This lesson was originally supposed to be in Room 55, but Tony Morrison explained to me that it had been changed to Room 38 because Room 55 was now computer equipped and was in use. When we got to Room 38 however, there was a class in there so we took some chairs and moved next door to Room 37 which was [a small canteen]. There were no desks in this room so the pupils had to fill in their worksheets on their laps.
>
> *[L3L4: 5]*

On another occasion, an in-service day clashed with one of the drug education lessons.

> On arrival in the school, I headed straight to the office where Tony Morrison…was working... He immediately pointed out that he had been doing some work over the holidays and noticed that there is an in-service day on the 16th November and so the session scheduled with him for that day - with 3L [which I was supposed to observe], would not take place as planned. He said that he would be happy to move things around if I wanted to have a look at it. I said that I would have a look and see if I could reschedule it. He asked Ruth [Mackay, PT Guidance] why they have an in-service day then and she answered that they always have an in-service day in November.
>
> *[GN7: 3]*

As well as other necessary tasks such as the issuing of pupil reports, lessons were disrupted by the unforeseen absence of guidance teachers.

> .....
>
> Ruth Mackay: The next period with my third years is going to be an absolute shambles because I haven't seen them the last two Wednesdays so I don't know what they've done. They had the bobby [police school liaison officer] last week. So if you're prepared for shambles!
>
> Researcher: I have the programme if you want.
>
> Ruth: I have the programme. I know what they're supposed to have done but they won't have stuck to it.
>
> Researcher: Who covered for you in the two weeks?
>
> Ruth: They had Tony [Morrison, PT Guidance] for part of it. They had two weeks when [PSE time was lost because] their [pupil] reports came out so they're out of sync anyway. But they had the bobby last week covering the legal side of it so I want to go over that with them.
>
> *[GN12: 3-11]*
>
> .....

Other lessons were cancelled or rescheduled when the police school liaison officer had to cancel at the last moment and when one of the guidance team was absent due to dental pain.

4.6. KEY MESSAGES

The guidance teachers and the rector described the concept of informed choice as what they felt to be the key focus of the drug education in Allandon Academy and they emphasised that the message was not one of "don't take drugs".

> I don't think its so much not to do it, I think it's the idea of giving them all the information and letting them make their own choices. But the information that they've got, by the time they've got the information on the legal side, and then they're looking at the social side, and they're looking at the health side, and obviously there are the good bits out of it otherwise people wouldn't be doing it; but we leave it up to them to make the choice and I think most of the time the children say their choice would be not to do it, so no, we don't say "don't do it".
>
> *David Kerr, PT Guidance [GI8: 97]*

> Just making healthy choices, basically. It's not a case of saying "thou shallt not". It's a case of saying, this is, these are the facts, these are the situations and these are the risks involved you know and if you give that information within a context, then you just hope that that will allow kids to make informed choices.
>
> *Jim Cameron, PT Guidance [GI4: 9]*

> What we really have to do in schools is try and play our part in educating people so that they make choices in life which are informed by that education rather than making choices in ignorance so that is what I think the role of an effective PSE programme is to do, it is to make people aware of the choices they face and to give them the information they need to make those choices.
>
> *George Hunt, Rector [RI1: 7]*

The provision of information was central to this approach, as David Kerr put it, on the health, legal and social sides of the drugs issue. Others of the guidance team also emphasised the facts, but specifically mentioned a need to outline "the dangers of drugs".

> Well, just really outlinin' to the kids the dangers and the choices that they have to make because undoubtedly they're going to have to make these choices because it's so prevalent. And you know its decisions that they have to reach through education, and they don't realise the dangers unless they have it spelt out to them... So that they can then decide for themselves and make that choice.
>
> *Catherine Baxter, PT Guidance [GI5: 6]*

The pupils who participated in feedback sessions with the researcher were also asked what they felt were the key messages from their drug education. Most of the pupils were clear that the message was not to take drugs – they felt that the dangers or negative consequences were emphasised.

.....

> Researcher: What do you think the messages from the video were?
>
> Pupil: Basically "don't do drugs".
>
> *[3E1: 9-11]*

.....

> I [the researcher] asked the pupils for their first impressions of today's lesson.
>
> S5 Pupil: Never take drugs. Just never take drugs.
>
> *[5D1: 3-5]*

.....

Despite this negative emphasis, the pupils were very much aware that the teachers were also emphasising choice-making. The message was not to take drugs, but this was not said "out fully".

.....

> Pupil A: It's a lot of information - mostly what's bad about it, how much it costs.
>
> Pupil B: It shows how dangerous they can be and what results from taking it, what happens...
>
> Pupil A: In the parents way - no is no. This way, [the teachers] are saying no - but not saying it out fully, they're giving you information to help you say no.
>
> Pupil B: It really is up to the individual what to do. It's about trying to make good choices.
>
> *[3A1: 7-9; 161-163]*

.....

.....

Researcher: What messages would you say your drug education is trying to put across?

Pupil A: Drugs are bad for you.

Pupil B: Just don't do it. And if you did - think really hard about what would happen and think if you don't want to do it or not.

Researcher: Do they give you a choice? Or just tell you not to do it?

Pupil B: It's your own choice.

Pupil C: It's up to you whether you want to take them.

[3LA: 106-115]

.....

This parallel message of choice, alongside an emphasis on the negative consequences was also apparent in education about legal drugs according to this second year pupil:

> Our teacher in first year just went on and on about smoking for three weeks...The smoking bit was just her talking all the time saying "I'm not telling you not to do it but please don't do it" and "I'm not telling you not to smoke, it's your choice" but then she went on and on about smoking for three weeks.
>
> *[2C1: 178]*

4.7. Curriculum Content

Over the course of the case study, nineteen drug education lessons within the PSE programme from first to fifth year were observed. During observations the researcher made note of the content of each lesson and classified it according to the categories devised by Hansen (1993) in his review of drug education programmes. A summary of the content observed in these lessons according to this classification is provided in Table 4.5 which begins overleaf and continues onto page 198. Hansen's categories are first presented in Table 4.4 (overleaf).

Categories of Content in Drug Education Lessons (Hansen, 1993)
7. Drug abuse **resistance skills** or refusal assertion training
8. **Normative education** (decreasing perceptions about prevalence and acceptability of use)
9. Information about the **consequences** of use.
10. Personal commitment or **pledges**
11. **Values.**
12. **Alternatives** to drug use.
13. **Goal-setting** skills.
14. **Decision-making** skills.
15. **Self-esteem** training.
16. **Stress skills** (coping skills).
17. **Support** system access skills (availability of help).
18. **General life skills** (for positive social relations).

Table 4.4: Curriculum Content Classification of Hansen (1993).

Lesson Details:	Lesson Code:	Content of Lesson (according to the categories of Hansen,1993)
01/11/01: 2C, Constable Gordon	L2C1	**Consequences** (physical), appearance, and methods of use of Cannabis (20 mins) and Heroin (20 mins).
02/11/01: 2D, Constable Gordon	L2D1	**Consequences** (physical), appearance, and methods of use of Cannabis (20 mins), Heroin (20 mins), and LSD (5 mins).
13/11/01: 2L, S6	L2L1	**Consequences** (physical) of use of whole range of drugs, each covered briefly.
15/11/01: 2C, S6	L2C2	Most of lesson did not cover any of the categories, nor any specific drug. Some information about heroin use.
23/11/01: 2A, S6	L2A1	Most of lesson did not cover any of the categories, nor any specific drug. Some information about heroin use.
01/11/01: 3E, David Kerr	L3E1	None of the categories. Focus on world of drug dealing and dealers and preparation of drugs.

02/11/01: 3L Tony Morrison	L3L1	None of the categories. Focus on world of drug dealing and dealers, their profits and the origins and preparation of drugs.
23/11/01: 3L Tony Morrison	L3L2	Most of the lesson could not be categorised. Some information on legal **consequences.**
05/12/01: 3A Ruth Mackay	L3A1	**Decision-making** was discussed, although skills for decision-making were not taught.
06/12/01: 3F Jim Cameron	L3F1	**Consequences** (legal).
07/12/01: 3J Catherine Baxter	L3J1	Information about drug names, history of drug use, and social attitudes to drug use. A little on **consequences** (physical).
13/12/01: 3H Ann Brown	L3H1	**Consequences** (social, personal and legal). Pupils chose which drug to study.
14/12/01: 3L Tony Morrison	L3L3	**Consequences** (legal). Focus on sentencing for drugs offences, police and court powers and processes.
11/01/02: 3L Tony Morrison	L3L4	Legal categories of drugs, **consequences** of use (legal, personal).
06/09/01: 4K Jim Cameron	L4K1	Physical **consequences** of ecstasy use, and briefly of other drugs. Also classification and origins of drugs and date rape.
13/09/01: 4L, 4M Tony Morrison, Ruth Mackay	L4LM	Whole lesson on physical **consequences** of ecstasy use.
18/09/01: 4G Ann Brown	L4G1	Mostly physical **consequences** of ecstasy use; other drugs covered briefly; some discussion of **values.**
22/10/01: 5D, Catherine Baxter	L5D1	Whole lesson on physical **consequences** of ecstasy use.
29/10/01: 5G Jim Cameron	L5G1	Whole lesson on physical **consequences** of ecstasy use apart from 10 mins discussion of cannabis legalisation.

Table 4.5 Observed Lesson Content

It is clear from the above table that almost all the lessons included information about the consequences of drug use. These observations are therefore broadly in accord with the descriptions given by teachers and pupils of lessons about the "dangers" of drug use. In second year, the police constable discussed the effects of heroin and cannabis on the body, as well as how they are prepared for use and taken.

Much of the third year course focused on legal aspects of drug classification, penalties and sentencing, although many of the lessons could not be categorised as they focused on the origins of drugs, and the world of drug dealing and dealers. In fourth and in fifth year, the physical consequences of the use of ecstasy were covered for most or all of a lesson with each class. Further details and examples of this kind of information are provided in Section 4.7.2.

Much of the rest of the lesson content could not be classified according to Hansen's categories, and this is described in much more detail in the rest of this section.

4.7.1. Drug Information

Most of the information in this section was provided during the classes led by Constable Gordon, the police school liaison officer. However, other classes also covered it occasionally, and this is mentioned where it is the case.

(i) Definition of a Drug

In some lessons, most commonly those led by the police school liaison officer, the pupils were asked and/or told what the definition of a drug was. The definition given in one lesson was "a substance other than food that alters the way your body behaves".

(ii) Names for Drugs

Many of the lessons included sections which asked or told the pupils different names for drugs, including medical and slang names. Some of the lessons included a list of anagrams of drug names that the pupils had to try to decipher.

> The class were then asked if there were any other names for ecstasy. "E's" was the only reply at first. Then one boy questioned "does it not have like, code names?". Ruth Mackay (PT Guidance) confirmed that there are lots of names for it, that it comes in tablet form sometimes with symbols printed on the tablets, and it is often the symbols that give it a name. "Mitsubishis" one boy commented, to some amusement.
>
> *Extract from Lesson Observation Notes, [LALM: 18]*

(iii) Forms and Origins of Drugs

In the lessons led by Constable Gordon with second year pupils (and with the sixth year peer educators), he showed the pupils his placebo kit which contained replicas of various types of illegal drugs in display cases. He also explained in some detail how heroin is prepared from the opium poppy and the routes by which it and other drugs travel to the UK. This was also covered by Jim Cameron with one of his fourth year classes.

> [Constable Gordon] told the pupils that 80% of the heroin in the UK comes from Afghanistan. He then noted that it is not a country like "ours" but it is very primitive, that the kids don't even have pencils, and that's where the heroin comes from. He asked them what plant it comes from. "The opium poppy" they suggested. [Constable Gordon] then drew a picture of the opium poppy [see figure 4.1]. He explained "they scratch the surface of the poppy, then scrape off the gungy substance with knives. It's very unhygienic, they use old rusty knives."
>
> *Lesson Observation Notes, [L2D1: 83-89]*

Figure 4.1.

> [Mr. Cameron, PT Guidance] went on to try to get [the pupils] to tell him where heroin comes from. They suggested all sorts of countries and at the end of it, he didn't really seem to tell them which one was the correct one. He did say that it works its way from the East, and mentioned the small farmers that are dependent on it. "It comes from a plant" the pupils offered, but didn't know which one, even with heavy prompting. "The poppy" he told them – "It's made out of poppy seeds". "What about ecstasy?" he asked, "Where does that come from?" He then asked me to tell them. "It's a chemical", I said, "it's manufactured."
>
> *Extract from Lesson Observation Notes [LAK1: 27, 29]*

(iv) Methods of Use

Constable Gordon went into considerable detail with the second year pupils about cannabis and heroin including details of the components of a "joint" and how heroin is prepared for injection.

.....

Constable Gordon: [Cannabis] is smoked in a rolled up cigarette called a reefer, or joint. It's twisted at both ends, why is that?

Pupil A: so the stuff won't fall out.

Constable Gordon: Exactly, so it won't fall out the end. And a bit of rolled card is put at the mouth end - like a filter, but it doesn't filter anything - so why is it there?

Pupil B: To hold the paper in a circle so that you can get a decent draw.

Constable Gordon: Well, maybe that might be true, but that's not the reason. It's there because marijuana burns much hotter than tobacco and the rolled up paper stops you burning your lips.

Next Constable Gordon showed the class various pipes that are used for smoking cannabis. He explained that long metal pipes are used to cool down the smoke before it reaches the mouth. He also mentioned how sometimes "bongs" are used where the smoke passes through a pipe which is immersed in water, again to cool it down before it reaches the user.

Constable Gordon: You can also bake cannabis into cakes - cannabis cakes.

Extract from Lesson Observation Notes [L2C1: 59-71]

.....

.....

Constable Gordon: Someone mentioned needles - how can you take heroin?

The pupils answered "smoke, inhale, inject"; "put a belt around your arm so that the veins get bigger and bigger".

[Constable Gordon] explained how its taken - mixed with citric acid, heated on a spoon with a lighter or candle, into the syringe, tapped to expel the air, put into a vein and some blood drawn to make sure its in a vein. He explained how needles are shared and the blood gets mixed in, each time the needle is passed on. He mentioned the problem of AIDS in Africa affecting millions of people and explained that needle exchanges have been set up, not to encourage the habit but to try to prevent the spread of disease. He explained that the veins get hard over time and the needle doesn't go in so users have to inject all over the body. He told how he once found a guy dead with the needle sticking out of his temple.

Extract from Lesson Observation Notes [L2D1: 122-127]

.....

(v) Prices

Constable Gordon also explained to the second years the approximate cost of each of the drugs he mentioned. For example, he explained what a "wrap" of heroin was, and that it would cost approximately £10, whereas black cannabis resin would cost £5 per gram. Ruth Mackay also mentioned the cost of ecstasy tablets in her lessons with third and fourth year pupils, although she gave different figures to the two classes observed.

(vi) Use of Medicines

A number of the guidance teachers and some of the sixth year peer educators mentioned prescribed and over the counter medicines over the course of their drug education lessons. The information given in this context varied enormously, as only brief references were made.

4.7.2. Consequences of Use

As is clear from the summary of key messages of drug education, a considerable proportion of the lesson time was spent discussing the consequences of drug use for the individual. These consequences fell into three broad categories – physical, legal and social/personal. Further details of each are given below.

(i) Physical Consequences

Discussions about the physical consequences of drug use focused mainly on the risk of long-term damage to organs of the body, addiction, or death. At second year stage, Constable Gordon emphasised the dangers of cannabis and of impure heroin.

> Last year, 18 addicts died of a flesh-eating disease. Doctors didn't know why. Samples were sent to the US and just this week we see the results of the investigation published in the Press and Journal - "Afghanistan linked to batch of killer heroin" [He held up a newspaper cut-out]. It wasn't deliberate poisoning; it is thought to be linked to poor hygiene. But Bin Laden has a weapon with which he could kill many people, if he were to contaminate heroin supplies. Hopefully he will never use it, but its an extra worry, that this nutter has this power. In Holland two or three years ago, some other nutter contaminated ecstasy with strychnine - ecstasy that he manufactured himself - just because he wanted to see what it would do.
>
> *Constable Gordon [L2C1: 89]*

> [Constable Gordon] then asked, "How does cannabis affect you? Some people think it is an innocent little drug. This may have been true thirty or forty years ago when it was a far weaker drug than it is now. It's strong now, it's changing to being a more hallucinogenic drug. The active chemical in cannabis, called THC targets fatty tissue and with long term use can cause brain damage. One joint is the same as ten or twenty normal cigarettes. Nicotine kills 300,000 people per year, if they were smoking cannabis that number would be even more horrendous so it's not such an innocent little drug".
>
> *Extract from Lesson Observation Notes [L2D1: 73]*

With one second year class, the sixth year peer educators went through a list of drugs and told the class the parts of the body to which they caused damage. In third year, the emphasis was mainly on legal consequences (see below) however, the topic of "cutting" drugs also arose and the dangers of the substances used to cut the drugs for the user were mentioned.

In fourth and fifth year there was a major focus on the consequences of ecstasy use, and two videos in which the main characters died from using ecstasy were shown. There was therefore, a considerable emphasis on the risk of death from taking ecstasy in these lessons. This is illustrated by the following quote and the passage overleaf.

> Ruth Mackay [PT Guidance] asked why someone might take more than one tablet [of ecstasy] together. No-one replied. She explained that people take one tablet and then they don't wait for it to get into their system, so they think it hasn't worked and so they take another one. She asked what effect that would have on the body. "You'd die", "double effect", "dehydration" were some of the suggestions. "What risks are there when someone takes ecstasy?", she then asked. "You'd die"; "You might get an allergic reaction" came the replies.
>
> *Extract from Lesson Observation Notes [LALM: 32]*

.....

Catherine Baxter, PT Guidance: What else do we know about [ecstasy]?

Pupil - after taking it you need to drink a lot of water.

CB: so if you need to drink a lot of water after taking it, what does that mean it does to the body? It's dehydrating.

Pupil A: if you drink too much, your brain swells
Pupil B: it can be lethal
Pupil A: if you drink too much, your brain swells [repeated]

CB: so you have to be careful if you're using it.

Extract from Lesson Observation Notes [L5D1: 18-28]

.....

Some of the lessons also included discussion about the risk of becoming dependent on drugs. In these cases, the emphasis was that although a substance might not be physically addictive, it was still possible to become dependent on it. There was also a risk that a person would move onto something "stronger" or "harder" to get the same effect as initially.

> Cannabis is not addictive, but you can develop a dependence on it. It can lead, not always, but it can lead onto other drugs. Let's say we call the feeling you get from drugs "the buzz". Doesn't matter whether it's a stimulant and it makes you high, or it's a depressant and it relaxes you, let's call that the buzz. And it's great. It's a fantastic feeling, in the beginning - the first time you take it, it's a wonderful feelin' - but after a while your body starts to get used to the drug and you have to use more to get the initial buzz. That's why people move onto something stronger or "harder" as its known.
>
> *Constable Gordon [L2C1: 71]*

(ii) Legal Consequences

In all years of drug education, the classification of drugs under the Misuse of Drugs Act, 1971, was discussed with pupils during the lessons. It was the focus of a fact sheet and activity sheet during the third year Drugwise Drug Free programme of lessons and it also included discussion of the possible penalties for an offence involving drugs from the different classes.

> Next the class were asked how drugs are classified. "A, B, C", or in one case "A, B, C, D" came the replies. "What is class A?" asked Ruth Mackay (PT Guidance). The class responded that class A represents the dangerous drugs, that you get life-imprisonment for them. RM agreed. One boy was particularly persistent in stating/asking "they are the most harmful", and finally RM answered him that if a drug is class A it does mean that it is considered particularly harmful. She then explained that you can get seven to fourteen years in prison for possession of a class A drug for personal use - just one tablet. You can get twenty years upwards for possession with intent to supply, and supply used to be twelve tablets, now supply is just three tablets. Tony Morrison (PT Guidance) pointed out that it can be life for supply.
>
> *Extract from Lesson Observation Notes [L4LM: 28]*

> Someone with 10, 7, 4 tablets - would find it difficult to tell the police that they were only in possession, they would end up being charged with possession with intent to supply. Of course drugs is a criminal activity, you get a criminal record. Also in reality, when you go to prison with that kind of charge - you could have a very unpleasant life - drugs are big currency in prisons - it used to be cigarettes but now drugs are the currency and there are big boys in prison who would be very interested in anyone who comes in with a drugs background.
>
> *Jim Cameron [L5G1: 157]*

In some of the lessons police and court powers in relation to drugs were also outlined.

> [Tony Morrison] also noted that if the court has reasonable suspicion that a person has gained a big house, nice car etc. from the supply of drugs then they can seize the house etc.
>
> *[L3L3: 43]*

> The police have a lot of powers in relation to drugs, if they have reasonable grounds to believe that someone is in possession or using. That's all that's required for a stop and search. In school, the school would go through that process if you were found with drugs, the police would be called and because you're still classified as a child - your parents would be called or a member of staff would stay with you while you are questioned.
>
> *Constable Gordon [L2C1: 138]*

(iii) Social/Personal Consequences

In other lessons the emphasis was not so much on physical or legal consequences but on the more immediate consequences in terms of what action the school might take if you were found using drugs, or the longer term effects of a drug conviction on career prospects.

.....

Ann Brown, PT Guidance: If you were caught in possession on the premises, you would be excluded from school. You would have to make an application to another school, to make a fresh start. Obviously, that school would have to be not too far away or you would have to move house. If [you were caught] outside the school, we need not know anything about that.

Pupil: So you do nothing?

AB: We would be called to give a report if there was a children's panel hearing.

...

AB: [If you are caught] you could get compulsory supervision, have regular meetings with a social worker or be brought up before a children's panel. So there are penalties. What you might see as a little bit of fun could have implications. Think about it. If you're applying for a loan for a car or for a mortgage, you could be asked if you have a record and you have to answer questions honestly. I'm not saying you would be asked but you could be.

Extract from Lesson Observation Notes, [L3H1: 30-34; 51]

.....

Let me remind you that there are certain careers where if you have a criminal record you could not continue with that career. So you may have a certain career in mind for years and certain careers would not just be in doubt but you would definitely have to stop.

Tony Morrison, PT Guidance [L3LA: 51]

4.7.3. Drugs Covered

Table 4.6 illustrates the drugs that were discussed over the course of all the nineteen lessons observed and the topics that were discussed in relation to the drug. Drugs that were only briefly mentioned, but not discussed in any detail in lessons, are not included in this table (e.g. amphetamines, tranquillisers, magic mushrooms etc.). It is unlikely that any pupil would be taught all of these topics as each pupil would be present at most for ten timetabled drug education lessons over the course of their time at the school. In the table, the following symbols are used:

TOPICS COVERED → / DRUG NAME ↓	Names for the Drug	Short Term Effects	Short Term Risks	Long Term Risks	Potential for Addiction	Appearance	Origins	Legal Status	Methods of Use	Price
Cannabis	✓	—	—	✓	✓	✓	✓	✓	✓	✓
Heroin	—	×	✓	✓	✓	✓	✓	✓	✓	✓
Ecstasy	✓	✓	✓	—	—	✓	×	✓	—	✓
Cocaine	—	×	×	—	—	—	×	—	—	×
LSD	—	—	✓	—	×	✓	×	—	—	×

Table 4.6: Summary of Drugs and Topics discussed in Observed Lessons.

(✓) is used when the topic was covered in some detail (i.e. for more than a couple of minutes); (—) is used when the topic was briefly touched on or was available in literature used with pupils but not discussed; and (×) is used when the topic was not covered at all for that drug.

4.7.4. Drug Cultures

Many of the lessons included information about the culture of drug dealing and drug addiction and how drugs affect the local community. "Drug dealers" were discussed in a stereotypical way as evil people, who care nothing for drug users, but only wish to make profit for themselves.

> The drug culture is not about the safety of anyone, dealers will go to extraordinary lengths. It's all about the self-preservation of dealers.
>
> *Tony Morrison [L3LA: 125]*

> Drug dealers are devious, greedy people, so they wouldn't sell pure heroin – they would cut it, add substances to it...scouring powder, Ajax powder, sweepings off the floor, brick dust. The average purity of heroin is 11-13%. So you can multiply the profit in two – £614,660 profit from one kilo of heroin. So it's big money, it's huge money we're talking about. That is why drug dealers are so vicious, that's why they're so violent – they're making huge money but they're making it from people's lives – destroying people's lives.
>
> *Constable Gordon [L2C1: 123;132]*

This comment was made as part of a detailed discussion of the profit that could be made by a dealer from buying and selling on one kilo of heroin. This specific discussion was repeated with the other second year class led by Constable Gordon, as well as during a third year class led by Tony Morrison.

The violence and crime associated with drug dealing and addiction were discussed on other occasions with pupils: they were told that 74% of crime in Grampian was drug-related and that 99% of prostitutes in Aberdeen were addicted to heroin. Addiction was presented as a downward spiral into crime, specifically in relation to heroin.

> Very few people can take [heroin] without getting addicted - if you take it on a regular basis, you will get addicted. So you start selling stuff, but of course people know you're trying to get rid of it so you get a bad price for it - then you start to steal. There have been a number of muggings in Hilton in Aberdeen - of old ladies. Addicts who knew that they were getting their pensions at the post office and then mugged them. So your addiction starts to affect other people. Maybe you start breaking into houses, stealing. It's a downward slope.
>
> *Constable Gordon [L2C1: 99]*

The topic of cutting drugs was also discussed with other classes, particularly in third year where it was depicted on the Drugwise Drug Free video.

> .....
>
> David Kerr, PT Guidance: Why did the dealers [in the video] cut the drugs?
>
> Pupil: They were breaking it down so that it looks right.
> Pupil: If it's big lumps you can't snort it.
> Pupil: Cutting means mixing it with another substance
>
> DK: I think some of you may have misunderstood what is meant by cutting - it's not to do with the actual chopping up of the drug, it's done to mix the drug with something else - to make a bigger quantity for selling it on. What would the substances used to cut the drugs do to the user?
>
> Pupil: Kill them.
> Pupil: Poisons the blood.
>
> *Extract from Lesson Observation Notes [L3E1: 19-30]*
>
> .....

In some of the lessons, the pupils were told of how drug dealers specifically target children in trying to sell their drugs, and that they would give children free samples to get them addicted to the drug. This kind of discussion was sometimes stimulated by the Drugwise Drug Free video, in which the "drug dealers" discuss going to places where children gather, in order to try to sell their drugs.

> Did you notice the places where they said they were going to sell the drugs? The skate park, the youth club. Unfortunately there are people who will pick primary school children and offer them drugs for free. They catch them and then they get them later when they're hooked.
>
> *Ruth Mackay [L3A1: 47]*

.....

> Constable Gordon: In some places abroad, drug dealers have been giving away crack cocaine to children, why?
>
> Pupil: To get them addicted.
>
> Constable Gordon: That happens here in Scotland, not with cocaine, but in Glasgow there have been incidents where heroin has been given away to primary school children. The dealers don't care. They are living on other people's misery.
>
> *Extract from Lesson Observation Notes, [L2C1: 152-156]*

.....

On at least one observed occasion, bouncers, publicans and nightclubs were each separately portrayed as being part of the greedy drug culture described. The bouncer could be involved in supplying drugs, they were told, and the water supply was switched off in clubs and pubs to force people who have taken ecstasy to pay for tap water.

> Ruth Mackay asked the pupils: "What other effect does [ecstasy] have? You said it at the beginning". They did not reply. She answered for them: "It makes you active, makes you dance, that's what causes dehydration and many of these clubs charge you money for tap water". Some pupils commented that it was stupid to charge for ordinary tap water. RM elaborated "some clubs turn off the water in the loos so people have to buy water. There's been a huge hoo-haa in the papers about charging for water. You really need to avoid dehydration". The class was asked what they would do in that situation. "You could decide not to take it if that happens" said one pupil. RM explained: "Lots of people buy alcohol elsewhere before they come to clubs, entrance is cheap and they charge you huge prices for drinks. They're out to screw you for whatever they can get out of you," she concluded emphatically.
>
> *Extract from Lesson Observation Notes [LALM: 42]*

Finally, some of the lessons covered the topic of drug traffickers, in particular those people who smuggle drugs into the UK by swallowing them "in bags". The pupils were told why this is dangerous "there's a risk it might burst" and were also given detailed information as to how customs officials would deal with a suspected case of this kind of trafficking.

4.7.5. Persuasion Information/Messages

Much of the information that was provided to pupils during drug education lessons used anecdotes and other messages that seemed intended to persuade pupils that taking drugs would be a bad idea. Although some of the messages were based on facts, or on events that had actually happened, others were more akin to hearsay or speculation. A great emphasis was placed on the message that "you don't know what you're getting" when you take drugs. This message was repeated during the discussions of cutting drugs, and came up again in the context of the story of Leah Betts (the video "Sorted") which was shown to all fourth year classes. Sometimes it was exaggerated – Constable Gordon referred to strychnine in ecstasy tablets, and as can be seen from an earlier quote (repeated here) speculated about Osama Bin Laden contaminating Afghan heroin.

> Last year, 18 addicts died of a flesh-eating disease. Doctors didn't know why. Samples were sent to the US and just this week we see the results of the investigation published in the Press and Journal - "Afghanistan linked to batch of killer heroin" (holds up newspaper cut-out). It wasn't deliberate poisoning; it is thought to be linked to poor hygiene. But Bin Laden has a weapon with which he could kill many people, if he were to contaminate heroin supplies. Hopefully he will never use it, but it's an extra worry, that this nutter has this power. In Holland two or three years ago, some other nutter contaminated ecstasy with strychnine - ecstasy that he manufactured himself - just because he wanted to see what it would do.
>
> *Constable Gordon [L2D1: 89]*

.....

> Helena [S6 Peer Educator] explained that street drugs can be mixed with anything – floor sweepings, brick dust, even rat poison.
>
> Michael [S6 Peer Educator] added that that is one of the most dangerous things about drugs, that you never know what you're getting.
>
> *Extract from Lesson Observation Notes [L2L1: 243, 245]*

.....

Some of the stories were told in a rather sensationalist way, as a kind of real-life scare-tactics – that is true stories, but presented in a way that tries to shock.

> Jim Cameron then asked the pupils "how did [Leah Betts] die?". "Her brain swelled up" came the answer from the girl at the front. He explained: "the best way I can describe it is that it's like turning your insides into a microwave oven".
>
> *[L4K1: 32]*

> Before we started I wanted to show you this article from the Daily Mail - the parents of a girl who was 19 years old, she was in her first year at Uni, and she took an ecstasy tablet and she died. And they have been very brave in allowing pictures of her to be published and having their story published on the basis that they hope that their agony and their misfortune would not happen to anyone else. There's a quote in it here where her mother says "it was like a scene from a horror film". She was bleeding, she had organ failure, and eventually her pupils stopped reacting to light and they had to switch her life-support machine off. So we have that, and I'll put it on the wall and you can have a look at it, but the message is that basically, that girl didn't have a clue what she was taking.
>
> *Tony Morrison [L3L2: 12]*

Some of the stories did not appear to have any clear purpose or message:

> Constable Gordon told a story about a boy who had been a drug addict and who had taken magic mushrooms and had ended up headed butting the walls of the flat he was in, because he thought he was a bull. Unfortunately, he ran into a curtain and went head first through a glass window, two stories up. He hit a metal fence on the way down and fell back into the garden where Constable Gordon found him unconscious. He escaped with hardly any injuries because he had been so relaxed when he fell that he simply bounced off the fence - his body was like rubber. "I still see that guy", Constable Gordon added, "and he's still a heroin addict".
>
> *[L2D1: 139]*

Finally, it was emphasised by more than one teacher that drugs and deaths from drug use were not something that happened to other people or in other places. They emphasised that "normal" people take drugs and that people had died from drug use even in the local area.

.....

Catherine Baxter, PT Guidance: What do you think of with ecstasy - what sort of image does it conjure up?... Yes, a nightclub. Ecstasy was very associated with the rave scene especially when it first came out. Is the person a down and out, etc.? Is that the kind of image you see? What kind of image do you have?

Pupil: Anyone at a party.

CB: So its normal people who can come from any walk of life.

Extract from Lesson Observation Notes [L5D1:95-111]

.....

.....

Ann Brown, PT Guidance: Leah Betts - her family live up here now, her father speaks in schools and he came into this school last year. What about anyone else? Do you remember Daniel Kerr? [A young boy who died after inhaling solvents].

"Yes, Dr. Kerr's son", replied one girl in the middle.

AB: You would have been in primary school when it happened. Mrs. Kerr was a teacher in a local primary school. So you see these things are not far away - they happen locally - near home.

Extract from Lesson Observation Notes [L4G1: 47]

.....

It has happened in the past - pupils have been permanently excluded for supplying drugs. It wasn't anywhere else, it was here in Allandon.

Tony Morrison [L3LA: 97]

4.7.6. Harm Reduction

There was little or no emphasis on the provision of harm reduction information during the drug education lessons. The only drug for which it was touched on was ecstasy, and then it was only done so briefly and incompletely. In some lessons pupils were told that dehydration is a risk and in others they were told that it can be dangerous to drink too much water, in both cases no further details or explanations were given. Constable Gordon referred to "taking precautions" if taking ecstasy, but did not elaborate.

> The chances of dying with ecstasy are millions to one, and you could say that you have a higher chance of dying crossing the road and getting killed by a big truck coming, and its true, you do, but you don't walk out in front of a big truck deliberately, you take precautions. Leah Betts didn't take any precautions and she died.
>
> *Constable Gordon [L2C1: 158]*

> [Ecstasy] gets your heart pumping really hard, you have lots of energy. So you spend lots of time on the dance floor expending energy for a long time time. So dehydration is a risk.
>
> *Catherine Baxter [L5D1: 132]*

> When the [Sorted] video finished, Tony Morrison (PT Guidance) asked if there were any comments. No-one said anything. He then asked "could anything have been done to change the outcome?" He noted that there was a misconception that the more water you take the better it is.
>
> *Extract from Lesson Observation Notes [L4LM: 48]*

In one case, the pupils brought up the issue of the danger of drinking too much water, and the teacher still did not explain it, but focused on the risk of dehydration and particularly on the issue of clubs charging people for tap water. The harm reduction message was lost as the pupils still were not told the correct advice in relation to how much water it is advisable to drink or not drink. This is illustrated in Ruth Mackay's discussion of water provision in night clubs that is repeated here.

> Ruth Mackay (PT Guidance) asked the class "can you tell me about drinking water?". One pupil said that [ecstasy] makes you drink water and you can drink too much. RM then asked "What other effect does it have? You said it at the beginning". There was no reply from the pupils. RM explained: "It makes you active, makes you dance, that's what causes dehydration and many of these clubs charge you money for tap water". Some pupils commented that it was stupid to charge for ordinary tap water. RM elaborated: "some clubs turn off the water in the loos so people have to buy water. There's been a huge hoo-haa in the papers about charging for water. You really need to avoid dehydration". The class was asked what they would do in that situation. "You could decide not to take it if that happens" says one pupil. RM explained "lots of people buy alcohol elsewhere before they come to clubs, entrance is cheap and they charge you huge prices for drinks." "They're out to screw you for whatever they can get out of you" she concluded emphatically.
>
> *Extract from Lesson Observation Notes [L4LM: 42]*

This lack of harm reduction information in lessons is not surprising, given that most of the guidance team indicated their aversion to its provision. Their reasons for being against it were very similar to those found in the interview study (Section 3.4.4) – worries about parent reaction and what advice is correct, and fears of encouraging pupils to use drugs. If any pupil who was known to be using drugs, they might give some harm reduction information on a one to one basis, but it was likely that other agencies would be involved and could do that.

> We would never really give [harm reduction information], no. We wouldn't. Quite tight, quite clear. You run the risk with even one tablet. Oh yeah, you just scare them, tell them straight. I think you have to do that. I don't think our kids go into that kind of conversation, harm reduction. It's the kind of thing that they will think about themselves, I think, you know.
>
> *Jim Cameron, PT Guidance [GI4: 199]*

> I wouldn't want to put myself in a position of saying right "Go on, you can take it as long as you don't..." I just couldn't put myself in that position. Because that's saying to the kids, it's okay.
>
> *Catherine Baxter, PT Guidance [GI5: 153]*

> I think it's difficult for the simple reason that it varies from person to person, some people say yeah take on water and a lot of people say, nah that's not right - depending on the reaction that you have...Again, I think you've got to give them as much information as you can and yes, they have to make value judgements. I think it's a danger if they go away saying "The manny Morrison says it's okay to take such and such as long as we do this or we do that or the next thing". I think it's got to be balanced...Certainly, I personally have never had any parents coming back and saying "you know you're almost encouraging so and so to do this". I think there is a danger that some people might see that, if you overlook that message, that they might think that's what you're getting at.
>
> *Tony Morrison, PT Guidance [GI3: 113]*

In relation to alcohol, however, it was accepted that some pupils drank, and that harm reduction information could be given on safety grounds.

> I think it comes under safety really. I suppose and accepting [that] kids who go out, even our sixth years, fifth years and sixth years. We know they're going to go out, we know they're going to drink. So without actually condoning the drinking, just looking it as a fact and making sure that they're safe in terms of making sure they've got enough money to get home, that they try and stay in groups, making sure that they know what to do with someone if [they're drunk].
>
> *David Kerr, PT Guidance [GI7: 113]*

4.7.7. Decision Making

Throughout the drug education programme, teachers emphasised that the pupils had to make their own choices about drugs. The concept was one of "informed choice" and there was clearly an expectation that if pupils were "informed" that they would then only choose not to take drugs.

> If you're aware of things - if you're wise - that means you have knowledge and you can make a balanced judgement. If you have all the facts, you can make the decision to be drug free.
>
> *Tony Morrison, PT Guidance [L3L1: 9]*

> Ruth Mackay explained "we are not telling you not to take it. We're giving you the information and you have to make that decision for yourselves". Tony Morrison added "It used to be that drug education was based on telling people to "just say no", but we know that that doesn't work. So the message is not to just say no, but to know what you're speaking about when it comes to drugs, and make a judgement on that, and stick to that judgement. You have to be strong enough to stick to your decision, and that's not easy to do when you're out on a Saturday night with everyone else. Ultimately that decision is yours, and you should be strong enough to stick to it".
>
> *Extract from Lesson Observation Notes [L4LM: 38]*

> So the message is, be very careful - be very sensible - especially when you're moving on and you're in college or university. We can't say don't do it, we say here are the facts and you've got to make the decision for yourselves.
>
> *Jim Cameron, PT Guidance [L5G1: 171]*

As discussed in Section 4.6, this concept of informed choice was central to the whole philosophy of drug education provision in the school.

4.7.8. Any Other Content

Other issues were touched upon briefly in some lessons, not discussed in any detail, but mentioned, almost in passing. These other issues included peer pressure:

> What about Alex [in the Drugwise Drug Free video]? He was the one that said: "Do what you want, I'm not going to do it" and he backed off. It's quite hard to do that sometimes but it's about believing in the decision that you've made and sticking to it. Maybe the girls just kind of got carried along. Like the girl who was buying her trainers – she could have said no. In a way, her trainers gave her an excuse and she didn't have to make an issue about it like Alex if she didn't feel she could stick to that. She could have said "No, I would normally, but I can't today because I want to spend my money on my trainers". So think of an excuse and practice it. Go over it at home, and make sure that you're comfortable with it.
>
> *Ruth Mackay, PT Guidance, [L3A1: 70]*

This extract includes the most extensive coverage of peer pressure that was given in any lesson.

4.8. Delivery

4.8.1. Teaching Method

The teaching methods, materials used and level of interactivity in each lesson are summarised in Table 4.7 on this page and continued oveleaf. The lessons were classified into group types according to the categories devised by Toseland and Rivas (1984[xix]) as described earlier in Table 1.7. The activities used, and the levels of pupil to pupil communication and self-disclosure that existed over the course of the lesson were used to assign each lesson to group types A to D: A being the least interactive. The level of self-disclosure is not listed in the table, as it was low in all of the lessons.

Lesson Code:	Teaching Methods and Materials Used in Lessons	Group Type and Interactivity
L2C1	Lecture style with some class discussion led by Constable Gordon.	Non-Interactive A
L2D1	Lecture style with some class discussion led by Constable Gordon.	Non-Interactive A
L2L1	Discussion led by peer educators.	Non-Interactive A
L2C2	Small group drama activity followed by Buzz video and peer educator-led class discussion.	Interactive C and Non-Interactive A.

[xix] See also Tobler and Stratton, 1997.

L2A1	Small group drama activity followed by Buzz video and peer educator-led class discussion.	Interactive C and Non-Interactive A.
L3E1	DWDF* video followed by small group work on worksheets. Discussion mostly led by teacher.	Non-Interactive B.
L3L1	DWDF video followed by individual and small group work on worksheets.	Non-Interactive B.
L3L2	DWDF video followed by individual and small group work on worksheets.	Non-Interactive B.
L3A1	DWDF video followed by teacher-led class discussion.	Non-Interactive A.
L3F1	DWDF video followed by small group work on worksheets and teacher-led class discussion.	Non-Interactive B.
L3J1	Off Limits (Channel 4) video followed by teacher-led class discussion and a worksheet-based anagrams exercise.	Non-Interactive B.
L3H1	Small group investigative activity with drug information leaflets followed by individual worksheet-based exercise.	Non-Interactive B.
L3L3	DWDF video followed by worksheet-based small group activity and some teacher-led discussion.	Non-Interactive B.
L3L4	DWDF video followed by worksheet-based small group and individual exercises and some teacher-led discussion.	Non-Interactive B.
L4K1	Sorted video followed by teacher-led class discussion.	Non-Interactive A.
L4LM	Sorted video followed by teacher-led class discussion.	Non-Interactive A.
L4G1	Sorted video followed by teacher-led discussion.	Non-Interactive A.
L5D1	Danny's Story video followed by teacher-led class discussion.	Non-Interactive A.
L5G1	Danny's Story video followed by teacher-led class discussion.	Non-Interactive A.

*Drugwise Drug Free

Table 4.7 Observed Teaching Methods and Materials Used.

It is clear from the table that most of the lessons would be classed as non-interactive according to this topology. Although many of the lessons included some class discussion and some small group work, videos were used very commonly which do not in themselves actively involve pupils. Most of the pupil participation was passive, and most of the discussions were teacher-led, rather than in small groups.

4.8.1.a. Class Discussions

Both pupils and teachers agreed that discussion was important in drug education and they wanted to increase the amount of discussion in the current provision. The opportunity to discuss issues and give your own opinion was identified by one group of pupils as a key difference between drug education in primary and secondary schools.

> It's better in discussion...you can talk things through with each other and then share with the rest of the class.
>
> *S3 Pupil [3A1: 195, 203]*

> I would just like to think that maybe it would eventually generate a little bit more discussion than it does but again that's the same in any area that you do, there are some kids that are better at contributing to discussion than others.
>
> *Tony Morrison [GI3: 45]*

.....

> Pupil A: It's more fun to have worksheets and discussion [in drug education], you actually get to discuss it and write down things.
>
> Pupil B: It's not as boring as somebody telling you what it is and telling you what to do.
>
> Pupil C: We had it in primary school, but this is much better - this is much more personal.
>
> Pupil A: You can give your own views.
>
> Pupil C: You get to say what you think. In primary school we just got told things and you were working on your own.
>
> Researcher: So it was worksheets as well but you filled them in by yourself?
>
> Pupil C: Yeah.
>
> Pupil B: You never got to speak about it. It was always just writing it down and keeping it to yourself. We never had any discussion or anything like that.
>
> *Extract from Pupil Feedback [3L1: 9-23]*

.....

Older pupils (S5 and S6) did not report receiving this kind of discussion-based drug education, and they gave somewhat negative descriptions of the drug education that they had received.

> It was usually booklets, working through booklets, filling in sheets – you just answer the questions and put it to the side. There were no discussions.
>
> *Sandra, S6 Peer Educator [S62: 25]*

.....

> Researcher: What about discussion like this in small groups, do you think more of that would be good?
>
> Pupil A: I think discussion is more effective than just getting someone to tick a box.
>
> Researcher: Have you had any small group discussion like this in any lessons?
>
> Pupil B: No, we don't have this kind of discussion.
>
> *Extract from Pupil Feedback [5D1: 217-223]*

.....

In the drug education lessons observed, most of the discussions involved the teacher leading the topic from the front of the whole class, and asking questions or for comments from the pupils. In every lesson the majority of the class remained passive and were not involved in making any comments. In some cases, it was almost impossible to get any of the pupils actively involved and the teacher had to call on pupils by name to get a response as can be seen from the following passage (continued overleaf).

.....

> Ruth Mackay, PT Guidance: What do we mean by aggressive behaviour?
>
> Silence.
>
> RM: Come on! Engage brains! I'm going to have to ask people – Fiona?
>
> Fiona: violent

RM: Yes, violent, but not always physically violent. It can be verbally threatening or intimidating. You might think when the police come to move you on that they're going to be aggressive but they want what's best in a situation. What about passive? What do we mean by that?

Silence.

RM: Gary? What do we mean by passive?

Gary: just letting it go.

Extract from Lesson Observation Notes [L3A1: 17-31]

.....

In other cases, many pupils were giving responses at the same time and as noted during the observation below, it was not possible for the teacher to deal with all the comments.

.....

Ann Brown, PT Guidance then asked the class "what kind of drugs are we talking about?" The following were the various answers. AB repeated them as she heard them and she wrote them down on a flipchart.

Pupil: Harmful
AB: Okay, harmful.

Pupil: depends how you use it. (This comment was not noted by AB).

Pupil: Most people that get it on a prescription it keeps them alive.
AB: Okay so they can be used as a cure or where they don't cure you, they can be used for pain relief.

Pupil: Can be addictive (written up on flipchart by AB)
Pupil: Dangerous (written up)

Pupil: Can kill.
Pupil: Comes in different forms (Comment not noted by AB)

AB: John, have you got an answer?
No reply.
Pupil: Some are illegal.

Continued overleaf...

> Pupil: comes in different forms (This was said by a different girl to previously, and it was noted by AB).
> Another girl added "and different uses".
>
> This passage illustrates one of the difficulties of working with the class as a whole. Pupils are making points at the same time and so AB doesn't hear what everyone has to say. It would have been better to get them in small groups brainstorming this point, and then feeding back their answers.
>
> *Extract from Lesson Observation Notes [LAG1: 5-27]*

.....

Much of the classroom discussion focused on getting the pupils to give feedback but it was noted after the following passage that it was largely a wasted effort because there were no attempts to develop or challenge the comments that the pupils made, discuss, correct misconceptions, or consider their views in any greater depth.

> Next the pupils commented on what their families would do [if they were caught using drugs]:
> "be annoyed"
> "be disappointed"
> "lose trust in me, question where they went wrong"
> "be disgusted"
> "be very upset, would-
> "would disown me"
> There was no attempt to discuss what they say or consider it in more depth.
>
> *Extract from Lesson Observation Notes [L3H1: 19-27]*

This lack of any in-depth discussion was also noted during the lessons led by the peer educators and by the police school liaison officer.

> Again, the lesson revolved around the answers from the class, allowing some pupils to provide the answers to the questions posed [by the peer educators] rather than actually discussing what an informed person would discuss as the reasons. A missed opportunity again.
>
> *Extract from Lesson Observation Notes [L2C2: 65]*

One guy raised his hand and asked "if they go to the hospital, do they have to give them clean needles?"

Constable Gordon: We'll talk about needles in a minute.

I [the researcher] feel he never really explained the answer to this question in the lesson. The tone of his answer was pretty curt. It wouldn't have encouraged other pupils to ask questions. I would have been interested to know the motives of the boy who asked the question.

Extract from Lesson Observation Notes [L2D1: 104-108]

It was apparent from the lessons observed that leading discussion from the front of the classroom was a difficult thing to do and that even with the best efforts to tease out the comments of the pupils, it was a long way from allowing them to consider their own knowledge or attitudes in any depth.

4.8.1.b. Small Group Work

Small groups potentially allow more discussion, and crucially, pupil to pupil communication and self-disclosure to take place. Many of the lessons observed split pupils into small groups for various tasks or discussions and this was well-received by the pupils.

.....

Pupil A: [Drug education is] better in groups.

Researcher: Do you all agree?

Pupils A, B, C: Yeah.

Researcher: Why?

Pupil C: You get to, I don't know, talk about it more and
Pupil A: Tell the teacher the ideas and see what other groups think about that situation.

Researcher: Is that good?

Pupil C: Yeah, because sometimes they know something that you didn't know and they've said it.

Extract from Pupil Feedback [3L3: 218-231]

.....

.....

Pupil A: I think [drug education is] better in groups. In cases, someone will know something different so you can learn more.

Pupil B: At least that way everybody gets to say something.

Extract from Pupil Feedback [3L2: 64-66]

.....

In the above extracts the pupils identified two important aspects of small group work – the fact that it allows more pupils to speak more about issues and it allows them to learn from other pupils. Most of the small group work revolved around various work sheets which the pupils were asked either to fill in individually and then discuss with the group, or to fill in as a group. In many of the lessons observed however, the discussion that took place was poor for a variety of reasons. In some cases, pupils did not pay attention at all, talked about other things or argued; in one group the female majority intimidated the only male pupil in the group; in another when asked to share their answers to a worksheet, the pupils simply read out what they had written but did not discuss them in any way.

Half the people knew the answers and half the people didn't. No-one was listening. Mark was jabbering on; Colin wasn't really listening; Alan was just staring at the walls – he just waits for someone to tell him.

S3 Pupil [3E2: 25]

In the groups some of the pupils were discussing other things, not the lesson. Most of one group were speaking about other things and I overheard one boy say "I want to talk about this – you keep talking about other things. Let's talk about this. Do you want to talk about this?" The group ignored his requests.

Extract from Lesson Observation Notes [L3E1: 55-56]

.....

The first group consisted of two boys and two girls. They were speaking about "The Bill". One of them was reading the question "how much information did the police know..." The other group members replied:

"They didn't know much."
"Yes, they did."
"They knew loads."

The two boys began to argue with each other and were bickering constantly. "Shut up" one said to the other. "Stop screamin'" he replied. The girls were getting frustrated with the two boys fighting: "Right you two, just shag and make up" she said, and then added "If you two don't shut up, I'm going to start screaming."

Jim Cameron, PT Guidance, came over to the group. The two boys were hitting each other with pens.

Extract from Lesson Observation Notes [L3F1: 13-21]

.....

Not all of the small group activity was like this however, in some cases the pupils got into some good discussion and questioned each other.

First I [the researcher] listened to group two, some of them had already filled in the first three questions [on their worksheet]. "You're supposed to discuss them with us" one of them said. They discussed how long the stakeout had been in place - half an hour or 45 minutes, suggested one pupil. "They knew quite a lot of information" said another. They then discussed how the police were feeling - "a bit nervous"; "scared". "Why would they be scared?" asked one of them. The next question was "why is the search warrant important?" "They wouldn't be able to search the house otherwise" came the answer. "Are scared and worried the same thing?" asked one of them. They discussed their answers with each other - "I think he feels scared"; "regretful".

Extract from Lesson Observation Notes [L3L2: 38]

The most active exercise that was used in the drug education in any lesson was carried out by Ann Brown with one of her third year classes.

.....

Ann Brown then explained the final exercise "you will have a little bit of investigation to do. Some research. This is not a test of your knowledge, you are to go to the leaflets and find the information, and be able to show where you got the information from. The leaflets are at the back. Work in pairs or in threes. Chose the drug that you want to work on."

In the document given to the pupils by Ann Brown some of the pupils were not sure what was meant by the heading "Type of drug". They were also unsure of what street use meant and asked me. I told them that I thought it meant how it would be used on the street - injected or smoked but I admitted that it wasn't very clear. I felt that the headings in the table might have needed some explanation. It was not entirely clear what was meant by headings such as "street use" or what was intended to be put in that table.

All of the groups discussed the exercise among themselves, looked up leaflets and checked answers. They asked what the difference between personal and social risks were. I tried to help but I wasn't very sure myself, and told them to think of social risks as the risk of what might happen between the user and their family etc. I started to say that personal risks would be the risks to health, but then realised that physical risks was also listed. I advised them to fill it in as best they could and not worry too much about which heading the risks were listed under.

In one group the girls were writing out each answer in different coloured pens, with each girl writing a different answer. Some groups were not as interested as others and finished very quickly. Others protested "we're not finished". Ann Brown noted "this is interesting for you, it's not a test".

Extract from Lesson Observation Notes [L3H1:

.....

Despite the fact that a clearer worksheet or a little more explanation would have been helpful, this exercise had a number of advantages over other activities. Most of the pupils participated in the groups, each group chose their own topic for their investigation; and they had to actively seek out new information in order to complete the task. It would have been even better had the pupils then been asked to present and explain their findings to the rest of the class.

4.8.1.c. Drama Based Activities

In two of the observed lessons led by the sixth year peer educators, the pupils were divided into groups and asked to develop a play about drugs. They were instructed as follows:

> Right we're going to divide you into groups and you're going to make up a play...Some of you in the group will have to be drug users and some of you their family and friends and you have to show the effect of the drug use on the friends and family.
>
> *Rachel, S6 Peer Educator [L2A1: 3, 16]*

The pupils were given 15 minutes to work on their plays. During the planning, the sixth years and the observer moved from group to group, asking them if they had ideas, prompting them to focus on the task and listening to what was taking place. Neither the sixth years nor the observer offered any suggestions as to what the content of the plays should be nor gave any other information to the pupils. As in other small group work, the level of attention given to the work by each group was variable, however they all managed to present a play when asked to do so at the end of the planning time.

> Group two [from Class 2A] (four boys and one girl) were in the middle of a rehearsal: "snort it up" one boy instructed the boy acting as the drug user. They were trying to work out what to do in their play but none of them was really taking lead of the group. Two of the boys were sitting down on chairs. One of the boys was looking at them. The other boy was looking at the posters on the wall. The girl was sat on a table swinging her legs the whole time and not really being included by the boys.
>
> *Extract from Lesson Observation Notes [L2A1: 37]*

> Group three [from Class 2C] were busy writing down a script: "Chris and Becca come in and Chris is pretending not to take drugs, but he's high and his eyes are wide open and he's acting stupid. Becca is out of it." They were carefully writing down each line the characters would say.
>
> *Extract from Lesson Observation Notes [L2C2: 18]*

> Group four [from Class 2C] were not really paying attention and were messing about. They had written nothing on the paper and were busy arguing over a pencil case, and falling off their chairs. I asked them what drug their play would discuss and one boy said "we haven't thought about it". Another boy answered "dope and heroin" matter of factly. I asked them if they had finished their play but they didn't really answer.
>
> *Extract from Lesson Observation Notes [L2C2: 20]*

After their preparation time, the pupils were asked to present their plays. Many of the plays focused on extreme examples of drug use and extreme consequences and it was far from clear what was supposed to be happening on more than one occasion.

.....

Group two were called to do their presentation. It was based on two users who were caught by someone (police?). This was reported to their parents who were told and reacted aghast "our son's on heroin". Then £500 goes missing from the mother's purse. The father phones the police. They catch the son with a knife and "the police" beat him with truncheons. "That's it" they say.

The boy who was supposed to be phoning the police about the money kept doing it before they had acted out about the money being stolen yet so it was a bit confusing.

Extract from Lesson Observation Notes [L2A1: 41-43]

.....

The next group devised a play where two characters are buying drugs. "Have you got the money" the "dealer" asks them. "Have you got the drugs?" they reply. They buy the drugs and go home to "score". Then they go stumbling to the chemist to get some talcum powder and return to the house. After this someone comes to the door and one of the users runs out. The other user attacks the person at the door (stabs him, we are told) and he falls over. So ends the play.

Extract from Lesson Observation Notes [L2C2: 32]

.....

There are two pupils in class when another two enter, one of whom is stumbling. "Oh no, you've not been on that stuff again, what's it called? Cannabis".

"Never touch the stuff"

"What about you Becca? (to the other entering character). "I've tried it a couple of times". She takes out a joint and gives it to the drugged character. He then briefly mimed the making and lighting of a "spliff" and passed it to the one of the girls. She smokes it and says "Oh, this is okay, actually its good, it's quite nice". The other girl says "I don't have to stay here and watch you do this to yourselves".

Extract from Lesson Observation Notes [L2C2: 34-36]

.....

At the time of the lesson observations, a number of notes were made that expressed doubts about the value of these plays as they were organised in the two observed lessons:

> They are not asked to discuss the plays in any way. In a way, the plays serve to reinforce their stereotypical views of drug users and dealers, rather than being aware of how they might really come across drugs in their lives. It is not ideal, though it is definitely interactive. The plays may also have made some of the drug taking look quite cool, in the sense of trying cannabis, and saying "its nice" etc. Because the plays weren't discussed, the opportunity to raise levels of knowledge and understanding was missed. It was entertaining for the pupils but really wouldn't have added to their knowledge in any way. It might have got them thinking a little, but since any thoughts or attitudes were not teased out, it would not really have developed their attitudes either, except perhaps a little by observing other groups, and planning things with each other. But it would be only a marginal improvement on what they would learn informally outside the classroom from their peers.
>
> *Extract from Lesson Observation Notes [L2C2: 40]*

> All of the plays again focused on extreme examples of drug use, and the consequences and there was no discussion of how realistic or accurate the portrayals were. The lesson moved straight on to the video so I again feel that the pupils would not have learnt anything new, except more possible muddle from other muddled peers. There was actually no new input at all from the sixth years for this whole part of the lesson. It might as well have been drama class, because that is what they were doing, not learning about drugs. It was an easy way for the sixth years to pass the time of the lesson without having to have any personal expertise or having to teach anything.
>
> *Extract from Lesson Observation Notes [L2A1: 59]*

Although this was clearly an interactive teaching method that involved pupil to pupil communication, the pupil to pupil discussion was not related to the pupils' own knowledge, attitudes or values, and therefore it did not require significant self-disclosure. Drama-based activities clearly have the potential to be useful; however it is clear from the above notes that their value in this context, without feedback or discussion was considered questionable.

4.8.1.d. Resources

As described in Table 4.5 many of the lessons involved the use of videos and/or worksheets for the pupils to fill in.

In general, the pupils gave mixed reviews of these resources although preferred videos or discussion to worksheets which they felt they got too many of and were boring.

.....

Researcher: What are the boring things in drug education?

Pupil A: Written work. It's boring. It doesn't help really.
Pupil B: We had to do a worksheet about the video - it was boring. It was more or less nothing to do with drugs.
...
Pupil A: You do do a lot of looking through sheets and trying to find the answers to questions in other subjects so it does get kind of boring.

Extract from Pupil Feedback [2A1: 142-167]

.....

.....

Researcher: What about other drug education? Can you remember anything else?

Pupil A: Mostly sheets.
Pupil B: We had a video then heaps of worksheets with questions.

Researcher: Did you fill in the worksheets by yourselves?

Pupil A: Mostly by ourselves
Pupil B: Sometimes in groups

Researcher: Is it more interesting in groups?

Pupils: Yes, but its still boring.

Extract from Pupil Feedback [3H1: 50-62]

.....

Some pupils enjoyed the worksheets, though they agreed it was better to fill them in in groups. They did concentrate on the task in some cases, although they complained that they were not given enough time for discussion. The specific resources that were used in the observed lessons are discussed from page 231 onwards.

.....

Researcher: How did you find the worksheets?

Pupil A: Good.
Pupil B: Easy.
Pupil A: Yeah, I didn't struggle to do them.

Extract from Pupil Feedback [3L3: 32-36]

.....

Researcher: Do you end up chatting about other things when you're in groups?

Pupil A: It's a bit slow but we do talk about it.

Researcher: So you go back and forward to the sheet.

Pupil A: Yeah.
Pupil B: Yeah, that's what we do.
Pupil C: I don't think he gives us enough time to think about it. We're just started and he'll go "five minutes".

Extract from Pupil Feedback [3L2: 72-81]

.....

Having watched the Drugwise Drug Free video, the pupils particularly noted the importance of having videos that were up to date or they lost interest.

.....

Researcher: You mentioned that the videos are always old-fashioned?

Pupil A: They always look like the fifties or something.
Pupil B: Yeah.
Pupil C: They're not like the fifties (scornfully, laughing), more like the early nineties.

Researcher: Why does that matter if people interact in the same way?

Pupil B: If you're watching a video and it's old-fashioned it doesn't make you as interested in it.

Researcher: Does it distract you then?

Pupil A: They come out with stupid old words.
Pupil B: You assume its going to be boring.

Extract from Pupil Feedback [3H1: 126-139]

"The Buzz" - Video and Resource Pack

The first video that was used was "The Buzz" which was developed by Grampian Police and pupils from a secondary school in Aberdeen city and is accompanied by a resource pack. The video itself is quite dark and focuses very much on heroin and injecting drug use. It shows a girl shooting up and collapsing in the bathroom and there are other scenes of someone shooting up in a toilet, both of these are shown in black and white. These scenes are contrasted with colour scenes where people are shown doing lots of activities – ice-skating, trampolining, playing football or guitar. The question "which Buzz?" is shown on the screen before each section of colour footage. One part of the video shows what are intended to look like body bags on the beach in Aberdeen, which represent the number of people who died from drug use in the year prior to the making of the resource.

In general the feedback about this resource (from the two classes which were observed) was positive, although one pupil did note that it was hard to understand. According to the police school liaison officer, they were not the only pupils to note this, he told the sixth year peer educators that other schools had found it a bit confusing also.

.....

Pupil A: I think the video that showed what it did to your family and that, the effects it can have, that was good. Although some of it was kind of hard to understand.

Researcher: You mean the Buzz video.

Pupil A: Yeah.

Researcher: What bits were hard to understand?

Pupil A: You saw things on the beach, and didn't know what they were. It was moving all the time, seeing a bit of one thing and then going on to something else.

Researcher: What did you think of the video (to other pupils)?

Pupil B: It was alright. You saw more what you actually do with the drugs.
Pupil A: You saw them putting belts around their arms, I didn't know they did that.

Extract from Pupil Feedback [2A1: 124-136]

.....

> I thought it was pretty realistic, the black and white got your attention...One quote stuck in my head, that was the girl who said at first she got a buzz from it but now she's got to take it to feel normal.
>
> *S3 Pupil [2C1: 27,47]*

After watching the video, the pupils were asked to fill in an activity sheet, which was taken from the Buzz resource materials. It consisted of three questions:

1. I think people take drugs because...
2. The bit of this video that really made me think was when...
3. In my opinion this video was... because...

This feedback revolved around the pupils' answers to these questions, without any actual factual discussion such as the research that has identified the reasons why people take drugs. There was also a lack of discussion in relation to the other two questions.

.....

> The discussion moved on to the second question - what bit of the video really made you think?
>
> Pupil A: The girl lying on the floor with her mum and dad there
>
> Pupil B: The girl who said she had to take it to feel normal
>
> S6 Peer Educator: Why do you think the girl lying on the floor affected you? Is it because you could relate to it?
>
> Pupil A: No, it was just the way she was lying there - her mum shoutin' and her dad just saying "she's dead".
>
> S6 Peer Educator: She wasn't dead.
>
> Again, there was no real discussion of how the parents might feel, how the girl might feel when she recovers, what might have led her to that state, what she might need to try and do to get off drugs or how easy/difficult that is.
>
> *Extract from Lesson Observation Notes [L2C2: 67-77]*

.....

Overall, it was felt that the lessons involving the video "The Buzz" and the resource pack could have been more useful had there been more in-depth discussion of the issues involved along with provision of factual background information.

"Off Limits: Talking about Drugs" – Video – Programme One: "Society".

This 25 minute programme was shown in the first drug education lesson of the third year programme, prior to the use of the Drugwise Drug Free resource. It is part one of a three part video, produced by Channel 4 and shows how drugs have been portrayed in the media and society in a historical context. It has been reviewed previously by the ResourceNet website at the UK Department of Health.

> The slightly ironic commentary leaves the young viewer with plenty to think about, especially the role of governments in times of war. It outlines legal issues and examines why young people use drugs. It ends by asserting that young people need information that allows them to make informed choices. The video is linked together by the Eastenders actor Todd Carty and a few clips of drug-related soap drama are used to highlight issues.
>
> *[Department of Health, 2003]*

This video was highly rated by both the teachers and the pupils.

.....

> Pupil A: It was better than the usual ones. Normally it's just an adult saying "just say no", you shouldn't do this but that had other information - how long its been used for and that.
>
> Pupil B: I liked it. It told you they used drugs in war and that. I never knew a thing about that. I thought it started not that long ago.
>
> Pupil A: It told you that it started in the 1800's and that, and army people. I thought it just started up with the hippies.
>
> *Extract from Pupil Feedback [3]1: 7-11]*

> The first [video] that was drugs and society was a very, very informative thing...That was the one where drugs historically were mentioned, various personalities were mentioned. Well-known historical people were mentioned as drug takers and so on and how society changes its attitude and so on and that's all interesting.
>
> *Jim Cameron [GI4: 187,191]*

The pupils were given a sheet on which to write down issues that they would like to discuss more, and they were split into groups after the video to have a discussion. However, the first thing they were asked to do in their groups was to decipher a list of anagrams, and this took up the rest of the time in the observed lesson. There was therefore, no discussion of the topics raised in the video in that lesson.

"Drugwise Drug Free" – Video and Resource Pack

Drugwise Drug Free is a resource that was developed by Strathclyde Regional Educational Authority in 1995. And it consists of six short video clips along with fact sheets and activity sheets. The stated aim of the resource is to provide young people aged over 14 years opportunities to:

- be aware that substances sold on the streets are often of unknown purity;
- increase knowledge about the exploitation which accompanies drug dealing;
- consider that adulterants can be harmful;
- understand that dealers are only interested in making money and not producing high quality substances;
- learn the penalties for possessing and supplying drugs.

[HEBS, 2003]

The six video clips (entitled "The Dealers"; "The Buyers"; "The Drugs Squad"; "The Raid"; "The Police Station"; "The Trial") tell the story of two boys "Tony" and "Smiddy" who go to a drug dealers flat to buy some drugs for themselves and their friends. The police have been staking out the flat and when the two boys arrive they carry out a raid and the boys are arrested. The final part depicts the trial of the drug dealer.

This resource was given mixed reviews by pupils. The format of dividing up the video into short clips was found helpful by some.

> It's easier because the video was split into different bits so you can understand different bits and then there's a worksheet...[Otherwise] I would have to remember what happened at the start to [be able to] answer all of the sheets.
>
> *Pupil Feedback [3L3: 26-30]*

Others felt it was a little out of date or that it was accompanied by too many worksheets and not enough discussion as described above. The lack of sufficient discussion was also what was noted during the observations of these lessons, as was the relevance of the focus of the resource.

> Again, things were not covered in much depth. It wasn't really an information giving exercise nor was it developing attitudes and skills. It's hard to say what category this comes under. It was a vague discussion about the world of heroin and hard drug dealing, with a little bit on peer pressure thrown in. It's hard to see how relevant the heroin and dealing would be to third year pupils, or if it would ever be relevant to them.
>
> *Extract from Lesson Observation Notes [L3L1: 139]*

> Again, [there was] not enough discussion. [The] focus [was] on knowledge of drugs, the law, the school's policy, not on attitudes or decision-making in relation to drugs. [It] ignored giving them information on the (real) kinds of situations they might find themselves in where drugs are being used, or where they have a chance to join in with some drug use.
>
> *Extract from Lesson Observation Notes [L3L4: 135]*

Considering the focus of the videos and the lack of discussion accompanying the worksheets, it is again questionable how valuable these lessons would have been to the pupils.

"Sorted" Video

This video was produced by the family of Leah Betts, a girl who died on her 18th birthday after having taken an ecstasy tablet. It is partly the story of Leah Betts and how she died and partly a tribute to her as a person by her family and friends. This video was shown to all fourth year pupils and was considered excellent by the pupils and the teachers.

> "Great video" was the general consensus. One pupil said that she felt it was very hard-hitting, particularly to see Leah's Dad crying and the fact that her sister and friends also appeared on the video. "It was good because it explained some of the bad effects and all you really know is the good effects before this", she added.
>
> *Extract from Pupil Feedback [4LM: 11]*

There is no doubt that the video is hard-hitting, as it deals with the death of a young girl, and it is quite a strong anti-drug message.

It only deals with one drug, ecstasy, which is certainly not the most commonly used one among pupils. In addition, it deals with the extreme, and indeed very rare, consequences of taking ecstasy, and therefore may not be seen as credible by anyone who has used or is familiar with the use of ecstasy.

> The pupils were quiet all the way through [the video] and when it finished, they remained quiet and waited for [the teacher] to initiate any discussion. [One] can clearly see the effect of the video on the pupils – it is easy to see why the teachers value it. It's powerful (I [the researcher] was affected too) and it keeps them very quiet. It's hard to imagine them watching it and then going out to take E the next weekend. Does it work? Very short term maybe. More than a month?
>
> *Extract from Lesson Observation Notes [L4K1: 15]*

As the video does not come accompanied by any other resources or educational guidelines, it was followed by a general discussion about ecstasy in the observed lessons. This was a teacher-led class discussion along the same lines as described previously.

"Off Limits: A Life of Ecstasy" – Video – Section One: "Danny's Story"

This video is split into two sections, the first 25 minute section is called "Danny's story" and is a drama dealing with the life and tragic death of seventeen year old Daniel Ashton. It was published by Channel 4.

The video depicts a group of young men preparing to put on a school play about the dangers of drugs. The play focuses on peer pressure and bullying, the main character, Danny, who is diligent and against drug use, is persuaded to go to a nightclub with his classmates, although he doesn't really want to. While there Danny's drink is spiked with ecstasy and he then takes (snorts) some amphetamine on top of this. He becomes unwell and dies in the nightclub. At the end of the video it is made clear that in real life, Daniel Ashton, who wrote this play with his friends died himself some months later from taking ecstasy and amphetamine in a club.

The video has been reviewed independently by the ResourceNet website at the UK Department of Health (see extract overleaf):

> The story is fairly credible, although some stereotypes still seem to be perpetuated. Some young people may have been introduced to ecstasy through a spiked drink but this is not necessarily a common route... The central character is seen to be a bright, successful, hard working young man. He reassures his parents that he intends to live his life to the full without the use of drugs. It appears that Danny is well informed of the risks of substance use but still loses his life. The focus of the video, that this can happen to anyone, needs to be put into context and used as a way of raising debate within families without scaring parents or putting young people off.
>
> *[Department of Health, 2003]*

The above review highlights a number of possible concerns about this video. The pupils did not find it unrealistic however, they felt that drink-spiking was not uncommon and that the club scene was realistic:

.....

Researcher: Do you think it was realistic, what happened to Danny?

Pupil: I think it was realistic because I've heard a lot of stories about people having their drinks spiked.

Researcher: Do you know anyone that that has happened to?

Pupil: No, I don't know anyone, but I've read in magazines a lot of stories about spiking drinks.

Extract from Pupil Feedback [5D1: 12-18]

.....

.....

Pupil A: The video was good.
Pupil B: It was realistic, when it was in the club it was very realistic.
Pupil A: I could relate to it.

Extract from Pupil Feedback [5G1: 9-11]

.....

Despite the pupils' endorsement, some concerns remain. Given Danny's strong anti-drug stance, it seemed unlikely that just because his drink had been spiked with ecstasy, he would then have willingly snorted amphetamine, even if he was supposed to be under the influence.

It also seemed somewhat incredible that although Danny's "friends" who were portrayed as a stereotypical bad influence, were also on drugs, it was hardworking, bright Danny who ended up dead. It was a black and white portrayal of the good guy striving (and failing) to overcome the gang of bad guys. The "bad guys" appeared to be having a great time in the video with no ill effects at all.

Although not commented on by pupils, the video focused on a very masculine world; there were no girls in Danny's peer group and this may have affected its credibility with some pupils. The video was also difficult to follow as it deals with a real character writing a play in which he is actually depicted (but doesn't know it yet), and the time-frames involved become confusing.

The overall message of the video seems to be that a person cannot afford to be too careful, even those who are clearly anti-drugs can end up dying from them.

> Catherine Baxter's first comment after the video: "He still got caught up in it" gives the drugs a kind of mystical power, that even if you are completely innocent, they can end up taking over and causing you damage...some kind of evil drugs underworld [might exist] among your friends/peers [such] that one poor decision can mean that [drugs] take you over.
>
> *Extract from Lesson Observation Notes [L5D1: 91]*

4.8.1.e. Other Activities

Over the course of the pupil feedback, some pupils suggested that small group-based project work would be an interesting addition to the drug education.

> .....
>
> Pupil A: I think it might be more interesting if they made up like a little project. Go to the library, find books, look it up on the internet.
>
> Researcher: So it would be better if you had to find it out for yourselves?
>
> Pupil A: Well, I think it is.
> Pupil B: It would be better than doing it in class.
> Pupil C: It's better than doing worksheets but not if there started to be too much of it. It would be probably be boring as well if all the subjects started doing it.
>
> *Continued overleaf...*

Researcher: But just if it was in drug education?

Pupil C: It would probably be better.

Researcher: What if you split into groups and had to research different drugs and present it back to the class?

Pupil B: You would find out more about the drug.
Pupil A: You might take in more from other people in your classs than you might from teachers.
Pupil C: That would be pretty good - it would just be better than the usual stuff.

Extract from Pupil Feedback [3L2: 168-182]

.....

This suggestion was supported by the sixth year peer educators:

If you're given a task, not just questions, you actually have to think about it. It's such an up to date topic, it's so big, people are interested. They're going to be curious and projects give them an opportunity to find out information without being geeky – otherwise you can get teased for finding out information like that.

Helena, S6 Peer Educator [S62: 162]

Another pupil suggested having some kind of team-based quiz as part of the drug education programme.

4.8.2. Teacher

As can be seen from Table 4.5, the drug education lessons were delivered by members of the guidance team, except for the second year programme which was delivered by sixth year peer educators and the police school liaison officer. Although no two lessons were the same, even with the same teacher, no one teacher or deliverer appeared to the researcher to be outstanding in terms of quality (or indeed lack of quality) of drug education delivery. All of the guidance teachers had been trained at various stages in health promotion and drug education, though none of the training was very recent. "Three or four years ago" the school received funding from Barclay's New Futures to put in place a peer-led drugs education programme and guidance staff were trained for a number of days over the summer period by Health Promotions and Grampian Police as a part of that. They have also done various courses run by Health Promotions, and

some of them mentioned the postgraduate course in guidance. None of them expressed an urgent need for training – one felt that training on other areas was required more than drugs issues, and another felt that there was less opportunity to be trained than previously.

> If you're looking at the whole, the global position of training in the job, to be quite honest I think there's training in other areas that I would need before I had training in the drugs...Things like using PPMS and the like on the computer...[PPMS] is to do with pupil tracking, pupil logging, I mean whole school guidance issues. I mean, training seems to be such an issue, getting trained in certain things.
>
> *David Kerr, PT Guidance [GI7: 206-214]*

> I think what we've done at different times is we've done the various courses that have been offered. I suspect now that because of the way things are with our time and everything, I think there is probably less opportunity now to do training. And that kinda concerns me as well, because I think everybody should be constantly updating their knowledge even if they do points of delivery things.
>
> *Tony Morrison, PT Guidance [GI3: 137]*

The most significant recent development in drug education delivery in the school was the change from the use of first-level guidance teachers (FLGTs) to delivery only by full time principal teachers of guidance. The reasons for this change were described by Ruth Mackay during the interview study which was conducted towards the end of the 2000/2001 academic year, before the change had taken place (Section 3.5.2.b). The case study was carried out in the school during the first half of the year 2001/2002 and it was therefore possible to consider the impact of the change in delivery. This is discussed in Section 4.8.2.a below. Sections 4.8.2.b. – 4.8.2.d. discuss specific features of the delivery led by teachers, the police school liaison officer and the sixth year peer educators.

4.8.2.a. Change to Guidance Delivery

As described in section 3.5.2.b, most of the guidance teachers were in favour of taking over responsibility for PSE delivery, as they had doubts about the quality of what had been delivered by many of the FLGTs in the past. Their experience in the first year of the actual delivery only served to confirm those doubts and they were satisfied that they had made the right decision in changing.

> With pupils as well, they're used to with social education, being handed a worksheet, told to do the worksheet, take the worksheet then give out another and the discussion hasn't been very healthy in the past...Certainly that's what I've seen and other little things like the progress file, when you speak to them about core skills and it goes straight over their heads and to some extent I suppose what I'm finding out here is that its reinforcing that the decision to change has been a right one.
>
> *Tony Morrison, PT Guidance [GI3: 53, 57]*

> It was done lesson by lesson with lesson plans, worksheets, everything done and then when you hear the youngsters talking about SE they were so negative. Some not all, but a lot of them were negative and they obviously weren't getting the same experience across the board. This way, and we might not be superb and we all have our off days but at least, we're comfortable with it which not all teachers are and that's fair enough. We know the stuff because we've been preparing it and it's a terrific chance to get to know our youngsters even better.
>
> *David Kerr, PT Guidance [GI7: 137]*

> Before things were very regimented – full of worksheets etc. But now it is much more flexible, the guidance team can react to things that are happening in the town. They know the pupils much better, they are likely to know who is involved if something happens locally and they can adapt the lessons appropriately...The tutors would not react to things that were happening because they weren't interested enough, didn't know the pupils as well and just didn't have the time.
>
> *Jim Cameron, PT Guidance [TF3: 32]*

> Catherine, PT Guidance noted that she had been finding some of her SE classes quite difficult. "It seems that they have been used to coming to SE classes and doing sweet fanny adams while they're there", she reported [to the guidance team meeting].
>
> *[GN5: 38]*

> Last year, register teachers would have been delivering this lesson and they would most probably simply have shown the video and then let the kids talk among themselves while they got on with their own work.
>
> *Jim Cameron, PT Guidance [TF4: 17]*

The pupils also felt that delivery had improved with the guidance teachers, in terms of pacing, interest in the pupils, discipline and knowledge.

.....

Pupil A: It's better [with our guidance teacher]. The register teacher we had was more a support teacher. It seems to be a lot slower, we spend more time on one issue before you move onto the next.

Pupil B: Our register teacher just said "don't do this"...

Pupil A: With your guidance teacher they want to hear your problems and questions and they want to know what's happening with you in school.

Extract from Pupil Feedback [3F1: 230-232, 242]

.....

.....

Pupil A: Our registration teachers took us for S.E.

Pupil B: And that was a waste of time, it was a skive, we never did anything, it was like a zoo. No-one was working, everyone was chatting and shouting. He didn't care, he would just sit there and keep on writing.

Pupil A: Our guidance teacher is more strict...

Researcher: Is it better with Mr. Morrison?

Pupil A: You learn more.

Extract from Pupil Feedback [3L2: 186-192]

.....

.....

Pupil A: I think [teachers] should be trained more.

Pupil B: It was just a regy teacher and they didn't know anything. Ms. Mackay and Mr. Morrison know what they're talking about, they're much better.

Extract from Pupil Feedback [4LM: 19]

.....

There were some disadvantages to the changeover, but these were not related to the quality of the drug education. Teachers had to give up all but a few periods teaching their own subject area, and seeing the pupils so regularly meant that they picked up on more issues with pupils making the guidance side of things busier than ever.

This may have been good for pupil welfare but was considered a disadvantage of the change by guidance teachers. The additional PSE teaching commitment also meant less time on an individual basis with pupils, though this was compensated for somewhat by having more teaching time with them.

Overall, however, all but one of the guidance team was happy with the changeover. This particular PT guidance did not enjoy teaching PSE and found it very difficult but despite this, even (s)he could see some benefits.

> I've put a lot of effort into it, you know, I do try hard, but I absolutely hate it...What I do enjoy though, I do enjoy, it's really useful seeing the kids every week... I suppose I've got to know my first year class quicker. Aaah, its just some days, I just think, no, not this again.
>
> *PT Guidance*[xx]

Despite this reluctance, there was no indication at all that this teacher's delivery was in any way of a poorer quality than that of the other PTs Guidance. In fact, it came as a complete surprise to the observer that (s)he reported hating the delivery.

4.8.2.b. Guidance Teacher Delivery

Perhaps because they were not in the habit of delivering the drug education programme, there were basic gaps in the knowledge of some of the guidance teachers and they often failed to pick up on and correct myths presented by the pupils or to take advantage of opportunities to improve knowledge.

Firstly, the lack of knowledge of one teacher in particular became clear over the course of some of the more lengthy and more active class discussions that was observed.

> "Speed is also a class B drug" Jim Cameron, PT Guidance, tells the class. "Is that not just like ecstasy?" one pupil asks. "Yes, I suppose it is, in that it speeds you up, gives you energy as well" the teacher replied.
>
> *Extracts from Lesson Observation Notes [LAK1: 34]*

[xx] This quote is not referenced as it is possible that the teachers in the school would be aware of who did not like the changeover to guidance delivery and it would therefore compromise that person's anonymity for all other quotes too.

> Jim Cameron then asked me "Is it with speed you get flashbacks?"
>
> *Extracts from Lesson Observation Notes [L4K1: 34]*

> So we also read in today's Press and Journal, I don't know if any of you read it over breakfast but following on from last week's change, they have moved cannabis from Class, moved it from class B to C.
>
> *Jim Cameron, PT Guidance [L5G1: 31]*

In fact, speed is not "just like ecstasy", it is a different class of drug with different effects, it does not give you flashbacks, and at the time of the case study (and until July 2003), cannabis remained (and remains) a Class B drug. Despite the fact that no other teacher exhibited a lack of such basic knowledge, it cannot be concluded that this teacher knew any less than the others as they were not observed leading such wide ranging discussions. In any case, while their basic knowledge did not show up as flawed, there were still inaccuracies in information presented by other teachers to the pupils, though these were more related to a lack of streetwise information.

> People on E don't usually drink alcohol.
>
> *Catherine Baxter, PT Guidance [L5D1: 135]*

.....

> "How much does [an ecstasy tablet] cost?" Ruth Mackay asked the class.
>
> £4 and £5 were the figures mentioned by quite a few pupils. "Me and [another pupil] were talking and we said £4 and someone else corrected us and said £5", explained one boy.
>
> Ruth Mackay explained that generally speaking the cost of an ecstasy tablet is nearer to £12-£15, though that it is becoming cheaper and nearer to the price-range that the pupils would be able to afford.
>
> The teacher seemed to assume here that her information would be more accurate than the pupils'. It was as if she was correcting them, that they were wrong. Rather than correcting them here, it would have been better if she had said that she believed that they were more expensive, and could then have asked if anyone was definitely sure that it was possible to buy ecstasy for £5 in the area.
>
> *Extract from Lesson Observation Notes [L4LM: 20-22]*

.....

In fact as reported in Section 1.2, it is known that regular users of ecstasy (and other club drugs) frequently use other substances, and alcohol is one that is very commonly combined with ecstasy. At that time in Grampian, it was possible to buy ecstasy for £5 or even less per tablet, and this was actually correctly pointed out by the same teacher in a later lesson.

Even more common than misinformation was a failure to pick up on pupil comments, answer questions properly or take opportunities to enhance knowledge.

> Jim Cameron asked them about "mazzies, temazepam". "I've heard of it but I don't know what it is" said one boy. He received no explanation. Again, one gets the impression that this is not discussed because the teacher is not particularly sure himself about the facts in relation to the drug.
>
> *Extract from Lesson Observation Notes [L4K1: 40]*

.....

> Pupil: The actual drug isn't always dangerous but its mixed in with stuff – like rat poison and stuff.
>
> Catherine Baxter, PT Guidance: So it could be mixed – you don't know what you're taking.
> The pupils comment was said in the context of a discussion about ecstasy, and is one of the key myths about drugs that exist currently. In fact most ecstasy deaths are due to the effects of the ecstasy, not any adulterants. In addition, it is highly unlikely that ecstasy would be cut with rat poison as this would be likely to kill or seriously harm users (which is not in the interests of dealers). And as ecstasy is a tablet, it is less likely to be cut than other drugs anyway. But none of these points were picked up on by the teacher here.
>
> *Extract from Lesson Observation Notes [L5D1: 34-37]*

.....

> One girl at the front asked the PT Guidance "What is the difference between cannabis herbal and cannabis resin?"
>
> Tony Morrison, PT Guidance noted that cannabis is not in class C yet. The girls question was not answered.
>
> *Extract from Lesson Observation Notes [L3L3: 20-24]*

.....

One girl mentioned that [if she was caught taking drugs] people at school would talk about her.

This was not discussed. It could have been explored more, about how people view you if you take drugs, what impression that creates of you with other people. Is it cool? Or is it stupid? What do people think? Does it matter what people think?

Extract from Lesson Observation Notes [L3L4: 64-66]

.....

Thus, while the provision of drug education seemed to be much improved with the guidance teachers compared to the previous delivery by FLGTs, there was still considerable room for improvement in the knowledge of the guidance team and their ability to pick up on pupil input.

4.8.2.c. Police-Led Delivery

The police school liaison officer, Constable Gordon, delivered one session to each second year class on drugs, and was also responsible for two of the training sessions for the sixth year peer educators. In general, the pupils enjoyed his input and felt that he was in a position to know more than the teachers.

In one of the classes, a policeman came in and brought in cases and showed us what the drugs looked like. That was better. He can tell us more information than the teachers. He knows because he's maybe seen real cases, the teachers haven't.

S3 Pupil [L3L2: 218]

When you're speaking to a teacher you're not really sure where the information is coming from, its like they're trying to persuade you. With a policeman you know where the information is coming from, you know it's the truth.

S6 Peer Educator [S62: 9]

In the S2 lesson that Constable Gordon delivered, he covered a large amount of information, mostly relating to cannabis and heroin. As described in Table 4.5, the information provided was about the physical appearance of the drugs, the long-term effect of the drugs on the body, and the methods by which the drugs are used.

Although the lesson focused very much on the negative effects of the drugs, Constable Gordon did emphasise why people took drugs in the first place and that it was up to each pupil to make their own choice. The information given was generally of a high standard, accurate and credible, apart from a couple of inaccuracies, most notably the following.

.....

Constable Gordon: What's the most popular drug in this area?

Pupil: Cannabis and heroin

Constable Gordon: That's correct.

Extract from Lesson Observation Notes [L2C1: 37-41]

.....

It is likely that this was just a slip-up however, as Constable Gordon correctly pointed out to the sixth years that amphetamines are the next most popular (illegal) drug in the area, as identified by the local youth lifestyle survey (Health Promotions, 1998).

Although most of the information given was accurate, a number of reservations about the lessons were noted at the time. Specifically, although the pupils were given placebo boxes to look at, the lessons were not interactive in nature as Constable Gordon spoke for most of the period. Even within a good, (interactive), drug education programme, there is room for non-interactive input for provision of information. The lesson would have benefited, however, from the provision of handouts to the pupils with which they could have followed the lesson and which they could have taken away with them as a reference. Another alternative would have be to use an overhead projector to present more comprehensive information.

The level of detail that was provided in relation to how heroin and cannabis are used, as was described in Section 4.7.1 was a source of potential concern to the researcher. It was noted that this kind of information was almost a "How to..." guide to the use of these two drugs. In relation to cannabis, which a significant proportion of pupils are likely to use at some stage, it is possible that the information given would give the pupils ideas about using a bong and how to roll a joint.

It could be argued however, as is done in relation to harm reduction information, that information alone will not make someone decide to use a drug.

Constable Gordon was asked about why he gave such detailed information:

> They've got to know. Ignorance is a huge problem. They see it on TV anyway...It's not just the drug itself that can be dangerous, it's the way it's used that can also be dangerous, so it's important to cover the various harms, not just from the drugs.
>
> *Constable Gordon [CGI: 6]*

His feeling was that most of the pupils would already see drug-taking, for example, in the film Trainspotting, and that it was important to cover the practicalities of drug use.

Finally, the input of Constable Gordon was considered in light of the guidelines on the use of external agencies outlined in Table 1.5. Most of the guidelines were easily fulfilled as police could reasonably be expected to fulfil all the requirements of guideline 1. The rest of the guidelines required further consideration however. As all of the teachers were familiar with Constable Gordon's presentations which were well-established in the school, they did not carry out any prior meetings or checking of materials. It was not uncommon, however, for teachers to be absent from the classroom while he spoke to the pupils and this meant that they would have been unable to follow up on any specific issues raised by a particular class. It is also not known if parents were explicitly informed of the nature of his input into the drug education programme.

4.8.2.d. Peer-Led Delivery

As shown in Table 4.5, some of the lessons in second year were led by sixth year pupils who were trained as peer educators. In fact, they delivered two out of the three lessons that each second year class received of drug education. The origins of this innovative programme were explained by Ruth Mackay, PT Guidance.

> What happened was when we set it off initially, we, the six guidance staff were trained. We did six days during the summer holidays with Health Promotions and the police...We did specifically drugs, but we did a lot of sort of group work and peer led work. Barclay's New Futures funded it, so we got an award, it was quite, it was £3,000 or something, so that actually paid for this holiday work and so on and so forth. And it paid for us to get materials, so we had a lot of materials from them.
>
> *Ruth Mackay, PT Guidance [GI1: 452-464]*

The sixth year involvement was totally voluntary and the running of the programme depended partly on the numbers that chose to become peer educators.

> The peer-led drugs is a volunteer thing, they volunteer in. This year, we've got, I can't remember whether I said this but we've got quite small numbers [of sixth years] but in fact in some ways it's been better. They have had more chance. I mean if you have a group of thirty, then basically you work four with a class or five with a class, but they only get a couple of goes at it. But if you have a group of twenty, then they are getting more goes at it, and the feedback from them suggests that the first time, they're nervous and they're not sure, but you know they get better. So the classes that get the third or fourth go are at a definite advantage!
>
> *Ruth Mackay, PT Guidance [GI2: 186-190]*

The training received by the sixth years who were involved in the peer-led drug education programme for the 2001/2002 academic year consisted of four sessions, two with Constable Gordon and two with the PT Guidance with responsibility for the programme. The two sessions with Constable Gordon were similar in content to the sessions provided to the second year pupils, although a broader range of drugs were covered as described in Table 4.8 (on this page and continued overleaf). The sessions with the PT Guidance concentrated mainly on the review and provision of various resources (leaflets and videos) that were available for the sixth years to use in the S2 lessons.

S6 Peer Educator Training
Session One: PT Guidance – 55 minutes
This session consisted of a factual quiz about drugs for the sixth years to find the answers to themselves. The sixth years also viewed some videos that they could use with second years if they wished: David's Story; Think Twice Drugs Can Kill; The Buzz. The session included a general discussion and advice from the PT Guidance about how to approach the sessions with the S2 classes.

Session Two: Constable Gordon – 90 Minutes. **Drugs Covered:** Cannabis, heroin, ecstasy, amphetamine, LSD, "magic mushrooms", nicotine, alcohol. **Topics Covered:** Pupils reasons for getting involved in the peer-led programme; Drug definition and mode of action; Physical effects of drugs; Why people take drugs; Police powers and procedures; Anecdotes about LSD, alcohol, heroin and ecstasy.
Session Three: Constable Gordon – 55 minutes In this second session, Constable Gordon went through a set of quiz questions about a whole range of drugs with the pupils, asking them to suggest answers and then giving the correct answers and some of his own background knowledge.
Session Four: PT Guidance – 110 minutes This session was not observed by the researcher. The sixth years reported that they were provided with "a whole heap of leaflets that we were supposed to read through".

Table 4.8: Summary of S6 Peer Educator Training.

In the past, the peer-led lessons had been delivered without the presence of a teacher, however this changed slightly for the year 2001/2002, due to problems that had arisen:

> [In] the first year, we didn't have staff in at all when the sixth year were delivering because we felt that it gave both the sixth year and the second year more freedom. There were one or two problems so we actually now ask staff to be either next door or working in a corner, but they do try and not be a significant part of what's going on. One was a control problem and the second was inappropriate information from a sixth year. This was someone who spoke about actually growing plants himself and what you could do with it and things... And needless to say you can't have things like that... When we take the sixth years on they have to, they go through they have to fill in a fairly comprehensive application form and they then go through an interview system. Who knows? The discipline [problem] was purely that the class, because it's done as a sort of games basis, the class got high and slightly rowdy and it's just easier for staff to step in at that stage than a sixth year. That wasn't a particularly bad problem but we just felt that we could avoid both. What we had said previously was that the staff had to let the sixth years know where they were and be nearby, but what we've said now is stay in the room, keep it low-key, keep out of the way.
>
> *Ruth Mackay, PT Guidance [GI1: 490-556]*

In the observed lessons (during 2001/2002), the teachers were sometimes present in the room, but did not interfere at any point and there were no problems such as those described above. The quality of the S6 input was variable however.

Two of the observed lessons consisted of the drama activities and the video "The Buzz", and generally lacked any in-depth discussion as described in Section 4.8.1.a. above. In the other observed lesson the sixth years provided general factual information about a wide range of drugs in the format of a whole-class discussion. They posed questions to the class, and then provided feedback on the answers given. For part of the lesson the pupils were divided into small groups and given drug information cards to work from to find out information about various drugs. The sixth years then questioned the whole class on what information they had found. The information given by the sixth years was of a high standard, and they made some attempt to address attitudes to use. There were some instances of inaccuracy though probably no more than in the lessons led by the guidance team (see part (b) of this section, above).

.....

S6 Peer Educator: All these drugs - valium, morphine - are commonly known as barbiturates. What do these do? They can give you pneumonia.

This is just wrong - valium and morphine are not known as barbiturates and how do they give you pneumonia? Questionable.

Extract from Lesson Observation Notes [L2L1: 199-201]

.....

.....

S6 Peer Educator: What form does cannabis take? You smoke the resin or weed. The oil is injected.

This is wrong - the oil is not injected, it is also smoked.

Extract from Lesson Observation Notes [L2L1: 87-89]

.....

According to Ruth Mackay, the programme was usually evaluated by means of questionnaires for both the peer leaders and the recipients of the programme. These evaluations were not carried out during or at the end of any of the observed lessons however and no results were made available to the researcher for the year 2001/2002.

In speaking to the sixth year peer educators during the case study however, it was clear that they felt the programme could be improved considerably, particularly in relation to their training. They had experienced some problems over the course of the programme. Some of the peer educators felt that although their own knowledge about drugs was fine, they had had difficulties in knowing how to deal with individual pupils or particular situations that arose in the classroom. They felt that they needed training in teaching skills, but weren't sure if that was feasible for a short-term project.

> I did a class with learning support people, they couldn't read or write. We weren't told how to deal with them at all. I just discussed the worksheets with them but everybody else got out of hand. I couldn't keep a watch on them...I gave out anagram sheets and they said "we can't do this", I had to speak through it. So I think we have been under-prepared for some of it.
>
> *Michael, S6 Peer Educator [S6 4: 17, 21]*

.....

> Andy, S6 Peer Educator: It's really teacher training that we would need, and for such a short project, there would hardly be any point – we need leadership skills. I mean you get a certain amount in guides or scouts but never enough to handle twenty crazed second years.
>
> Rachel, S6 Peer Educator: I actually started screaming at one boy probably because I didn't know how to handle the situation.
>
> *Extract from Peer Educator Feedback [S65: 25-27]*

.....

> The information is there. We know the answers to all the questions they ask us, but the teaching side of it, more support is needed in how to teach them, how to deal with the learning support side, how to deal with disruptive people.
>
> *Extract from Peer Educator Feedback [S64: 21]*

The peer educators also felt that they were not given enough direction as to the information or messages they were supposed to be giving the second years. It was put to them, that maybe they were responsible for deciding this themselves, but they did not feel that this should be the case.

.....

Helena: We need more [preparation]. We need to know which direction we're taking it in. We don't know where we're going or what information we're going to be giving to [the second years].

...

Researcher: Do you think that that might be part of the peer-led project that to a certain extent you should decide yourselves what to tell [the second years]?

Rachel, S6 Peer Educator: I don't think so. I think on an issue like this we need to be told. Okay, if they ask questions we should give them the answers but it should be a set thing and we shouldn't go outside that.

Helena, S6 Peer Educator: Yeah, because it could be very dangerous, what we say.

Extract from Peer Educator Feedback [S62: 56, 60-64]

.....

This sense of not knowing what they would be teaching, meant that they felt they didn't get as much benefit from the training sessions with Constable Gordon as they could have. They clearly felt that the PT Guidance in charge of the programme and Constable Gordon ought to be communicating more about the content of the peer-led lesson.

I don't mean to be bad but it seems like there's a bit of a lack of communication between [our PT Guidance] and Constable Gordon. He doesn't know what we will be telling the second years and neither do we...I think it would have been much better if we'd gotten a sheet with the structure of what we're saying on it and then been given the talk. We would have taken in more of what is relevant to what we're actually teaching.

Rachel, S6 Peer Educator [S62: 58, 84]

Overall, from the peer educators' feedback, one gets a sense that they took the programme and indeed the topic very seriously. It seems they felt that they were not guided or supported sufficiently to deal with such a serious topic and the difficult task of teaching it. They were therefore unhappy about taking on the responsibility of deciding the content of the programme for second years.

.....

> Andy, S6 Peer Educator: The training they gave us was a heap of leaflets that we were supposed to read over.
>
> Rachel, S6 Peer Educator: It was really limited. We really didn't know what we were supposed to be doing. I know we're sixth years and we're supposed to do our own thing but we really didn't know and there was so much in that box [of resources] – that we just picked out different things.
>
> *Extract from Peer Educator Feedback [S65: 29-31]*

This sense of ill-preparedness seemed to impact on the morale of at least some of the peer educators, and this was apparent in one of the later lessons where they no longer seemed enthusiastic while delivering the lessons.

> Justin and Sandra [S6 Peer Educators] tried to get each other to ask [the class] the questions [from the quiz], but it was clear that neither of them wanted to do it Eventually one of them asked the next question.
>
> *Extract from Lesson Observation Notes [L2A1: 161]*

> One boy put up his hand and asked something like "what happens if you get a prescription from a lookalike doctor and you take it to the place to get it, what would happen to you?". The sixth years just looked at each other and gave a kind of facial shrug.
>
> *Extract from Lesson Observation Notes [L2A1: 171]*

For at least one of the sixth years, the whole experience left her feeling "like a complete failure" and she reported this to her own guidance teacher.

> I think possibly the sixth years could do with a bit more time, just to give them a fair chance of it as well because I think Rachel felt a sense of failure. She had a horrible day, one day she had a horrible day and she's a lovely girl, who would have given it her all... And at the end of one day she felt complete failure, she went home and it bothered her through the night probably just like a teacher is about lessons, but then its our job and we've trained for it. She's just a sixth year and I think with teaching, when it goes really well, its great and you get a high but when it goes badly it can have a serious effect on your psyche.
>
> *Rachel's PT Guidance*

It is not known if any of the other peer educators felt so strongly. This is in contrast with the outcomes reported in the evaluations carried out in previous years, according to Ruth Mackay.

> The sixth year gain a lot from it in personal development. They go into it, it's amazing, some of them go into it, totally lacking in confidence in handling and they come out and they really feel that they've made progress. It's very worthwhile I think for both sides.
>
> *Ruth Mackay, PT Guidance [GI1: 514, 568]*

For the 2001/2002 second years, the experience was a more positive one as most of those who gave feedback reported learning more from and being better able to speak to the sixth years, than a teacher.

.....

> Pupil A: They weren't very strict, people messed about and they didn't do anything to stop it.
>
> Researcher: Did that mean you didn't learn as much?
>
> Pupil B: We probably learned more. With the teacher talkin' you just shut off and ignore them. With the teacher, if they just speak for five minutes then I think I'm bored, and I don't listen.
>
> Researcher: So even though the discipline was not as good, you still learned more?
> Both pupils: Yeah
>
> *Extract from Pupil Feedback [2A1: 27-35]*

.....

.....

> Researcher: Was it easier to speak with them than a teacher?
>
> Pupil A: I think it was easier? (looking at Pupil B)
>
> Pupil B: Easier.
>
> *Extract from Pupil Feedback [2A1: 45-48]*

.....

Some pupils were in disagreement over which form of delivery was best, but suggested that a combination would be best of all.

.....

Pupil A: I think Ms. Mackay would have done it better.

Pupil B: I would listen more to [the sixth years] than to Mrs. Young.

Pupil A: I think Mrs. Young would cover everything.

Pupil C: I think it would be better to have a mix - adults and young people, then you would hear different views and you could make up your own mind.

Extract from Pupil Feedback [2C: 57-61]

The third year pupils (who had also been taught in the previous year by the then S6 peer educators) also gave positive reports of the programme. They felt that the sixth years were more up to date and would probably have first hand experience, unlike the teachers.

.....

Researcher: What about when you had the sixth years in teaching you?

Pupil A: I thought it was good - they're nearer our age. It's better than the teachers saying "don't do it". They know. They've had experience.

Pupil B: They'll know more up to date stuff - the slang names and that. The teachers don't have a clue.

Researcher: Would you not feel that the teachers would know a lot as well?

Pupil B: The teachers get it from books and that, but the sixth years will probably have first hand experience.

Pupil C: It's better from the sixth years, the teachers know stuff that's older.

Pupil A: It's not as real as what the sixth years have.

Extract from Pupil Feedback [3F1: 98-110]

.....

The 2001/2002 peer educators also remembered being taught by sixth years when they were in second year however their experience of the programme was entirely different.

> The sixth years that came into us were promoting it as a good thing. They were talking about their own experiences when they had taken LSD, their hallucinations and that. It was terrible.
>
> *Rachel, S6 Peer Educator [S62: 45]*

Despite the perceptions of the pupils, there was no observed evidence that the sixth years knew more than the teachers. It is possible that pupils may have been more open in discussions with the sixth years, but the peer-led lessons were not designed to facilitate open discussion and so this could not really be gauged. The issue of openness in general in drug education is discussed further in the next section.

4.8.3. Openness

In discussions about openness, the teachers reported that pupils were far more likely to be open in discussing their drinking or smoking habits than their drug use. In fact, they were not encouraged to discuss any drug use.

> I'm not prepared to push them. I'm not prepared to push them because I just think the alcohol situation to a certain extent, okay, maybe its part of the area, part of the culture, you know that they're going to have a wee go at, especially when they're that age...Whereas you know if they did start [talking about drug use], I just think, God, I think I'd rather not know.
>
> *Ann Brown, PT Guidance [GI6: 228]*

The pupils themselves were aware that they shouldn't talk about drug use, as can be seen from their reaction to one pupil who broke this unwritten rule.

.....

> Pupil A: In our RE class we were discussing the legalisation of cannabis and the teacher was saying that it shouldn't be legalised and so were most of the people who were speaking and this one guy stood up and said "I think they should go ahead and legalise it, I smoke it and there's nothing wrong with it" and we were like "Shsssh. You'll get into trouble".
>
> Researcher: And what happened, what did the teacher do?
>
> Pupil A: She just said, "Well, that's your perspective and all the rest of the class don't agree with you" and he said "They do." And we were like "Shssssh".
>
> *Extract from Pupil Feedback [5D1: 237-241]*

.....

Some pupils reported that they wouldn't even discuss their alcohol or tobacco use with guidance teachers because they feared that they would inform their parents. There was some confusion about this as pupils weren't sure if teachers would inform parents or not if they told them about weekend drug use.

.....

Pupil A: When you're with the guidance teacher, they want to hear your problems and questions and they want to know what's happening with you in school.

Pupil B: Yeah, they'll try to solve your problems.

Pupil A: You don't really want to go to them, you're never too keen, you're scared that they'll go to your parents.

Extract from Pupil Feedback [3F1: 242-246]

.....

.....

Researcher: Like if I was a teacher would you have admitted to me that you smoke and drink at the weekend?

Pupil A: No, I wouldn't, I would be afraid that they would tell my parents.

Pupil B: But they can't really do that. Like if you're smoking cannabis at the weekend, it's none of their business, I think.

Extract from Pupil Feedback [5D1: 251-255]

.....

One of the teachers reported that her reaction would depend on the specific circumstances of any admission, but that she would most likely discuss it with the pupil, as there would be no proof of whether it was just bravado or not.

Finally, one of the teachers noted that some of the more difficult pupils actually helped to make discussions more open because of the outrageous things they say:

> There is quite a hardcore of difficult youngsters in that class and youngsters with learning difficulties as well which is quite a mix, but in some ways once we got into the swing of it, its those characters who helped the discussion. They're the ones who say outrageous things, absolutely outrageous things and it kind of gives other people the confidence to say something that isn't outrageous but is on their mind. So possibly the classes that you might consider to be difficult have more fruitful discussions.
>
> *David Kerr, PT Guidance [GI7: 37]*

Further data relating to the involvement of these difficult pupils in drug education is presented in the next section.

4.8.4. Discipline

No major episodes of indiscipline were witnessed at any stage during the observed drug education lessons, regardless of who led the lessons – the sixth years, the teachers or Constable Gordon. In fact, although the pupils may have "pushed their luck" somewhat with the peer educators, the sixth year pupils seemed well able to deal with them.

> .....
>
> Rachel, S6 Peer Educator: Right we're going to divide you up into groups and you're going to make up a play.
>
> A boy at the back of the classroom raised his hand: "Can I just make a point? We've had praise slips in drama when we're working together - we always get praise slips - can we choose our groups?"
>
> Rachel: No.
>
> The boy responds: "That's pupil discrimination, why not?"
>
> Justin: Just be quiet and do as you're told.
>
> This kind of cheek from the pupils would probably be less common with the normal class teacher but the sixth years deal with it adequately.
>
> *Extract from Lesson Observation Notes [L2A1: 3-14]*
>
> .....

.....

Group three were then asked for their play. "We're not ready yet!" they protested, but the sixth years told them "You had plenty of time - improvise - ad lib! You had the same time as everyone else".

Again this was dealt with quite well by the sixth years. But Ruth Mackay was in the room by this stage.

Extract from Lesson Observation Notes [L2A1: 45]

.....

Apart from bickering or failing to pay attention to the task at hand when in small groups (Section 4.8.1.b), the other main discipline issue involved pupils who did not take the lessons seriously and made fun of exercises. As noted below, these pupils were perhaps the more streetwise ones who were most likely to have been exposed to or to have used cannabis, and it was difficult to see how the drug education would appeal to or reach them in any way.

After the video, some of the boys at the table nearest me complained "is that it? Can we not see the rest?" They then said quietly to each other "I want to see them dealing to the kids". "We want to see the kids get stoned". "Yeah, we want to see the kids get coked".

Extract from Lesson Observation Notes [L3E1: 9]

The boys who were sitting behind me [the researcher] chose cannabis as their drug to investigate. On their sheets they had written "high" for short term effects and "more high" for long term effects. They finished quickly and got one boy in the group to fill in the whole sheet. The other groups took the exercise more seriously. These boys are a classic example of lads who are a bit "cooler" or more streetwise than the rest of the class. They joked all the time about cannabis and getting high, and didn't really take any of the exercises seriously. They were probably the group most likely to be using cannabis, and yet, they did not bother to find out the short or long term effects in this exercise. This does not bode well for drug education reaching those who actually need it.

Extract from Lesson Observation Notes [L3H1: 80-82]

Finally, there was one observed incident of intimidation or bullying during small group work. This was a case where the group consisted of three girls who seemed to be friends with each other and one boy who was not.

.....

In one of the groups, three girls were sitting together in a row and the boy in front of them, who was supposed to be in their group was not really included, as he was only turning backwards to face them with his chair still facing forwards. As they began to discuss things, one of the girls asks him "why do they make these comments?" and orders him "Turn around your chair." He doesn't answer but turns around to sit with them. She continues to ask him "why do they make these comments?"

I [the researcher] got the distinct feeling that a subtle form of intimidation was going on in this group. It was three against one, and I felt that she was mocking him with the way she kept asking him to answer the question.

One of the girls asked the boy what he thought about the judge's view. The girls repeatedly asked him questions in an accusatory style. He answered "I think drugs have to stop". The girls were laughing a little, it was not clear whether they really want his answers (as well as to tease him) or if teasing him was the sole purpose.

Extract from Lesson Observation Notes [L3L3: 58-64]

.....

Other than these issues, which were relatively small, discipline, or lack of discipline had little effect on the provision of drug education in the school.

4.8.5. Differentiation

Although it was clear that there were pupils with very different levels of experience within each class, the drug education did not have any special provision to cater for the specific needs of individual pupils. This was a source of concern to the teachers.

> The kids who are knowledgeable speak for the kids who are not. The kids who are not, maybe don't want to speak out when you've got kids who are more knowledgeable in the classroom. That concerns me.
>
> *Catherine Baxter, PT Guidance [GI5: 102]*

They hoped, however, that by promoting discussion in class, some of the differences could be compensated for.

> I think it's the idea really, certainly in class discussion, everybody's got an equal opportunity to contribute if they want to, so they select how much information they want to give.
>
> *David Kerr, PT Guidance [GI7: 170]*

> The difficult thing is to know if everybody is taking the message in. The wide variety in knowledge that different pupils have within the class, you know, some will be able to talk about slang names for drugs, some kids knew it all... I've not an answer for this. I don't know if it generates enough discussion, I think what the wee snippets that Drugwise does try to do, is it does try to give them the chance rather than sit too long, have a wee chat in the group, get some feedback...The same [as] in any area that you do there are some kids that are better at contributing to discussion than others. I would just like to think that the message that gets across is being taken in by everyone.
>
> *Tony Morrison, PT Guidance [GI3: 45]*

> It depends on the class, but hopefully by making the classroom situation easy, at ease, relaxed, helps [people to speak out].
>
> *Catherine Baxter, PT Guidance [GI5: 110]*

Despite the intentions of the teachers, the quality of discussion in the lessons that was observed over the course of the case study, makes it difficult to be confident that the diverse needs of pupils were being met.

4.9. Conclusions

It is clear from the results presented in this chapter that there is some room for improvement in drug education delivery in the case study school despite the best intentions and efforts of the staff concerned. The full implications of these findings for current and future drug education practice are discussed in Chapter 6 which also includes a consideration of the key factors that hindered the provision of drug education in line with best practice guidelines as outlined in Chapter 1. Furthermore, the validity and reliability of these results are discussed in Chapter 5.

Chapter 5. Discussion of Methods

All research is concerned with producing valid and reliable knowledge in an ethical manner and this study is no different. In fact, because of the nature of qualitative research, these issues require careful and reflective consideration right throughout data collection, interpretation and analysis and cannot be accounted for entirely in advance, as might be the case in experimental work. This chapter explores the issues of validity and reliability as they apply to qualitative research and examines the methods used in this study in terms of their contribution to the validity and reliability of the findings. The ethical issues that arose in relation to the research as a whole are also considered in detail.

5.1. Internal Validity

Internal validity in quantitative research generally means the extent to which the data collection instruments or meters accurately measure what they are supposed to measure. In qualitative research, internal validity is more usefully seen as the extent to which the findings represent reality so issues of credibility and truth take prominence (Slevin and Sines, 1999; Perakyla, 1997). In considering how true findings are, the researcher is forced to consider his/her own position or background and how it may have influenced data generation and interpretation; how effectively the methods used can actually illuminate the research issues; and the likelihood that individual respondents or observed settings provide accurate and truthful pictures of the topic under investigation.

5.1.1. Researcher Background and Position

All of the fieldwork for this study was carried out by the author in her capacity as a full-time doctoral research student at The Robert Gordon University in Aberdeen. Although the research was approved by the three local authorities and the head teacher in each school, they exerted no unsolicited influence on any of the fieldwork, data analysis or interpretation which was completed independently both financially and administratively. The researcher, who is a pharmacist by profession, was not connected in any way with a secondary school community at the time of the research and had no prior experience of any kind of the Scottish education system.

Any previous experience of drug education stemmed from her training as an undergraduate pharmacy student at Trinity College, Dublin, Ireland during which a broad range of topics related to drug use and misuse were covered. These topics included the pharmacology and pharmacognosy of "drugs of abuse" (as the module was named) as well as consideration of the legal, personal and social issues surrounding drug use and addiction, particularly from the point of view of the pharmacy profession. In addition to this, the researcher carried out an extensive study of developments in undergraduate pharmacy education while she was involved with the European Pharmaceutical Students' Association. This study was used to promote improvements in pharmacy education, and focused in part on interactive teaching methods and educational evaluation (Fitzgerald et al., 1999).

5.1.2. Potential Sources of Bias

The researcher's lack of direct experience of, or connection with the research setting meant she carried few preconceived ideas were carried into her initial study of the topic as she genuinely had no idea what might have been happening in schools in relation to drug education prior to commencing her PhD. Once the PhD was underway however, and she had studied the components of effective drug education programmes in the literature, it is possible that the researcher may have been more critical of drug education than would be someone who was more familiar with the practical pressures and constraints on school staff. There is no doubt that the study compared school provision with the best features of some "ideal" drug education programmes recommended by researchers, which may or may not be realistic in practice in Scotland, however, this was one of the key aims of the study. These "ideal" programmes are the ones that have actually been shown to be in some way effective, and it was therefore important to consider how realistic they are for Scottish schools. Both the interview study and case study allowed the researcher to learn about and indeed observe first-hand the pressures and constraints on schools and to take them into account in analysing the results of the research.

Most importantly, the researcher's lack of connection with schools or the local authorities meant that she had no vested interest in either positive or negative findings about school-based drug education.

In fact, it was most in the interests of the researcher from the point of view of her own personal satisfaction and her career, to generate accurate and truthful descriptions of drug education that would "ring true" to school pupils and staff and would prove genuinely useful to policy-makers. The next sections describe the steps taken to achieve this ring of truth and the level to which it could be assured in both the interview and the case study.

5.1.3. Internal Validity in the Interview Study

As all the interviews, data management, and analysis, were carried out by the same researcher, the potential for the focus of the interviews to be biased by the perspective of that person was greater than if the interviews and analysis had been carried out by a team of researchers with different backgrounds. In the initial pilot interview study, the questions and prompts used were based primarily on the areas of interest identified from researcher's initial study of the topic, as well as on informal discussions with those working in the field. Although the researcher was already biased in favour of the use of interactive teaching methods and evaluation in education through her previous work, it is clear from the research evidence (see Chapter 1) that these issues are also important in drug education. It is unlikely therefore, that another researcher with a different background who had reviewed the literature would have omitted them from the interview guide.

Despite the fact that convenience sampling, rather than theoretical sampling was used to select the schools for the pilot study, the respondents and schools involved represented a range of experiences and settings (see Table 2.3). Their feedback as well as that of the "independent experts" (Section 2.4.3) was used to adapt the interview guide. This adaptation, which continued throughout the main study interviews, ensured that the interview guide covered the issues identified by the schools themselves, whether or not they had been previously considered by the researcher, thus minimising the effect of any bias. The pilot work also allowed any irrelevant or poorly worded questions to be identified and the length of the interview to be tested, as well as allowing the interviewer to discuss with the pilot respondents how the interview was arranged and carried out.

The researcher's position of "outsider" to the field of study could have affected her ability to seem sympathetic and unthreatening to the respondents in the interviews and thus may have increased the likelihood of them providing incomplete, inaccurate or misleading information. The pilot interview study helped to minimise this risk by allowing some insight to be gained into the secondary school setting in Scotland and thus a degree of empathy with respondents to be established. The issue of threat more commonly arises if the interviewer is in a position of power, or working for someone who is perceived to have power over the respondent in some way (e.g. the local authority). In this study, the background to the work, how the results would be used and the independence of the research from the schools and local authorities was carefully explained to each respondent at the beginning of each interview. This independence along with the fact that respondents were assured of confidentiality meant that it was unlikely that the researcher could in any way be perceived to have power over the respondent.

The consideration of issues such as the researcher's background and the distribution of power in the interviews forms part of framework used to analyse reactivity in this research. Reactivity in qualitative research is defined by Paterson (1994) as the response of the researcher and research participants to each other during the research process. Paterson outlines five key issues to be considered in relation to reactivity in qualitative research. These constitute a useful framework for reflection on the interaction occurring between the researcher and the interview study respondents and are illustrated in Table 5.1.

Issues in Reactivity Analysis
1. Emotional Valence
2. Distribution of Power
3. Goal of the Interaction
4. Importance of the Interaction
5. Normative or Cultural Criteria

Table 5.1 The Reactivity Analysis Framework of Paterson (1994)

The first issue, emotional valence, relates to the researcher's empathy with the respondent and the trust that exists between them. This stems from the background of the researcher and efforts to build understanding of the field as described above but crucially is also influenced by the personal characteristics and demeanour of the researcher and participants. In this study, the researcher sought to demonstrate an enthusiasm for the research, and a friendly, open demeanour. This was done by engaging in general conversation prior to the interview, sharing humour during the interview process at timely moments and being helpful and candid with the respondent where appropriate.

The second issue highlighted by Paterson is the distribution of power between principals and as discussed above, this was unlikely to have been a significant issue in this study since the researcher in no way held power over the respondents. The goals of the interview study were made explicit to the respondents in advance of their agreeing to be interviewed, at the beginning of each interview and in written form in the interview study consent form, thus fulfilling Paterson's third criterion. The intention to develop understanding of drug education planning and practice in schools in order to make recommendations regarding policy, practice and research was outlined and the respondents were informed that the results of the study would be widely distributed, including to schools and local authorities. Although this was the central aim of the research, it was also clearly explained that the research was being undertaken to obtain a doctoral degree and that this was obviously a personal goal for the researcher. Being honest regarding all the goals of the research encouraged the development of trust between the researcher and respondents.

The fourth aspect of the reactivity framework, the importance of the interaction, relates to attentiveness. A researcher who is bored, tired or discouraged may inadvertently portray a disinterest in the respondent. The respondent may then be discouraged from providing any sensitive or detailed information. In this study, as well as displaying enthusiasm for the research, care was taken to put respondents at their ease, to look interested in what they were saying and to reassure them of both the importance and confidentiality of their feedback at any sensitive moments.

The researcher's interest in the discussions was communicated to the respondent by verbal means, by commenting "yes" or "right" at regular intervals and questioning the respondent further on reported issues. Non-verbal means such as nodding, eye contact and facial expressions also contributed to the expression of interest.

The final aspect of the framework involves the researcher in being sensitive to the respondents' cultural and social norms. This part of the framework is closely linked with that of emotional valence as discussed above. It is possible that interview questions which related to innovative or best practice in drug education could have aroused a defensive response in some respondents, if they felt that the question implied criticism of practices in their school. To minimise discomfort in respondents, the researcher was careful to build up to these issues slowly, asking about less innovative practices first so that the respondent would be reassured that they were not "doing too badly". In addition, where necessary, the researcher posed these questions in an open-ended, non-threatening way, such as by asking the respondent what they thought about an innovative practice, such as peer-led drug education, rather than asking them directly if their school had such a programme in place. Similarly, when discussing what might be perceived as out of date or inappropriate practices, the researcher was careful both to appear understanding of the constraints and pressures on school staff, and to listen to the respondents' descriptions without implying any criticism.

Aside from the reactivity framework, the position of the researcher as "outsider" had implications for the researcher's ability to understand the terminology, abbreviations and acronyms used by respondents and the issues raised by them that were specific to the Scottish school setting. The pilot interviews and expert consultation allowed the researcher to gain significantly in understanding of such issues as well as increasing her confidence and experience in guiding semi-structured interviews of this kind. The researcher also read widely on the topic, consulted knowledgeable peers (see Table 5.3), and was careful to avoid making assumptions about the field as far as possible. During the interviews, respondents were asked to explain terminology and abbreviations, even where they may not have been central to the issues being studied. In addition, throughout each discussion, the researcher carried out checks on her own understanding.

This was done by feeding back her understanding of the respondents' perspective to the respondent(s) and seeking confirmation or clarification of their position. This meant that when it came to data analysis the researcher could be surer that her interpretation of the practices reported by respondent(s) was more likely to reflect reality. This is an informal method of "member checking". Member checking is one of a series of strategies identified by Merriam (1988) that a researcher can use to enhance internal validity. The other strategies are shown in Table 5.2.

Strategies for Internal Validity (Merriam, 1988)
1. Triangulation
2. Member Checks
3. Long-term Observation
4. Peer Examination
5. Participatory Modes of Research
6. Clarification of Researcher Bias

Table 5.2: Strategies for Internal Validity

Member checking involves taking data and interpretations back to the people from whom they were derived and asking them if the results are plausible (Merriam, 1988). More formal methods, which involve providing respondents with the study results to comment on them, are more difficult to implement and are not without controversy. Mason (1996) argues that as qualitative research involves acceptance of the concept of multiple interpretations of reality, there is no reason to assume that the interpretations of respondents are any more valid than those of the researcher. In addition, the method is problematic, as respondents may be unable, unwilling or simply not have the time to review extensive findings and if they do disagree with the interpretation of the researcher, then the question arises as to how to decide which is correct. While bearing in mind these concerns, the researcher in this study attempted to use member checking in the pilot interview study. A summary of the themes that emerged from the pilot study were provided to respondents, along with an invitation to respond and comment. As only one of the three pilot respondents got back in touch, and he had no comments on the results, it was not found to be a helpful exercise under these circumstances.

An alternative strategy is the use of peer examination, or asking colleagues and other individuals to consider the findings as they emerge. In the research reported here, this strategy was not used to strictly validate the interpretations of the researcher, but it allowed consideration of how well the emerging themes "rang true" for other people both familiar and unfamiliar with the field. It also crucially allowed consideration of alternative perspectives and possible explanations which could be fed into the next interview. As the results emerged, they were discussed at various intervals with the extended supervisory team, the drug misuse research interest group at Grampian Health Board, as well as representatives of the local authorities in Grampian and other researchers (see Table 5.3).

List of Persons Involved in Peer Examination of Emerging Results
Dr. Derek Stewart, Senior Lecturer, RGU School of Pharmacy – Director of Studies
Mrs. June Wells, Lecturer, RGU School of Applied Social Studies – PhD Supervisor
Dr. Dorothy McCaig, Senior Lecturer, RGU School of Pharmacy – PhD Supervisor
Mrs. Sandra Hutchinson, Lecturer, RGU School of Pharmacy – PhD Advisor
Ms. Dawn Tuckwood, Health Improvement Officer – Education and Recreation, Aberdeenshire Council and Health Promotions, Public Health Service, NHS Grampian – PhD Advisor
Ms. Sara Wallace, Health Improvement Officer – Education and Recreation, Aberdeenshire Council and Health Promotions, Public Health Service, NHS Grampian – PhD Advisor
Ms. Gillian Anderson, Health Promotion Specialist, Health Promotions, Public Health Service, NHS Grampian – PhD Advisor
Prof. Clare Mackie, Head of RGU School of Pharmacy – PhD Advisor
Mr. Terry Ashton, Advisor (Guidance and Careers), Learning and Leisure Strategic Services, Aberdeen City Council
Mr. Kenneth Corsar, Chairperson of the School Drug Safety Team & Director of Glasgow City Council Education Department
Mr. Kevin Lowden, Research Officer/Project Manager, Scottish Council for Research in Education
Dr. John Love, Lecturer, RGU School of Applied Social Studies
Mr. Grahame Cronkshaw, Director of Commissioning (Drug Misuse), Grampian Health Board

Table 5.3: List of Persons involved in Peer Examination of Emerging Results

As a further check, one independent researcher was asked to perform his own thematic analysis on one of the interviews and his results were later compared with the results already developed in the study, which he had not seen, to identify any gaps or bias. There were no major themes identified by him that had not been noted in the analysis carried out by the researcher herself or vice versa. While he did detect some evidence that the particular respondent in that one interview softened her position on some issues over the course of the interview, he felt that the themes from the interview were still clear and unaffected by this. Overall, he did not highlight any major weaknesses or bias in either the questioning or data analysis for that interview.

The other strategies described by Merriam were less relevant in this study. Triangulation, which involves using multiple investigators, multiple sources of data or multiple methods to confirm emerging findings, needs to be approached with caution. The use of multiple investigators, methods and sources of data to confirm findings assumes that there is one, objective social reality that can be pinned down. In practice it may be more useful to think of triangulation as a way of assisting the researcher to "approach their research questions from different angles and to explore their intellectual puzzles in a rounded and multi-faceted way" (Mason, 1996). In this study, some schools had more than one respondent at the interview; in others more than one interview was carried out with the same respondent; and in most, documentary evidence was used to add to the body of data for analysis. The results of the case study can also be said to contribute to triangulation of the interview study results (and vice versa) as they included consideration of some of the same topics from an alternative angle.

Participatory modes of research involve participants in all phases of the research from conceptualisation to writing up and were not used in this study. A "truer" and more detailed picture of drug education may have emerged had a more participatory study been possible, although the converse might also be true in that participants would have had more opportunity to edit or filter the findings. In any case, greater participant involvement was not considered feasible in this study, as respondents were full-time teachers who were already under considerable time constraints. Long-term observation of the research site was not relevant to the interview study (although it was used to some extent in the case study).

The final strategy outlined by Merriam, clarification of researcher bias, was something that was reflected on throughout the study, and is considered at a number of stages over the course of this chapter.

As the respondents were chosen by the schools themselves (Section 2.4.7), there was some variation in their ability to answer the questions asked. This was because the issues considered broadly fell into two categories: that of planning, which included policy and development; and that of practice which considered what actually happened in the classroom during teaching. Not all of the respondents had current experience of both areas, if they were a classroom teacher, they were not always aware of the schools future plans/direction for drug education, and if they were an assistant head teacher, their knowledge of policy was comprehensive but they were not always fully aware of the details of classroom practice. Four of the nine schools selected two respondents to be interviewed either together or separately, so that both of the fields were covered. In the other schools, it was not possible to get a clear picture of both areas from every respondent. This issue also arose in a similar interview study carried out by Bishop et al., (2001) of staff responsible for drug education co-ordination in Welsh schools, in which the extent to which the interviewees had a detailed knowledge of the programme throughout the school varied, as did their responsibility for other aspects of PSE. In this study, each respondent was asked to explain their own role and experience in relation to drug education at the beginning of each interview and this later gave an indication of how well prepared they were to answer questions about the different areas. Although this elicited the relevant information, it may have been helpful to have gotten each respondent to fill out a brief survey form about themselves, their role and the school prior to interview about the substantive issues. This may have taken less time than asking for the information as part of the interview and would have ensured that standardised information would have been obtained from every school. In many cases in this study, having been sent details of the interview topics in advance, respondents had made efforts to speak to their colleagues so that they could give a more complete account regardless of their own individual role.

Finally, despite all of the above efforts, during data analysis it was important to consider how sure the respondent was of their responses, if they were saying what they felt the researcher wanted to hear, or if they were being in any way evasive or misleading as well as possible alternative interpretations of the data.

5.1.4. Internal Validity in the Case Study

The case study differed from the interview study in that it was not based around a set of questions in an interview guide which were pre-decided by the researcher and could therefore potentially bias the interview interaction as discussed in the previous section. Rather, the case study utilised a diverse range of methodologies, including both general and selective observation of activities related to drug education as well as interviews. In the researcher's position as a passive observer, the issue of bias does not arise from the possibility of her knowingly dictating what happens in the school. The potential for bias arises instead because as noted by Mason (1996), it is not possible to produce a complete and neutral account of any setting. Any observation is inevitably selective and is based on a particular observational perspective. It is important therefore to carefully consider how the researcher's own position may have affected what she actually noticed and recorded from the entirety of what was observed, and whether her presence may have altered the "reality" of drug education in the school.

By the time of the case study, the researcher was considerably more experienced and knowledgeable about drug education in secondary schools. Although this was a composite view and did not allow assumptions to be made about any one school, it is likely that the researcher had some expectations. This is particularly likely in relation to staff attitudes to controversial topics such as harm reduction and pupil consultation which had been discussed in some detail with interview respondents. Apart from in specific guidance interviews however, most of the case study did not focus on staff attitudes, but on classroom practices and interaction, and on pupil feedback. The results of the interview study did not allow in-depth consideration of classroom practice or interaction and so few preconceived ideas were formed in relation to those issues. To minimise the potential effect of any bias in relation to staff attitudes therefore, the researcher concentrated on general observations, lesson observations and pupil feedback in the first months of the case study.

More formal interviews with staff at the case study school were not carried out until near the end of the study. This allowed the researcher to get a feel for the situation in that particular school before considering staff attitudes in any depth and thus diluted any preconceptions that might have been formed.

In order to minimise any direct impact of the researcher's presence on what was happening in the school, the researcher remained passive during lesson and general observations. Apart from discussions related to the practicalities of conducting the research and general conversation necessary to maintain a friendly and open relationship with participants, the researcher refrained from commenting on any issues or intervening in any way unless directly addressed. In this way, any direct effect of the actions of the researcher was minimised. It is also possible however, that the presence of the researcher may have indirectly influenced practice in the school if the participants in any way altered their normal practices or behaviours because they were being observed. This possibility is considered below in the context of the reactivity framework described in the last section (Table 5.1)

The strategies described above in the consideration of the reactivity framework for the interview study were also used during both the pupil and staff interviews in the case study (see Section 5.1.3). Once again, the researcher's position as an "outsider" in the school was an important consideration, as it could have affected her ability to empathise and build up trust with the participants in the study i.e. emotional valence. By the time of the case study however, the researcher had already completed interviews in nine other schools in Grampian and as can be seen from Chapter 3, an understanding of a broad range of relevant issues had been gained. In addition, as part of the interview study the researcher had already visited the case study school twice to interview one of the guidance teachers and a good rapport had already been built with that teacher. The role of that teacher as "gatekeeper" for the research setting was essential in building rapport with the rest of the participants in the study. It was the gatekeeper who agreed initial arrangements for the researcher to visit the school and who introduced the researcher to the other guidance teachers, the police school liaison officer and the head teacher. A number of steps were taken to build trust and rapport with these research participants.

- Initial visits to the school were short and focused on discussing and agreeing practical arrangements for more formal research. This helped to establish trust with staff before any lesson observations were carried out and allowed the researcher to consider and be sensitive to the normative and cultural aspects of the setting.
- When spending days in the school, the researcher spent her morning tea break in the staff room, chatting and interacting informally with the guidance team and other members of staff.
- The importance of the interaction to the researcher was demonstrated by her behaviour and commitment while in the school and her willingness to be flexible and adapt to the needs and availability of the participants. In particular, she was careful to be sensitive to the pressures on staff and to express interest and empathy if someone was "having a bad day".
- During the field work, the researcher regularly expressed to the respondents her appreciation of them giving up their time and energy to take part in the study and emphasised the vital part they were playing in the research project. This gratitude was reinforced by small gestures such as the provision of boxes of chocolates for each guidance office half-way through the field work.

In addition to the above steps, the ethical agreement which was drawn up, discussed, and agreed with the guidance team in advance of any lesson observations, pupil feedback or staff interviews played a crucial role in establishing trust (see Appendix 2.15). This extensive document clearly detailed the background and goals of the case study and makes specific commitments in relation to confidentiality and the openness of the research process. In particular, the agreement sought to minimise any perceived threat by stating explicitly that the case study was not an evaluation of the case study school, but "an exploratory study designed to enhance understanding of drug education in ways that might be relevant to schools *in general*". Staff were invited to view the notes of the research, ask questions, make comments, and give or receive information at any time during the research process. In return, they were asked to be honest, open and forthcoming with the researcher at all times.

The importance of clarifying commitments and expectations on both sides in this way was clearly demonstrated during this study, not just from an ethical point of view (see Section 5.4). Initially, the researcher had hoped to spend more time observing and discussing drug education with each individual guidance teacher and this was outlined in the ethical agreement. In discussing the agreement however, it quickly became clear that the framework proposed was perceived as an excessive demand on the teachers' time and it therefore generated considerable unease. The ethical agreement allowed this issue to be identified at an early stage and it was necessary for the researcher to sacrifice the quantity of feedback time spent with respondents, in order to maintain their co-operation and trust and not jeopardise the study. Had the issue not been resolved in advance, the relationship between the respondents and the researcher could have been damaged in the middle of fieldwork and the potential hostility arising from this could have seriously affected the usefulness and validity of the findings.

In the pupil feedback sessions, as well as remaining attentive, friendly and non-judgemental as outlined previously, additional steps were taken to encourage openness and to ensure that pupils did not feel in any way threatened by the respondent. At the beginning of each pupil feedback session, the background to the research and the purpose of the study were outlined in simple terms. The pupils were told that the researcher was carrying out this work as part of a PhD and the term "PhD" was explained to them. Importantly, the pupils were informed that they were free to choose not to be involved if they did not wish to do so and that they could withdraw at any stage without any negative outcomes for themselves. They were also reassured that if they were uncomfortable about answering any question that they did not have to do so and they were encouraged not to answer any question that they did not want to answer.

The importance of being honest and open with the researcher was explained to the pupils and they were told that it was much better to remain silent than to give an inaccurate answer if they weren't sure or did not want to tell the truth. Throughout the pupil sessions the researcher maintained an open, interested demeanour and used her position as an outsider (to the area, the setting and to their position as pupils) as an excuse to probe for more in-depth explanations of their experiences as well as slang words and local terminology.

Finally, pupils were assured that none of their answers or identities would be shared with any other person, including their teachers, the school, their parents or other pupils. This was reinforced by showing them the researcher's notes, in which their identities were referred to as "A", "B", or "C", rather than their real names. All of these strategies contributed to trust and rapport and served to minimise any sense on the part of the pupils that the researcher may have in any way been in a position of power over them or that they had anything to fear from being honest and open during the feedback sessions.

Of the strategies described in Table 5.2 for enhancing internal validity in qualitative studies, clarification of the researcher bias (as outlined above) triangulation, long-term observation and peer examination were the ones most relevant to the case study. In outlining the case study results (see Chapter 4), data from multiple respondents and sources are presented to illustrate different perspectives on the same topic and allow the reader to consider different versions of "reality", a concept central to the philosophy of qualitative research. Cross-references are also made to discussion of the same topics in the interview study, thus allowing the interview study to contribute to triangulation of the case study and vice versa.

The 160 hours of field work for the case study were spread over approximately five months. This does not constitute long-term observation as compared to some ethnographic or anthropological research, as the fieldwork was restrained by the timeframe of a PhD and by the fact that only one researcher was involved. Nonetheless, all of the drug education provided over the course of a year in the school was delivered during this period and the researcher was able to observe any lessons that she chose across the whole range of year stages. As the case study data and results emerged they were discussed with members of the supervisory team and other peers similar to the peer examination described for the interview study (Table 5.3).

Member checking and participatory modes of research were to a certain extent ruled out for the case study by the time pressures and availability of both the staff and pupils. Both groups already had full timetables and were very busy even during any free periods. As described above, the researcher had initially tried to gain agreement to a greater level of staff involvement in providing feedback on the lessons that had been observed.

Such involvement was used to great effect in Brown and McIntyre (1993) for example, in their study of the process of teaching. They point out that in the absence of teacher feedback, lesson observations alone "were often superficial and lacking the richness which comes with established knowledge about the pupils and the other conditions impinging on the teaching".

Unfortunately, however, while staff were willing to be observed and interviewed as it was requested of them, they were not willing to commit to reviewing the observation notes after each lesson or to become involved at any deeper level in the process of the research. In fact, although staff were invited to view the observation notes and interview transcripts or ask questions about the findings at any time, they did not choose to do so at any point. Once again, it is likely that greater staff (or indeed pupil) involvement at all stages of the process would have allowed access to a greater level of detail on all topics and a deeper, and perhaps "truer" understanding of the whole process of drug education could have been gained. Such involvement may have been possible in a less busy school or if such a high level of staff commitment was promoted by the local authority. Neither solution is ideal however, because given the reports in the interview study, a less busy school would be unlikely to reflect the reality of most schools, and local authority involvement would have compromised the independence of the research and therefore the validity of the findings.

This difficulty was only uncovered when the case study school had been selected. At that stage, the process was too far on to attempt to move the case study to another school where the staff themselves, without any local authority pressure and despite time constraints, were willing to commit more time to it. It would have been helpful if the ability and willingness of staff to get involved at a deeper level with the research process had been part of the criteria for selection of the case study school, and this is something that should be borne in mind for future studies. In addition, a much higher level of administrative support (for transcription of massive volumes of data) and researcher input (for data collection, analysis and interpretation) than was available or practical for this PhD study would have been an advantage. This ought to be borne in mind in any future studies that seek a deeper insight into education practice in relation to this or any other subject.

Despite all the efforts to enhance the validity of the findings, there is no doubt that the researcher's presence and involvement would have had some impact on the drug education she was seeking to observe. As pointed out by Ratcliffe (1983), data do not speak for themselves: there is always an interpreter or a translator and one cannot observe or measure a phenomenon without changing it. In this study, one can only speculate as to what that impact might have been. While the researcher was present, staff may have been trying harder than usual to do their best in their teaching and to behave in ways that they felt would be positively received by the researcher. In interviews, pupils may have been trying to impress each other or the researcher. In one of the guidance interviews, Tony Morrison reported that he was directly stimulated into thinking about alternative ways of consulting pupils, by the presence of the researcher (see Page 187). Alternatively if the respondents felt under pressure to perform well due to the presence of the researcher, this pressure could actually have negatively affected their performances. Whatever the influence, the staff were still operating within the same constraints and time pressures as when the researcher was not present; they had no additional preparation time or training before the observations and the extent to which they would have been able to improve the quality of their practice at will is questionable. Nonetheless, these potential influences were borne in mind in the analysis of all the case study data and in the selection of extracts to illustrate the emergent themes.

5.2. Reliability

Conventional measures of reliability are more comfortably associated with quantitative research where standardised "research instruments" are used. In this traditional sense, reliability refers to the ability of a piece of equipment or research instrument to give a consistent result when measuring a particular phenomenon on multiple occasions. As noted by Merriam (1988) however: because what is being studied in education is assumed to be in flux, multifaceted, and highly contextual; because information gathered is a function of who gives it and how skilled the researcher is at getting it; and because the emergent design of a qualitative case study precludes a priori controls, achieving reliability in the traditional sense is not only fanciful, but impossible.

Nonetheless, reliability can be conceptualised in qualitative research in terms of the consistency with which results have been obtained from the data generated. That is, rather than demanding that another researcher would get the same results, the goal is to convince the reader that given the data collected, the results make sense – that they are consistent and dependable. There are a number of influences on reliability in this sense. In qualitative interviews, reliability is determined largely by the extent to which all of the data generated in the interviews, that is everything that was said, has been fully and accurately included in the body of data that is analysed. The best way to ensure this is to use electronic means to record the entire interaction. In this study, all of the interviews in the interview study, and the interviews with staff in the case study were audio taped and these were carefully and thoroughly transcribed in full. In transcription, any words or phrases which were unclear were not guessed at, but rather marked with the number of the tape count at which they occurred, for subsequent checking either by the researcher herself, or by an independent colleague. In addition to the care taken when transcribing each interview, one of the interview study transcripts was checked by an independent researcher by listening to the original recording. He was able to identify a small number of minor inaccuracies in the twenty-page transcript, only one of which altered the meaning of the sentence in which it occurred in the interview. This was not thought by him to change significantly the themes emerging from the interview.

Other than the staff interviews, the field work during the case study was not recorded electronically. There are some difficulties with audio-recordings where more than two people are being recorded, as was the case with the pupil feedback and in the lesson observations. It is difficult for the transcriber to determine who has said what; sophisticated (and expensive) equipment is needed even to pick up the voices from around a classroom; and any movement or action on the part of the participants is missed. Nonetheless, the use of audiotapes, especially if supplemented by notes could have substantially increased the level of detail and volume of data that it was possible to collect in this study. Even more ideal, is the use of video recording but this is even more expensive and for reporting in thesis format, it also generally requires some form of translation/transcription into text at some point (although this may change in the future if electronic theses become the norm). In any case, in this case study, it was simply not possible for the researcher to consider reviewing and transcribing 160 hours of observation even if the necessary equipment had been available or affordable.

Once again, the provision of adequate secretarial and administrative support would have been of benefit to the study, and should be considered essential for any future qualitative studies in the school setting.

In the absence of electronic recording for the pupil feedback, general observations and lesson observations, notes were written by hand by the researcher as the case study progressed. A number of steps were taken to enhance the reliability of the data. As soon as possible, and often immediately after each session, the researcher read over her notes, clarifying any meanings that might later be unclear, expanding notes of any incidents and generally ensuring that the notes were as complete as possible before she would forget what had happened. Once this had been done the notes were typed up by the researcher and entered into the NVivo project file. During pupil feedback sessions, the researcher explained to the pupils that she would be making notes of what they were saying and for that reason it was important that they did not interrupt each other or speak at the same time. Additionally, she regularly asked them to repeat what they had said so that she could make a note of it and fed back her notes to them for confirmation. Despite these efforts, it must be acknowledged that the researcher's notes may have been influenced by her own interests, biases and position, as discussed above.

The first of three strategies recommended by Merriam (1988) to enhance reliability involves the provision of a description of: the assumptions and theory behind the study (see Chapters 1 and 2); the researcher's position (see Section 5.1.1); and the procedures for selecting respondents and settings (see Sections 2.4.6; 2.4.7; 2.5.2; 2.5.4). The second strategy, triangulation, as described in Section 5.1.3, strengthens reliability as well as internal validity. The third strategy involves the production of what is known as an "audit trail". A research report can be said to provide an audit trail if the methods used in the research are described in such detail that other researchers can use the report as an operating manual by which they may replicate the study. Ideally, the researcher should be constantly and continuously reflective on how he/she has collected, analysed and presented the data generated by his/her research and these reflections should form part of the body of data in the study and be available to the reader to peruse in order to form an opinion of their own about the reliability of the results presented.

Even in this relatively small study, the volume of notes generated was enormous, and it was not possible to reproduce them all in this thesis or to present the thinking behind every decision taken. Nonetheless, the methodology chapter is comprehensive and detailed and anyone wishing to repeat the study should be able to follow the procedures described. In addition, the researcher decided to include this separate chapter to discuss and reflect on the methods used in order to provide the reader with as much detail as possible of the care taken in the carrying out the research and therefore allow them to form their own opinion of the reliability of the data.

5.3. External Validity

Generalisability in qualitative research is not addressed empirically, by means of random sampling and statistical significance. Rather, a range of strategies is used to consider how the results of the study may be generalisable or *transferable*, in this case to other schools in Grampian or elsewhere. According to Merriam (1988) there are four possible kinds of generalisation: working hypotheses, concrete universals, naturalistic generalisation and user or reader generalisability. Of these, only the first and the last are relevant to this study and are considered here.

The concept of any generalisation as a working hypothesis rather than a concrete conclusion, takes account of the local conditions inherent in this kind of research. It also allows the educational researcher to offer some guidance to schools or policy-makers in making choices, while allowing for the hypothesis to be amended depending on the outcomes of those decisions. This practical view is shared by Patton (1980) who argues that qualitative research should provide context-bound information and perspective rather than generalisations. Reader or user generalisability, on the other hand, involves leaving the extent to which a study's findings apply to other situations, up to the people in those situations. It is then up to the reader to judge what there is in the research that can be applied to their own situation and what clearly does not apply. This is common practice in law and medicine when the applicability of one case to another is determined by the practitioner (Merriam, 1988). In this study, the researcher did not attempt to provide a universal description of drug education in schools.

Rather, it was hoped that a greater understanding of drug education in these schools would be developed, and that this "working hypothesis" might be useful to schools and policy-makers in improving provision as required. The research report describes the respondents and case study setting and how they were selected in as much detail as possible and considers how typical they are compared with others to allow the reader to form his/her own judgement about the likely applicability of the findings to other settings. Providing this level of detail is not without its difficulties though: too much detail about any school has the potential to compromise confidentiality (see Section 5.4). In addition, as a semi-structured format was used for all of the data generation in the interview study, the same background information and descriptions were not obtained for every school. It would have been more useful to have had a standard protocol for collecting this kind of background descriptive information, and then using the semi-structured approach for the rest of the interview.

5.3.1. External Validity in the Interview Study

One of the practical disadvantages associated with qualitative research is that it is time-consuming to arrange and conduct interviews, and transcription is a long, tedious process. These factors meant that a limited number of schools had to be selected to be involved in the interview study and the question therefore arises as to what extent the findings may apply to other schools in Grampian or elsewhere. The selection of the schools was based on theoretical rather than random or convenience sampling. It is suggested here and elsewhere (Slevin & Sines, 1999) that theoretical sampling is superior to either of the other two methods as it allows the selection of a sample likely to provide the broadest perspective. Random sampling in this region would not guarantee the inclusion of a broad range of different schools in the sample, and convenience sampling could bias the results in any number of ways. Theoretical sampling also allowed the researcher to continue to generate data until she could be confident that the central research questions had been addressed and that additional interviews were no longer adding major new themes. In this study, it was found that while the exact content and organisation of drug education was different in every school, the ways in which schools organised drug education were similar, and the respondents' reactions to many issues reflected the same broad themes.

In addition, the issues and themes that emerged from the pilot study, which was carried out in East and West Dunbartonshire, are strikingly similar to those identified in Grampian (Appendix 2.6). This greatly increases confidence in the transferability of the findings of this research.

The method of theoretical sampling is not without fault. Although criteria for the selection of schools were decided by the researcher alone (see Section 2.4.6.) she was not entitled to access certain confidential information on individual schools that would be necessary to apply these criteria and it was therefore necessary to ask key personnel at the local authorities to select the schools. As a result, it is possible that the particular interests of these representatives would in some way bias the sample. This potential bias was minimised by asking them to identify more schools than would be approached in total, and by making it clear that they would not be provided with feedback on any individual school. Of the twelve schools approached, three refused to take part on the grounds of lack of time. Whether or not this was the real reason for non-participation, it raises the possibility that the results obtained reflect those schools that may have more time and resources, or interest in drug education issues. This is exacerbated by the purposeful selection of innovative schools in the latter stages of data collection in order to study the leading edge of change (as discussed below) and means that the results are likely to paint a picture that is "rosier" than typical. This was borne in mind during data analysis and ought to be remembered by the reader when considering the study findings.

Finally, transferability also depends on how the passage of time may change the circumstances studied. In this study, the selection of the most innovative and progressive schools is in line with the recommendation of Schofield (1993). He recommends studying what is termed the "leading edge of change" in a field of practice, to act as a means of enhancing the transferability of findings beyond the time span of the data collection. If research focuses on new or innovative practices, it can provide early indications of the issues to be dealt with and overcome in implementing those practices in the future. Thus, studying the leading edge of change may have enhanced transferability across time to future practice, but along with the procedures used to select the schools for the interview study, it may have reduced transferability to schools that are currently less progressive or innovative.

5.3.2. External Validity in the Case Study

Given the time-consuming nature of fieldwork for case studies and large volumes of data and subsequent careful, reflective analysis which are necessary to reap the potential benefits of the method, it is often not practical to study more than one case. This is particularly true when the research in question is doctoral research, carried out by one researcher. The result of this limitation is that questions arise about the external validity or transferability of the results as described above.

In order to assess transferability in this study, it is necessary to consider how typical the case study school is of other schools in Grampian or elsewhere and how easily that may be judged from the study report. In the presentation of the case study results (Chapter 4), the school, staff and the context in which they deliver drug education is described as fully as possible within the confines of confidentiality and ethics (see Section 5.4). This allows the reader to consider similarities to and differences from elsewhere, and thus to judge how well the results may transfer. The selection of the school for the case study was based on purposeful rather than random or convenience sampling and it resulted in the selection of a reasonably large, comprehensive school in a country town, not very far from a big city. It is possible therefore, that the issues identified in the case study would not apply to a small, single denominational school in a rural area, or indeed to any other school in any other town.

This seems unlikely however, as the themes identified in the case study were broadly in agreement with the findings of both the interview study and the pilot study. In fact, although the exact content and timetable of provision is different in every school, the results suggest that the issues affecting drug education may be similar across a wide range of schools in Scotland. The in depth nature of the case study allowed a greater understanding to be gained of the issues and just how they exert their effect. In addition, the school had six principal teachers of guidance of varying age, gender, opinion, and experience. There is no reason to believe that these teachers in any way represent an exceptional or atypical sample, and therefore the observations of their classroom practice may very well be a good indication of the processes and interactions that occur in drug education lessons in Scottish schools in general.

One issue on which the school was notably different from other schools that would be expected to have a direct effect on the results obtained is the fact that the school was selected by the representative of the local authority as an innovative school in the field. This was at least partly because the school had a well-established programme of peer-led drug education. Thus, it might be expected that the school represents the higher performance end of the spectrum when it comes to drug education. It is worth noting however, that to judge from the issues arising in the case study school, the teaching does not appear to be particularly innovative outside of the peer-led programme, relative to the other schools studied. For example, established drug education packages and videos were used such as "Drugwise Drug Free", "Sorted" rather than ones that might be considered more enlightened such as TACADE materials. Although the fact of the peer-led programme means that the staff may have been thinking in some more innovative ways to have come up with in the first place, it did not appear to be related to any other major innovations in what was taught in drug education lessons in the school.

The methods of selection of pupils for the pupil feedback sessions will undoubtedly have influenced how typical those pupils were, compared to others, however it is difficult to say how this influence may have affected the overall findings. As described in Section 2.5.4.c, pupils were selected on various occasions by the teacher, by volunteering, by the researcher, by lottery or by a combination of these methods. The researcher chose (and asked for) a range of pupils, particularly those who had been active in the drug education lessons. As these pupils were more outspoken in class, it was considered likely that they would also be willing to speak openly in an interview situation. There is also some evidence however that young people who are more outgoing and self-confident may be more likely to have experimented with drugs (Shedler and Block, 1990), and thus these children may have been in a better position to provide information on the nature of the drugs scene in the town. This perspective may also have skewed their perceptions or indeed memories of the drug education they had received, though in what way this bias would operate is difficult to estimate. It is also possible that where pupils were self-selected, they may have been more outgoing, simply more willing to help or more anxious to avoid their next lesson.

In addition, where the pupils were selected by their teacher, it is possible that the teacher chose better-behaved pupils he/she felt would co-operate with the researcher and not cause any embarrassment to the teacher or the school. As so many different methods were used to select the pupils, it is impossible to speculate as to what any overall effect might have been on the typicality of their feedback, although there did not appear to be any clear bias in any one direction.

The situation that prevailed in the school at the time of the case study was one of transition, as it was the first year that drug education had been delivered solely by the guidance team who also developed the course. Delivery by a dedicated guidance team appeared to have a number of advantages (see Chapters 3 and 4), however in the initial changeover year, these advantages may have been somewhat negated by the fact that the guidance teachers had little or no recent experience drug education delivery. Although they had planned the drug education courses in the past, they were not used to delivering them and their delivery might therefore have been somewhat inferior to schools where dedicated teams of teachers had been involved in both developing and delivering the course for a number of years. Again, it is necessary to bear this in mind when considering the findings of the case study in relation to the quality of the drug education delivered by the teachers in Allandon Academy.

A further consideration necessary in the case study is how typical the lessons which were selected for observation were, in comparison with other lessons in the school. It was necessary to select which lessons would be observed as clearly not all drug education lessons could be observed by the researcher, particularly given that many ran concurrently. In order to select the optimum combination of lessons to ensure maximum coverage of different deliverers, year groups and lesson content, theoretical sampling was used. As part of those lessons which were selected, each guidance teacher was observed at least once as was each year group, and every different lesson (in terms of planned content) was observed with at least one class. Although lesson observations were agreed with guidance teachers in advance, no teacher ever refused to be observed for any lesson or attempted to influence the selection of lessons in any way.

One particular class was followed through the whole third year drug education programme to get a picture of the complete course as received by them, thus allowing for the fact that the planned content of an individual lesson might overrun and might be followed up the following week. Three teams of sixth year peer educators were observed delivering a lesson, as were two lessons delivered by the police school liaison officer. As such a wide variety of lessons were observed (see Table 2.5), it seems unlikely that those selected were biased in terms of content, delivery or quality.

Finally, it is necessary to consider whether the days that the researcher spent at the school were in any way unrepresentative of typical days at the Academy. The selection of which days to spend in the school was determined by which lessons were selected by the researcher for observations as well as by any prior commitments elsewhere. Visits to the school occurred on varying days of the week, and were spread out over the case study period from August 2000, to January 2001. Although planned visits were discussed in advance with staff; as with the selection of lessons, staff made no attempt to influence the timing of visits in any way and the researcher was made to feel that she was free to choose days as suited her. There is therefore no reason to believe that the selection of visit dates in any way biased the case study data or meant that similar issues would not arise in any other school over a similar period.

5.4. Ethical Considerations

In their review of ethical issues in educational and social research, Cohen and Manion (1994) note that researchers have to strike a balance between the demands placed on them as professional scientists in pursuit of truth and their subjects' rights and values potentially threatened by the research. Stake (1998) argues that although realisation and resolution of ethical conflict comes largely from within and relies on deeply considered personal judgement, multiple codes of ethics allow consideration of different perspectives and therefore better reflection on the issues. In this study, the researcher considered a range of sources of advice on ethics as part of her research into qualitative methodology. In addition to the discussion of ethical issues in evaluation research (Stake, 1998), and in educational research (Cohen and Manion, 1994), she considered the guidelines of the Social Research Association (2002), and those proposed by Elliston (2002) for health promotion research.

Key ethical principles are illustrated in Table 5.4 which is adapted from Elliston (2002). These principles are used as the framework for discussing ethical issues in this study, however, the discussion draws on the advice in all four documents.

Ethical Principles for Health Promotion Research (Summarised from Elliston, 2002)
Beneficence: The benefits of research should be toward the research participant and society, should outweigh the risks, and should not take precedence over the safety of the research participant.
Non-Maleficence: Research participants should be protected from harm. In most cases there should be either no anticipated effects of harm or only temporary discomfort.
Informed Consent: The subjects should know the purpose of the study and should be free to withdraw from it at any time. Where the direction of research is not known by the researcher, this should be communicated to participants.
Justice: The needs of the research participant should always come before the objectives of the study.
Veracity: The research process should be conducted with respect for the research participant and the researcher should tell the truth about the research.
Privacy, Confidentiality and Anonymity: The extents and limits to the privacy, confidentiality and anonymity of those participating in the study should be explained to the research participants before the study commences.
Respect for Autonomy: The researcher must respect the right of individuals or communities not to be intervened upon, even if it might do them some good.

Table 5.4: Ethical Principles for Health Promotion Research (adapted from Elliston, 2002)

Beneficence/Non-Maleficence

The findings of this research project are likely to be beneficial both to society in general, in terms of helping policy-makers to improve the conditions for drug education in schools, and to the individual respondents in improving the provision in their own school. In order to facilitate this benefit, the researcher is committed to providing each school involved in the study with a written summary of her findings, as well as access to the full thesis. No maleficence beyond temporary discomfort at worst is likely to have occurred for any of the research participants, as the topics considered and discussed with respondents were not of a personal or emotionally sensitive nature. The most sensitive discussions occurred in pupil feedback sessions, where levels of drug use among pupils and in the local community were considered.

To minimise any discomfort on the part of the pupils and to protect them, they were encouraged not to disclose their own behaviour or to identify any drug users, but to speak in general terms. Some pupils chose to volunteer information on their own behaviour in relation to drinking alcohol or smoking, but no-one disclosed any personal use of illegal drugs.

Informed Consent and Respect for Autonomy

At all stages in the research process, the background, goals and purpose of the research were explained to the interview respondents and case study participants. In addition, they were informed that they were free to choose not to participate in the study or having agreed to participate, to withdraw their participation at any time without adverse consequences for them. The information and commitments were outlined in the consent form for the interview study (Appendix 2.11), the case study ethical agreement (Appendix 2.15), and were reiterated orally in advance of any interviews or feedback sessions. The staff involved in each school were provided with a copy of the consent form or ethical agreement to allow them to reconsider issues at a later date should they wish to do so. In the case study, it was only possible to negotiate direct consent from pupils or staff who were involved in feedback or directly observed; no such negotiations took place with staff outside of the rector and guidance team for example, nor with pupils who were present in observed lessons but who were not involved in feedback afterwards. All pupils were issued with a letter for their parents (see Appendix 2.16) however, informing them of the research and inviting them to contact the school if they had any queries. Although this kind of passive parental consent is not ideal, it would have been virtually impossible to obtain the active consent of every pupil in an observed classroom and their parents, and as no harm was anticipated, this was considered an acceptable compromise both by the school staff and by the researcher. Staff in the school outside of the guidance team and rector, who may or may not have heard of the research through the "grapevine" were informed of the study through a notice which was placed in the school bulletin.

In addition to respondent consent, the permission of the director of education in each of the three local authority areas was sought and obtained prior to the commencement of the research in any school, as was the permission of the head teacher of each school before any contact was made with respondents.

All respondents were informed of the intentions of the researcher in relation to publishing the study findings not only in a thesis but, also in possible journal publications, and summary reports to interested parties.

Justice and Veracity

At all stages the research was carried out with respect for and consideration of the needs of respondents. The researcher arrived on time for appointments, re-arranged interviews if necessary to suit the respondent, and attempted to keep within the time requested for the interview. In practice, however, it was not always possible to estimate how long an interview or feedback session would take and initially, in the interview study, the researcher may have underestimated the time required. This was partly due to the additional time required to meet up with the respondent upon arrival at a school, find a room and to explain the consent form and background to the research. In addition, in some interviews, more topics were considered than others, more than one respondent was present, or the respondent(s) had more to say on every issue, all of which extended the time required. As soon as this was noticed, the estimates given to respondents of the length of the interview were increased, however in some cases, it was still necessary for the researcher to return to the school on a second occasion. This was considered preferable than extending the interview beyond the original time, however it would have been better to flag up the possibility of a second interview with all respondents in advance. In future studies, it is also advisable to over-estimate the time required for each interview, as this is likely to cause less inconvenience to respondents than any overruns.

As a matter of respect and courtesy, letters of thanks were sent to the case study school and to each respondent in the interview study. In addition, when respondents requested more information about any particular issue, the researcher made every effort to be as helpful as possible.

Privacy, Confidentiality and Anonymity

Although anonymity (where the names and personal identities of the participants are never attached to the research data or known to the researcher) cannot be offered in qualitative research studies, every effort was made to guarantee confidentiality.

In both the interview and case study, respondents were assured that neither they nor their school would be named in connection with anything they said to the researcher and that notes, tapes, paper and electronic copies of transcripts and identifying data would be stored securely by the researcher and/or password protected as appropriate. Interview study respondents were told that any information provided by them that would allow someone not connected with the school to easily deduce which school they came from, such as the name of local areas or facilities for example, would be deleted or disguised in the transcribed text. A similar level of confidentiality was guaranteed to the pupils who participated in the feedback sessions of the case study. They were informed that they would be identified only by their year group and in some cases, their gender and/or a pseudonym.

For the staff who participated in the case study, confidentiality was less than clear-cut. Firstly it was possible that the school itself or the town would be identifiable from the descriptions given at the beginning of the results chapter, and this was explained to the staff. They were provided with the text of Sections 4.1 and 4.2 and invited to review it and to express any concerns they had, if they felt the descriptions compromised confidentiality in any way. They asked that the gender of respondents be changed to help maintain confidentiality, and as this study did not attempt to analyse any data by gender, this request was fulfilled. A few other minor changes were requested and subsequently made to the description of the school location. Despite the efforts to remove any information that would immediately identify the school, it was explained to all staff that anyone who was familiar with the drug education provision in the school, and in particular the fact that it was perhaps the only school in the region to provide a peer-led drug education programme, might be able to identify the school by reading the case study results. This was explained in the ethical agreement and discussed with all staff, who agreed to proceed despite such a potential breach of confidentiality.

The implications of the school being identified varied for different respondents. As guidance teachers were given pseudonyms for all reporting, even if the school was identified, a reader would not be aware of which teacher had said what. The only exception to this, again, would be if a reader was already very familiar with the views, way of speaking or teaching style of that respondent.

In some cases (such as on page 243), the position taken by one of the guidance teachers on an issue was such that his/her colleagues would have been able to identify him/her from the comments made. Although it was not possible to identify all comments to which this risk applied, the researcher was vigilant and did not reference any comments where she felt the issue might arise.

The identification of the case study school had even more serious consequences for the confidentiality of the rector of the school, and potentially, the police school liaison officer, as there was only one rector and one police school liaison officer for that school (although there were twelve in Grampian). Both these individuals were consulted separately and specifically about this possibility. It was clearly explained to them firstly, that when Allandon Academy was provided with a copy of the report, staff within the school would be able to read their comments and the observation notes relating to the teaching of the police school liaison officer, and would know exactly to whom they referred. Secondly, they were informed that anyone from outside the school who was able to deduce which school was involved would then be able to connect them to the data. Both the rector and the police school liaison officer acknowledged these possibilities and were happy for the researcher to go ahead and use her data relating to them without any restrictions.

Because of the potential for confidentiality to be breached in the case study, respondents were offered the opportunity to review and/or challenge any of the researcher's written accounts at any time "if necessary to improve accuracy, fairness or relevance" although they were not given any entitlement to veto findings. Although this potentially had time and cost implications, the researcher decided that it was important to give this commitment to the respondents so that they had the option to be part of, rather than subjects of, the research process. It remains the opinion of this researcher, that the study could only have benefited from greater staff involvement, as discussed previously, despite any time or cost implications. In addition to making all her work open for review, the researcher gave a commitment that any journal publications would be made available to the school in advance of publication. She also offered to personally present a summary of her findings to the school at a later date. Finally, as a matter of courtesy and a token of gratitude, the ethical agreement commits the researcher to providing a copy of the final thesis to the case study school library.

5.5. Conclusion

Despite all of these efforts, any study of something as complex and diverse as the social world, is subject to the interpretations of the researcher. This is something that applies to all qualitative research and had to be borne in mind particularly in the data analysis stage of the research, where each emerging description had to be considered carefully, to ensure that it was grounded in the data. Nonetheless, achieving the "truth" in research is an ongoing process, and as Hammersley argues, absolutely certain knowledge is impossible:

> I believe that we can never be certain about the truth of anything, not even in the natural sciences or in our personal lives. On the other hand, there are many things about whose truth we are very confident and about which we have every right to be confident.
>
> [Hammersley, 1990]

Thus, while validity of findings may never be established beyond doubt, there are means by which the likelihood of error can be continuously assessed and confidence in the results enhanced. The precautions and procedures described in this chapter demonstrate an attempt to do just that without compromising ethics.

Chapter 6. Discussion of Results

This research set out to study the policy, planning and practice of drug education in secondary schools in Grampian, Scotland. Internationally, there has been a huge amount of research that has done much to improve understanding of what works in drug education and why, as outlined in Section 1.4. Although much remains to be studied, a clear consensus has emerged in relation to good practice, and this is reflected both in the research literature and in the guidelines on drug education provided to Scottish schools described in Section 1.5. It is clear that most schools in Scotland are providing some form of drug education and although they claim to be providing it in line with national guidelines, there has been little independent confirmation of this. In fact, the quality of drug education in Scottish schools has been little studied.

In the past, research has focused on the outcomes of drug education in terms of a change in pupils' reported drug use, knowledge or attitudes, and has been primarily quantitative in nature, based on surveys of schools. While valuable in terms of *outcome* measurement, such quantitative approaches have done little to illuminate the *process* by which drug education is planned and delivered in schools, the quality of that delivery, or the factors that impact on decisions about drug education made by teachers and schools. In fact, the most recent study of this kind in Scotland (Lowden and Powney, 2000) reported a lack of complex and focused studies that could account for the contextual processes that affect drug education. As described in Section 2.2, the research described in this thesis used in-depth interviewing and observation to gain a deeper understanding of these processes, and of the quality of the drug education itself.

The purpose of this chapter is to discuss the findings of this research in relation to drug education policy, planning and practice in the schools studied. The findings are considered in the light of the drug education literature and current Scottish guidelines as discussed in Chapter 1. In addition, the need for further work in this field is discussed.

6.1. POLICY

It is clear from the findings described in Section 3.1 that very few of the schools involved in this study had developed a comprehensive drug education policy for their school outlining the goals of drug education, describing key messages, and giving guidance to teachers on the delivery of the drug education programme. This is in accordance with the findings of Lowden and Powney (2000) in their national study of drug education in Scotland that only 21% of secondary schools (n=318) claimed to possess specific written policy statements on their drug education. In a separate interview study of school-based drug education in Wales, Bishop et al., (2001) found that 46% of schools (n=50), had no written policy for drug education, and that few schools were able to communicate the overall philosophy underpinning their drug education programme. In the current study, respondents were familiar with the idea of having a policy for dealing with drug-related incidents but they were unconvinced of the need for a written policy on drug education. Some reported that they planned their drug education on the basis of existing guidelines, and therefore believed that developing their own policy would be tantamount to "reinventing the wheel".

In the opinion of this author, there are two main reasons why carefully developed policies, both at school and local authority level, would be beneficial to school-based drug education programmes, and would not duplicate existing documents. Firstly, as will be outlined below, this study found that existing documents that were being used by schools did not provide sufficient clarity about drug education goals and approaches and that confusion remained among teaching staff about what to teach in relation to difficult issues. Secondly, it will be argued that the process of developing and updating a drug education policy at school level provides the opportunity to involve major stakeholders in agreeing joint goals and actions, increases their sense of ownership of the programme, and helps to avoid misinformation.

Various authors have proposed goals for drug education over the years, the most common of these having been the reduction or prevention of drug use among those pupils to whom the programme is delivered (see Section 1.4.2).

Others have proposed that the goal should be the minimisation of harm associated with drug use (O'Hare, 1988) or simply to educate young people about drugs without any explicit behavioural or harm-reduction goal (Evans, 2002a). The philosophy behind each of these goals is different and drug education based on each goal would likely incorporate quite different messages and approaches. It is therefore necessary to be clear about which goals are being pursued when planning and delivering a drug education programme and to provide guidelines on what a stated goal means in practice for the ongoing delivery of drug education. Unfortunately, neither current national nor existing Grampian-based guidelines provide such clarity to schools: although goals are stated, little explanation is given in relation to how to interpret these goals or what they mean in practice (Section 1.5.1). For example, one respondent mentioned that they did not need a policy on drug education as they used the Grampian Health Promoting School drugs pack (Health Promotions, 1998b; see Section 1.5.2). In this pack, two main goals are stated for drug education:

> To prevent drug misuse and to reduce the harm caused through existing drug misuse.
>
> *[Health Promotions, 1998b]*

These two goals may appear to be in conflict at times, as the provision of information to reduce harm associated with drug use, could be seen to compromise efforts to prevent "misuse". Although this resource states that harm minimisation approaches should only be used in community education settings, not in schools, no guidance is provided as to what a teacher should say if a question is asked about harm reduction or if the topic comes up in discussion. Similarly in the HELP guidelines (Learning and Teaching Scotland, 1998), there are a number of different references to the prevention of harm caused by drug misuse, but no clear guidance on what this means in practice (Section 1.5.1.c).

If schools are using the above documents without further guidance on goals or a clear policy, there is little clarity about what messages are appropriate or how to provide balance in terms of the perceived benefits and risks associated with drug use. This results in confusion among teachers which was especially common among the teachers in this study when it came to the "difficult" issue of harm reduction (Section 3.4.4).

Some teachers reported that they would not provide harm reduction information at all, but then later said that they would provide some information if the topic came up in the classroom. Others felt that it was inappropriate, but reported that outside agencies would provide that kind of information to pupils. In addition, many teachers indicated that they were not at all clear in their own minds about what messages were recommended in relation to harm reduction. This confusion was reflected in the lessons observed in the case study (Section 4.7.6) when the issue of harm reduction for ecstasy users was brought up – some pupils were told that dehydration is a risk whereas others were told that it could be dangerous to drink too much water – no clear guidance was given on just what quantities of water are recommended. The issue of harm reduction was discussed with both interview and case study teachers, some of whom suggested that a local authority policy would guide them on how to deliver a harm reduction approach and therefore allow them to cater better for pupils with different drug experiences. Others felt that if official guidance existed from the local authority, it would provide a sort of protection for schools so long as they acted within that guidance. It is the opinion of this author that a sensible policy covering these difficult issues at local authority level and disseminated to all drug education teachers accompanied by appropriate training, would go a long way towards clearing up the confusion described above.

The second argument offered in favour of drug education policy suggests that each school should also develop its own drug education policy covering broader issues such as goals and plans for drug education in the school because of the benefits derived, not just from the existence of the policy, but from the process of development itself. Mallick et al. (1998) found that parents were often misinformed about drugs in relation to their children, were largely unaware of school drug policies and believed in the "Just say No!" message (Section 1.4.4e) . These findings were echoed by one respondent in this study who reported that "parents expect teachers and schools to say "No! Don't do it."" This was clearly not the stance taken by most of the schools in this study (Section 3.4.2) and although no respondents reported that parents had complained about the drug education that was delivered, they expressed concerns about what messages parents would think were appropriate (Section 3.4.4). Despite these concerns, parents were rarely involved in the process of planning drug education or developing policies in the schools studied and communication with them was sporadic (Section 3.2.6).

The development of a school policy on drug education is an ideal opportunity to involve parents in discussions about the drug education being delivered to their children and would relieve much of the potential for misinformation or confusion at a later stage. The establishment of school health groups including parents, or the involvement of the school board in policy development, would extend and strengthen the schools' relationship with parents and is very much in keeping with guidelines for best practice (Section 1.5.1). A number of respondents felt that parents should take greater responsibility for educating their children (Section 3.3.1): mutually agreeing and discussing drug education policy with parents is an opportunity to clarify the commitments and responsibilities of both sides. Increased involvement of parents would not be without its difficulties however, in that many may not be aware of best practice in the field and this requires further investigation.

An open and inclusive approach to developing a drug education policy also provides an opportunity to involve school pupils and other key stakeholders, such as members of the local community, representatives of community groups, health and social workers, local initiatives and the local police. It is suggested here, and elsewhere (Drugs Prevention Initiative, 1998b) that involving and consulting pupils offers the prospect of a greater degree of ownership and acceptance of programmes on their part. Opening the process of policy development up to a wider range of groups and individuals allows discussion about how everyone can contribute to the achievement of the agreed goals and would be the first step towards developing programmes which include components aimed at and based in communities and families as well as pupils and classrooms. Such comprehensive programmes are a promising development in the drug prevention field and have been shown to be successful elsewhere (Perry et al., 1996; Pentz et al., 1989; Spoth et al., 1999; See Section 1.4.3.d). As most of the schools in this study did not have a policy on drug education, these opportunities were missed.

Once policies are agreed upon, it is important that they are regularly reviewed and updated because otherwise, as found by Pateman et al. (1999) in relation to health education, there is the possibility that teachers will feel bound by policies that with time may become outdated, unreasonable or unresponsive to pupil needs (Section 1.4.4.c). It is worth pointing out a final crucial reason for the importance of a clear statement of goals of drug education.

If the goals of a programme are not clear, then there is no benchmark on which to judge its success. Such goals would not have to include ambitious targets in relation to behaviour change (though this could be included if desired) but could be outlined simply in terms of information provision or skills development or the level of drug incidents in school. Whatever the goals, agreeing them explicitly should avoid unrealistic expectations and paves the way for evaluation of the drug education programme. Evaluating drug education is discussed in more detail below.

6.2. PLANNING AND DEVELOPMENT

In the schools studied in this research, the drug education curriculum was constantly changing and evolving, rather than following any carefully developed plan. Topics were added in, extra events (such as a talk from an outside speaker) were arranged and sections were omitted, deleted or altered in an admittedly haphazard way. Such amendments were carried out both at individual teacher and at school level depending on the availability of "something new and interesting" or perceived government or public pressures (Section 3.2.1; 3.3.4). More often, practical issues such as the availability of staff, rooms or equipment, or competing meetings or events resulted in last minute changes to the structure and/or content of the curriculum (Section 4.5). The overriding theme was one of constant, loosely structured evolution. As a result, most schools were unable to present detailed, written plans of drug education provision or if they were, they pointed out that the plans were not closely adhered to.

Most schools carried out regular reviews of the personal and social education (PSE) programme, at least on an annual basis with one or two staff usually taking responsibility for each topic including drug education. The regularity and comprehensiveness of these reviews was sometimes questionable however, where the language used by respondents indicated that a review was something that "might" happen, rather than a central part of an overall development process for PSE (Section 3.2.2). Where reviews were carried out, respondents reported that teachers used their experience and expertise to judge how well the pupils had responded to the material (Section 3.2.8) and updates or changes were based primarily on that judgement. Informal discussions with other teachers and with pupils were also used as well as pupil questionnaires in some schools.

The opinions expressed in pupil questionnaires were taken into account, but some respondents reported that they did not have a great impact on the drug education provided (Section 3.2.3).

Although sometimes consulted after delivery of sections of drug education, pupils were not actively involved or consulted in the process by which the programme was planned and developed. Respondents reported various reasons for this (Section 3.2.4): some said that it had never been considered; others questioned pupils' abilities to contribute in a constructive way or their willingness to give up their time to be involved; and some pointed out that the kinds of pupils who might volunteer to be involved might not be representative of those pupils most in need of drug education. Other stakeholders such as parents or community representatives were rarely consulted and were not involved in the planning process. Although many schools held parent awareness evenings every few years, or gave them an overview of the content of the Personal and Social Education (PSE) programme, there were no attempts to involve them in any more active way.

Apart from the kind of informal feedback described above, and pupil questionnaires in some schools, no more formal measures were used to evaluate the effectiveness or success of drug education in the schools studied. Although figures were available to each school in relation to the substance use of their pupils from breakdowns of youth lifestyle surveys, these were rarely mentioned by respondents, and were not considered in the planning or development process. In addition, although a few schools used the Grampian Health Promoting School materials, respondents made little reference to national guidance on drug education as outlined in the "HELP" guidelines or "A Route to Health Promotion" document (Section 1.5.1). Some schools were aware of these documents but most did not mention them. They were not described as in any way central to the planning and development process for drug education or to self-evaluations of the quality of provision.

Overall, these findings are strikingly similar to those of other studies both in Scotland and elsewhere. In their study of drug education in Scottish schools, Lowden and Powney (2000) found that while three-quarters of secondary schools (n=318) claimed to evaluate or monitor drug education provision, this was almost completely based on internal evaluations conducted by teachers involved with this subject.

Relatively few schools (14%) engaged pupils in the actual development of their drug education policy or deployed systematic pupil feedback in evaluation or planning. As above, most schools claimed to draw on day-to-day teacher and pupil informal feedback when reflecting on their school's drug education. In their interview study in fifty Welsh schools, Bishop et al. (2001) found that respondents were unable to outline programme content in detail and that no formal assessments of existing pupil knowledge or levels of experimentation were taken into account in planning. Bosworth (1998) carried out interviews with "drug-free schools co-ordinators" in seventy-six schools in Arizona, USA, and found that 70% of them could not describe any kind of systematic development process for their drug education programmes. Only 24% of Bosworth's respondents reported any kind of formal evaluation of programmes and those evaluations that did exist were for the most part based on teacher satisfaction with the curriculum. According to Bosworth, evaluations were poorly acted on, and government and state guidelines for drug education were rarely used.

Although monitoring systems for drug education may have become more common in schools (Lowden and Powney, 2000; Scottish Executive, 2002b), the existing systems in the schools studied in this research, were inadequate on more than one front. Had the overall philosophy and goals of drug education been agreed and developed into a drug education policy in a school, one would expect that this policy should then be used as the basis for curriculum planning and development in that school. As most schools did not have such a policy however, their curriculum planning processes lacked focus and direction, relying instead on casual feedback and impressions (Section 3.2.2). In addition, the admittedly haphazard and seemingly routine practice of deviation from or alteration of existing plans for drug education, is likely to undermine the process of developing plans in the first place. Many schools did not even possess written plans and it is difficult in these circumstances to understand how any overview of provision was maintained, nor how any necessary amendments would be identified, not to mention communicated to or implemented in practice by teaching staff.

Judging from the comments of respondents, the constant evolution is at least in part a result of the new topics that regularly emerge and that schools are expected to cover in PSE (Section 3.3.1).

It is important that schools can adjust their programmes to incorporate new topics and can adapt to developments such as new information about the effects of drugs or legal changes such as those proposed by the current UK government (Blunkett, 2002). It is equally important, however, that such evolution takes place alongside a clear curriculum framework which ensures that key elements are properly covered. Such a framework would require a careful and deliberate planning process. It is the opinion of this author that existing systems of review of PSE in schools could be built upon to provide this clear framework as suggested in the next paragraph.

Once a policy has been agreed with stakeholders, the goals and philosophy outlined should be used to plan or amend units, lessons and activities to meet a specific set of progressive learning outcomes for each year group. National guidelines on drug education should play a central role in the process, which would also be usefully informed by any up to date figures on substance use among pupils or local young people. Establishing clear learning outcomes for each unit would allow some flexibility, in that teachers could choose to use alternative activities for a particular lesson, provided that the replacement activities also achieved the required outcomes. In defining learning outcomes and selecting resources, it is important that other stakeholders, and particularly pupils, are consulted and/or involved.

Although little is known about the impact of greater pupil involvement on the effectiveness of programmes, there are indications from the literature that pupil consultation may reveal important aspects of drug education that would otherwise go unnoticed (Cole, 2000; D'Emidio-Caston and Brown, 1998). It is suggested here, and elsewhere (Drugs Prevention Initiative, 1998b) that involving and consulting pupils offers the prospect of a greater degree of ownership and acceptance of programmes on their part. It is also in keeping with the principles of differentiation, which is widely accepted as good practice within education (Section 1.4.4.d) though little practised in the drug education observed in this study (Section 4.8.5). Given the many doubts of staff about involving pupils (Section 3.2.4), it is important to consider how best their opinions might be ascertained and used. The questionnaires that were used in some schools were brief, and while they may be useful in getting a broad overview of pupils initial reactions to a lesson or unit, they were unlikely to give any in-depth insights.

This may explain why drug education rarely changed as a result of these questionnaires, as described by some respondents (Section 3.2.3). Questionnaires also disadvantage children who may have poor literacy skills and would therefore be less able to write detailed comments.

Alternative methods of consultation could involve the kind of short in-depth interviews with a small number of pupils that were used in the case study of this research as suggested by one teacher in the case study school (Section 4.4). Although the interviews in this study were not designed specifically to stimulate feedback for the purpose of planning or amending the drug education programme, it was clear that pupils were able to express their opinions clearly and made constructive suggestions for improving the curriculum (Section 4.8.1). Further study of this idea is required if it is to be developed into a successful model that could be used routinely by schools. It is not known if it could be used to consult with a broad range of pupils, not just those who are the most willing volunteers. It also remains to be seen if pupils would be willing to give honest feedback to teachers in the same way as they appeared to do with the researcher in this study. It may be that these short interviews would need to be conducted by individuals other than teachers whether other school staff, such as the school nurse or health development officer (where one exists), other pupils as peer researchers, or outside individuals. These options require further investigation as do the practicalities of the model in terms of resources and staff/pupil time.

In any case, it is clear from the experience of one school that pupil consultation generally needs to be carefully directed and structured to facilitate constructive, innovative feedback based on agreed topics (Section 3.2.4). Their "pupil forum" had been used for issues like bullying; however as a successful model that could possibly be extended to cover curriculum planning and development for drug education, it should be investigated further. Existing school councils may also be an opportunity to extend pupil consultation, despite the fact that some respondents stated that they dealt mostly with "bread and butter" issues. They have a number of advantages, as existing structures with which people are familiar, and which are usually elected democratically from within the body of pupils. They should therefore also be investigated further as potential fora for consultation with pupils on more academic issues, including drug education policies and curricula.

Young people are increasingly being recognised as being both interested and capable of playing a constructive role in shaping services and policy, and it is the opinion of this author that the education service must move forward on these issuesas other fields such as primary care have sought to do (Fast Forward Positive Lifestyles, 2000).

Teachers' feedback was the most common source of information used in developing drug education programmes in the studied schools. With their experience, expertise and familiarity with their own pupils, teachers are well-placed to consider the value of different activities and resources. It is important however, that their feedback is not solely focused on pupils' reactions to a particular input, but also considers how well the learning outcomes for that lesson have been achieved. For example, it was clear in the case study that pupils really enjoyed the drama activities used by the sixth year peer educators but that their educational value was questionable (Section 4.8.1.c). This is also a danger with some videos, which pupils may enjoy because they are dramatic and entertaining in a similar way to watching a TV drama, but do not *necessarily* improve pupil knowledge or understanding of drug issues. While it is important that pupils react positively to drug education lessons, this is only an initial factor of many that should be considered when reflecting on the overall impact of these lessons.

While it is easy to judge if pupils have enjoyed a lesson, it is undoubtedly more difficult to judge how well learning outcomes have been achieved. Some have suggested formal pupil assessment for this purpose but many teachers had doubts about this (Section 3.2.5). There are other ways to judge if learning outcomes have been achieved, many of which draw on the principles of differentiation including: agreeing pupil-health plans; setting learning targets with pupils; assigning tasks appropriate to each pupil's stage and abilities; and monitoring progress towards these plans, targets and tasks. In particular, pupil projects and assignments could be used more frequently in drug education: they were not observed at any stage in the case study school. Teachers should be able to use their expertise and knowledge of pupils to assess the quality of the projects or assignments completed and therefore make judgements as to how well learning outcomes had been achieved without the pressure or formality of examinations. This information would also seem to offer the possibility of a more robust indicator of the success of a particular unit of drug education than the current system of reliance on teachers' impressions of pupil reactions.

Once a clear planned curriculum for drug education has been agreed and drawn up, monitoring and evaluation activities must be decided on and put into practice. As discussed in Section 1.4.5, evaluation and monitoring are important to determine if the programme has been delivered as planned, if it is achieving its learning outcomes and goals, and if it is having any unintended effects. The exact nature of evaluation and monitoring activities must be decided at school level as they will depend largely on what goals have been identified for the drug education programme. As a minimum however, one would expect that schools would monitor what lessons have been delivered to each class, any changes or amendments made to the curriculum in between formal reviews, and any new activities or resources used by teachers. One would also expect that schools would seek out pupil and teacher feedback on the programme in constructive ways such as those suggested above and use this in further development. Other possible indicators that schools could easily utilise are the number of drug incidents occurring among pupils (which are already monitored by most schools), the levels of experimentation reported by pupils in local youth lifestyle surveys and pupil performance in project work and/or assignments. It is of course important not to assume that the drug education programme is responsible for any reduction in incidents or drug use, or equally that a programme has failed should these figures rise but they are nonetheless important indicators that can inform the whole process of planning around drug issues.

All of these indicators could usefully form part of a system for monitoring drug education, however more formal outcome evaluations, that actually measure the impact of a programme on levels of drug use among pupils, are notoriously tricky (ACMD, 1993). They are rife with confounding variables, and large sample sizes are required to demonstrate statistically significant effects. Such outcome evaluations require considerable time, resources, and research expertise, beyond that which could be reasonably expected to be present in schools. For these reasons, they are rarely carried out in individual schools, but tend to be large national studies as described previously (Coggans et al., 1991; Lowden and Powney, 2000).

6.3. CURRICULUM CONTENT

The concept of informed choice was most commonly described as the core message in schools' drug education provision in this study (Section 3.4.2; Section 4.6). This message was promoted by providing pupils with "the facts" or giving them information "so that they could make their own choices". This is in accord with the findings of the recent SCRE study of drug education (Lowden and Powney, 2000) which found that "almost all schools" saw the main aims of drug education as being:

- the provision of accurate information on drugs as a basis for informed and responsible decision-making
- the promotion of pupil decision-making skills.

In contrast, in the early 1990s, a national evaluation by Coggans et al., (1991) found general agreement among teachers that drug education should teach pupils to say "no" to drugs. Although respondents in the current research were keen to emphasise that an explicit "say no to drugs" approach would not work with young people, it seems that this message was still implicit in much of the drug education that was delivered (Section 4.6). It was clear from respondents' descriptions and by their own admissions that the information provided by the teachers and schools was in most cases designed specifically to support a decision not to use drugs (Section 3.4.2). These implicit messages were not discussed in the SCRE study but are similar to the situation found by Coggans et al. (1991) in the drug education packages at that time.

> Many of the available packages were based on the 'life skills' approach to drug and health education and some emphasised 'decision-making' and 'social skills'. It was clear, however, that certain aspects of the packages were more about decision-implementation than decision-making, the decision being implicit or explicit in the package content. This directive aspect could be counterproductive if perceived by the pupil as being simply moralistic and opinion-based.
>
> [Coggans et al., 1991]

The anti-drug message, implicit in much of the drug education delivered in the schools in this study, manifested itself in a number of ways. Some of the materials used, particularly videos such as "DrugWise Drug Free", "Sorted" and "Danny's Story" emphasised the negative consequences of drug use in ways that are unlikely to be relevant to the experiences of most young people.

In "Sorted" and "Danny's Story", the central character is portrayed as a hero/heroine who succumbed to the powerful temptations of drugs. It seems that they are seen as victims, not of their own decisions, but of some kind of mystical power of drugs that means that even the "good guys" have to be wary of all things associated with drugs (Section 4.8.1.d).

It is the opinion of this author that these videos are in actual fact a sophisticated form of scare-tactics. Rather than the scare-tactics of the past, which were based on fictional representations of the horrible consequences of drug use (Section 1.4.3.a), the current trend is towards real-life stories despite their sometimes disproportionate portrayal of drug deaths. It seems that despite the evidence, a view still prevails among the general public that if pupils are presented with stories of drug-related tragedy in the lives and families of real people that this will discourage them from using drugs. Recently, a video with a very similar style to that of "Sorted" was launched in Herefordshire, England. This video, entitled "Rachel's Story", describes the life of Rachel Whitear up to and including the discovery of her body in her bed-sit three days after she had died, aged 21, from a heroin overdose. Despite criticism of the initiative as shock-tactics by professionals, the video received support locally and was sent to all secondary schools in the region for use with 14 to 16 year olds (BBC News 2002b; 2002c; 2002d).

Outside of these videos, the reality is that the vast majority of young people do not "succumb" to drugs, but rather they choose to use them (Section 1.3). Very few teenagers in mainstream education will ever experiment with heroin and the chances of dying from taking ecstasy or amphetamine are extremely small. DrugScope estimate that over 500,000 people take ecstasy every weekend in the UK and that there have been just under a hundred deaths from the drug in the UK over the past 15 years (DrugScope 2002d; 2002f). These videos therefore offer a one-sided view of the consequences of drug use, and do not reflect the experiences of most young people. This is worrying because as expressed clearly by Coggans et al., (1991), the provision of accurate information about drugs is essential to the credibility of teachers:

> Enabling teachers to be credible sources of information...requires the utmost rigour in examples of knowledge given within packages. The success of this crucial aspect of drug education was in some instances detracted from by examples both of misleading assertions about drugs and of opinion being presented as fact.
>
> [Coggans et al., 1991]

Previous studies in California (D'Emidio-Caston and Brown, 1998; Brown et al., 1997; Brown et al., 1995) found that as pupils got older they increasingly identified inconsistencies between the messages being taught in school and what they observed outside school. This cognitive inconsistency led to dissatisfaction with drug education that was often resolved by the pupils concluding that teachers were lying to them about the information that was provided (Section 1.4.4.d). There is a real risk of this happening in Scotland if these real-life scare-tactics continue to be used. As the relative danger of the drugs highlighted, such as ecstasy, is not accurately portrayed, such videos are unlikely to maintain credibility with young people who may know, or know of, many people (possibly including themselves) who have used it without adverse effect.

In addition to their impact on the credibility of drug education, it is the opinion of this author that stories such as those described above run the risk of perpetuating the tabloid-led campaign of fear in relation to drugs that fails to distinguish between different drugs and their varying risks and contributes to parental over-reaction to the use of any drug by their children. It is disturbing that although shown to be ineffective and long considered by many to be inappropriate (De Haes and Schuurman, 1975; Schaps et al., 1981), the use of scare-tactics continues both openly (Section 3.4.2) and under various guises in the schools studied in this research.

The emphasis on ecstasy and heroin in the drug education delivered in the case study school despite the fact that they were not widely used by pupils in the school (Section 4.7.3) may also be a consequence of the media's portrayal of drug issues. The most commonly used drug among young people in the case study school (as elsewhere) was cannabis (Health Promotions, 1998); others such as diazepam and cocaine were also considered common by some pupils (Section 4.3). In contrast, outside of the one police-led lesson on drugs to second year pupils, cannabis was not covered in detail with pupils; cocaine was only touched upon; and diazepam was not discussed at all (Section 4.7.3). Ecstasy was the central focus of drug education lessons in both fourth and fifth year. This focus on ecstasy seems disproportionate given that statistically, amphetamine, LSD and magic mushrooms are used by similar numbers of young people in the area and their use also carries serious risks (Health Promotions, 1998; DrugScope, 2003; Shapiro, 2003).

It is the opinion of this author that the most commonly used substances, both legal and illegal, should be given the greatest attention in schools, rather than those substances which are hyped by the media.

A considerable proportion of the third year drug education course focused, through the DrugWise Drug Free programme, not on drug information, but on a portrayal of the world of drug dealing and related criminal justice issues (Section 4.7.4). The package itself was out of date, making it a turn-off for some pupils (Section 4.8.1.d), but the relevance of its content was also questionable as most young people do not acquire drugs from a "dealer" as portrayed in the video, but from a friend or sibling (Sherlock and Conner, 1999). Young people who have experimented with drugs, or who may do so at some time in the future are unlikely to be able to relate to the scenario pictured in this video.

Much of the police-led lessons and the "Buzz" video used by the peer educators with second year pupils, focused on heroin use. While some schools may draw pupils from communities where heroin use and "drug dealers" are part of the culture, the average age for heroin use to begin is 17.5 years old (Pudney, 2002) and discussions such as these are therefore unlikely to be personally relevant to the vast majority of pupils in mainstream education. Resources that are used in lessons should reflect the reality of drug use and drug offer situations as they apply to the majority of young people in that school. Once the most relevant substances and information have been covered, issues surrounding less commonly used substances such as heroin, and the development of problem drug use, could then be addressed where considered relevant. The TACADE materials which were in use by many schools tend to be more balanced and comprehensive in their approach to drug education, and although some of them are rather old (e.g. Skills for Adolescence), they are more likely to be credible with pupils.

In most of the observed lessons, drug information was provided in an unstructured way: topics were discussed if pupils asked questions or following on from pupil comments but no structured or written information was provided (Section 4.8.1). Some of the information provided was of a somewhat sensationalist nature, designed to shock, entertain or persuade, rather than being based on a balanced perspective.

This was particularly true of the input of the police school liaison officer, who told many anecdotes, which though interesting and entertaining to listen to, were of varying educational value. Although pupils may remember the stories after the lessons, it was difficult to understand what purpose many of them would serve (Section 4.7.5). Despite the stories of the police school liaison officer, the police-led lesson was the only input in which any kind of structured and comprehensive information about illegal drugs was provided. Drug names, forms and origins, methods of use, prices and physical effects were outlined in detail in relation to heroin and cannabis (Section 4.7.1; Section 4.7.2). Although written materials were used as part of some lessons, no written information on drugs was provided to pupils in any lesson to take away for later referral or which might have covered drugs not dealt with in the lesson. At no stage were the different categories of drugs (stimulants/depressants/hallucinogens), legal classifications, short and long-term effects, and relative risks of the most commonly used drugs outlined clearly and comprehensively to pupils. In fact, where drug information was addressed in some detail by one teacher, a number of mistakes were made (4.8.2.b).

It is true that some of the pupils had already received drug education some years earlier in primary school, which may or may not have adequately covered the facts about drugs, but some pupils had not. Pupils are unlikely to retain any detailed knowledge from inputs years earlier and it would be useful to clearly establish the basic facts about each drug in advance of further lessons. In keeping with the life skills approach to drug education, it is important that schools firstly should provide pupils with objective and accurate information about the risks, benefits and unknowns of drug use from a variety of perspectives and secondly, equip them with the skills required to weigh up the risks and benefits of different courses of action, and to take responsibility for the consequences of their decisions. It is not possible to estimate from this research what life skills such as assertiveness, responsibility and decision-making were taught as part of the overall PSE programme in the schools studied, but there is no doubt that clear, comprehensive and unbiased information about illegal drugs was critically lacking in the case study school.

Although factual information should form the basis of any drug education programme, it is important that pupils are also given an understanding of broader issues relating to drug use in society. It is clear from the drama activities carried out with second year pupils, that their perception of illegal drugs and drug use was based largely on stereotypical images of down and out homeless addicts (Section 4.8.1.c.). There is a need therefore for education over and above facts and skills, to focus on the contexts and subtleties of drug use, and to tackle unhelpful stereotypes and attitudes. Where problem drug use is a feature of the local community, schools might want to focus on helping pupils to gain an understanding of the processes of addiction and overcoming addiction, to consider the effects of addiction on the individual and society and to examine their own and others' attitudes to drug users. As can be seen from this suggested list of learning objectives for drug education developed by the Australian Drug Foundation (2000), factual information is only a small part of a range of issues that impact on peoples understanding of drug use and related decisions.

Drug Education can assist Students to:
• gain accurate information about drugs and drug use
• appreciate the impact of drugs on society
• understand public policy issues posed by drug availability and use
• understand motives for use of drugs
• understand potential risks of drug taking
• consider strategies to reduce the demand for drugs within the community
• develop individual and social strategies to lessen drug problems
• identify future sources of information and assistance
• be active in reducing drug harms in their community

Table 6.1: Learning Objectives for Drug Education

The range of issues described in Table 6.1 is quite broad and it would take a significant amount of curriculum time to deal with each issue. It is not surprising therefore, that most of these issues were not mentioned by respondents in the interview study. It is clear from the case study school, that even information about drugs and drug use and the potential risks of drug taking, was not provided clearly and comprehensively.

Many of the resources that were most commonly used in schools, such as the Sorted video and DrugWise Drug Free materials did not address the broader issues identified above such as public policy on drugs, the impact of drugs on society or activity to reduce drug-related harm in the community. A great deal of further consideration is therefore required in planning curricula and selecting resources for school-based drug education.

6.4. DELIVERY

Respondents in this research reported that a variety of teaching methods were used to deliver drug education including classroom discussion, small group work, written work, videos and project work. Of these, teacher-led classroom discussion was very commonly mentioned and respondents reported that some teachers were still most comfortable with a "stand in front of the class" approach (Section 3.5.1). This approach was central to much of the teaching in the case study school and a number of problems were observed with it. These included unwillingness on the part of pupils to contribute to discussion, difficulties for the teacher in noting all pupil responses, and crucially, a failure to follow up or challenge the pupils' comments and questions (Section 4.8.1.a). This latter issue was not just observed with teacher-led discussions but also in the lessons led by the police school liaison officer and by the peer educators. This is unfortunate because pupils' comments and responses offer excellent opportunities to directly target and correct myths and misconceptions that pupils hold. In the drug education observed in this study, many of these opportunities were missed allowing the misinformation and myths to persist.

In addition to classroom discussions, videos were commonly used by schools in lessons, sometimes as triggers for discussion. This model of lesson was commonly used in the case study school where videos either followed or preceded classroom discussions. Some of the video packages such as DrugWise Drug Free also included sets of worksheets for pupils to fill in. These worksheets were usually filled in by individual pupils but were sometimes then discussed in small groups.

Although small group work was mentioned by the interview study respondents, in the case study school it was only used for a small proportion of the overall time devoted to drug education. It was not without its difficulties in that pupils did not always pay attention to the task in hand, or simply read out their answers without any discussion.

In terms of interactivity, there was some indication that the amount of discussion used in drug education may have increased in the years prior to the case study. Although older pupils spoke of little discussion and lots of written work; younger pupils seemed happy that there was lots of discussion (Section 4.8.1.a). This may have been an artefact of memory; however in the lessons observed during the case study, there was more class discussion than written work, which is an encouraging sign. Nonetheless, the level of interactivity across the board in the case study school was very low. There are two main criteria that were crucial in determining whether the observed lessons were interactive or non-interactive according to the topology of Toseland and Rivas (1984) (Section 4.8.1). These were the level of pupil to pupil communication and the level of pupil self-disclosure. Some of the small group work allowed pupil to pupil communication, but it was generally only for a small proportion of the lesson, or was only from reading, not actual discussion.

The small group work may have functioned better in other schools, such as in School 3, where co-operative learning methods were being introduced (Section 3.5.1). These methods involved setting each small group an overall assignment and assigning each group member a separate task that would need to be completed for the group to be successful in the overall assignment. Such carefully structured and directive work, with a requirement to feedback the overall outcome to the rest of the class, may help to increase pupil attention to the assigned group work and to promote communication between pupils. Although some respondents reported that there was not enough time or space to arrange desks for small group work, this issue was not present in the case study school. Class sizes were less than twenty pupils for PSE and classrooms were comfortable size. It is vital that the design of any new schools takes into account the need for non-traditional arrangements of furniture for interactive teaching methodologies and the influence that has on required classroom size. Apart from the small group work; videos, individual worksheets and classroom discussions involved largely passive participation, with very little pupil to pupil communication.

Drama-based activities were used in more than one way in schools. Some of the schools arranged for amateur theatre groups to work with pupils on PSE-related issues in the school, though this was not discussed in any detail or observed in the schools. In the case study school, the sixth year peer educators used drama with the second year pupils. They got them to make up plays about the impact of drugs on people families and society (Section 4.8.1.c). These were interactive, got the pupils communicating with each other and entailed a small amount of self-disclosure. Such methods therefore have a lot of potential, but they need further development as in this case the plays were very much based on the existing stereotypes held by pupils. The lessons may have been much more successful if these stereotypes were challenged and if the issues raised were discussed. Pupils could have been asked at a later stage to re-do the plays, with more positive outcomes for the characters. As with other resources discussed in the previous section it is not enough that pupils enjoy their drug education, it must also contribute to their knowledge and understanding of drug issues. Although unlikely to have been successful as observed, drama-based activities have great potential to make this contribution and to really engage with pupils in a truly interactive way. To achieve this potential however, the lesson would have to be carefully planned and the peer educators, teacher or other, would need considerable guidance and support.

The other key factor that meant that very few of the observed lessons could be considered interactive according to the above topology was that levels of self-disclosure during drug education were very low. It is clear from respondents both in the interview study (Section 3.4.5) and in the case study (Section 4.8.3) that self-disclosure was actively discouraged by teaching staff. Staff did not want pupils to discuss their own drug use in classroom situations, and pupils were aware that this was the unwritten rule. Although pupils were aware that they could go to guidance teachers with their problems, they did not know whether teachers would tell their parents or not. Teachers were unsure how to deal with admissions of drug use, as they couldn't be certain whether they were genuine or just "bravado" (Section 3.4.5). There were no clear guidelines for teachers on dealing with these situations, and admissions of drug use, though rare, were treated differently in different schools and by different teachers.

The interest and confidence of teachers of drug education was also variable, and the number and content of drug education lessons varied with different teachers, especially, it would seem, if they were "conscripted volunteers" rather than a team with ongoing responsibility for PSE (Section 4.8.2). These volunteers, known in the case study school as first level guidance teachers (FLGTs), were teachers who delivered PSE as an add-on to their own subject and the individuals involved varied from year to year depending on their subject commitments. More than one respondent expressed concerns about the quality of PSE delivery by these teachers, some of whom were neither interested nor comfortable with the topics (Section 3.5.2.b; Section 4.8.2.a.). It is clear from the case study school that neither these teachers nor the subject of PSE were taken seriously by the pupils and that the lessons were, by necessity, inflexible and based primarily on videos and worksheets, rather than discussion (Section 4.8.2.a). Sometimes PSE lessons were used by FLGTs as an opportunity to get some of their own work done, while letting the pupils do their homework rather than deliver the prescribed lesson. For all of these reasons, it was decided in the case study school to move to a system where PSE was delivered only by the six full-time guidance teachers. Although one or two of the guidance teachers were less than happy with the move from a personal point of view, all agreed, including the pupils, that the quality and consistency of lessons had improved (Section 4.8.2.a).

Dedicated delivery by the guidance team potentially allows the experience and expertise of this small team to be built on and is likely to result in improvements in delivery over the years as the team gets more and more comfortable with the subject. It seems likely too, that the credibility of the subject with pupils would be increased if teachers were more experienced and comfortable. Even with a dedicated team, adequate support, preparation and training would still be essential to facilitate a constructive planning process and to ensure accuracy, consistency and relevance in the topics that are delivered as part of the programme. Training is also important because, as many studies have shown, the drug education delivered is likely to diversify significantly from what is planned unless teachers are trained appropriately (Dane and Schneider, 1998; Ross et al., 1991; Perry et al., 1990). Unfortunately, training provision in the schools studied in this research was minimal (Section 3.5.2.c; Section 4.8.2) and teachers reported difficulties with some issues.

The use of external agencies was common among all schools included in this study (Section 3.5.3; Section 4.8.2) although the nature of their inputs varied widely. In the cases of Paul Betts, Narcotics Anonymous, Calton Athletic and drama groups, the inputs tended to be one-offs, involving large numbers of pupils, but only delivered once every year or even every two years. In the cases of Health Promotions, Grampian police, and delivery by school nurses, the input was more likely to be timetabled into the annual curriculum and therefore more sustained. There were a number of advantages perceived by respondents to the use of external agencies. These included a sense that external agencies were more credible to pupils, were more flexible in their methodologies and were less restricted in dealing with difficult issues (Section 3.5.3). Pupil also reported that they found the police input to be more credible than that of their regular teachers (Section 4.8.2.c).

There were some disadvantages to the use of external agencies however. Some of these agencies delivered a message that focused particularly on the negative consequences of drug use: Paul Betts and the inputs of recovering addicts such as from Calton Athletic and Narcotics Anonymous in particular. As with some of the resources described in the previous section, focusing on these kinds of real-life horror stories is of questionable value, as it borders on scare tactics. There were other concerns about the appropriateness of Paul Bett's input, his language and attitude to teachers was offensive to some respondents (Section 3.5.3.d) and was unlikely to enhance the credibility of teachers with pupils. This offence and indeed other concerns could have been avoided, had schools routinely met with outside agencies in advance to review materials, ensured integration into the existing programme, and set out ground rules (Section 3.5.3). This did not appear to be common practice in any of the schools in this study, neither for one-off inputs from new agencies nor for regular inputs from well-known bodies (Section 3.5.3).

There was little evidence in this study that outside agencies were employed as substitutes for regular curricular input by classroom teachers however it was common for teachers not to be present during inputs (Section 3.5.3). This goes against the advice of the School Drug Safety Team (Table 1.5) and makes it difficult for the teacher to address any issues that arise in the course of the input or to ensure ground rules are being adhered to.

In some cases difficult issues like harm reduction were left to outside agencies to deliver. This may have been due to a lack of confidence on behalf of some teachers however such topics were sometimes seen as inappropriate for classroom teachers to cover but okay if outside agencies did it (Section 3.4.4). This is an inconsistent approach that avoids dealing with the real issue of whether or not the school supports the provision of such harm reduction information. It is understandable that schools are concerned about parental reactions to such provision but if it is approved of as an approach by the school, the messages should be incorporated into the curriculum as a whole and teachers should be appropriately trained and supported. It is the opinion of this author that failure to do this, allowing the delivery of controversial topics only by outside agencies, is likely to further perpetuate the perception among pupils that teachers are a less credible source of information on drug issues.

Although peers were little used in the schools in this study, the observed peer education programme in the case study school suggests that peer-led drug education has the potential to be more interactive and involve more open discussion, than that led by classroom teachers. The effectiveness of peer-led programmes in the Scottish context has been little studied, however pupils reported being better able to talk to them, and the peer-led lessons were among the most interactive observed (4.8.2.d). Like some of the case study drug education teachers, however, the peer educators were lacking in expertise, and unlike the teachers they also lacked experience and skills in classroom-management techniques. The few hours of training that were provided in the case study school were woefully inadequate, and this was noted by the sixth years themselves who became somewhat disheartened or in one case, quite upset. Considerably more training and support would have to be provided for the peer educators before they would be competent to manage the classes and deal with arising issues. An example of the training provided to peer educators in one US peer-led smoking prevention programme is described in this quote.

> All of the peer leaders attended an initial 4-hour training workshop designed to familiarise them with the various aspects of the curriculum and to clarify their responsibilities. Each peer leader was given a Teacher's Manual which provided detailed lesson plans for the entire programme. In addition, 1-hour briefing sessions were held at the beginning of each week in order to review the material to be covered in the upcoming session (as described in the lesson plan) and to discuss problems encountered during the preceding session.
>
> [Botvin and Eng, 1982]

Such training along with adherence to good practice criteria such as those described in Table 1.6, would go a long way to resolving the difficulties encountered in the case study school and would help the peer-led programme in the case study school to realise its potential. It would also, however, require a considerably greater level of commitment in terms of both time and resources by the school, its staff and pupils and by outside agencies. Further research is required both to determine if the perceived advantages of peer-led drug education programmes are measurable in the Scottish context and if so, to identify how the programmes can best be implemented in Scottish schools.

6.5. Key Issues: Goals, Time, Priorities, and Expertise

It is clear from this chapter that the drug education that was being delivered in the schools in this study was some way short of the guidelines for best practice outlined in Chapter 1 and summarised in Table 1.9 which is reproduced overleaf.

The quality of provision fell short despite the fact that respondents felt that drug education was a high priority, and that they were sincere in their efforts to protect pupils from harm. The peer educators and police-school liaison officer also put considerable effort into preparing and delivering their lessons, and were genuinely interested in achieving a successful outcome. In the case study school, the priority attached to personal and social education is clearly illustrated by the decision by the guidance team to virtually give up teaching their principal subjects, in order to be part of a dedicated team for teaching PSE. This was done because they were not happy with the quality of the previous delivery, despite the impact it might have on their career prospects. The case study school was originally selected for interview because it was one of the more innovative schools for drug education in the region, and PSE class sizes were small with no more than about twenty pupils per class (Section 2.5.2; Section 5.3.2). In the interview study too, there was a selection bias towards schools with better provision (Section 2.4.6; Section 5.3.1). It is important therefore to consider why the drug education described in these schools fell so far short of best practice.

Best Practice in School-Based Drug Education
Policy and Planning: Goals, objectives, methods and the theory behind the programme should be agreed in advance by the school (including classroom teachers and senior staff), pupils, parents and the community, and expressed explicitly in a policy document open to all for inspection. Pupil knowledge, attitudes and behaviour should be established and considered in advance as well as social, developmental and cultural factors.
Development: A process of feedback, assessment and evaluation should be in place to allow continuous updating and development of the programme and to encourage a wider feeling of ownership of the programme. This process should include staff, parents, pupils and the community and should take account of the latest research, national guidelines, and initiatives. Evaluation should focus on whether, how, and why the original goals of the programme are being achieved or not.
Time and Resources: Adequate resources should be decided and secured in advance including curriculum and staff (or deliverer) time, external agency input, classroom materials, venues for parent and community involvement and funding for training of deliverers and evaluation of the programme.
Curriculum: To maximise impact on drug use, the curriculum should be intense and comprehensive including accurate, credible and unbiased information, normative education, skills development and components which involve families and the community. Although planned in advance, it should be sufficiently flexible and include specific strategies to ensure that the needs of different groups can be met. The programme should continue throughout each child's school career.
Delivery: Delivery should be led by carefully selected classroom teachers who are knowledgeable, comfortable and confident, complimented by the involvement of peer educators, the police service or other groups/ individuals as appropriate and feasible given their expertise and experience. It should be primarily based on interactive teaching methods with pupil to pupil discussion of attitudes, views and experiences in small group settings. All deliverers should be comprehensively trained and receive ongoing support.
Environment: The programme should be integrated within a broader programme of personal, social and health education, supported by a positive school ethos emphasising honesty, trust and respect, within a safe, secure and stimulating environment that encourages the health and wellbeing of all. A clear and inclusive system should exist for pupils who need extra support, help or referral.

Table 6.2: Best Practice in School-Based Drug Education (see Table 1.9)

It is the opinion of this author that there are a few key issues that limited the quality of the drug education that could be delivered in the studied schools. These issues will be considered below and are listed overleaf.

(i) A lack of clarity and understanding about the goals of drug education.
(ii) A lack of time and support for researching, planning and reviewing drug education.
(iii) A low priority assigned to Personal and Social Education (PSE) in general.
(iv) A failure to recognise drug education (and PSE) as broad and complex subjects that require considerable expertise to plan, deliver and teach.

These four issues are not dissimilar to those found in previous reports and studies both in Scotland (School Drug Safety Team, 2000; Lowden and Powney, 2000; Coggans et al., 1991) and abroad (Pateman et al., 1999) which are described in Section 1.4.4.c.

(i) Goals of Drug Education

The importance of providing teachers with clear, realistic aims and objectives for drug education which are regularly monitored and evaluated was highlighted by the School Drug Safety Team (2000). They also recommended that drug education should take full account of the issues and viewpoints in modern society and the realities of drug sue as viewed by young people themselves. Lowden and Powney (2000) noted the actual content and style of lessons in schools was influenced by teachers' attitudes and understanding concerning the aims of drug education. In this study, almost all the schools agreed that "informed choice" was a central concept in their drug education, the concept was more elusive than at first appeared from this assertion. There was a worrying lack of objective, comprehensive and accurate information provided in the case study school, and many schools continued to use resources that owed more to scare-tactics than to balance. In fact, as described openly by some respondents, the goal of drug education was to provide pupils with information in the hope that they will then choose not to use drugs. In practice this meant that the information provided was biased and incomplete and therefore choices made by pupils could not be fully informed. The ultimate goal was therefore not informed choice but rather prevention of drug use.

Drug use was viewed as an entirely negative choice and the education therefore focused on the risks associated with drug use, lacked openness about enjoyable aspects of use, employed persuasion (or sometimes even scare) tactics, and featured a reluctance to admit that some drug use can be fairly harmless for many people.

At the heart of this approach is a failure to be open, honest and objective about the genuine and very real risks, but not inevitable consequences, of drug use. Choices that are made based on this kind of drug education are therefore unlikely to be truly or comprehensively informed and as shown by other studies, pupils will be quick to spot the inconsistencies of the approach (D'Emidio-Caston and Brown, 1998; Brown et al., 1997; Brown et al., 1995).

Drug education that was focused on helping pupils to make truly informed choices would need to have at its heart, honest, comprehensive and accurate information about the risks and enjoyable aspects of drug use. This focus is central to both the harm reduction approach to drug education (Watson, 1991) and to Evans' (2002a) argument for drug education that truly has education as its central goal, rather than any behavioural outcome. In order to genuinely promote informed choice, educators would need to acknowledge that many pupils do choose to use illegal drugs and that for some of them this will be an informed choice. In other words, some pupils will decide that a certain level of drug use or experimentation is right for them at a particular time even though they fully understand the facts and potential consequences of their choice. Acknowledging that choices to use drugs can be made even when pupils are fully informed leads to the argument that pupils should be taught how to minimise the risks of any problems occurring with such use.

When examined reflectively therefore a truly informed choice approach to drug education leads to a need to be open and honest about harm reduction as well. This is likely to be at the heart of the failure of schools in this study to deliver on informed choice as many objections were raised by respondents in relation to the provision of harm reduction information. These objections relate to the appropriateness of this kind of information at classroom level and particularly to concerns about the reaction of parents and the possibility of being seen to condone drug use or encourage pupils to use drugs. The issue of appropriateness arises due to the lack of clear guidance or policy on this kind of information at local authority level and could be relatively easily resolved if other concerns could be adequately addressed. In relation to parental reaction, studies in Australia have shown that if adequate time and attention is given to communication with parents and discussion of their issues and concerns about harm reduction, that a certain level of comfort with the approach can be reached (Midford et al., 1998).

A large majority of parents in these Australian studies approved of a harm reduction approach during secondary school, particularly in relation to alcohol (ibid). If an informed choice approach, including the provision of harm reduction information is to be adopted by schools, considerable extra time is likely to be required for educating and communicating with parents. The issue of time is discussed further below.

Further concerns were raised by teachers about being seen to condone drug use. The issue of "condoning" drug use implies that drug use is something that is implicitly wrong, and should not therefore be tolerated. In contrast, if the spirit of informed choice is taken on board, drug use is not necessarily considered a "wrongdoing" and is therefore neither condoned nor condemned. In fact, as outlined by the report of the ministerial drugs task force, "Drugs in Scotland – Meeting the Challenge", harm reduction information should be provided within a framework message that there are always risks associated with the use of both legal and illegal drugs, and making it clear that while the risks can be reduced, they cannot be eliminated altogether. Although this report does not address the settings in which such "harm minimisation" information ought to be provided, it clearly acknowledges that such information has a legitimate role as it would be "foolish" to pretend that drug taking does not take place.

> In appropriate circumstances it seems to us that harm minimisation has an important part to play in the prevention and education effort. For example, it seems to us right that health education campaigns should explain, in appropriate terms, how needles can best be sterilised or how those attending "raves" can minimise the risks of Ecstacy use, through drinking soft drinks and "chilling out". We believe therefore that in the prevention and education fields, harm minimisation is a legitimate approach. This is not to condone drug taking but simply to acknowledge that it would be foolish to pretend that drug taking of this kind does not take place; and therefore the pragmatic response is to provide information and advice about minimising the risks. However in applying the harm minimisation approach, the risks involved in drug misuse should never be under-played and the message that abstinence is the only risk-free option must be emphasised.
>
> [Ministerial Drugs Task Force, 1994]

The list overleaf illustrates messages that could in the author's opinion form part of a drug education programme based on objective information and reduction of overall harm.

- All drugs, legal and illegal, carry risks regardless of how they are taken.
- The risks of drug use can be reduced in various ways, but never eliminated.
- Although more research is being carried out all the time, for many illegal drugs the short or long term health risks are not known for sure.
- Illegal drugs can be more risky than legal ones because their exact content cannot be known to the user, and their effects therefore are somewhat more unpredictable. In addition, users run the risk of legal sanctions if apprehended which could have implications for their long term prospects.

This list is not exhaustive but illustrates that harm reduction messages can sit within a drug education programme without promoting drug use. In fact, in an informed choice approach drug use is neither promoted nor condemned, but the learner is encouraged to consider the overall harm resulting from their choices. This is not dissimilar to the moderate philosophy of harm reduction outlined by Lenton and Single:

> The true champion of harm reduction is not necessarily anti-drugs; nor necessarily pro-drugs. He or she expresses support, opposition or indifference to a proposed public or personal health approach or a proposed legal or social response solely on the basis of the extent to which it increases or decreases the amount of harm consequent upon the drug in question. A pre-determined position on drug use as intrinsically "bad" or "good" has no meaning in this context, where the response is determined solely by the extent of observed or anticipated harm which results from the drug use. Thus the champion of harm reduction is neither for nor against increased civil rights for drug users; neither for nor against the increased availability of drug substitution programmes or drug-free programmes; neither for nor against the legalisation or decriminalisation of drug use; neither for nor against diversions from the criminal justice system - except insofar as one or other of these choices influences the nature and extent of harms consequent upon use.
>
> [Lenton and Single, 1998]

Pupils could be taught that some ways of using are more risky than others, and that there are some things that they can do to reduce risks. However there is more to harm reduction than simply focusing on drinking water or chilling out.

Pupils could be taught to understand the risks/benefits of using in different situations, settings, with different people, in different moods, different amounts and patterns of use. They could learn how to recognise a change in their use or another person's use from recreational to problem use to dependent use, how best to help others and what steps they can take to ensure that they do not develop problems with illegal drugs or become dependent on them. Indeed, as Beck (1998) explains, for some people harm reduction may mean never using drugs at all:

> Drug education programmes should focus on preventing problems associated with drug use. For some students, that may mean the ability to develop decision-making skills that lead them to avoid alcohol, tobacco, and illegal drugs completely; for other students, that might mean being more careful than they previously were when experimenting with substances; for others that might mean making the decision to get help for a substance-abuse problem.
>
> [Beck, 1998]

It is quite likely that pupils of different ages and experiences would benefit from drug education with goals and strategies tailored for their specific stage and needs. It is difficult for schools to single out pupils or groups of pupils for special inputs, and in some cases can be detrimental (Williams, 2003). The issue of tailoring specific education or prevention inputs to particularly vulnerable or at-risk groups (Section 1.4.4.d.) for whom the more extreme consequences of drug use may be more relevant was not addressed in detail by this study and is an important area for further consideration. Some level of tailoring could be achieved however by adjusting provision as pupils move through the school, and the goals of drug education should also shift as pupils grow older. For example, a prevention-oriented programme for illegal drugs may be appropriate in S1 but might well lack credibility with pupils beyond that stage. In other secondary schools, a harm reduction goal may be appropriate even for S1 pupils.

It is clear that drug use continues to rise in young people right up until they are in their twenties (Section 1.2) and it is vital that provision in schools does not fall away in S4, S5 and S6 as these older pupils are the ones who are most likely to be actually using substances. It is difficult for schools to make judgements as to what is appropriate for their pupils without adequate and accurate information on pupils' behaviour that is specific to their school.

In Grampian, however, such information was collected through the youth lifestyle surveys (NHS Grampian, 2002) and provided to individual schools. Unfortunately, there was little indication in this study that it was used by teachers. Possible reasons for this are discussed below.

Harm reduction information such as that described above is not at all taboo in relation to alcohol, because the use of alcohol by teenagers is openly acknowledged and to a certain extent accepted by schools (and possibly society). This is unlikely to be the case for primary school pupils, and judging from the comments of respondents in this study, the use of drugs, even by secondary school pupils has not in any way reached the same level of acceptance. This lack of acceptance prevents the provision of this kind of information for illegal drugs, regardless of whether it is provided under the label of "harm reduction" or "informed choice" (Section 3.4.5, Section 4.8.3). It is also clear that teachers did not feel sufficiently trained or informed to be able to deliver these kinds of messages about illegal drugs and this would have to be resolved before drug education could be said to be based on stimulating true informed choices. The issue of teacher training is discussed further below.

The only remaining objection to this kind of approach to drug education, including provision of objective, balanced information designed to promote truly informed choices and minimise harm, is the concern that such an objective stance will result in increased numbers of pupils experimenting with drugs. There is no doubt that this is possible, especially considering the reported outcomes of some information-only approaches to drug education in the 1970s (Berberian et al., 1976; Kinder et al., 1980). It is not clear however that an increase in the numbers of people experimenting would in itself necessarily increase overall harm, especially if it was accompanied by improved understanding of how to recognise and reduce risks, dependence and other drug-related problems. In other words, the real issue is not if the numbers using increase, but the impact on overall harm resulting from this kind of approach. This question remains unanswered and is likely to be a significant barrier to this kind of drug education until it is resolved either way. Further investigation of the concept of informed choice was recommended in 1991 (Coggans et al.) and is still required to elucidate the issues and implications of adopting drug education based truly on this approach.

Future drug education outcome studies are required to determine the effectiveness of as harm reduction education and/or the informed choice approach to drug education in reducing the overall harm caused by drug use.

(ii) Time

It is proposed here and elsewhere (see Section 1.4.4.c) that the quality of drug education depends at least in a good part on each school's ability to spend time considering existing provision, access the expertise required to recognise weaknesses and propose improvements, and to source resources to effect changes where required. Due to time pressures (Section 3.3), staff reported that it was difficult for them to have adequate time to read and review the latest statistics, information, new resources or guidelines that would inform their decision-making. This showed clearly in the fact that many staff were unfamiliar with or did not make any use of existing national guidelines or local figures for drug misuse. Many schools were unable to demonstrate a clear, up to date plan for drug education and as was seen in the case study school, teachers' own knowledge of emerging issues was sometimes lacking or incomplete (Section 4.8.2). In addition to time for keeping up to date, considerable time would also be required if schools were to involve and consult parents, pupils and the local community more actively in planning, developing and delivering on drug education and related initiatives. In this study, schools did not involve these stakeholders actively, and time was often the reason given for the omission.

There were two main explanations given for the severe time pressure staff found themselves working under. These were the expectation by society/government that more and more topics would be covered as part of personal and social education in schools (Section 3.3.1), and the difficulties associated with a policy of social inclusion for pupils with a wide range of problems and abilities (Section 3.3.2). The first of these explanations was the most commonly cited. Respondents expressed frustration at the increasing number of topics that they were expected to cover without any increase in preparation or curriculum time. Topics that were considered relatively new by respondents included mental health, citizenship and parenting skills, and these were expected to be delivered in addition to the more traditional PSE topics of nutrition, sexual health, road safety, careers, tobacco education, and personal hygiene among others.

As some respondents perceived the situation, schools were expected to provide the solution to many social problems through personal and social education (Section 3.3.1).

The increasing number of topics put pressure on both curriculum and staff time. Although it was clear that every topic that arose could not be comprehensively covered in the curriculum time available, some schools did not see it as a problem (Section 3.3.3). In reality, different topics were prioritised at different times, or the time for each topic shrank as more were added in (Section 3.3.1) and the PSE programme changed constantly. Although this made it difficult to cover topics adequately, a far more crippling issue was lack of any extra time for staff to research, plan and prepare for the delivery of all of these extra topics.

The issue of inclusion was also raised by a number of respondents. Many of the staff to whom the author spoke were guidance teachers and it was their role to provide pastoral care to caseloads of up to 250 pupils in the schools, in addition to any PSE delivery commitments. Respondents felt that adequate support was lacking to help them to manage large case loads and provide for pupils who in the past would not have been in mainstream education, either because of special needs or because they would have been excluded for their behaviour. Coping with the needs of these pupils put a lot of pressure on staff and although they agreed with the principle of inclusion, some openly admitted that they simply did not have the time, skills or expertise to deal with the complex problems that arose. Current provision levels were simply not considered adequate and respondents then struggled to find time to plan, consult and develop PSE topics such as drug education or to monitor PSE teaching quality (Section 3.3). This is a worrying finding. If schools are going to be able to adequately provide for all pupils, it is vital that adequate supports are put in place. More "adult bodies" are necessary both in and outside school for pupils who were not coping – "specialist provision" with the necessary expertise such as social workers, counsellors and psychologists. It remains to be seen if the roll-out of the new community school model including on-site providers of these kinds of services will ameliorate the problems described in this study.

(iii) Priorities

It was apparent from the comments of some respondents and during the case study that as a subject, personal and social education was assigned a low priority. Respondents admitted that it was the first lesson to be cancelled to make way for meetings or events, and that this was picked up on by pupils many of whom then failed to respect it as a subject. This was also found by Pateman et al., (1999) in relation to health education in US schools, who reported that it was not treated with the same priority as other subjects. In this study, there was a sense in the case study school that though the school was well-resourced generally in terms of IT and audiovisual equipment, this was not made available for PSE lessons, as it was not prioritised sufficiently. It is not known why this is the case though some suggestions can be made. It may be that schools prioritise exam subjects because attainment is closely monitored by the authorities and HMI, as well as being publicised by the media in so-called "league tables". On the other hand, PSE is only briefly mentioned in HMI reports and good PSE provision has no impact on a school's position in the league tables.

The value of such league tables is questionable, as they also fail to consider issues such as funding, ethos and management, and they have been scrapped in both Wales and in Northern Ireland (BBC News, 2003a; 2003b; 2003c). When the figures for 2003 were published, the whole idea of league tables was heavily criticised as taking no account of deprivation, focusing too narrowly on exam results, and working against the idea of social inclusion (ibid). Parents do need information about schools in order to inform their choices for their children, but it is very questionable if league tables are the best way to provide that information. It is the opinion of this author that further work is necessary to establish objective, acceptable measures of school performance in addition to exam results, taking into account social inclusion concerns. It would also be valuable to investigate how best this information could be presented and disseminated to parents and other interested parties.

The role of HMI in stimulating improved quality in drug education (and PSE) practice in schools has not yet been maximised, in the view of this author. It is clear from comments by respondents that notice is taken of inspection reports (Section 3.3.4; Section 4.4), however they contain very little emphasis on drug education or even health education in general (Section 4.2).

If these topics are not assigned priority by HMI, then it is not surprising that schools may also de-prioritise them. At the time of writing HMI were conducting inspections specifically on the quality of drug education programmes in schools and it is clear from personal communications of the author with schools that a visit from HMI was a sharp stimulus to "get the drug education into shape!" It is therefore a recommendation of this thesis that each aspect of drug (and health) education, including planning, development, content and delivery, should be examined in depth during every HMI inspection and carefully compared to existing guidance on best practice. Each school's inspection report should address these topics in detail and make recommendations for required change or improvement.

The Scottish Executive Education Department's annual survey of drug education in schools could also potentially be used as a stimulus for improved quality of provision in schools (Scottish Executive, 2002b). This opportunity is currently missed as the survey is a tick-box exercise that mainly considers whether or not schools provide progressive drug education to all pupils and fails to focus on quality in any meaningful way. Each year when the results of the survey are published, the high figures for provision across the country are warmly welcomed without any mention of quality assurance (BBC News, 2001; Scottish Executive, 2002c). This creates the false impression that all is well with drug education and allows schools and local authorities to be complacent about quality, provided "the box is ticked". On the other hand an in-depth audit which asked difficult questions about adequate planning and development time, pupil and parent consultation, and teacher expertise and training could really stimulate schools to think about these issues and improve their provision. It would seem wise to carefully re-consider the content of this survey or risk accusations that the failure to consider quality issues might be due to the less than perfect figures that might emerge.

The school drug safety team report recommended a review of the place of PSE within the school curriculum to consider giving formal recognition to the status of PSE teaching. This recommendation is further endorsed by this author.

(iv) Expertise

Resolving the issues of goals, time and priorities as described above, would not be sufficient to bring drug education in line with best practice, without further input to enhance the expertise of those planning and delivering it. For example, in many schools further pupil consultation had not ever been thought about or considered (Section 3.2.4). This illustrates that even if teachers had more time for planning and development, they may not necessarily be aware of how best to move forward. The existing increases in levels of monitoring of drug education (Lowden and Powney, 2000), such as by means of pupil questionnaires, sometimes seemed to be because school staff sensed that this was increasingly expected of them, rather than because of a genuine appreciation of any benefits derived from the practice. In fact, many staff questioned the value of pupil questionnaires but needed to be prompted to consider alternative methods of pupil consultation (Section 3.2.4). This suggests that, in addition to adequate time, the planning process for drug or indeed health education needs a certain level of experience and expertise that is currently lacking in some schools.

This lack is further illustrated by the fact that the content of drug education in the case study school was poor (Section 4.7; Section 6.3) and as well as teachers' own knowledge being incomplete (Section 4.8.2.b), many failed to correct or adequately develop comments made by pupils (Section 4.8.1.a). In addition to guidance on the informed choice approach and difficult issues like harm reduction, teachers need to be trained so that they can routinely and automatically pick up on comments made by pupils and develop discussion around those comments. They also need to be aware of key points of information, or often misinformation, about each of the most commonly used drugs, and be able to identify opportunities in pupil feedback to teach about these key points. These skills require considerable expertise and experience that must be developed either within schools, or made available to schools from outside.

It would be helpful for schools drug education provision to be supported and facilitated by outside professionals who could act as sources of expertise and as links to resources and other organisations. Such support could be in the form of a health education advisor at the local authority or in the local health promotion department or preferably both – working together. In fact, it is likely that a team of such advisors would be required to provide adequate support for all health education topics to every school.

It may be that these advisors would need to work with head teachers and with the local authority as well as directly with schools, to ensure that health education is prioritised appropriately. It is the responsibility of local authorities to take the lead in ensuring that schools have access to this level of support, although it would be helpful if the Scottish Executive took responsibility for investigating the most appropriate and effective models of support. A model of this kind is currently being devised and considered in Grampian (Tuckwood, 2003) and it is the opinion of this author that it should be carefully described and evaluated at each stage of development to determine its effectiveness and to inform initiatives in other regions.

In the schools in this study, many teachers had not received any specific training on drug education within some years prior to the interviews (Section 3.5.2.c). Since the case study was completed, a national initiative to train secondary school teachers on drug-related issues has been rolled out by Scotland Against Drugs and this will provide opportunities for many staff in Grampian. Every teacher that is responsible for delivering drug education lessons could benefit from training and this is a welcome initiative. Unfortunately however, it is a one-off input that does not provide for any ongoing or sustainable training and the onus falls back onto each local authority to follow up any issues identified during the training course and plan future training and support measures. Local authorities must take this responsibility seriously and it is not an easy task.

In many authorities it is difficult for schools to find the resources and cover staff necessary to allow their teaching staff to be released for training courses. In some cases, it may be necessary to organise evening, weekend or summer courses to facilitate teachers. As the McCrone agreement (McCrone Committee, 2000; Scottish Executive 2001c) on teaching conditions is put into practice, teachers will be obliged to engage in professional development outside of their normal working week, so these out of hours courses are likely to become more common. When considering training, the model of delivery of PSE in a school becomes paramount, especially if the delivery is by so-called first level guidance teachers as described above. This means that rather than a small team of teachers delivering a large number of PSE lessons, a very large number of teachers each taught small sections of the PSE programme over the years.

This latter model of delivery spreads the perceived "burden" of PSE across many teachers, but it raises a number of issues for the quality of the programme. Firstly, it means that there is a much larger number of teachers who require training on PSE issues and it is unlikely that schools will be in a position to release those staff for specific in-service training on health topics. Secondly, as the staff delivering the programme vary from year to year, the value of any training provided is diminished, as a teacher trained in drug education one year, might not be involved in delivering that subject the following year. Although one way to help to counter these problems might be to provide intense training within the school to the FLGTs prior to the lessons on each topic within the PSE programme, this simply did not happen in practice. Instead, many teachers delivering PSE were "neither interested nor comfortable" and they expected to be able to pick up PSE lesson plans and "run with them" with a minimum of preparation time and effort, and were often struggling with or simply avoiding any difficult or sensitive issues. This is simply unacceptable and it devalues the whole subject of personal and social education to pretend that teachers should be able to teach it without adequate training and preparation.

A small dedicated team of PSE teachers is much more manageable when it comes to training – it may even be possible for the whole team to be trained together over a summer course, or during study leave times when there are less demands on staff. Delivery by the dedicated guidance team in the case study school clearly improved the quality of provision over and above the previous situation. It must be remembered however that drug education is only one of an increasing number of sensitive and complex topics that are taught as part of PSE and for which staff would need to be trained. In fact, if each of these topics was to be covered by just two days of training every couple of years, a huge commitment would still be required to keep even a small, dedicated team of staff up to date on all topics. For many schools that still expect virtually all staff to be able deliver PSE with a minimum of commitment and training, moving to delivery by a dedicated team would be a huge step forward and would undoubtedly benefit both staff and pupils. It is likely that the development of the new community school model will see more professionals on-site in schools with the expertise to help with training PSE teachers, as well as providing schools with support to meet the emerging social needs of pupils and their families. Such opportunities for multi-disciplinary working are valuable and should be maximised. In the long term

however, it is still difficult to expect teachers whose principal subject might be english or geography or maths to keep up to date and sufficiently expert on topics such as drug education, sex education, mental health etc. even with a couple of days training every couple of years.

It is suggested here that the level of training and education required may ultimately be beyond that which can be delivered in a couple of days per year of in-service training. In the long term, drug education and indeed personal and social education in general may be best served by having teachers who are qualified specifically in PSE and are responsible for teaching only PSE in schools. The background expertise of such teachers and resulting credibility with other staff, as well as with parents and pupils would all lend to a significant improvement in the quality of delivery in schools. The idea that PSE is any less complex or important than any other subject taught in schools cannot be supported long term. In the opinion of this author, PSE should be accorded the same status as any other subject, be taught by teachers with accredited qualifications (in PSE), whose efforts would be recognised and rewarded within an established career structure as suggested by the School Drug Safety Team (2000). It would take time and effort to develop such qualifications and to support the changes in schools internal structures that would result. This must be investigated as a positive step towards achieving top quality drug education in secondary schools.

Chapter 7. Conclusions and Recommendations

The aim of this research was to carry out an in-depth study of policy, planning and practice of drug education in secondary schools in Grampian, Scotland. To achieve this aim a two-part study was conducted involving interviews with staff in nine secondary schools across the region and a detailed case study of drug education in one selected school. Although the focus of this fieldwork evolved as the research progressed, the issues identified in Table 1.12 (reproduced here for convenience) were addressed and considered in detail. Over the course of the fieldwork the author gained in understanding of drug education in schools as well as the qualitative methods used. This final chapter draws together and summarises the main findings and recommendations which emerged from this study both in relation to the methodology used in the study and to the issues in the table below.

Research Issues
General
How does drug education compare to the criteria laid out in research findings (Section 1.4) and in national and local guidelines (Section 1.5)?
What facilitates and hinders best practice in drug education?
At what levels of drug education is there any parent, family or community involvement?
Policy
What policies exist at school and local level for drug education and how are they developed?
Who and what influences school decisions on drug education?
How do such policies and influences affect ongoing drug education practice?
Planning
How is drug education planned and organised both at programme and individual lesson level?
How do schools identify and/or take into account pupil needs and experiences?
What do schools and staff identify as the goals of drug education?
How is drug education monitored or evaluated by schools?
What feedback mechanisms are in place in relation to drug education?

Practice
To what extent is drug education delivered as planned?
What approaches, messages, lesson content and resources are used in drug education?
Who delivers drug education in schools and what training do they receive?
How does delivery vary between different deliverers, pupils and schools?
What teaching methods and group processes are used in drug education?
What level of openness and confidentiality exists in classrooms when discussing drug use issues?

Table 7.1: Issues Considered in this Research (Repeat of Table 1.12).

7.1. METHODOLOGY

7.1.1. Prior to this study, drug education in secondary schools in Scotland had not been examined or recorded in the depth and detail allowed by a purely qualitative process. The qualitative nature of this research facilitated a deeper insight into the practicalities and realities of the delivery of drug education in secondary schools than could have been obtained by a quantitative study.

7.1.2. Previous studies of drug education in Scottish schools used primarily quantitative methods and focused on measuring the outcomes of drug education. Such evaluative studies are essential to judging the success or otherwise of drug education programmes and as such must be ongoing. However it is suggested here that future outcome studies should seek to determine the effectiveness of different approaches to drug education in reducing the overall harm caused by drug use, rather than focusing on how many young people use drugs and how often. The current lack of such outcome studies appears to be a critical gap in the drug education literature.

7.1.3. In addition to or in combination with the above outcome studies, qualitative research studies such as this one must also be supported and implemented on an ongoing basis as they are essential to explaining *how* and *why* drug education may or may not achieve the desired outcomes.

7.1.4. The position of the researcher as an outsider to the schools with no connection to the local authority or HMI allowed her to operate from a position where she held no power over respondents. This is an important factor that enhanced the internal validity of the findings. The implications of this issue of power for the validity of information obtained in HMI inspections of drug education in schools need to be carefully considered.

7.1.5. Future qualitative studies of drug education may best be conducted by researchers acting independently from, but actively supported by, local authorities and/or HMI and ensuring the confidentiality of schools and respondents. In this way, local authorities could use their influence to encourage schools to give a high level of commitment to the research but without undue compromise of internal validity.

7.1.6. In this study, the researcher employed many quality assurance steps and procedures to enhance the validity and reliability of the findings, along with constant vigilance to ensure that each emerging theme and description was truly grounded in the data. This fastidiousness and vigilance enhances confidence that the findings in this thesis closely reflect the reality of drug education in the schools studied over the period of fieldwork (November 2000 to January 2002).

7.2. School-Based Drug Education

7.2.1. Most schools had not developed a written policy on drug education outlining the goals and key messages of their programme. In the absence of clear direction in relation to goals and key messages, confusion was widespread among teaching staff particularly in relation to difficult issues such as harm reduction.

7.2.2. National guidelines were rarely referred to or used by schools when planning their drug education. This calls into question the credibility of Scottish Executive claims that the vast majority of secondary schools provide drug education in line with these guidelines.

7.2.3. Schools were not in the habit of actively consulting or involving parents, pupils or the local community in discussions about drug education policy, planning or practice. As such drug education practice in Scottish schools would appear to be a long way from the kind of comprehensive programmes that have been successful elsewhere (Section 1.4.3.d).

7.2.4. In the schools studied the drug education curriculum was constantly changing and evolving, sometimes in quite a haphazard or whimsical way rather than following any carefully developed plan.

7.2.5. Drug education was monitored and evaluated by schools in this study but these evaluations tended to be internally-led and were largely based on the impressions and opinions of staff in the school rather than on any more detailed records or objective measures. Where pupil evaluations were carried out, they had little effect on the drug education in practice. In some schools there were examples of more useful pupil consultation models which could be extended to cover drug education issues. These models should be investigated further to determine their usefulness in developing effective drug education programmes.

7.2.6. Although the concept of "informed choice" was described as central to many schools' drug education provision, many of the resources used employed what the author has dubbed a "real life scare-tactics" approach. Provision of comprehensive, structured, balanced information was critically lacking in the case study school. A great deal of further consideration is required in planning drug education curricula in schools and in providing guidance to schools on appropriate resources.

7.2.7. The lessons observed in the case study school could not be classed as interactive because of low levels of pupil to pupil communication and pupil self-disclosure. Current research literature on drug education would suggest that schools and teachers need to actively encourage a greater level of pupil to pupil communication in small group settings if lessons are to have an impact on pupil behaviour. Although pupils should be encouraged to be open and honest about their opinions and values in relation to drug use, the issue of pupil self-disclosure of personal drug use is a very difficult one. Further consideration and investigation of the feasibility of encouraging true openness in classroom settings is required and additional guidance for teachers on how to deal with any disclosures of drug use would be valuable.

7.2.8. The available evidence about the content and (lack of) interactivity of the drug education described in this study suggests that current practice will not result in reduced numbers of young people using drugs and as harm reduction information was not routinely provided, a reduction in overall harm due to drug use by pupils also seems unlikely.

7.2.9. Schools were not routinely following good practice guidelines (School Drug Safety Team, 2000; summarised in Table 1.5) in involving external agencies in the drug education provision and this had led to a number of avoidable problems in some schools (Section 3.5.3).

7.2.10. The respondents in this study reported that teachers had not been trained within years of the time of the interviews on drug education issues and that such training was not a requirement for delivery of drug education. It is not sufficient that teachers are trained and retrained by means of a similar basic course once every two or three years. Progressive, sustainable training to certain minimum standards is required to ensure accuracy, consistency and relevance in drug education teaching.

7.2.11. In this study the quality of drug education appeared to improve considerably when lessons were delivered by a small, dedicated team of teachers. These small teams of teachers with long-term responsibility for Personal and Social Education (PSE) delivery can be more easily and intensively trained and their expertise could be built on over the years.

7.2.12. It is not realistic to expect schools to deliver on an ever-increasing number of topics in PSE while still seeking to cover each topic adequately and effectively. Additional time or support must be provided for staff to research, plan and deliver effectively on new issues. In addition, schools and staff require more support to help them cope with large guidance caseloads and pupils with special needs or behavioural difficulties. All aspects of PSE delivery including drug education suffer when staff are unable to commit time to concentrating on them.

7.2.13. The use of pupils as peer educators for drug education lessons may hold some promise in that lessons led by them were interactive and pupils could relate well to them. However, the training that was received by sixth year peer educators in the case study school would suggest that they were inadequately prepared for the responsibility. Much more guidance on the content of the lessons to be delivered and much more support and training in relation to how to manage pupils was required. Future peer education initiatives would be well-advised to commit considerably more time, expertise and resources to providing such training and support before allowing peer educators to lead drug education lessons. Further research is also required to determine if the perceived advantages of peer-led drug education programmes are measurable in the Scottish context and if so, to identify how the programmes can best be implemented in Scottish schools.

7.2.14. Overall, it is clear that the drug education that was being delivered in the schools in this study in general fell short of the guidelines for best

practice outlined in Chapter 1. This was the case despite the fact that individual respondents felt that drug education was a high priority, and that they were sincere in their efforts to protect pupils from harm. Four key issues were identified as having limited the quality of the drug education that could be delivered in the studied schools.

- A lack of clarity and understanding about the goals of drug education.
- A lack of time and support for researching, planning and reviewing drug education.
- A low priority assigned to PSE in general.
- A failure to recognise drug education (and PSE) as a sensitive and complex subject requiring considerable expertise to teach.

7.2.15. Detailed consideration of the research findings in relation to these four issues allowed the author to suggest how the quality of drug education in schools might be improved. In short, these suggestions are:

- Maximising the role of HMI in stimulating improved quality in drug education by giving it detailed consideration in all school inspections.
- Redesigning the Scottish Executive Education Department's annual survey of drug education in schools to ensure that it focuses on quality in a more meaningful way.
- Reviewing the place of PSE within the school curriculum to consider giving formal recognition to the status of PSE teaching.
- Moving towards a system in which PSE (including drug education) is taught by teachers who are qualified specifically in PSE and are responsible for teaching only PSE in schools.
- Developing objective, acceptable measures of school performance that take into account issues other than just exam results, including PSE delivery.

7.3. Overall Conclusion

If drug education is considered essential and appropriate as part of the schooling of young people then it must be organised in a way that acknowledges it as a priority equal to academic subjects. The philosophy, theory and goals of drug education must be made explicit and delivery must then be measured according to adherence to these principles. Such a system would require some fundamental changes to how school-based drug education is approached both locally and nationally.

References

ABERDEEN CITY COUNCIL, HEALTH EDUCATION BOARD FOR SCOTLAND, HMI AUDIT UNIT (1999). A Route to Health Promotion. Self-Evaluation Using Performance Indicators. Edinburgh: Scottish Executive Education Department. [online] http://www.scotland.gov.uk/library2/_doc08/rthp-00.htm [10th September, 2002]

ACMD (1993). Drug Education in Schools. The Need for New Impetus. London: HMSO.

AGAR, M. H. (1980). The Professional Stranger: An Informal Introduction to Ethnography. San Diego: Academic Press.

AJZEN, I. (1985). From intentions to actions: a theory of planned behaviour. In: Action Control: From Cognition to Behavior. Kuhl, J. and Beckmann J. (Editors). New York: Springer-Verlag

ALLOTT, R.A., PAXTON, R. and LEONARD, R. (1999). Drug education: a review of British Government policy and evidence on effectiveness. Health Education Research, 14(4), 491-505.

APPLETON, J.V. (1995). Analysing qualitative data: addressing issues of validity and reliability. Journal of Advanced Nursing, 23, pp. 441-447.

ASHTON, M. (1999). False dawn for drug-free schools in Taiwan. Drug and Alcohol Findings, 1999(2), 30-31.

AUSTRALIAN DRUG FOUNDATION, DRUGEDNET (2000). Education in Schools. [online] http://www.adf.org.au/drugednet/es.html [6th April 2000].

BANGERT-DROWNS, R.L., (1988). The effects of school-based substance abuse education - a meta-analysis. Journal of Drug Education, 18(3), 243-265.

BARNARD, M. and FORSYTH A.J.M. (1998). Drug use among schoolchildren in rural Scotland. Addiction Research, 6(5), 421-434.

BBC NEWS, (2001). Schools step up drugs fight. 25th July, 2001 [online] http://news.bbc.co.uk/1/hi/scotland/1456208.stm. [31st March, 2003].

BBC NEWS, (2002a). Rave Drivers Face Drug Tests. 16th June, 2002. [online] http://news.bbc.co.uk/1/hi/uk/england/2048026.stm [29th July, 2002]

BBC NEWS, (2002b). Shock drugs lessons 'do not work'. 1st March 2002 [online] http://news.bbc.co.uk/1/hi/education/1849234.stm. [2nd March, 2003].

BBC NEWS, (2002c). Rachel video 'not just shock tactics'. 21st May 2002 [online] http://news.bbc.co.uk/1/hi/education/2000287.stm. [2nd March, 2003].

BBC NEWS, (2002d). Heroin death video shown in schools. 18th November, 2002 [online] http://news.bbc.co.uk/1/hi/education/2489465.stm. [2nd March, 2003].

BBC NEWS, (2003a). Call to scrap school league tables. 14th February 2003 [online] http://news.bbc.co.uk/1/hi/scotland/2516247.stm [31st March, 2003].

BBC NEWS, (2003b). Welsh school league tables abolished. 14th February 2003 [online] http://news.bbc.co.uk/1/hi/education/1448158.stm. [31st March, 2003].

BBC NEWS, (2003c). School league tables scrapped. 14th February 2002 [online] http://news.bbc.co.uk/1/hi/education/1109516.stm. [31st March, 2003].

BECK, J. (1998). 100 years of "just say no" versus "just say know", Reevaluating drug education goals for the coming century. Evaluation Review, 22(1), 15-45.

BECKER, H.K., AGOPIAN, M.W. and YEH, S. (1992). Impact evaluation of Drug Abuse Resistance Education (DARE). Journal of Drug Education, 22(4), 283-291.

BERBERIAN, R., GROSS, C., LOVEJOY, J. and PAPERELLA, S. (1976). The effectiveness of drug education programs: a critical review. Health Education Monographs, 4(4), 377-398.

BISHOP, J., WHITEAR, B.A. and BROWN, S. (2001). A review of substance use education in fifty secondary schools in South Wales. Health Education Journal, 60(2), 164-172.

BLACKWELL, J.S. (1983). Drifting, controlling and overcoming: opiate users who avoid becoming chronically dependent. Journal of Drug Issues, Spring 1983, 219-235.

BLAIKIE, N., (1993). Approaches to Social Enquiry. Cambridge: Polity Press.

BLUNKETT, D. (2002). Hansard (House of Commons Debates), Wednesday 10th July 2002, Column 887: Drugs Strategy. [online] http://www.parliament.the-stationery-office.co.uk/pa/cm200102/cmhansrd/cm020710/debtext/20710-04.htm#20710-04_spmin5 [29th July, 2002]

BOSWORTH, K. (1998). Assessment of drug abuse prevention curricula developed at the local level. Journal of Drug Education, 28(4), 307-325.

BOSWORTH, K. and SAILES, J. (1993). Content and teaching strategies in 10 selected drug abuse prevention curricula. Journal of School Health, 63(6), 247-253.

BOTVIN, G.J., BAKER, E., DUSENBURY, L., BOVIN, E.M., and DIAZ, T. (1995). Long-term follow-up results of a randomized drug abuse prevention trial in a white middle-class population. Journal of the American Medical Association, 273(14), 1106-1112.

BOTVIN, G.J., BAKER, E., RENICK, N.L., FILAZZOLA, A.D. and BOTVIN, E.M. (1984). A cognitive-behavioural approach to substance abuse prevention. Addictive Behaviors, 9, 137-147.

BOTVIN, G.J. and ENG, A. (1982). The efficacy of a multicomponent approach to the prevention of cigarette smoking. Preventive Medicine, 11, 199-211.

BOYS, A., FOUNTAIN, J., MARSDEN, J., GRIFFITHS, P., STILLWELL, G. and STRANG, J. (2000). Drugs Decisions: A Qualitative Study of Young People. London: Health Education Authority.

BOYS, A., MARSDEN, J. and STRANG, J. (2001). Understanding reasons for drug use amongst young people: a functional perspective. Health Education Research, 16(4), 457-469.

BOYS, A., MARSDEN, J., FOUNTAIN, J., GRIFFITHS, P., STILLWELL, G. and STRANG, J. (1999a). What influences young people's use of drugs? A qualitative study of decision-making. Drugs: Education, Prevention and Policy, 6(3), 373-387.

BOYS, A., MARSDEN, J., GRIFFITHS, P., FOUNTAIN, J., STILLWELL, G. and STRANG, J. (1999b). Substance use among young people: the relationship between perceived functions and intentions. Addiction, 94(7), 1043-1050.

BRITISH LUNG FOUNDATION, (2002). A Smoking Gun – The Impact of Cannabis Smoking on Respiratory Health. London: British Lung Foundation. [online] http://www.lunguk.org/news/a_smoking_gun.pdf [4th April, 2003]

BROWN, J.H., D'EMIDIO-CASTON, M. and POLLARD, J. (1997). Students and substances: social power in drug education. Educational Evaluation and Policy Analysis, 19(1), 65-82.

BROWN, J.H., D'EMIDIO-CASTON, M., KAUFMAN, K., GOLDSWORTHY-HANNER, T. and ALIOTO, M. (1995). In Their Own Voices: Students and Educators Evaluate California School-Based Drug, Alcohol and Tobacco Education (DATE) Programs. Prepared for the California State Department of Education. San Francisco: Pacific Institute for Research and Evaluation (PIRE).

BROWN, J.W., GLASER, D., WAXER, E. and GEIS, G. (1974). Turning off: cessation of marijuana use after college. Social Problems 21(4), 526-538.

BROWN, S. and MCINTYRE, D. (1993). Making Sense of Teaching. Buckingham: Open University Press.

CAHRU (2002). The Scottish Schools Adolescent and Substance Use Survey (SALSUS), 2002. [online] http://www.drugmisuse.isdscotland.org/publications/abstracts/salsus.htm [20th April, 2003]

CHARITIES DIRECT website: [online]: http://www.charitiesdirect.com/charity1/ch011291.htm [23rd November, 2002]

CHEN, H-T (1997). Normative evaluation of an anti-drug abuse program. Evaluation and Program Planning, 20(2), 195-204.

CLAYTON, R.R., CATTARELLO, A.M. and JOHNSTONE, B.M. (1996). The effectiveness of Drug Abuse Resistance Education (Project DARE): 5-year follow-up results. Preventive Medicine, 25, 307-318.

COFFIELD, F. and GOFTON, L. (1994). Drugs and Young People. London: Institute for Public Policy Research.

COGGANS, N. and MCKELLAR, S. (1994). Drug use amongst peers: peer pressure or peer preference? Drugs: Education, Prevention and Policy, 1(1), 15-26.

COGGANS, N., CHEYNE, B. and MCKELLAR, S. (2002). The Life Skills Training Drug Education Programme: A Review of Research. Edinburgh: Effective Interventions Unit. [online] http://www.drugmisuse.isdscotland.org/eiu/pdfs/eiu_lifeskl.pdf [5th April, 2003]

COGGANS, N., EVANS, R. and O'CONNOR, L. (1999). Drug education and effectiveness: the contribution of the police service to work in schools. Early Child Development and Care, 157, 109-145.

COGGANS, N., SHEWAN, D., HENDERSON, M. AND DAVIES, J.B. (1991). National Evaluation of Drug Education in Scotland, ISDD Research Monograph Four. London: Institute for the Study of Drug Dependence (now DrugScope).

COGGANS, N.S. and WATSON J. (1995). Drug education: approaches, effectiveness and delivery. [Health Education Board for Scotland (HEBS) Working Paper Number One]. Drugs Education, Prevention and Policy, 2(3), 211-224. [online] http://www.hebs.scot.nhs.uk/research/pd/index.htm [8th June, 2000].

COHEN, D.A. and LINTON, K.L.P. (1995). Parent participation in an adolescent drug abuse prevention program. Journal of Drug Education, 25(2), 159-169.

COHEN, J. (1993). Achieving a reduction in drug-related harm through education. In: Psychoactive Drugs and Harm Reduction: From Faith to Science. Heather, N., Wodak, A., Nadelmann, E.A. and O'Hare, P. (Editors). London: Whurr Publications.

COHEN, J. (2002). Just say – 'Oh no, not again'. Druglink, 17(4), 13-14.

COHEN, L. and MANION, L. (1994). Research Methods in Education. London: Routledge. First published 1980, fourth edition 1994.

COLE, P. (2000). Drugs education at the transition from primary to secondary school: the pupils' views. Educational Review, 52(1), 55-63.

COOKE, C., MACDONALD, S. and JONES, I.G. (1997). Alcohol, tobacco and other drug use amongst secondary school children in Fife, Scotland. Drugs: Education, Prevention and Policy, 4(3), 243-253.

CRAGG, A., (1998). Crackdown on Drugs: Qualitative research to inform initiatives by the metropolitan police. London: Metropolitan Police Service. Cited in Coggans et al., (1999), op. cit.

CRESWELL, J.W., (1998). Qualitative Inquiry and Research Design: Choosing Among Five Traditions. California: SAGE Publications.

D'EMIDIO-CASTON, M. and BROWN, J.H. (1998). The other side of the story: students narratives on the California drug, alcohol and tobacco education programs. Evaluation Review, 22(1), 95-117.

DANE, A.V. and SCHNEIDER, B.H. (1998). Program integrity in primary and early secondary prevention: are implementation effects out of control? Clinical Psychology Review, 18(1), 23-45.

DAVIES, J.B. (1997). The Myth of Addiction. Amsterdam: Harwood Academic.

DAW, R. and JOYCE, R. (1996). Drugs awareness for parents. Health Education, 3(May), 8-11.

DE HAES, W and SCHUURMAN, J. (1975). Results of an evaluation study of three drug education methods. International Journal of Health Education, 18, Supplement, 1-16.

DECORTE, T. (2001). Drug users' perceptions of 'controlled' and 'uncontrolled' use. International Journal of Drug Policy, 12, 297-320.

DONALDSON, S.I., GRAHAM, J.W. and HANSEN, W.B. (1994). Testing the generalisability of intervening mechanism theories: understanding the effects of adolescent drug use prevention interventions. Journal of Behavioral Medicine, 17(2), 195-216.

DORN, N. and MURJI, K. (1992). Drug Prevention: a Review of the English Language Literature - ISDD Research Monograph Five. London: Institute for the Study of Drug Dependence.

DRUGS PREVENTION INITIATIVE (1998a). Developing Local Drugs Prevention Strategies. Overview guidance to drug action teams. London: HMSO

DRUGS PREVENTION INITIATIVE (1998b). Guidance on Good Practice. A supplement to the DPI's overview guidance to drug action teams on developing local drugs prevention strategies, London: HMSO.

DRUGSCOPE (1999). The Right Approach. Quality Standards in Drug Education. London: DrugScope/Drug and Alcohol Education and Prevention Team.

DRUGSCOPE (2000). UK Drug Report 2000. London: DrugScope.

DRUGSCOPE (2002a). DrugSearch Database: Cannabis. [online] http://www.drugscope.org.uk/druginfo/drugsearch/ds_results.asp?file=\wip\11\1\1\cannabis.html [29th July, 2002]

DRUGSCOPE (2002b). DrugScope Members Briefing July 2002. London: DrugScope.

DRUGSCOPE (2002c). DrugSearch Database: Amphetamines. [online] http://www.drugscope.org.uk/druginfo/drugsearch/ds_results.asp?file=\wip\11\1\1\amphetamines.html [29th July, 2002]

DRUGSCOPE (2002d). DrugSearch Database: Ecstasy. [online] http://www.drugscope.org.uk/druginfo/drugsearch/ds_results.asp?file=\wip\11\1\1\ecstasy.html [29th July, 2002]

DRUGSCOPE (2002e). DrugSearch Database: Cocaine. [online] http://www.drugscope.org.uk/druginfo/drugsearch/ds_results.asp?file=\wip\11\1\1\cocaine_crack.html [29th July, 2002]

DRUGSCOPE (2002f). DrugSearch Database: FAQs – Why do people die from taking ecstasy? [online] http://www.drugscope.org.uk/druginfo/drugsearch/faq_template.asp?file=%5Cwip%5C11%5C1%5C2%5Cecstasy.html [29th July, 2002]

DRUGSCOPE (2002g). DrugSearch Database: LSD. [online] http://www.drugscope.org.uk/druginfo/drugsearch/ds_results.asp?file=\wip\11\1\1\lsd.html [7th August, 2002]

DRUGSCOPE (2002h). DrugSearch Database: Injecting. [online] http://www.drugscope.org.uk/druginfo/drugsearch/ds_results.asp?file=\wip\11\1\1\injecting.html [30th July, 2002]

DRUGSCOPE, (2003). Drugsearch Database. [online] http://www.drugscope.org.uk/druginfo/drugsearch/home2.asp [9th April, 2003]

DUKES, R.L., STEIN, J.A. and ULLMAN, J.B. (1997). Long-term impact of Drug Abuse Resistance Education (D.A.R.E.). Evaluation Review, 21, 259-276. In Lynam et al., (1999), op. cit.

DUSENBURY, L. and FALCO, M. (1995). Eleven components of effective drug abuse prevention curricula. Journal of School Health, 65(10), 420-425.

DUSENBURY, L., FALCO, M. and LAKE, A. (1997). A review of the evaluation of 47 prevention curricula available nationally. Journal of School Health, 67(4), 127-132.

ELLISTON, K.M. (2002). Establishing a 'code of ethical research practice' in health promotion – A discussion paper. International Journal of Health Promotion and Education, 40(1), 15-20.

EMCDDA, (1998). Guidelines for the Evaluation of Drug Prevention – A Manual for Programme-Planners and Evaluators. Luxembourg: Officer for Official Publications of the European Communities.

EMCDDA, (2001). 2001 Annual Report on the State of the Drugs Problem in the European Union. Luxembourg: Office for Official Publications of the European Communities.

ENNETT, S.T., ROSENBAUM, D.P., FLEWELLING, R.L., BIELER, G.S., RINGWALT, C.L. and BAILEY, S.L. (1994b). Long-term evaluation of Drug Abuse Resistance Education. Addictive Behaviors 19(2), 113-125.

ENNETT, S.T., TOBLER, N.S., RINGWALT, C.L. and FLEWELLING, R.L. (1994a). How effective is Drug Abuse Resistance Education? A meta-analysis of Project D.A.R.E. outcome evaluations. American Journal of Public Health, 84(9), 1394-1401.

EVANS, K. (2002a). Drug education: teach or treat? Druglink, 17(4), 18-20.

EVANS, V. (2002b). The long winding road. Druglink, 17(4), 21-23.

FAST FORWARD POSITIVE LIFESTYLES (2000). Walk the Talk. Edinburgh: Fast Forward Positive Lifestyles.

FINNIGAN, S., PAXTON, R. and HADDOW, M. (1997). Parents in partnership on drug education. Health Education, 4(July), 136-138.

FISHBEIN, A. and AJZEN, I. (1975). Belief, Attitude, Intention and Behavior: An Introduction to Theory and Research. Massachusetts: Addison Wesley.

FITZGERALD, N., SOUSA PINTO, G. and KOS, K. (1999). Pharmacy Education: A Vision of the Future. The Hague: European Pharmaceutical Students' Association and International Pharmaceutical Students' Federation. [online] http://pharmacy-education.virtualave.net/ [26th January, 2003]

FORSYTH, A., BARNARD, M., REID, L., and MCKEGANEY, N. (1998). Levels of drug use in a sample of Scottish independent secondary school pupils. Drugs: Education, Prevention and Policy, 5(2), 157-168.

FRASER, D., (2000). QSR NVivo: Reference Guide. Melbourne: QSR International.

FRASER, F. (2002). Drug Misuse in Scotland: Findings from the 2000 Scottish Crime Survey. Edinburgh: Scottish Executive Central Research Unit.

GAMBLE, L. and GEORGE, M. (1997). 'Really useful knowledge': the boundaries, customs and folk laws governing recreational drug use in a sample of young people. In: Harm Reduction: a New Direction for Drug Policies and Programs. Erickson, P.G., Riley DM, Cheung YW, O'Hare PA (Editors). Toronto: University of Toronto Press.

GERSHMAN, S.T. (1987). The temperance movement in the public primary schools of France. Abstract and discussion in The Social History of Alcohol: Drinking and culture in modern society. Barrows, S.; Room, R. and Verhey, J. (Editors). Berkeley CA: Alcohol Research Group. Cited in Beck (1998), op. cit.

GLANTZ, M.D. (1992). A developmental psychopathology model of drug abuse vulnerability. In Vulnerability to Drug Abuse. M.D. Glantz and R.W. Pickins (Editors). Washington D.C.: American Psychological Association. Cited in Lloyd (1998), op. cit.

GLASER, B.G., (1992). Emergence vs Forcing. Basics of Grounded Theory Analysis. Mill Valley, California: Sociology Press.

GOODSTADT, M. (1975). Impact and roles of drug information in drug education. Journal of Drug Education, 10(2), 89-99.

GOODSTADT, M. (1978). Alcohol and drug education: models and outcomes. Health Education Monographs, 6(3), 263-279.

GOODSTADT, M.S. (1986). School-based drug education in North America: What is wrong? What can be done? Journal of School Health, 56(7), 278-281.

GORSUCH, R. (1980). Interactive models of nonmedical drug use. In: Lettieri, D., Sayers, M. and Pearson, H. (Editors). Theories on Drug Abuse: selected contemporary perspectives. NIDA Research Monograph no. 30. Rockville, MD: National Institute on Drug Abuse, 1980: 18-23. Cited in Spooner, 1999, op cit.

GRAMPIAN POLICE website: [online]: http://www.grampian.police.uk/drugs/drugs.htm [15th April, 2003]

GRAMPIAN POLICE, (1995). The Police Box – Learning for Life. Aberdeen: Grampian Police.

GRAMPIAN POLICE, (1999). Learning for Life – Interactive CD-ROM Volume 1. Aberdeen: Grampian Police.

GRAMPIAN POLICE, (2000). Learning for Life – Interactive CD-ROM Volume 2. Aberdeen: Grampian Police.

GRAMPIAN POLICE, (2001). The Buzz. Aberdeen: Grampian Police.

GRUND, J.-P.G., KAPLAN C.D. and DE VRIES, M. (1993). Rituals of regulation: controlled and uncontrolled drug use in natural settings. In: Psychoactive Drugs and Harm Reduction: from Faith to Science. Heather, N., Wodak, A., Nadelmann E.A. and O'Hare, P. (Editors). London: Whurr Publications.

HAMMERSLEY, M., (1990). Reading Ethnographic Research. New York: Longman.

HANSEN, D., MAYCOCK, B. and LOWER, T. (2001). 'Weddings, parties, anything...', a qualitative analysis of ecstasy use in Perth, Western Australia. International Journal of Drug Policy, 12, 181-199.

HANSEN, W.B. (1992). School-based substance abuse prevention: a review of the state of the art in curriculum, 1980-1990. Health Education Research, 7(3), 403-430.

HARMON, M.A. (1993). Reducing the risk of drug involvement among early adolescents. An evaluation of Drug Abuse Resistance Education (DARE). Evaluation Review, 17(2), 221-239.

HAWKINS, J.D., CATALANO, R.F. and ARTHUR, M.W. (2002). Promoting science-based prevention in communities. Addictive Behaviors, 27, 951-976.

HAWKINS, J.D., CATALANO, R.F. and MILLER, J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. Psychological Bulletin, 112(1), 64-105.

HAY, G., MCKEGANEY, N. and HUTCHINSON, S. (2001). Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland. Executive Report, September 2001. Glasgow: Centre for Drug Misuse Research & Scottish Centre for Infection and Environmental Health. [online] http://www.drugmisuse.isdscotland.org/publications/local/Prevalence.pdf [30th July 2002]

HEALTH EDUCATION BOARD FOR SCOTLAND, (1997). Guidelines for Planning and Evaluating Drug Education. Edinburgh: Health Education Board for Scotland.

HEALTH PROMOTIONS (A division of Grampian Health Board), (1998). Drugs in the Health Promoting School Community (a whole school approach). Aberdeen: Grampian Health Board.

HEALTH PROMOTIONS (A division of Grampian Health Board), (1998a). Grampian Youth Lifestyle Survey 1998. Aberdeen: Grampian Health Board.

HEALTH PROMOTIONS (A division of Grampian Health Board), (2002). Direct Services for Secondary Schools – from website [online]: http://www.health-promotions.com/ [21st November, 2002]

HENRY, J.A., OLDFIELD, W. L. G. and MIN KON, O. (2003). Comparing cannabis with tobacco. British Medical Journal, 326, 942-943.

HIRST, J. and MCCAMLEY-FINNEY, A. (1994). The Place and Meaning of Drugs in the Lives of Young People. Health Research Institute Report No 7. Sheffield: Sheffield Hallam University.

HMI, (1999). Drug and Nutrition Education. Edinburgh: HM Inspectorate of Education. [online] http://www.scotland.gov.uk/hmie/Pdf/Inspection_information/drugsnut.PDF

HMI, (2001). How Good is Our School? 2002 Edition. Self-evaluation using Quality Indicators. Edinburgh: HM Inspectorate of Education. [online] http://www.scotland.gov.uk/hmie/schoolsfolder_/SchoolsFolder/HGIOS.pdf [10th September, 2002]

HUBA, G.J. and BENTLER, P.M. (1982). A developmental theory of drug use: derivation and assessment of causal modelling approach. Life-Span Development and Behavior, 4, 147-203.

ISD SCOTLAND, (2000). Drug Misuse Statistics Scotland, 2000. Edinburgh: ISD Scotland. [online] http://www.drugmisuse.isdscotland.org/publications/00bull/00bull.pdf [30th July 2002]

ISD SCOTLAND, (2002). Drug Misuse Statistics Scotland, 2002. Edinburgh: ISD Scotland. [online] http://www.drugmisuse.isdscotland.org/publications/02bull/02bull.htm [February, 2003]

IVES, R., and CLEMENTS, I. (1996). Drug education in schools: a review. Children and Society, 10(1), 14-27.

JACKSON, G.W.L. (2002). Drug-Related Deaths in Scotland in 2001, Occasional Paper No. 8. Edinburgh: General Register Office for Scotland. [online] http://www.drugmisuse.isdscotland.org/publications/local/gros_2001.pdf [7th August 2002]

JESSOR, R. and JESSOR, S. (1977). Problem Behavior and Psychological Development: A Longitudinal Study of Youth. New York: Academic Press.

JESSOR, R., JESSOR, S.L. and FINNEY, J. (1973). A social psychology of marijuana use: longitudinal studies of high school and college youth. Journal of Personality and Social Psychology, 26, 1-15. Cited in Coggans and McKellar, (1994), op cit.

JOHNSTON, L.D. and O'MALLEY, P.M. (1986). Why do the nation's students use drugs and alcohol? Self-reported reasons from nine national surveys. The Journal of Drug Issues, 16(1), 29-66.

KANDEL, D.B. (1980). Drug and drinking behaviour among youth. Annual Review of Sociology, 6, 235-85.

KINDER, B., PAPE, N. and WALFISH, S. (1980). Drug and alcohol education programmes: a review of outcome studies. International Journal of the Addictions, 15(7), 1035-1054).

KUMPFER, K (1997). What works in the prevention of drug abuse? Individual, school and family approaches. In: Secretary's Youth Substance Abuse Prevention Initiative: Resource Papers (pp69-106). US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

LEARNING AND TEACHING SCOTLAND, (1998). Health Education for Living Project (HELP) Up-Date. Glasgow: Learning and Teaching Scotland.

LEARNING AND TEACHING SCOTLAND, (2002a). 5-14 National Guidelines on Health Education. Glasgow: Learning and Teaching Scotland. [online] http://www.ngflscotland.gov.uk/5-14/guidelines/htmlguidelines/health/intropage1.htm [10th September, 2002].

LEARNING AND TEACHING SCOTLAND, (2002b). Health Education 5-14. Guide for Teachers and Managers. Glasgow: Learning and Teaching Scotland. [online] http://www.ngflscotland.gov.uk/5-14/guidelines/htmlguidelines/guide-health/intro1.htm [10th September, 2002].

LENTON, S. and DAVIDSON, P. (1999). Raves, drugs, dealing and driving: qualitative data from a West Australian sample. Drug and Alcohol Review, 18(2), 153-161.

LENTON, S. and SINGLE, E. (1998). The definition of harm reduction. Drug and Alcohol Review, 17, 213-220.

LISTER-SHARP, D., CHAPMAN, S., STEWART-BROWN, S. and SOWDEN, A. (1999). Health promoting schools and health promotion in schools: two systematic reviews. Health Technology Assessment, 3(22).

LLOYD, C. (1998). Risk factors for problem drug use: identifying vulnerable groups. Drugs: Education, Prevention and Policy, 5(3), 217-232.

LOWDEN, K. AND POWNEY, J. (2000). Drug Education in Scottish Schools 1996-1999. Edinburgh: The Scottish Council for Research in Education.

LYNAM, D.R., MILICH, R., ZIMMERMAN, R., NOVAK, S.P., LOGAN, T.K., MARTIN, C., LEUKEFELD, C. and CLAYTON, R., (1999). Project DARE: No effects at 10-year follow up. Journal of Consulting and Clinical Psychology, 67(4), 590-593. [online] http://www.apa.org/journals/ccp/ccp674590.html [21st August 2002].

MACKINNON, D.P., JOHNSON, C.A., PENTZ, M.A., DWYER, J.H., HANSEN, W.B., FLAY, B.R. and WANG, E.Y. (1991). Mediating mechanisms in a school-based drug prevention program: first year effects of the Midwestern Prevention Project. Health Psychology, 10(3), 164-172.

MALLICK, J., EVANS, R. and STEIN, G. (1998). Parents and drug education: parents' concerns, attitudes and needs. Drugs: Education, Prevention and Policy, 5(2), 169-176.

MALOFF, D., BECKER, H.S., FONAROFF, A. and RODIN, J. (1979). Informal social controls and their influence on substance use. Journal of Drug Issues, Spring 1979, 161-184.

MASON, J., (1996). Qualitative Researching. London: SAGE Publications.

MAY, C. (1993). Resistance to peer group pressure: an inadequate basis for alcohol education. Health Education Research, 8, 159-165.

MCBRIDE, N., FARRINGDON, F. and MIDFORD, R. (2002). Implementing a school drug education programme: reflections on fidelity. International Journal of Health Promotion and Education, 40(2), 40-50.

MCCRONE COMMITTEE (2000). A Teaching Profession for the 21st Century. [online] http://www.askatl.org.uk/pay_and_conditions/pay/scotland/mccrone1.pdf [16th April, 2003]

MCKEGANEY, N., BARNARD, M. and MCINTOSH, J. (2002). Paying the price for their parents' addiction: meeting the needs of the children of drug-using parents. Drugs: Education, Prevention and Policy, 9(3), 233-246.

MEASHAM, F., NEWCOMBE, R. and PARKER, H. (1994). The normalization of recreational drug use amongst young people in North-West England. British Journal of Sociology, 45(2), 287-312.

MERRIAM, S.B. (1988). Case Study Research in Education. San Francisco: Jossey-Bass Inc. Publishers.

MIDFORD, R., MCBRIDE, N. AND MUNRO, G., (1998). Harm reduction in school-based drug education: developing an Australian approach. Drug and Alcohol Review, 17, 319-328.

MILLER, L. (2001). SE Annual Report on Drug Misuse, Nov. [Email] Personal email to Fitzgerald, N. [28th December, 2001].

MINISTERIAL DRUGS TASK FORCE (1994). Drugs in Scotland: Meeting the Challenge; Report of Ministerial Drugs Task Force. The Scottish Office Home and Health Department. Edinburgh: HMSO.

MOON, A.M., MULLEE, M.A., ROGERS, L., THOMPSON, R.L., SPELLER, V. and RODERICK, P. (1999). Helping schools to become health-promoting environments – an evaluation of the Wessex Health Schools Award. Health Promotion International, 14(2), 111-122.

MOORE, D. and SAUNDERS, B. (1991). Youth drug use and the prevention of problems: why we've got it all wrong. International Journal of Drug Policy, 2(3), 29-33.

MURPHY, E., DINGWALL, R., GREATBATCH, D., PARKER, S. & WATSON, P., (1998). Qualitative research methods in health technology assessment: a review of the literature. Health Technology Assessment, 2 (16).

NATIONAL PEER HELPERS ASSOCIATION, (2002). Programmatic Standards. [online] http://www.peerhelping.org/NPHAPublications/Final%20standards.pdf [29th August, 2002].

NATIONAL STATISTICS, (2001). Smoking, Drinking and Drug Use among Young People in Scotland in 2000. Boreham, R. and Shaw, A., (editors). Edinburgh: The Stationary Office. [online] http://www.scotland.gov.uk/library3 /health/smoking.pdf [29th July, 2002].

NEALE, J. (2001). Driving on recreational drugs: a qualitative investigation of experiences from behind the wheel. Drugs: Education, Prevention and Policy, 8(4), 315-325.

NEWMAN, T. and BLACKBURN, S. (2002). Interchange 78. Transitions in the Lives of Children and Young People: Resilience Factors. Edinburgh: Scottish Executive Education Department. [online] http://www.scotland.gov.uk/library5/education/ic78-00.asp [5th April, 2003]

NHS GRAMPIAN, (2002). Grampian Youth Lifestyle Survey 2001. Aberdeen: NHS Grampian. [online] http://www.health-promotions.com/images/Grampian%20Youth%20Lifestyle%20Survey%20Combined.doc [4th April, 2003]

NORLAND, S., DICHIARA, A. and HENDERSHOTT, A. (1995). Teachers' use of and perceptions of a drug curriculum. Journal of Alcohol and Drug Education, 40(2), 100-111.

NORTON, L., (1999). The philosophical bases of grounded theory and their implications for research practice. Nurse Researcher, 7(1), 31-43.

O'CONNOR, L., BEST, R. and ROWLEY, J. (1997). Young People Drugs and Drugs Education: Missed Opportunities. London: Roehampton Institute. Cited in Coggans et al., (1999), op. cit.

O'HARE, P. (1988). Drug Education: A basis for reform. Paper presented at the international conference on drug policy reform. Maryland: USA. Cited in Cohen (1993), op. cit.

OGBORNE, A. (1988). School-based educational programs to prevent the personal use of psychoactive drugs for non-medical purposes. Australian Drug and Alcohol Review, 7, 305-314.

PARKER, H., MEASHAM, F. and ALDRIDGE, J. (1995). DRUG FUTURES: Changing Patterns of Drug Use Among English Youth. ISDD Research Monograph 7. London: Institute for the Study of Drug Dependence (now DrugScope).

PARSONS, C., STEARS, D. and THOMAS, C. (1996). The health promoting school in Europe: conceptualising and evaluating the change. Health Education Journal, 55, pp. 311-321.

PATEMAN, B., GRUNBAUM, J.A. and KANN, L. (1999). Voices from the field – a qualitative analysis of classroom, school, district and state health education policies and programs. Journal of School Health, 69(7), 258-263.

PATERSON, B.L. (1994). A framework to identify reactivity in qualitative research. Western Journal of Nursing Research, 16(3), 301-316.

PATTON, M.Q. (1980). Qualitative Evaluation Methods. California: Sage Publications. [Cited in Merriam, 1988]

PENTZ, M.A., DWYER, J.H., MACKINNON, D.P., FLAY, B.R., HANSEN, W.B., WANG, E.Y. and JOHNSON, C.A. (1989). A multicommunity trial for primary prevention of adolescent drug abuse. Effects on drug use prevalence. Journal of the American Medical Association (JAMA), 261(22), 3259-3266.

PERAKYLA, A. (1997). Reliability and validity in research based on tapes and manuscripts. Chapter 13 in: Silverman D. (Editor), Qualitative Research: Theory, Method and Practice, pages 201-220. London: Sage Publications.

PERRY, C.I., MURRAY, D.M. and GRIFFIN, G. (1990). Evaluating the statewide dissemination of smoking prevention curricula: Factors in teacher compliance. Journal of School Health, 60, 501-504. Cited in Dane and Schneider (1998), op. cit.

PERRY, C.L., WILLIAMS, C.L., VEBLEN-MORTENSEN, S., TOOMEY, T.L., KOMRO, K.A., ANSTINE, P.S., MCGOVERN, P.G., FINNEGAN, J.R., FORSTER, J.L., WAGENAAR, A.C. and WOLFSON, M. (1996). Project Northland: Outcomes of a community-wide alcohol use prevention program during early adolescence. American Journal of Public Health, 86(7), 956-965.

PLANT, E. and PLANT, M. (1999). Primary prevention for young children: a comment on the UK government's 10 year drug strategy. International Journal of Drug Policy, 10, (1999), 385-401.

PLANT, M.A., PLANT, M.L., THORNTON, C. and MASON, W. (1998). Parents and Health Education: An Exploratory Study in the Western Isles: A Report for the Western Isles Health Board. Edinburgh: Alcohol and Health Research Centre. Cited in Plant and Plant (1999), op. cit.

POMPIDOU GROUP, (1998). Handbook Prevention – Alcohol, Drugs and Tobacco. Van der Stel, Jaap (Editor). Strasbourg: Council of Europe. [online] http://www.coe.int/T/E/Social_Cohesion/pompidou_group/5.Publications/manueluk.pdf [5th April, 2003]

PUDNEY, (2002). The Road to Ruin. Sequences of Initiation into Drug Use and Offending by Young People in Britain. Home Office Research Study 253. London: Home Office Research, Development and Statistics Directorate. [online] http://www.homeoffice.gov.uk/rds/pdfs2/hors253.pdf [31st March, 2003]

QSR INTERNATIONAL PTY. LTD., (2000). NUD*IST VIVO, Version 1.2 (plus update 1.3). See www.qsrinternational.com for more information.

QUIGLEY, P. (2002). Family and community burdens of addiction: case mix-analysis at a new community-based methadone treatment service. Drugs: Education, Prevention and Policy, 9(3), 221-231.

RAMSAY, M., BAKER, P., GOULDEN, C., SHARP, C. AND SONDHI, A., (2001). Drug Misuse Declared in 2000: results from the British Crime Survey. London: Home Office Research, Development and Statistics Directorate.

RATCLIFFE, J.W. (1983). Notions of validity in qualitative research methodology. Knowledge, Creation, Diffusion, Utilization, 5(2), 147-167. [Cited in Merriam, 1988]

RESNICOW, K., DAVIS, M., SMITH, M., LAZARUS-YAROCH, A., BARANOWSKI, T., BARANOWSKI, J., DOYLE, C. and WANG, D.T. (1998). How best to measure implementation of school health curricula: a comparison of three measures. Health Education Research, 13(2), 239-250.

REY, J.M. and TENNANT, C.C. (2002). Cannabis and mental health. British Medical Journal, 325, 1183-1184.

RICHARDS, L., (2000). Using NVivo in Qualitative Research. Melbourne: QSR International.

ROBERTSON, N. (1996). Buzz: Scottish Schools Drugs Survey 1996. Glasgow: Scotland Against Drugs.

ROSENBAUM, D.P. and HANSON, G.S. (1998). Assessing the effects of school-based drug education: a six-year multilevel analysis of project D.A.R.E. Journal of Research in Crime and Delinquency, 35(4), 381-412.

ROSENBAUM, D.P., FLEWELLING, R.L., BAILEY, S.L., RINGWALT, C.L. and WILKINSON, D.L. (1994). Cops in the classroom: a longitudinal evaluation of drug abuse resistance education (DARE). Journal of Research in Crime and Delinquency, 31(1), 3-31.

ROSS, J.G., LUPECKER, R.V., NELSON, G.D., SAAVEDRA, P. and HUBBARD, B.M. (1991). Teenage health teaching modules: Impact of teacher training on implementation and student outcomes. Journal of School Health, 61, 31-34. Cited in Dane and Schneider, (1998), op. cit.

SAMHSA (SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION), (2002). Center for Substance Abuse Prevention Model Programs website. [online] http://www.samhsa.gov/centers/csap/modelprograms/default.htm [23rd August, 2002]

SCHAPS, E., DIBARTOLO, R., MOSKOWITZ, J., PALLEY, C., and CHURGIN, S. (1981). A review of 127 drug abuse prevention program evaluations. Journal of Drug Issues, 11(1), 17-43

SCHOFIELD, J.W. (1993). Increasing the generalisability of qualitative research. In Hammersley, M. (Editor), Naturalistic Inquiry. London: Sage Publications.

SCHOOL DRUG SAFETY TEAM, (2000). Final report of the school drug safety team. [online]: http://www.scotland.gov.uk/library3/health/sdst_final_report.pdf [27th August, 2002]

SCHROEDER, D.S., LAFLIN, M.T. and WEIS, D.L. (1993). Is there a relationship between self-esteem and drug use? Methodological and statistical limitations of the research. The Journal of Drug Issues, 23(4), 645-665.

SCOTTISH EXECUTIVE (2001a). New Reliable Estimate of Drug Misusers. News Release, 15th November 2001. [online] http://www.scotland.gov.uk/pages/news/2001/11/SE4354.aspx [30th July, 2002]

SCOTTISH EXECUTIVE (2001b). Annual Report on Drug Misuse. Edinburgh: Scottish Executive.

SCOTTISH EXECUTIVE, (2001c). A Teaching Profession for the 21st Century – Agreement reached following the recommendations of the McCrone report. [online] http://www.scotland.gov.uk/library3/education/tp21a.pdf [16th April, 2003]

SCOTTISH EXECUTIVE (2002a). New Campaign Targets Drug Driving. News Release, 20th May, 2002. [online] http://www.scotland.gov.uk/pages/news/2002/05/SEnw027.aspx [29th July, 2002]

SCOTTISH EXECUTIVE, (2002b). Drug Education in Schools 2001/2002. News Release, 17th October, 2002. [online] http://www.scotland.gov.uk/stats/bulletins/00200-00.asp [6th April, 2003]

SCOTTISH EXECUTIVE, (2002c). Schools get top marks for drug education. News Release, 17th October, 2002. [online]: http://www.scottishexecutive.gov.uk/pages/news/2002/10/SEed116.aspx [31st March, 2003].

SELECT COMMITTEE ON HOME AFFAIRS, (2002). The Government's Drugs Policy: Is it Working? [online] http://www.parliament.the-stationery-office.co.uk/pa/cm200102/cmselect/cmhaff/318/31802.htm [29th July, 2002]

SHAPIRO, H. (2003). Home rule. DrugLink, 18(1), 6-7.

SHEDLER, J. and BLOCK, J. (1990). Adolescent drug use and psychological health: a longitudinal study. American Psychologist, 45(5), 612-630.

SHEPPARD, M.A., WRIGHT, D. and GOODSTADT, M.S. (1985). Peer pressure and drug use – exploding the myth. Adolescence, 20(80), 949-958.

SHERLOCK K. and CONNER, M. (1999). Patterns of ecstasy use amongst club-goers on the UK 'dance scene'. International Journal of Drug Policy, 10, 117-129.

SHINER, M. (1999). Defining peer education. Journal of Adolescence, 22, 555-566.

SHINER, M. and NEWBURN, T. (1997). Definitely, maybe not? The normalisation of recreational drug use amongst young people. Sociology, 31(3), 511-529.

SIMPSON, M. and URE, J. (1994). Studies of Differentiation Practices in Primary and Secondary Schools. Scottish Office Education Department Interchange 30: Differentiation Practices. Edinburgh: Scottish Council for Research in Education.

SLEVIN, E. and SINES, D. (1999). Enhancing the truthfulness, consistency and transferability of a qualitative study: utilising a manifold of approaches. Nurse Researcher, 7(2), Winter 1999, 79-97.

SOCIAL RESEARCH ASSOCIATION (2002). Ethical Guidelines. [online] http://www.the-sra.org.uk/ethics02.pdf [26th January, 2003]

SPOONER, C. (1999). Causes and correlates of adolescent drug abuse and implications for treatment. Drug and Alcohol Review, 18, 453-475.

SPOTH, R., LOPEZ REYES, M., REDMOND, C. and SHIN, C. (1999). Assessing a public health approach to delay onset and progression of adolescent substance use: latent transition and log-linear analyses of longitudinal family preventive intervention outcomes. Journal of Consulting and Clinical Psychology, 67(5), 619-630.

STAKE, R. (1998). When policy is merely promotion, by what ethic lives an evaluator? Studies in Educational Evaluation, 24(2), 203-212.

STAKE, R.E., (1995). The Art of Case Study Research. California: SAGE Publications.

STEARS, D., CLIFT, S. and BLACKMAN, S. (1995). Health, sex and drugs education: rhetoric and realities. In: The Social Subjects Within the Curriculum: Children's Social Learning in the National Curriculum. Ahier, J. and Ross, A. (Editors). London: The Falmer Press.

STRAUSS, A. & CORBIN, J. (1990). Basics of Qualitative Research: Grounded Theory Procedures and Techniques. California: SAGE Publications.

SWIFT, W., HALL, W. and TEESSON, M. (2001). Characteristics of DSM-IV and ICD-10 cannabis dependence among Australian adults: results from the National Survey of Mental Health and Wellbeing. Drug and Alcohol Dependence, 63(2), 147-153.

TOBLER, N.S. and STRATTON, H.H. (1997). Effectiveness of school-based drug prevention programs: a meta-analysis of the research. The Journal of Primary Prevention, 18(1), 71-128.

TOBLER, N.S., (1986). Meta-analysis of 143 adolescent drug prevention programs: quantitative outcome results of program participants compared to a control or comparison group. Journal of Drug Issues, 16(4), 537-567.

TOBLER, N.S., LESSARD, T., MARSHALL, D., OCHSHORN, P. and ROONA, M. (1999). Effectiveness of school-based drug prevention programmes for marijuana use. School Psychology International, 20(1), 105-137.

TORTU, S. and BOTVIN, G.J. (1989). School-based smoking prevention: the teacher training process. Preventive Medicine, 18, 280-289. Cited in Plant and Plant (1999), op. cit.

TOSELAND, R. and RIVAS, R. (1984). Introduction to Group Work Practice. New York: Macmillan.

TUCKWOOD, D. (2003). In personal communication with the author by electronic mail, January, 2003.

UK ANTI-DRUG CO-ORDINATION UNIT (1998). Tackling Drugs to Build a Better Britain: The Government's Ten-Year Strategy for Tackling Drugs Misuse. London: The Stationary Office.

VAN DE WIJNAART, G.F. (1989). Drug abuse research and policy: a Dutch American debate. International Journal of Drug Policy, 1(3), 12-13.

WATSON, M., (1991). Harm reduction – why do it? International Journal of Drug Policy, 2(5), 13-15.

WHITE, D. AND PITTS, M. (1998). Educating young people about drugs: a systematic review. Addiction, 93(10), 1475-1487.

WILLIAMS, J.S. (2003). Grouping high-risk youths for prevention may harm more than help. NIDA Notes, 17 (5). [online] http://www.nida.nih.gov/NIDA_notes/NNVol17N5/Grouping.html [6th April, 2003]

WILLIAMS, M. and KEENE, J. (1995). Drug prevention and the police in the UK: a review of recent research studies. Drugs: Education, Prevention and Policy, 2(3), 225-241.

WINSTOCK, A.R., GRIFFITHS, P. and STEWART D. (2001). Drugs and the dance music scene: a survey of current drug use patterns among a sample of dance music enthusiasts in the UK. Drug and Alcohol Dependence, 64(1), 9-17.

WOLCOTT, H.F., (1990). Writing Up Qualitative Research. Qualitative Research Methods Series 20. California: Sage Publications.

YOUNG, I. (1992). School health education in Scotland: the health promoting school, encouraging parental involvement. Hygie, 11(3),40-44.

ZINBERG N.E., JACOBSON, R.C. and HARDING, W.M. (1975). Social sanctions and rituals as a basis for drug abuse prevention. American Journal of Drug and Alcohol Abuse, 2(2), 165-182.

APPENDICES

School-Based Drug Education in Northeast Scotland – Policy, Planning and Practice

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VOL 2

Appendices to Chapter One

A Route to Health Promotion – Self-evaluation Using Performance Indicators.

Summaries of the standard of practice needed to attain a level four (the top) rating under each indicator.

1.1 Structure of the Curriculum

For a level four rating under this indicator:

- Health education should form part of all pupils' core curriculum, be relevant to the age and stage of pupils and cover key health issues. Substance use is described as a priority area for action.
- Cross-curricular opportunities should be maximised through religious and moral education, physical education, science, home economics or English, for example.
- There should be integration of knowledge and skills development, and opportunities for pupils to develop their own beliefs and attitudes in relation to health issues.
- Timetables should be designed to give appropriate time and emphasis on health and life-skills issues.
- There should be appropriate opportunities for development of all pupils.

Suggested features to look for include learning plans and transfer records for pupils, personal action plans and research activities. Interviews with representative groups of pupils or detailed analysis of what the health curriculum means for defined groups of pupils (e.g. those with special needs or poor health) are also suggested.

1.2 Quality of Courses or Programmes

For a level four rating under this indicator:

- The health education programme should be relevant to the age and stage of pupils, and cover key health issues, including an exploration of underlying psychosocial issues relevant to health.

- The programme should follow a logical sequence and demonstrate clear progression. Key messages should be conveyed consistently throughout.
- Teachers should receive clear guidance in relation to the health education programme in terms of key resources and appropriate learning and teaching methods.

Features to look for include the linking of learning to pupils' health decisions and needs, and how well tasks focus on learning outcomes and give them balanced attention. Specifically, this resource focuses on whether emphasis is on building pupils' self-worth and ability to take control of their own health and what attention is given to knowledge and strategies to:

- Identify risks
- Know sources of help
- Resist/deflect pressure and manage stress
- Evaluate health needs and plan healthy action

Planned account should be taken of pupil and community values and sensitivities including religion and culture, family values and lifestyle and attitudes. An agreed school framework of learning outcomes and approaches to health education and health promotion should exist, utilising plans to build on previous learning. Plans should be evaluated and pupils' work monitored to ensure programmes match pupils' needs. Pupils should be given choice and responsibility for active learning:

- There should be a negotiated choice of tasks related to pupils' needs.
- Homework and investigation on issues should be negotiated with pupils.
- Options should be planned to build on interests/broaden experience
- Pupils should work on personal health action plans and record their health achievements.

Suggested features of good practice in relation to teaching staff include the provision of support by means of practical advice on resources, learning and teaching and assessment and feedback on plans and records of work. Management could work alongside teachers to identify and share good practice. The resource suggests consulting staff to

assess if they have adequate training and practical support for confident teaching, working together on programme advice and reviewing arrangements for assessment and self-evaluation to ensure consistent good practice.

1.3 Meeting Pupils' Needs

For a level four rating under this indicator:

- Targets, tasks and activities should be very well matched to the needs and aptitudes of individual pupils, taking account of pupils' pre-existing levels of knowledge and beliefs.
- The pace of learning should reflect pupils' different levels of maturity, experience, confidence and ability.
- The purpose of activities and contexts for teaching should be relevant and meaningful to pupils and pupils' experiences.
- Learning support staff should contribute effectively towards meeting pupils' needs.

Features to look for in relation to this indicator include records of previous learning, pre-topic assessments, the use of approaches to ascertain pre-existing knowledge and beliefs, provision of informative feedback to pupils and a choice of tasks to help pupils' personal health action planning. Clear arrangements to take account of different needs, including, adapted tasks or resources, a range of class, group and individual work, flexible groupings, supported group discussion or a suggestion box are also suggested. Other indications of good practice might include consultation of parents and the community, the sensitive use of information from other agencies and high ratings from pupils in post-unit assessments.

4.1 Pastoral care

4.2 Personal and Social Development

6.1 Provision of Accommodation and Facilities

These indicators focus on the broader provision of support for pupils and pupil development and the provision of an environment conducive to health. Some of the specific features more relevant to drug education that are suggested are as follows:

- Support for staff with good access to advice and training
- Clear policies for substance misuse, the involvement of parents and outside agencies and the handling of sensitive information.
- Involvement of pupils in assessing their needs and deciding action
- Surveys of pupils and their parents to find out how well their needs are met
- Provision of a safe, pleasant and stimulating environment well suited to supporting the curricular activities of pupils, the work of staff, and social and leisure activities where applicable.

5.1 Ethos

For a level four rating under this indicator:

- Pupils and staff should have contributed to the development of, and therefore identify strongly with, the school's health promotion aims. They should be proud to be associated with health promoting school developments and actively participate in related decision-making and development opportunities, which should also involve parents.
- The physical environment should be pleasant and conducive to pupil and staff health and morale should be high.
- Pupils should have, and utilise, the opportunity at all stages to contribute to the life of the school and to exercise responsibilities.

One feature which is highlighted as an indication of good practice would be that pupil and staff views are taken equitably into account in policy-making councils and committees, establishment of ground rules and complaints and redress procedures. Schools are invited to consult staff, pupils and parents on strengths and pressures and ways of strengthening the ethos and to consider the benefits of strengthening the involvement of pupils and staff in relevant decision-making to promote a sense of empowerment.

5.2 Partnerships with Parents and the School Board

To attain the top rating under this indicator schools would be expected to take steps to involve parents in supporting their child's learning about health and personal development. Such steps could include involving them in a school health working group, classroom activities, homework and extra-curricular activities. Parents should be consulted by means of regular surveys, briefings or workshops, their views taken into account and any enquiries responded to appropriately. Drug education is particularly singled out as a sensitive area in which parents should be consulted to identify pupils' needs.

5.3 Links with other Schools, Agencies, Employers and the Community

To achieve the top level rating for this indicator a school should:

- Have well-developed and effective links with other schools, units and educational establishments as appropriate
- Contribute to the life of the community and work with it, for example, by collaboratively developing health promoting initiatives
- Maintain effective links with statutory organisations including educational psychologists, medical and health promotion services, social work, the police and other such agencies.

Suggestions for good practice in this area include joint home-school approaches to problems, involvement of health professionals to advise on health education and to provide resources or training, and appropriate collaboration with community education and voluntary organisations.

6.3 Organisation and Use of Resources

For a level four rating under this indicator:

- Resources, including space and health-related resources from outwith the school, are efficiently and effectively organised for use by teachers and pupils who are aware of what resources are available and have easy access to them.
- Good use is made of resources to provide high quality support for health promotion. Pupils are encouraged to make regular, independent use of resources including specialist resources, where applicable.
- Well-presented and regularly-changed displays of pupils' work and other items of interest support learning and teaching about health.

Suggested features of good practice include good access to information on young people's health issues in the library via leaflets, internet access and CD-ROMs; promotion of local support services, and reviews and evaluation with pupils of resources related to pupils' health issues.

5-14 Guidelines for Health Education – Extracts from the guidelines under each strand for levels E and F (which apply to secondary school pupils).

Strand	Attainment Targets	
	Level E	**Level F**
Physical Health	Show their knowledge and understanding of the impact health choices can have on the quality of health e.g. choice of leisure activity Use decision-making skills to demonstrate their ability to make positive health choices e.g. risk assessment of substance misuse	Develop skills of personal management, including decision-making, problem-solving
Emotional Health	Identify the benefits to health of good personal relationships. Demonstrate responsible strategies to deal with a range of emotions in relationships. Recognise the impact of change on their lives Show ways in which they can seek help or advice	Demonstrate personal and inter-personal skills, e.g. coping with failure, negotiating and resolving conflict, strategies for seeking help with personal difficulties Show an ability to deal with changing expectations
Social Health	Identify global environmental issues that affect health. Identify some of the ways laws impact on health and safety Develop their knowledge of local health support services and of how to access them.	Demonstrate an understanding of interrelated rights and responsibilities e.g. within the family, with peers and through wider involvement in community action. Demonstrate skills for responding to risk situations in their local community. Identify their own role in supporting health and safety laws Recognise how people can work together in the community e.g. community action against drug misuse.

[Learning and Teaching Scotland, 2002]

Appendices to Chapter Two

22 May 2000

Mr. Donald Duncan
Director of Educational Services
The Moray Council
High Street
Elgin
Morayshire
IV30 1BX

Subject: Research Project - Drug Education

Dear Mr. Duncan,

As a research student in the School of Pharmacy at the Robert Gordon University, I am writing to you in relation to the project I am proposing as part of my PhD studies. The purpose of this letter is to request your permission to carry out some work in secondary schools in Moray.

The increasing integration of education, health and community services challenges all involved to provide a comprehensive support system to children, families and communities. One key area in which such co-operation can be expected to yield great benefits is that of health education, particularly in relation to substance misuse.

It has been noted in many recent publications that an understanding of how drug use manifests itself in youth culture is likely to lead to more sensitive and effective interventions in education and prevention. As schools focus more and more on pupil-centred learning, drug education is increasingly being called upon to target the specific needs of young people of different ages and drawn from different social and cultural backgrounds.

Tailoring drug education in such a way and involving young people in its planning and implementation is by no means easy, and further investigation is required to examine its feasibility and/or practicality on a broad scale. This is one of the issues which I hope to address in the course of my studies.

In fact, the research that I am proposing involves two stages:

- **The first stage (M.Phil.)** would involve gathering information on how Grampian secondary schools currently consider individual student beliefs/needs in the planning and implementation of their drug education programmes, and the factors that hinder/contribute to such consideration.
- This information would be gathered in the course of interviews with appropriate teachers in each school, during which a short survey would be completed. Naturally, permission will be sought from each head-teacher prior to any work in individual schools and the survey would be made available to the teachers and head-teachers in advance.
- This research will build on the work of researchers at the Scottish Council for Research in Education, who carried out a national survey on drug education in 1997 and 1999 and support the proposed work.

- **The second stage (Ph.D.)** which I envisage commencing late this year or early 2001 will involve an in-depth consideration of student attitudes, beliefs and drug-related behaviour in a small number of schools in Grampian to be selected when the first stage is complete.
- Using qualitative research methods, primarily interviews and focus groups, this stage seeks to provide concrete data on how substance use is manifested within the lives of specific groups of adolescents, as well as an insight into students' perceptions of drug education and their own needs.
- Due to the in-depth nature of the work, the number of students involved in this second stage would be quite small, and again, approval will be sought from individual schools, parents and students as appropriate.

Should you have any concerns or queries, I and/or my director of studies, Dr. Derek Stewart (Phone: 01224 262432) would be happy to meet with you or anyone whom you may consider more appropriate, to discuss the research at any time.

I trust that you will see the value of the proposed work and I look forward to hearing from you at your earliest convenience,

Yours sincerely,

Niamh Fitzgerald, BScPharm, MPSI, MRPharmS
Research Student
The School of Pharmacy

Direct Line: 01224 262522
Email: niamhief@hotmail.com

Dr. Derek Stewart, BScPharm, MSc, PhD, MRPharmS
Senior Lecturer
The School of Pharmacy

Direct Line: 01224 262432
Email: d.stewart@rgu.ac.uk

INTERVIEW GUIDE: PUPIL-CENTRED DRUG EDUCATION - 2000

INTRODUCTION:

Before I let you know my own background and the background to this research project, I'd like to say thank you very much for giving up your time to meet me and I hope that you will enjoy the interview.

I am a pharmacist by profession, and I am now studying for my PhD in the School of Pharmacy at The Robert Gordon University. As part of my PhD, I must first carry out research towards an MPhil (or Masters) degree, and then transfer to the PhD (or doctoral) programme during which I carry out a second phase of research.

This interview will form part of the research for my MPhil, during which I hope to interview the Health Education Co-ordinators, or other most relevant person, in every secondary school in the three local authorities in Grampian. The topic that I am researching is pupil-centred drug education - that is to what extent current drug education involves pupils and attempts to meet the needs of pupils with different drug-related behaviours. I am also concerned with identifying the views of health education co-ordinators on involving pupils or tailoring drug education in this way, what facilitates it, what are the barriers to be overcome and how feasible it is.

It is my hope that this work will provide those planning and developing drug education (both at school, and local authority/health board level) with information on how drug education is planned and provided in schools, and a better understanding of the issues and difficulties at school level. It is also hoped that by providing all the responding schools with the results of the research, they may learn from the achievements or avoid the difficulties already experienced elsewhere.

As you can understand, the results of the research will only be as useful as the knowledge and views that each health education co-ordinator shares with me. I want to encourage you to be as honest and open as you can be, what you have to say is very important to my research. If you are not sure what I mean or have any questions at any time, please do interrupt me and ask. I can assure you that under no circumstances will you or your school be identified in relation to any comments you make in this interview, and anything you say that might allow you to be identified will be removed/disguised in any published work.

Finally, before we start, is it okay if I record our conversation so that I don't miss any important points? I may also take some notes while we are talking if that's okay?

Definition of Drug Education:

During this interview, when I mention 'drug education', I am referring to all lessons/activities which deal with not only illegal drugs (or legal drugs used illegally) but also those that look at alcohol, tobacco or solvents. These may take the form of distinct courses, programmes (for example within the PSE curriculum), and also those elements which appear in other curricular areas such as the sciences and PE.

Also included are any associated activities such as competitions, presentations or outside visits.

Any questions before we move on?

SECTION I BACKGROUND INFORMATION

Can you tell me about your role in drug education?

1.1 What is your position within the school?

1.2 Please describe your role in drug education.

1.3 Can you explain how you came to assume this role?

1.4 To whom did you speak/discuss the interview with prior to today?

1.5 What other action did you take in relation to this interview prior to today?

Firstly, I am interested in background information that the school has in relation to drug use/issues among pupils or in the school community. Can you tell me...

1.6 Does the school/any teachers have any information on the pupils' drug education needs:

- ❑ Drug use statistics
- ❑ School incidents
- ❑ Crime figures
- ❑ Other local statistics
- ❑ Internal/external survey results
- ❑ Meetings
- ❑ Formal pupil requests
- ❑ Informal discussions with pupils
- ❑ Informal pupil contacts/requests

What are the sources of the information? How is informal information obtained?
Copies required if available.

1.7 Do you/the school have any feedback from the pupils in relation to the drug education?

Prompt: Formal (questionnaires, evaluation forms) or informal (comments, in conversation)

SECTION II DRUG EDUCATION POLICY DEVELOPMENT

This next part of the interview will deal with some questions relating to the schools policy on drug education. When discussing policy, I am referring to the philosophy, principles or objectives that underpin the drug education carried out in the school.

(need an example). I don't mean the content of the drug education curriculum or timetable.

Can you describe your schools policy on drug education?

2.1 Does your school have any written policy on drug education?

If yes, please supply a copy.

2.2 Does the school have any unwritten policy on drug education?

If yes, please describe the policy.
What format does it take, i.e. if it is not written, how is it articulated/disseminated.

2.3 Does the school use policy documents of outside agencies to guide its drug education?

If yes, please indicate which ones.

2.4 Please describe the thinking behind current policy (written OR unwritten OR from outside agencies).

2.5 What is your personal opinion of current policy?

If 'no' to both 2.1 and 2.2, please go to question 2.24

How were pupils involved in policy making?

2.6 Was any of the background information described in section I used to guide the policy development?
Prompt: How?

2.7 Were pupils involved in any way with the initiation of policy on drug education? Prompt: Was a policy requested by pupils? What led to the development of the policy?

2.8 Were pupils involved in any way with the planning or development of policy?

If yes to 2.8, pupils were involved with development:

2.9 Please describe their involvement - any consultation with pupils, any intervention by pupils, the contribution of pupils

Please supply any written submissions/minutes of development meetings/other relevant documentation

2.10 Which pupils were involved? What years? How were they selected?

2.11 What was the school's motivation for involving pupils?
2.12 What do you think facilitated the involvement of pupils you have described in your school?
2.13 What were the advantages of involving pupils in your opinion?
2.14 Were there any difficulties with pupil involvement?
2.15 Is there anything that you would identify as a barrier to further pupil involvement?
2.16 What would you advise other schools considering involving pupils in their policy development?

Now go to question 2.21

If no to 2.8, pupils were NOT involved in development:

2.17 Why, in your opinion, were pupils not involved in policy development in your school?
2.18 What do you see as barriers to pupil involvement?
2.19 What advantages or disadvantages would you see in involving pupils in policy development?
2.20 Do you think it is realistic to consider involving pupils?

2.21 Who approved the current policy?
Prompt: Were pupils given the opportunity to review the policy and/or approve/reject it? Why?/Why not?

2.22 Is the policy developed on an ongoing basis?

If not, why not?

2.23 Please describe any pupil involvement in ongoing policy development.

Now go to Section III

2.24 Are there any plans to develop a policy on drug education?

If YES to 2.24, there ARE plans to develop a policy...

2.25 Please describe the plans - in particular any provision for pupil involvement.
Prompt: Motivation for development of policy?, Purpose of policy?, Consultation process completed or planned?, Responsibility for development, approval procedure etc.?
Prompt: 'Why?/Why not?' in relation to pupil consultation and involvement.

If NO to 2.24, there are NO plans to develop a policy...

2.26 In your opinion, why are there no such plans?

SECTION III PUPIL-CENTRED DRUG EDUCATION

This next section of the interview will deal with the actual drug education that takes place in the classrooms, and how it caters for pupils with differing drug-related behaviours. It is also concerned with pupil involvement in the planning/delivery of the lessons that take place in the classroom, and the extent to which pupils have control over the drug education received.

Prompt: By 'catering for pupils with differing drug-related behaviours' I mean, catering equally well for pupils who neither drink, smoke, nor use any illicit drugs, as for those pupils who may do all three, and those pupils in between.

3.1 *(If the school has a policy on drug education)*
Please describe how the schools drug education policy is applied to drug education in the classroom.
Prompt: what impact does policy have on teaching practices/curriculum? How are lessons monitored to ensure compliance with policy?

3.2 Does the school use its own set curriculum for drug education in any year of study?

Prompt: By referring to 'its own set curriculum', I mean course descriptions and lesson plans for drug education for one/more year groups in the school that the school has developed in-house. I do not mean curricula designed by outside agencies, or courses that exist as part of standard drug education packages.

If so please supply a copy.

If yes, please go through the questions 2.6 to 2.23, referring to a set drug education curriculum rather than drug education policy. Then go to question 3.20

How are drug education lessons planned?

3.3 Which standard drug education packages does the school use in its teaching?

3.4 Please describe how the decisions on which packages to use are made.
Prompt: do pupils have the opportunity to review packages and state a preference?

3.5 Is any of the background information described in section I used to guide lesson planning?

3.6 Are pupils involved in any way in the planning of drug education lessons?
Prompt: How are the drug education lessons planned? Who is involved?, Are lesson plans prepared?

3.7 Is there any system for review or approval of plans for drug education lessons/courses?

If YES to 3.6, pupils ARE involved in lesson planning:

3.8 Please describe their involvement.

Prompt:

- ☐ Meetings with teachers (formal or informal)
- ☐ Discussions at the beginning of a course of lessons?
- ☐ Project work?
- ☐ Any other involvement?

Please supply any relevant documentation

3.9 Which pupils were involved? In what years? How were they selected?
3.10 What was the school's motivation for involving pupils?
3.11 What do you think facilitated the involvement of pupils you have described in your school?
3.12 What were the advantages of involving pupils in your opinion?
3.13 Were there any difficulties with pupil involvement?
3.14 Is there anything that you would identify as a barrier to further pupil involvement?
3.15 What would you advise other schools considering involving pupils in lesson planning?

Now go to question 3.20

If NO to 3.6, pupils were NOT involved in lesson planning:

3.16 Why, in your opinion were pupils not involved in drug education lesson planning at your school?
3.17 What are the barriers to pupil involvement?
3.18 What advantages or disadvantages would you see in involving pupils in lesson planning?
3.19 Is it realistic to consider involving pupils in your opinion?

The next few questions concern the content of the drug education lessons.

3.20 In your opinion, does the drug education provided cater for pupils with different drug-related behaviours?
Prompt: How?/Why not?, Are lessons designed to illustrate different points of view?

3.21 Do lessons have specific sections designed for pupils with different drug-related behaviours?

If yes, please describe.

3.22 Is there any scope for pupils to control their own progress through the drug education course?

3.23 Does the drug education provided discuss measures to reduce drug-related harm in pupils who do not wish to cease alcohol/drug/nicotine use?

If yes, please describe.

Prompt: Give Examples...
What do you think about this approach?

3.24 Is open discussion of drug use/abstinence by pupils encouraged in lessons?
Prompt: Why?/How?/Why not?

3.25 In your opinion, do pupils feel free to be honest about drug-related behaviour? smoking? alcohol intake? cannabis use? other illegal drug use? in classroom discussions on drugs?
Prompt: Why?/Why not?

After answers to 3.24, 3.25 or 3.26, Probe further as appropriate:

3.26 What do you think has led to that approach/atmosphere in your school?
Prompt: Pupil, parent, teacher, school or community factors?

3.27 What do you think are the barriers to such open discussions?
Prompt: Pupil-, parent-, teacher-, school- or community- related barriers?

The next few questions concern the teaching methods used in drug education lessons.

Please describe a typical drug education lesson.

3.28 Please describe, to the best of your knowledge, how much of drug education involves discussion/debate, project work, problem-solving or other interactive teaching methods?

3.29 Are teachers encouraged to use such interactive teaching methods in drug education?
Prompt: Why?/How?/Why not? Is there emphasis on interactive teaching methods for any traditional subjects?

3.30 What training/support do teachers receive to help them use interactive teaching methods?

3.31 What do you think are the factors that facilitate or hinder the use of interactive teaching methods in drug education in your school?

3.32 Is peer education used in any part of the drug education?

Peer education is where drug education is led and/or designed by young people, either from within the target audience, or a number of years ahead of them.

Prompt: Describe, How did this come about?, Motivation, experiences etc.

3.33 Are there any programmes of peer support in place in the school?

Prompt: Describe...

SECTION IV CONCLUSIONS!

The final section of the interview involves a few short questions about your role in the school, how you approached this interview and some overall impressions.

4.1 What is your perception of pupil satisfaction with current drug education?

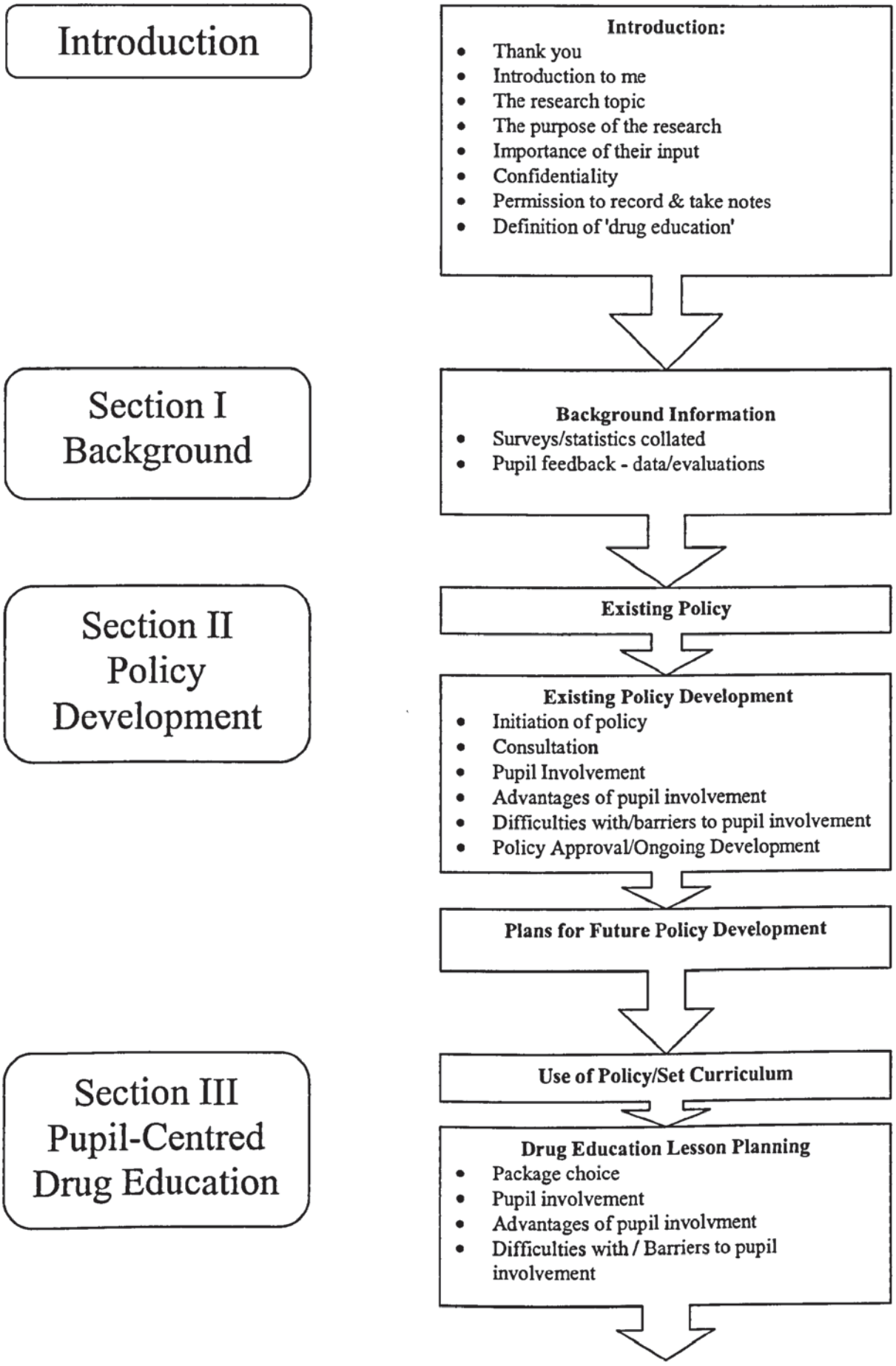
4.2 What is your perception of pupil satisfaction with current consultation procedures?

That brings us almost to the end of the interview, thank you very much once again for taking the time to help me with my research. Before we finish, can I ask...

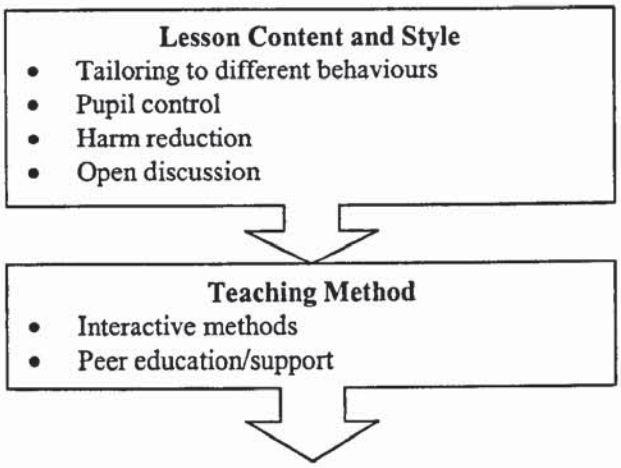
4.3 Is there anything you'd like to add about pupil involvement in drug education?

4.4 Is there anything you'd like to add in relation to how drug education could meet the needs of pupils with different drug-related behaviours?

4.5 Is there anything you would like to comment on in relation to how this interview has been arranged or carried out?


Introduction
Introduction:
Thank you
Introduction to me
The research topic
The purpose of the research
Importance of their input
Confidentiality
Permission to record & take notes
Definition of 'drug education'
Section I Background
Background Information
Surveys/statistics collated
Pupil feedback - data/evaluations
Section II Policy Development
Existing Policy
Existing Policy Development
Initiation of policy
Consultation
Pupil Involvement
Advantages of pupil involvement
Difficulties with/barriers to pupil involvement
Policy Approval/Ongoing Development
Plans for Future Policy Development
Section III Pupil-Centred Drug Education
Use of Policy/Set Curriculum
Drug Education Lesson Planning
Package choice
Pupil involvement
Advantages of pupil involvment
Difficulties with / Barriers to pupil involvement

Section III
...continued.



OBJECTIVES OF INTERVIEWS ON PUPIL-CENTRED DRUG EDUCATION:

To investigate:

(1) How Grampian secondary schools currently consider student beliefs and needs in planning and implementing their drug education[21] programmes

(2) The factors that hinder/assist such consideration and

(3) The experience and opinions of the respondents[22] in relation to student involvement in drug education planning and implementation.

Thus the major research questions to be answered pan out as follows:

A. How do schools (if they do) identify student beliefs and needs?
   - background info re. drug-related behaviours
   - own studies/outside research
   - informal knowledge

B. How do schools consider the beliefs and needs in planning drug education?
   - student involvement in policy development
   - student involvement in lesson planning
   - at stages of notification, consultation, development, approval?

C. How do schools consider student beliefs and needs in implementing drug education?
   - flexibility of lessons in catering for different viewpoints, breadth of content
   - student control of content/progress through lessons
   - interactivity of lessons, openness?
   - post-lesson/course feedback mechanisms

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21 **"Drug education"** is defined in the interview as "all lessons/activities which deal with not only illegal drugs (or legal drugs used illegally) but also those that look at alcohol, tobacco or solvents. These may take the form of distinct courses, programmes (for example within the PSE curriculum), and also those elements which appear in other curricular areas such as the sciences and PE. Also included are any associated activities such as competitions, presentations or outside visits".

22 **"Respondents"** refers to the Health Education Co-ordinator, or other member of staff selected by each school as most appropriate for the purposes of the interview.

D. What are the factors that hinder/assist such consideration?
   - Advantages/disadvantages of student involvement at levels of B and C above
   - Barriers to involvement/facilitating factors at levels of B and C above

E. What is the experience of the respondent and their opinion of student involvement as above?

PROCEDURE FOR ARRANGEMENT OF INTERVIEWS

Permission to contact schools directly has already been obtained from the three Grampian local authorities. Therefore, the Health Education Co-ordinator in each secondary school in Grampian will initially be contacted by means of a letter incorporating:

- An introduction to the researcher and interviewer (me) and the background to the research
- An introduction to the objectives and purpose of the research.
- An explanation of what topics will be covered in the interview
- Details of any documents of which copies will be requested if available
- Encouragement to discuss the topics as necessary with colleagues prior to the interview
- If they are not the most appropriate person to be interviewed, an instruction to pass on the letter

After the letters have been sent out, the HECs will be contacted by phone to arrange a suitable time for interview at the school.

NB: The interview guide is for my own use only as the interviewer, and I will be the only interviewer used in the study. The respondents will NOT be provided with a copy of the interview guide at any stage, prior to or during the interview.

FEEDBACK FORM

Objectives & Procedures for Interview

Are the objectives of the research covered adequately by the research questions?

Have you any comments on the procedure for the arrangement of the interviews?

The Interview Guide

Do the interview questions address the objectives of the research?

Is there anything that should to be added/omitted?

Are the questions and topics arranged in a logical order?

Is the meaning of each question clear and unambiguous?

Have you any other comments on the research or interview guide?

Please return by email, fax or post to:
Niamh Fitzgerald, Research Student
The School of Pharmacy
The Robert Gordon University
Schoolhill, Aberdeen
AB10 1FR, United Kingdom
Email: 9908521@mailer.rgu.ac.uk
Fax: 01224 262555

If you have any queries please phone: 01224 262531

The following themes emerged from the pilot interviews:

PRIORITY: The education that schools are expected to provide has become much broader in recent years and schools are under increasing pressure to provide health and social education under an ever-widening range of headings. Thus drug education has to compete with a range of other issues that may or may not take a higher priority. Time is precious within schools as is, and academic (exam) subjects are likely to be prioritised over the "hidden curriculum" of drug education.

Respondent B best summed up this issue: *"The definition of health education and health promotion itself and the health promoting school, that gets wider and wider and wider, and so because of that widening, we've identified big gaps where we've got nothing. ...so if people say "oh yes, we should maybe have more up to date materials" but...you can only work in so many fronts at once".*

The information that is made public about the school (league tables, truancy figures) and impending inspections have considerable influence on how priorities are determined although the personal priorities of the head teacher also receive attention. It was felt that centrally led audits of drug and health education often fail to contribute to improvement but instead lead to a "tick-box mentality". The work is seen to be done on a surface level, but that doesn't mean the end result is effective. Respondent A: *"If you audit everything you do in school and you tick the box and say they've had forty hours of it over a programme then you can say "Yeah, we've covered it". But was it relevant? Did they know it? Do you reinforce it?".*

PHILOSOPHY: Each school's philosophy on drug education is reflected in their policies on drug education and drug incidents. The schools tended to include their drug education policy within the overall framework of a general PSE or health education policy, although one school did not yet have a written policy. All three respondents stated that they aimed to provide the kids with knowledge about drugs however the three schools varied in how directive they sought to be when giving information. Respondent C indicated that he was in favour of a zero-tolerance approach *"arming the kids with their education, arming the kids with information about drugs, but making them confident in their own skills and abilities and future, to reject that alternative lifestyle".* The level and culture of drug use in the local area directly influenced the approach taken with drugs incidents and during lessons e.g. how admissions of drug use by pupils would be dealt with.

LESSONS: In lessons various teaching methods and education packages are used depending on the school, class and particular teacher involved. Most of the drug education is carried out as part of the PSE (Personal and Social Education) course. Some schools use peer education in other areas but not in drug education. Respondent C emphasised the potential difficulties with peer education in this area *"My worry about senior students delivering some aspects of [drug education] is that they may not do it well. It may destroy their confidence and the message may get read badly...If convinced at all that it was valid I would be very very close to what's happening and it would be a very, very tight programme".*

Class size and the characteristics of the particular class also impact on the teaching methods used, for example, some workshop type lessons cannot be easily attempted with larger classes.

ABILITY & PREPAREDNESS: Teachers draw on their experiences, teacher training and in-service training to carry out drug education and some are better qualified than others. The subject that a teacher normally teaches also impacts on their ability to deliver drug education well. While resources and information that are relevant to drug education are available within the schools, how much they are actually used varies. Some teaching strategies, such as the use of worksheets or videos sometimes serve to protect the credibility of less knowledgeable or less able teachers or to prevent chaos in their classrooms.

Respondent A *"Hundreds of worksheets which are available, you don't necessarily need to use all of them. Some of these are used almost as a protection of the teacher's knowledge or lack of it... Because it's awful easy to expose a teacher who is really uncomfortable with this area because they're not trained in it, to give either a personal opinion or to say I know nothing' about this."*

NEED: Respondents' perceptions of levels of drug misuse by pupils, in their school and in their local community varied. In some cases these perceptions contribute to decisions about the drug education that is provided in the school. Perceptions of pupil satisfaction varied between respondents - one believed that many pupils may be bored, in another school, the respondent felt that the pupils were largely satisfied despite quite negative results from an evaluation. Changes in the respondent's perception of the drug problem in the local community led them to describe what changes if any, might be necessary in the drug education programme. Need was also defined by consideration of health audits carried out in the school. Respondent C: *"What I see is an acceptance that some people have a lifestyle or a family situation or a background that will leave them open to people that could peddle drugs in their direction...There's a life outside our school gate."*

FEEDBACK: All respondents stated that teachers used their experience in the classroom to judge how good various drug education strategies or teaching methods were. Whether or not the strategy was liked by the pupils or *"went down well"* with them was seen as indicating that it was a good strategy. Teachers would then bring this kind of informal feedback from the classroom into the planning process for drug education at various stages and levels. In the schools where no formal pupil consultation on drug education existed, the respondents did recognise the need to adapt drug education to meet with the needs of pupils with different drug-related behaviours:

Respondent A: *"I think we need to begin looking at what people know, what skills they need...One of the major changes that is happening in education is looking at different learning skills and teaching approaches in there. I don't think that's happened in PSE and it's certainly not happened in drug education...It's more than an audit that's required, its actually to say to the pupils and to the teachers do you think we're missing anything out? and the pupils, what would you like added in? And what's a load of rubbish? And we probably don't ask them enough that way."*

Respondent B: "*That's something we're trying to battle with throughout the syllabus, the curriculum, not just the drug education syllabus, coping with the different levels of ability and the different responses. It's a constant battle.*"

There were a number of difficulties with consulting the pupils in practice. "*Part of the problem is that the (pupils) in this case are so varied and that some of the people that you might get some of the best information from are perhaps not the ones that are best capable of expressing that information. And some of the people who are maybe better at expressing their views are perhaps some of the less knowledgeable ones about the drugs scene*" (Respondent B).

All of the schools carried out more formal pupil consultation but this only included consultation on drug education in school C. Evaluation of the drug education also varied between schools.

25 June 2003

«Title» «FirstName» «LastName»
«JobTitle»
«Company»
«Address1»
«Address2»
«City»
«PostalCode»

Subject: Research Project - Drug Education

Dear «Title» «LastName»,

As a research student in the School of Pharmacy at the Robert Gordon University, I am writing to inform you that I will be contacting your school in the near future in relation to research I am carrying out as part of my PhD studies. As you may be aware, I have been in contact with the Educational Services department at Moray Council in relation to the proposed research (see enclosed).

For this research, which will be carried out in a number of secondary schools in Grampian, I hope to meet with the member of staff in your school who is most involved in policy development and lesson planning in the field of drug education. By drug education, I mean lessons or activities that deal with the use of illegal drugs *and/or* alcohol, tobacco or solvents.

The purpose of the meeting, which should last no more than one hour, will be to discuss:

1. The philosophy of drug education in the school
2. How drug education in the school is planned, developed and delivered
3. The involvement of pupils in such planning, development and delivery
4. The experiences and opinions of the respondent in relation to drug education and pupil involvement.

All aspects of the discussion will be treated as ***highly confidential*** and NO respondent or school will be allowed to be identified in relation to any opinions expressed or information supplied. I hope to have an open discussion of the above issues, and aim above all to provide a clear picture of how drug education is conducted in a real school environment where all involved are subject to many other everyday pressures and concerns.

When the full study is completed, I will be happy to provide each school with my results which will form part of my doctoral thesis. If you would like to have individual feedback for your school (for example in PAT), then that may also be arranged. The overall outcomes will be made available to local and central authorities and agencies that are involved in school-based drug education planning (without identifying individuals/schools) in the hope that they will contribute to a better understanding of drug education provision and the issues and difficulties at school level.

I will contact you next week to find out if you are willing for your school to participate in the study and to identify the person whom you feel is most appropriate for me to talk to. I would then contact that person to arrange to meet in January or early February. In the meantime or at any stage, if you would like to discuss any aspect of this research or have any queries,

please feel free to contact me or my Director of Studies, Dr. Derek Stewart (see contact details, below).

I very much appreciate the time you have taken to consider this matter and I hope that you will lend it your full support.

Yours sincerely,

Niamh Fitzgerald, BScPharm, MPSI, MRPharmS
Research Student
The School of Pharmacy

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The Robert Gordon University

Fax

To: «FIRSTNAME2» «LASTNAME2» **From:** NIAMH FITZGERALD

Fax: «Fax» **Phone:** 01224 262522

Pages: 3 **Date:**

Re: Drug Education Research Project **Email:** niamhief@hotmail.com

☐ **Urgent** ☑ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

Dear «FirstName2»,

Thank you very much for agreeing to meet me as part of my research project. As we arranged, I will come to the school on «Interview_Date_and_Time»

I am enclosing further details of the topics that I would like to discuss with you, however the interview is intended to be flexible to adapt to your specific concerns and experiences and those of the school. I would encourage you to discuss any of the topics with your colleagues prior to our meeting. I am also enclosing details of the documents that I will be enquiring about. If these documents are available within the school, I would very much appreciate copies being made available to me, if that is possible.

Do remember that all our discussion will be kept strictly confidential, and neither you nor your school will be identified in association with any comments made.

The interview may take up to an hour and a half. If for any reason you find that you will not be able to be present for this length of time, I would appreciate it if you could let me know in advance and we can re-schedule.

Thank you once again for your co-operation, and I look forward to meeting you in a few weeks.

Sincerely,

DRUG EDUCATION RESEARCH PROJECT

Background Information for Interviews

Objectives:

To investigate:

1. Drug education in the school - policy, planning, development
2. The involvement of pupils in policy, planning and development
3. How pupil needs are identified and addressed, especially for at-risk pupils
4. General discussion on how drug education is developing; issues that need to be addressed; and the support the school needs to develop drug education further.

Topics to be discussed:

Section I - Introduction

- General questions about the school
- Your role in relation to drug education in the school
- Levels of substance use among pupils and in the community

Section II - Policy Development

- School policy on drug education
- Policy development
- The purpose of drug education
- Co-operation with local community
- School priorities in health and social education

Section III - Drug Education Planning

- How drug education lessons are planned
- Evaluation/monitoring of lessons

Section IV - Drug Education Lessons

- A typical drug education lesson
- Drug education teachers
- Tailoring of drug education to meet differing needs
- Openness in the classroom
- Dealing with at-risk pupils
- Peer education/support

Section V - Conclusions

- Overall impressions
- What could improve drug education?
- Any other points

Documents/Information that would be useful to have to hand if available:

- School policy on drug education
- School policy on drug incidents

- Any evaluations of drug education
- Outline (not any specific details) of school drug-related incidents
- Information on drug use in the local area
- Any survey/study results: internal school surveys/questionnaires/external surveys/audits
- Outline and/or details of meetings in which drug education was discussed
- General policies/documents relating to dealing with difficult/vulnerable pupils
- Any feedback from pupils

Interview Guide: Pupil-Centred Drug Education - 2000

Section I Introduction

Before I let you know my own background and the background to this research project, I'd like to say thank you very much for giving up your time to meet me and I hope that you will enjoy the interview.

As you know, this interview is being carried out as part of my research for my PhD studies which I am undertaking in the School of Pharmacy at The Robert Gordon University. My PhD involves two stages: an M.Phil. (masters) stage, and then a PhD (doctoral) stage. This interview will form part of the research for the masters stage.

I have spent the first twelve months of my studies looking at the literature on drug education in schools, both in Scotland and internationally. There is a huge volume of information on what works in drug education and discusses the effectiveness of various approaches and programmes. In Scotland, many surveys of drug education have been carried out by the government, independent bodies and universities. The most recent of these showed that 97% of secondary schools provide drug education to all their pupils.

These surveys, while they provide an overview of drug education provision, they offer little insight into what actually happens in secondary schools. There is very little published on the reality of drug education in school, how it is planned and taught in schools, the difficulties and pressures that schools face, and the factors that affect the drug education that is ultimately provided. By interviewing staff directly in secondary schools in Grampian, I hope to shed light on these issues.

I have already carried out three pilot interviews in Dumbartonshire. These have allowed me to identify relevant issues and test the length of the interview. The topics I will be focusing on today are:

1. The philosophy of drug education in the school
2. How drug education in the school is planned, developed and delivered
3. The involvement of pupils in such planning, development and delivery
4. Your own experiences and opinions in relation to drug education and pupil involvement

If at any stage, you feel that there is something relevant that I have not asked about, please bring it up. Anything you say will be used to improve the questions for the next interview.

Definition of Drug Education: All lessons/activities which deal with not only illegal drugs (or legal drugs used illegally) OR look at alcohol, tobacco or solvents. They may be distinct courses, programmes (for example within the PSE curriculum) or elements that appear in other curricular areas such as the sciences or home economics. Also included are any associated activities such as competitions, presentations or outside visits.

Naturally, the results of the research will be made available to all participating schools and I would be happy to discuss them with you at that stage if you would

like. In addition, I hope to provide those planning and developing drug education (both at school, and local authority/health board level) with my report to give them a better understanding of howdrug education is planned and provided in schools, and the issues and difficulties at school level.

Since the purpose of the research is to understand what really happens in schools, it is vital that you are honest and open with your knowledge and views. Whatever you tell me, it will be completely in confidence. Neither you nor the school will be identified in relation to anything you say without your permission and the tapes of the interview will be stored securely and erased when the research is complete.

If you are not sure what I mean or have any questions at any time, please do interrupt me and ask. Have you any questions just now about any aspect of the study or the interview?

Now that I have explained the study to you, I must ask you to sign this consent form. This simply states that you understand what the purpose of the study is and are participating willingly and freely.

1.1 Firstly, can you tell me a little bit more in general about the school: how many pupils there are, the local area etc.

1.2 Can you tell me about your role in drug education?

1.3 What level of substance use do you think there is among pupils?

1.4 Do you have access to any information on usage levels?

Section II Policy Development

2.1 Does the school have a policy on drug education?

2.2 What is the origin of the policy?

2.3 How was the policy developed?

Consultation, approval etc.
Who was consulted, which years, how were they selected?
What led to such consultation, facilitating factors/barriers in the school?
Advantages/disadvantages of consultation. Motivation/Difficulties etc.
Realistic or not?
Advice for other schools?

2.4 What do you think about involving pupils in policy development?

2.5 Do you (personally) think the current policy is a good one?
How do you believe the policy caters for the differing needs of pupils - with different home/family/personal values in relation to alcohol or drug use?

2.6 Can you tell me what you believe is the purpose of drug education?
Is this the same as the purpose underpinning the school policy?

2.7 Can you describe the policy to me?

Philosophy behind the policy? - Probe. Will that work? Why?
Key messages?
Theory behind the strategies?
Variation with age group?
Do you think that you try to present a balanced view on drugs or do you present a view more oriented towards prevention of use?

2.8 Are there any plans to develop the policy further/develop a policy?

2.9 Where does drug education come in the priorities of the school?

2.10 What decides the priorities?

Section III Drug Education Planning

This section discusses planning and monitoring of drug education.

3.1 How are drug education lessons planned?

If I was a teacher and I'm time-tabled in for one class a week with S3 on drug education, what steps would I take to plan the lesson?

3.2 How are drug education packages used?
How were the packages chosen?

3.3 What do you think about involving pupils in the planning of drug education lessons?

Are they involved in meetings/informal discussions on lesson planning?
Which pupils, selection? how did it work?
Advantages/disadvantages. Difficulties/motivations. Barriers?

Is it realistic to consider involving pupils more?
Advice for other schools?

3.4 How are lessons monitored to ensure that they comply with the policy and philosophy of the school that you have described?
If a teacher wanted to give a lesson that was at odds with policy, would anyone
find out?

3.5 What evaluation is carried out on the drug education?

Pupil feedback, teacher feedback, pupil questionnaires, consultation exercises etc.

Section IV Drug Education Lessons

The next few questions concern the content of the drug education lessons.

4.1 Please describe a typical drug education lesson
What kinds of teaching methods are used?
What kinds of activities are used in drug education?

4.2 How do lessons vary depending on the teacher?

4.3 What makes someone a good drug education teacher?

Impact of own subject, training issues, experience etc.

4.4 How well trained are the teachers -
in drug education?
in interactive teaching methods?

4.5 Is there anything (else) that facilitates/hinders the use of interactive teaching methods?

4.6 How does the drug education change as pupils get older?

4.7 Particularly for older age-groups, how well do you think the drug education caters for pupils with different lifestyles?
Are lessons designed to illustrate different points of view?

4.8 Is there scope for pupils to have any element of control over their progress through the drug education course?

4.9 What do you think of harm reduction?
Does the drug education provided discuss measures to reduce drug-related harm in pupils who do not wish to cease alcohol/drug/nicotine use?

4.10 How open do you think the lessons are?
Do you think pupils feel free to be honest about drug-related behaviour?
What action would be taken if pupils admit to drug taking of various kinds?

4.11 What do you think has led to that approach/atmosphere in your school? Pupil, parent, teacher, school or community factors?

4.12 What do you think are the barriers to such open discussions? Pupil-, parent-, teacher-, school- or community- related barriers?

4.13 What do you think of peer education? Is it used in any part of the drug education?

4.14 Are there any programmes of peer support in place in the school?

Section V Conclusions

5.1 Do you think the pupils are happy with the drug education they receive?

5.2 Do you think drug education works? In what way?

5.3 What do you think of involving pupils more in development and planning?

5.4 Do you have any ideas on how drug education could be improved?

5.5 Is there anything else you'd like to add?

Section VI - Procedural Questions:

6.1 Can I get copies of the policy/audits/statistics/evaluations that you mentioned?

6.2 If I have any queries about anything you have said, is it okay if I give you a phone in the next couple of weeks to clarify them? When is the best time to call?

6.3 When all the interviews are complete, I'll be drawing up a final report. I would then like to go back to a number of respondents to check that my conclusions ring true. Would you be will to meet with me again at that stage? (Probably March/April)

6.4 As I said at the beginning, these interviews are part of my masters research. For the PhD stage, I hope to select just one school out of all those interviewed and study it in greater detail. This would mean that I would interview the head teacher, other staff and a small sample of pupils in the school. I would also need to spend some time in the school just to observe what goes on, both in the classroom and in meetings. Do you think that Mr. Thomson would be willing to discuss this with me? Would it be a possibility in this school?

All that remains then is for me to say thank you very much once again for giving up your time to do this. I'll be in touch!

Interview Guide: Pupil-Centred Drug Education - 2000 - 08/05/01

Section I Introduction

Firstly: Thank Interviewee.

Explain Work to Date and Rationale of Interview Method.

- huge volume of information on what works in drug education discussing the effectiveness of various approaches and programmes
- many surveys of drug education in Scottish schools e.g. 97% of secondary schools provide drug education
- provide an overview but offer little insight into what actually happens in schools
- using interviews to try to get behind the statistics and highlight what issues need to be tackled to maximise the potential success of drug and health education in schools

Explain My Own Involvement.

- MPhil- PhD stages, (part of research for the masters stage).

Explain What Will be Done with the Results.

Progression of Topics for this Interview

- Now completed: three pilot interviews in Dunbartonshire and seven main study interviews in Grampian
- Focus of the interviews has evolved to reflect the topics that have been brought up in other schools so I may not stick exactly to the plan that I have faxed you.
- So to update slightly: the main topics of interest are:

1. Overall approach to drug education in the school
2. Involvement of pupils in policy, planning and development of drug education, especially catering for at-risk pupils
3. Messages and content of drug education
4. Development of drug education, monitoring/feedback mechanisms, prioritising within PSE etc.

- I would like you to particularly think of any problems or issues that have come up in this school or anything that you think is innovative.

- I'm not going to be firing loads of questions at you, we will just start with a few basic issues and I'll work around what comes up

If at any stage, you feel that there is something relevant that I have not asked about, please bring it up. Anything you say will be used to improve the questions for the next interview.

Definition of Drug Education: All lessons/activities which deal with not only illegal drugs (or legal drugs used illegally) OR look at alcohol, tobacco or solvents. They

may be distinct courses, programmes (for example within the PSE curriculum) or elements that appear in other curricular areas such as the sciences or home economics. Also included are any associated activities such as competitions, presentations or outside visits.

- Neither you nor the school will be identified in relation to anything you say without your permission and the tapes of the interview will be stored securely and erased when the research is complete

- Totally confidential so please be honest

- Have you any questions just now about any aspect of the study or the interview?

- If you are not sure what I mean or have any questions at any time, please do interrupt me and ask.

- Consent form. This simply states that you understand what the purpose of the study is and are participating willingly and freely.

Section I Background

1.1 Firstly, can you tell me a little bit more in general about the school: how many pupils there are, the local area etc.

1.2 Can you tell me about your role in drug education and how you got involved?

1.3 What do you know about pupils experiences of alcohol, tobacco and other drugs?

- Do you have access to any information on usage levels? What is your own feeling?

Section II Overall Approach to Drug Education

2.1 How does the school approach drug education?

2.2 Does the school have a policy on drug education?

- Would a local authority policy be useful? How?

- Would the school like to be involved with developing one?

- How would a policy actually affect practice?

2.3 Who teaches drug education?

- Division between year groups.

- Outline of education over the years

- Resources used

Involvement of other groups with drug education/with the school?

- Outside Agencies

- Local Community

- Parents

- Peer education

Section III Messsages & Content

3.1 What is the purpose of drug education?

3.2 How do you try to achieve that purpose?

3.3 How does the drug education cater for pupils who may have never used, and those who may be occasional users of substances?

3.4 Do you try to present a balance of viewpoints?

- reality that experimentation does not usually mean that you will end up in chaos, although it is a risk
- using resources that show the in-between people - not just the baddies and the goodies

3.5 Do you actively tell them how to deal with friends who may become very drunk, first aid information?

- what about if it was an illegal drug, say ecstasy?
- how do you give harm reduction information
- if the pupils are trying drugs, then they need the HR information before they try, not later when it may be too late

- do outside agencies give HR information to the pupils? Why then can the teachers not? Should the school not be able to stand by any information that is given to the pupils?

3.6 Are the lessons discussion based?

- in small groups or teacher led?
- how able are the pupils to discuss complex issues
- would issues such as the discussion of cannabis legalisation be planned into the curriculum or just come up?

3.7 How open are the discussions in the lessons?

- Can pupils admit to drug experimentation? In the past? Ongoing?
- What action would be taken if a pupil said they had tried cannabis last weekend?
- Is honesty practical? Can you really have an open discussion where pupils can explore their own behaviour and what that means for them? Is this possible in school?

3.8 Entertainment Value

- do you think the pupils are happy with the drug education they receive?
- what they want versus what they need?
- Leah Betts - still scare tactics - not realistic for most ecstasy users?
- What about discussion of lifestyle effects, why you would want to get out of your head to enjoy yourself? What kind of way is that to live? Tackling the reasons why people use and the everyday effects that has on them, rather than the doomsday scenario. Rather like everyday effects of smoking (smell, cough) rather than the lung cancer argument.

Section IV Monitoring/Feedback

4.1 How is the drug education monitored to see that it is as it should be?

- Are the courses evaluated?

4.2 How does it vary between classes and teachers?

- How do you ensure that messages are consistent between different classes?
- Do you think that different teachers give very different messages?
- Have all teachers received training - in drug ed, and in interactive teaching?

4.3 How is drug education developed and updated?

4.4 Are pupils asked what they thought of the courses?

- How are their needs assessed when planning the courses?
- Before each course, are they involved in planning, looking at packages etc?
- After each course, are they asked what they thought of it?
- Why not? Is this practical? Do you think it would be a good idea?

4.5 How do you fit in all the priorities of PSE?

- What has less emphasis than previously?
- What would you like to do more on?
- How has the expansion of PSE affected your role as a guidance teacher/AHT etc?

4.6 What decides the priorities?

- How does outside pressure e.g. from government apply to the school?
- What influence do the parents have on deciding PSE priorities?
- How much depends on the personal priorities of the head teacher or guidance team?

4.7 Has the school any experience of dealing with pupils who may be at a higher risk of developing drug or alcohol problems due to home situation, because they are in care or alienated?

- How are such pupils identified and catered for?
- Are there any steps taken to prevent them developing drug problems?
- What is done if a problem occurs?
- How are those pupils supported in the school?
- How does the school work with other agencies in this regard?

Section V Conclusions

5.1 Do you think drug education works? In what way?

5.2 What would you like to be able to do to develop drug education that you cannot currently do?
What needs to happen so that you can do that? What is preventing it?

5.3 What has been most helpful in improving drug education?

5.4 Do you have any other ideas on how drug education could be improved?

5.5 Is there anything else you'd like to add?

Section VI - Procedural Questions:

6.1 Can I get copies of the policy/audits/statistics/evaluations that you mentioned?

6.2 If I have any queries about anything you have said, is it okay if I give you a phone in the next couple of weeks to clarify them? When is the best time to call?

6.3 When all the interviews are complete, I'll be drawing up a final report. I would then like to go back to a number of respondents to check that my conclusions ring true. Would you be will to meet with me again at that stage? (Probably March/April)

6.4 As I said at the beginning, these interviews are part of my masters research. For the PhD stage, I hope to select just one school out of all those interviewed and study it in greater detail. This would mean that I would interview the head teacher, other staff and a small sample of pupils in the school. I would also need to spend some time in the school just to observe what goes on, both in the classroom and in meetings. Do you think that Mr. Thomson would be willing to discuss this with me? Would it be a possibility in this school?

All that remains then is for me to say thank you very much once again for giving up your time to do this. I'll be in touch!

THE ROBERT GORDON UNIVERSITY
School of Pharmacy

Grampian Secondary School Drug Education and Pupil Involvement Study

CONSENT FORM

Name of Interviewee: .....

Name of School: .....

Principal Investigator: ....Niamh Fitzgerald.....

I have read the background information on the above study and have had the opportunity to discuss the details with Niamh Fitzgerald and ask questions. The nature and purpose of the interview have been explained to me and I understand fully what is proposed.

I have agreed to take part in the study as it has been outlined to me, but I understand that I am completely free to withdraw from the study or any part of the study at any time. I undertake to answer questions openly and honestly to the best of my knowledge.

I understand that this study is part of a research project designed to enhance understanding of drug education provision in a selection of secondary schools in Grampian which has been notified to the Directors of Education in Aberdeen city, Aberdeenshire and Moray local authorities. I am also aware that the head teacher of this school has been informed of the study.

I give my consent for the interview to be audiotaped. I understand that the any documents or copies of documents relating to the school that I provide, as well as the audio tapes and content of the interview will be maintained securely and remain completely confidential. I also understand that the results of the study will be published as part of the doctoral thesis of the investigator and may also be written up for publication elsewhere. I further understand that neither the school nor I will be identified in any published work or by the investigator in relation to anything I say in the interview unless I otherwise give consent.

I hereby fully and freely consent to participate in the study, which has been fully explained to me.

Signature of Inverviewee:

.....

Date:

.....

I confirm that I have explained to the interviewee, the nature and purpose of the study to be undertaken.

Signature of Investigator:

.....

Date:

.....

Project: Drug Education in Northeast Scotland **User:** Niamh

Date: 20/04/2003 - 07:58:16

DOCUMENT TEXT REPORT

Document: School 8

Created: 23/01/2002 - 18:25:29
Modified: 21/03/2002 - 12:18:52
Description:
Main Study Interview - School 8 - 8th May 2001 - Two Respondents, James, and Scott, Principal Teachers of Guidance.

Document Text:

1: **School 8**

2: **Main Study Interview - School 8 - 8th May 2001 - Two Respondents, James, and Scott, Principal Teachers of Guidance.**

3: §1 **Introduction**

4: §2 Interviewer

5: I usually, not always but I can usually understand what I'm saying, but when I'm listening to it I'm not always great with the accents. I'm getting better but-

6: §3 James

7: Well, if you've been down in Glasgow and now up here-

8: §4 Interviewer

9: Well, I tell you, it's a lot easier up here than it was down in Glasgow!

10: §5 Scott

11: So far!

12: §6 **Demographics**

13: §7 Interviewer

14: So far yeah! So if you could just tell me first, just in general about the school and the area, the size of the school, the pupil background, that sort of thing as an introduction that would be great.

15: §8 James

16: Right. We're a standard comprehensive. Roll varies between 860 and 900 so we're a wee bit smaller than we were in the past because I think the maximum was about 1100, <R2> aye, at one time.

17: §9 Scott

18: Yeah, and we had <8> thousand at one stage.

19: §10 James

20: So we're just an average comprehensive I would say. In terms of attainment, we're probably around the national average.

21: §11 Interviewer

22: Okay.

23: §12 Scott

24: And our last HMI report said that we served a deprived area.

25: §13 James

26: A deprived area yeah.

27: §14 Interviewer

28: Okay. What about <place name>, the community? What are the main businesses or what's the?

29: §15 James

30: Well, the main industry would be the fishin' industry which is declinin' currently and there's a certain amount of employment offshore, oil-related and of course, your ancillary business to the fishin'. Obviously any contraction in the fishin industry has a spin-over back in the community generally.

31: §16 Interviewer

32: Okay. And are most of the pupils in the local area or are they bussed in?

33: §17 James

34: Well, the primary school bussin' in would be <place names> and also <place name>. <place name> would walk in.

35: §18 Scott

36: And then the surrounding villages all send their pupils here obviously.

37: §19 Role of Respondent

38: §20 Organisation

39: §21 Interviewer

40: Right, okay. And can you tell me then about your roles in drug education?

41: §22 James

42: Right, basically, there's five principal teachers guidance and the school is divided in a house basis so it's a vertical system where we teach from first to fifth year essentially for the PSE programme. Sixth year, the assistant rector takes over the sixth year as a group so we're with them from first to fifth year so my group-

43: §23 Interviewer

44: Does that mean that you stay with the same classes all along?

45: §24 James

46: We take them all the way through. Yeah.

47: §25 Interviewer

48: Okay, right.

49: §26 ***Who teaches it?***

50: §27 James

51: So, that being the case the PSE programme within the school is taught full time by the guidance staff. We're full time guidance staff. So our responsibility basically is the pastoral or curriculur care but also the teaching of the PSE programme. Added to that recently we've also been tacked in with equal opportunities, which is not relevant to this but its another project we've got just now.

52: §28 Interviewer

53: Okay, but its another project that's covered by the guidance team.

54: §29 James

55: Guidance team, yeah.

56: §30 **Prevalence**

57: §31 Interviewer

58: Okay. And what do you know about the pupils' experiences with drugs, alcohol, smoking?

59: §32 ***Alcohol***

60: §33 James

61: Well, its easier to be precise about alcohol because I think we'd be agreed that that's by far and away a major problem.

62: §34 Events

63: §35 James

64: To the extent that this year we were concerned that the age group seems to be coming down so we partly organised an alcohol awareness raisin' evening for parents of third year, second?

65: §36 Scott

66: third year.

67: §37 James

68: And we involved health Promotions, local police, <name> from the <local authority> protocol on alcohol

and the school nurse also, in just an information evening, plus bits and pieces, for parents. Just to highlight what we thought was a major problem in the school. There's quite large numbers of youngsters roamin' about on a Friday night, carrying coca-cola bottles which are almost certainly not pure coca-cola.

69: §38 Interviewer

70: Right.

71: §39 James

72: And creating some degree of problem for the police just by the sheer weight of numbers. Now they've got a difficulty moving them on and obviously getting all kinds of abuse for a fairly polite request just to move. So that was a <42> so we addressed that.

73: §40 Prevalence

74: §41 James

75: In terms of drugs the only thing I can say I think there's probably been in the distant past, one sort of a real incident. It was one not directly in school and we have never, I think taken any illegal substance off any pupil in school to the best of my knowledge at this point in time.

76: §42 Interviewer

77: Okay.

78: §43 James

79: Which doesn't mean to say of course that we will not have to do so. It doesn't mean to say that they haven't been around either. It just means that we have not taken anything-

80: §44 Scott

81: It's alcohol misuse that is the major drug problem in the community and this will probably emerge in our discussions later on. There is an awareness of a drug scene in <the local area> of which they claim not to be part but of which they are very knowledgeable and that is worrying. Would that be fair comment?

82: §45 Interviewer

83: Okay.

84: §46 James

85: Yeah. My fourth year have been looking at one of the, <51>, one of the more streetwise kids said "it's much worse than you would imagine".

86: §47 Interviewer

87: Right, okay.

88: §48 James

89: That was then qualified by some other people sayin' "well, nay near as bad as Glasgow etc." you know, but it's fairly -

90: §49 Interviewer

91: Okay.

92: §50 James

93: But we've certainly got more in common, I mean we have identified places, not in <this town>, we've identified, but we were gettin' a lot of comment about a place not a million miles from <this town> so we passed that information on to the police force who would be directly related to that area. I mean if you ask the kids, as Scott said, you do get some statements which would really indicate a problem and depending on how hard you push you get different conflicting evidence. I mean the drug that it is most commonly mentioned is, wouldn't surprise you is cannabis. And you do get reference to ecstasy, some slight mention of LSD which usually is referred to as acid like, but whatever. Amphetamine, speed is generally been reputed to be on the go at times but again, not as high a profile. So these are, I have certainly had one clear statement from a parent of a pupil that left that admitted to have tried heroin on one occasion. Now that may have been one occasion or two or otherwise but that was certainly one clear indication.

94: It's clear from these comments and later ones, highlighted below that the respondents are pretty well informed about the drugs scene. They seem to be aware of trends between different drugs, as well as *exactly* where they are used in the town etc.

95: §51 Interviewer

96: And the remote incident that you were talking about, what was that?

97: §52 James

98: I think it was, I have a feeling it was cannabis, but it's so long ago, it came up in conversation but that was it was rumoured rather than proven to be honest with you.

99: §53 Interviewer

100: And it wasn't on the school-

101: §54 James

102: It wasn't on the school premises, no.

103: §55 Scott

104: I generally find, in talking about drugs to classes, that they are aware of a local drugs scene and there are always a number of pupils in every class, if I say, "if I wanted drugs, could you point me in the right direction to the right person, to the right place to get them". Now there are always a few pupils in every class who can do that.

105: §56 Interviewer

106: Right.

107: §57 James

108: <73> it's available. I mean that would have been the area identified because at one time we were talking the <74> in <place name> but its kind of open. We're talking behind the local library which is convenient enough to be out of the sight for a deal and they were certainly talkin', well, I think the snooker lounge was bein' mentioned as well which was another possibility, <77> and that would have all have been I think quite probable. See previous comment on openness.

109: §58 Interviewer

110: Okay. And would those have been reported to the police then?

111: §59 James

112: We usually, we've got a good relationship with the police because one of the boys has come in and spoke here, spoken to the kids to try and improve police relationship. So very often if they get someone they're concerned they might phone us and say could you identify the young boy, name or whatever? But <81> obviously they're, I'm sure they're restricted, that they cannot really tell us, because you know there would be times when they couldnae say this or that's gonna go. But if we word of anything, like we've heard, there's a pub

113: §60 Scott

114: a local pub

115: §61 James

116: has come up and we've passed that back to the police and they were obviously aware of it and were monitoring it.

117: §62 Interviewer

118: Right, okay. And chances are that they sometimes hear about it first anyway.

119: §63 James

120: Type of thing you get is, you tend to hear if there's underage drinking going on where there's some funny smells coming from back rooms and things like this which is usually a reasonable giveaway.

121: §64 Organisation

122: §65 *Lesson Planning, Support Materials*

123: §66 Interviewer

124: If you could just tell me then how the school approaches drug education overall?

125: §67 James

126: Well, I think broadly what we would say, its a developmental approach. In first year, in the core thing we didn't do anythin that drug specific or anything, it was usually under cigarettes and alcohol and solvent abuse, I think that's in first year as well. But we had thought that we're actively trying to change one or two things, I've got it here. We thought that some of this needs looking at a wee bit and we've actually been coming up with bits and pieces so we're trying to produce little booklet type things that we can work through and this is by no means wonderful-

127: §68 Interviewer

128: Okay.

129: §69 James

130: We pinched some of this from <another school>, to be honest, their solvent one, because <one of our teachers> has just come from there and its quite good. It's quite a nice one. And that puts together too with other bits and pieces and we're gonna pilot this just to see how it goes, just as an idea, it's a rough go. We might look at that.

131: §70 Interviewer

132: So I'm not sure, was it that you used to focus mainly cigarettes, alcohol and solvents but now you're moving a little bit into drugs?

133: §71 James

134: In first year. Mainly. We feel like bringing drugs in a little bit earlier. Certainly not at a very high profile because most of the kids have, its really superficial knowledge but I think its got to be addressed. We then bring it in again a wee bit second year, again solvent alcohol and drug abuse is part of a block. And in third year, we certainly go into drugs in a bit more detail where we really want to establish you know, what a drug is, definition of a drug and to establish, changed it, I used to talk about drug use and abuse and now it's more politically correct to say use and misuse so we need to switch the language a bit and go to misuse, but you've got to excuse me but for years I've been doing drugs abuse rather than misuse, so its a kind of a fight so we'll put in misuse. I think it's a fair enough difference. So we <107> that but we also try to bring in you know that there's medicinal use of drugs. You know, that drugs themselves are not bad, it's the use and misuse that is the question. And then again in fourth year it comes in again in a slightly different way and I personally then target HIV as well at that point because I think you can really address that there. It sounds as if this is what he does himself, rather than what other teachers necessarily do. Should have followed up on this point. And again in fifth year, what we did this year, for a change we felt, we thought we'd ask Health Promotions to come in, rather than have us going over it again and again. Health Promotions came in and did sexual health, alcohol and drug education so they did it as a block, three separate weeks with the seniors.

135: §72 ***Frequency, Duration***

136: §73 Interviewer

137: Okay. How much time are you talking about in each year?

138: §74 James

139: Em. It depends.

140: §75 Interviewer

141: Well, for PSE overall, first of all?

142: §76 James

143: We have for first year, we've one period a week per class. Second year it's currently two periods per week but that's really been because of a timetable difference, normally it would have been one period. Third year we've a double period, fourth we've a double period and fifth a double period. So we've got a fair degree of time with the kids which is good.

144: §77 Interviewer

145: Yes, and the double period is good as well because you can do more, move things around and stuff.

146: §78 James

147: We can do more.

148: §79 Interviewer

149: Okay, and then is the amount of time within that, that is spent on drug education fixed or?

150: §80 Scott

151: No it's flexible.

152: §81 James

153: It's flexible. One of the things that we would like to think in devising the programme is that we can

actively respond to something if something comes up, you know we can switch to a lesson fairly easily. You know, say solvent abuse became a problem we could switch a lesson fairly quickly. So it has that benefit of being a wee bit flexible. This refers the usual problem of flexibility versus consistency. How can the schools ensure that they are able to respond to issues as necessary (a reactive approach) as well as covering all the essential topics (a proactive approach). The only answer would seem to be to have spare time in the programme to re-emphasise topics that come up during the year, while protecting the time for the coverage of everything else that is deemed essential. This may not be a realistic prospect in schools - but at least protecting some time and leaving some blanks would give some chance of achieving consistency with each class and year of pupils.

154: §82 Interviewer

155: So is it a case of you just sort of have a lesson plan and you follow that, however long it takes or how does it work?

156: §83 James

157: Well, we'd vary it a wee bit. I think it depends on you know what you're doing, who the class is and who <128>, I don't think there's one lesson that we do. You might want them working in groups, you might want them working individual, you might want to use a video just to encourage discussion. It seems that it is a part of the culture of teaching to have the freedom to adapt what you do to each and every class. This seems fine, but this adaptation is done on the basis of each teacher's personal feeling, rather than any more evidence based decision about what might be best for a class. There are lots of reasons why they might use a video, or have people working individually...and a good proportion of those reasons are probably related to things like discipline, the mood of the teacher, the ability of the class etc. Q? Is interactive drug education always better? My instinct is yes, that it must be, in terms of the likelihood of reducing use. However in terms of controlling a class, if interactive things means a virtual riot, then what is the point?

158: §84 ***Lesson Planning, Support Materials***

159: §85 James

160: The latest thing we've actually got in is the TACADE interactive cd-rom. Are you familiar with that one?

161: §86 Interviewer

162: I've not seen it but I've heard of it.

163: §87 James

164: Right. It's good. I think its good anyway. I've actually got it networked now so one of the rooms has got it networked so what we would do is, we havnae tried it yet but we'll try it with different age-groups and maybe different aspects of it because it is designed to be interactive. So I mean, the kids would enjoy it I think more than say us settin' something up for them, that they've got to do, it's a bit more flexible. And that's aged 11-16 so it covers quite a wide range. I put it through my laptop to have a look and it's got quite a good range of things. It's got scenarios, it's got factual information, it's got you know, follow your decision through and you know, revise your decision or are you still stayin with that or are you gonna change it? And they've got a quiz which I havnae looked at to be honest at this stage. I'll have a look at that, see how it goes. So we could use that, well, we could use it PowerPoint in the class as well if we wanted a specific thing but I think we would like to see them on the PCs themselves and give them a task and see how they get on with it. As I say we've still to have a go at that. We've only got it in a month ago.

165: §88 Scott

166: We've got quite a bank of resources, drug education and-

167: §89 James

168: We're well resourced. If that's any use to you, I mean you can have that - that's just basically resources we have.

169: §90 Interviewer

170: Oh, fantastic, yeah, that's great. [1] ***List of Resources Provided.***

171: §91 Scott

172: But while it's inbuilt into a programme, the lesson content isn't prescriptive. I mean we generally <149> depending on our mood perhaps. And how the class <150>This comment illustrates exactly how the progamme varies, similar to my comment above.

173: §92 James

174: It varies.

175: §93 Interviewer

176: And what are you working from? Is there an overview or?

177: §94 James

178: Well, to be honest we've kind of developed, the programme's been on the go for such a long time, that we're probably the teachers we have, we're probably comfortable with what we're doing. This theme comes up again and again (I think). It implies that they are pretty sure that what they're doing is reasonably good, and that there is no major problem with it. Nobody has ever told them that what they do is extremely unlikely to reduce use in any way, so why would they not be comfortable? They are not rated or criticised for their drug ed. In fact, HMI has praised them for it. Should praise be relative to other schools? I suppose so, but that shouldn't mean that good schools are led to believe that they already represent the best that should be done. Doesn't mean to say we stay with the same thing, we update and put a lot of, I've taken some of the stuff we have, just as an exemplar sort of thing. So we change things a wee bit and it depends pretty well on what you want to do at a particular time as I say. But we would want to cover you know obvious things like the categories of drugs, you know, A,Bs and Cs. We would want to cover also the legal issues, possession and sellin'.

179: §95 Scott

180: That is usually done by the police, they come in.

181: §96 James

182: The police input in there. <A policeman> comes in from that point of view. But we do cover all the drugs types and things, well, you know we can't actually cover them all, there's so many different ones, but main sort of characters and risk obviously. Though I mean, consciously, the policy, I don't think there is one way of delivering a programme to be honest with you, I don't think there is any one method but if there is a predominent method, I would say is, we tend to build in decision making into the programme because at the end of the day the decisions are going to be made out of school, not in school. You've no control over the decision that's actually going to be made. So hopefully we'll educate them to not but you know damn well somebody's going to do it. Very little confidence in the outcomes. Just a hope...

183: §97 **Policies**

184: §98 ***Theory, Key Messages***

185: §99 Interviewer

186: And would you say that's kind of the main purpose of, the main thrust of the education is to promote

decision-making?

187: §100 James, Scott

188: It's information giving and decision-making and it is proactive rather than reactive.

189: §101 James

190: That would be the hope anyway.

191: §102 Interviewer

192: Can you tell me a little bit more about what you mean by being proactive rather than reactive?

193: §103 Scott

194: Well, making them aware of the consequences.

195: §104 James

196: Likely scenarios and assertiveness, building assertiveness skills. Thinking of who's likely to offer them. And they're usually good at that, it's most likely to be a friend or somebody that you know than the idea of somebody standing down the corner.

197: §105 Scott

198: There's so many topics in the PSE programme, I always make the point to them. "We discuss this, we look at the pros and the cons and the consequences and at the end of the day, you make the decision but we will be happy if you're making the decision through knowledge not ignorance." This is said, but if that decision through knowledge is to take drugs, are they genuinely happy? It is clear that knowledge in this field does not lead to a change in behaviour.

199: §106 **Delivery**

200: §107 ***Messages***

201: §108 Balancing Views

202: §109 Interviewer

203: To what extent can you give a balanced viewpoint or do you have to be directive?

204: §110 Scott

205: Well, I sometimes play the devils advocate, depending on the viewpoints you're getting from them just to have an openness of debate. I often say things in these lessons that I don't necessarily believe but it will make them think, and make them argue their point.

206: §111 Interviewer

207: Like?

208: §112 James

209: Well, one of the good ones is you might be better with cannabis than alcohol. The police would rather police a rave than a drunken wedding. You know. <189>. But you know one of the things I take out of one of the quotes in there is that pupils can be presented with information and encouraged to develop skills and attitudes

which will enable them to make informed and sensible choices about their health and that really I think underpins our thinking. Do you agree?
210: Can they? Yes, they can develop skills, but that assumes they do not want to use drugs, and need the skill to refuse them. Yes, they are ENABLED to make informed and sensible choices, but do they choose not to? Most of the time - yes. There is discussion of this in relation to healthy eating in Int 6 I think.

211: §113 Scott

212: Yeah.

213: §114 James

214: I mean at the end of the day, I would accept fully that somebody is going to make a decision that you wouldnae want. You hope that the majority certainly would not but you know somebody is going to. Realism about the outcomes. Because that can come right through from sex education right through. You know, you can educate somebody about the risk of pregnancy, it doesn't mean they're not going to get pregnant. And you can tell them about sexually transmitted diseases but they're never going to believe it's going to happen to them. So you know, at the end of the day, we would all have a firm belief that education is a good way <198>, you know at the end of the day the choices are with them. I mean I do say to them, one of the reasons why people take drugs is because they enjoy them because you wouldnae take something you werenae enjoyin. But then I say right there's long term and short term. Short term might a positive, fit's (what's) the long term? You know and get them on to that.

215: §115 Interviewer

216: And are they able to discuss that even from quite a young age, to present the pros and cons or is it very black and white when they're younger?

217: §116 Openness

218: §117 James

219: No, they're not bad. I think our kids are reasonably honest as well. They'd always say somebody else is doing it-

220: §118 Interviewer

221: They would say somebody else is doing it?

222: §119 James

223: Well, they wouldnae directly finger somebody but they would suggest that they knew another person and we know its certainly going on. "you wouldnae believe this, Mr. <James' surname>". But they're on whole, they're reasonably frank.

224: §120 Scott

225: Yeah, people who've come to teach in this school from out and about, often comment about the openness of our pupils, that the kids are upfront. They're in your face sort of style, you know, they'll tell you what they think. But not having taught out and about, I'm just gonna go along with that.

226: §121 Interviewer

227: Well, a lot of schools will say their kids are honest but to varying degrees.

228: §122 James

229: Aye, I think that's true of all kids, a lie is, as one first headmaster said, "one definition of a lie is a very

pleasant help in times of trouble" which we think was <217>

230: §123 Interviewer

231: And do you think that, I'm understanding from what you say that they won't actually say what they themselves are doing.

232: §124 James

233: Yeah, I think it would be pretty unlikely that somebody's gonna be right upfront and say "I've had a go at this". It's just not reasonable to expect that pupils will truly be able to examine their own values in a classroom situation and openly discuss them with others. This sounds like a valuable thing, to reaffirm norms etc, but it is not really practical.

234: §125 Interviewer

235: Do you ever get that?

236: §126 Scott

237: Yeah, yeah.

238: §127 James

239: You might do. I've certainly had it in alcohol but not specifically on drugs.

240: §128 Interviewer

241: And what will they say, will they just say, "I have tried cannabis".

242: §129 Scott

243: Yeah, yeah.

244: §130 Interviewer

245: And how was that dealt with, is it discussed?

246: §131 Scott

247: This happened not so long ago, and I know the mother does know that the boy had done this and I just left it with that.

248: §132 Interviewer

249: And if she didn't, do you think you would feel obliged to report it?

250: §133 Scott

251: That puts me in a difficult situation actually.

252: §134 Interviewer

253: Okay. So would you encourage them to speak in third party, or would they be encouraged to be as honest as possible?

254: §135 Scott

255: I think they are honest in what they tell you.

256: §136 Interviewer

257: But I mean just from your own point of view is it better if, I mean which would you be hoping that they would do? If they have tried would prefer that they say my friend has or that they? This question was repeated but an answer not obtained - the wording of the question wasn't clear enough to elicit a clear answer.

258: §137 At-Risk Pupils

259: §138 James

260: I've certainly had in the past a few girls comin up<236> because they were concerned that she was smokin cannabis outside the school.

261: §139 Interviewer

262: About another girl?

263: §140 James

264: Yeah, because they were concerned about, they thought she was at risk really was what they were saying and I did contact the parents to say that "you know this has come", being very careful, "I'm not sure if its true but these kids are expressing a concern". They themselves said that they were aware, they thought they knew who she was with who <243> and that they had grounds for concern and thank you for telling us. So that was as far as you can go with that one I thought. But obviously you've got to be very careful because any kind of statement could be somebody deliberately mis-representing somebody. You'd have to be very diplomatic in how you approached a parent. This is a difficulty in schools - they can never be certain about information and have to be so careful not to make wrong assumptions - they are not dealing with rational adults but children who have rapidly changing allegiances and enemies! But certainly I think if we thought a child was at risk, I don't think any of us would have any hesitation about notifying who we thought needed to be notified I think in that situation. Because I think you have a peer responsibility so being as diplomatic as you could, you would need to try and-

265: §141 Interviewer

266: I suppose what I'm trying to get at is whether the kids feel, like are they aware of what will happen if they admit to using.

267: §142 James

268: If they came to you? I tell kids there is no complete confidentiality and I'll tell you if you're getting into deep water, because eh, I mean for example child abuse, if you get a statement, <258>, if they're taking an illegal substance, its clearly an illegal act. If they don't, if they just said they used it, in the first instance, if they say, I've taken a puff of cannabis I'd be inclined to say "fair enough, you've tried that", you really think it's the policy, but you tell me I wouldnae want to report that to the police because I know the police wouldnae particularly want to get that because they've no choice.

269: §143 Interviewer

270: But would you tell the parents.

271: §144 James

272: Aye, I think, depending on the issue, I think you'd really feel the parent would need to know I think.

273: §145 Interviewer

274: And the kids would know that that's the situation even if they admit it in class.

275: §146 James

276: Well, I think you need to say it to the kid. I would have to explain to the children, say "look I really have to, I really dinnae think I can keep this to myself". And I'll put it in such a way as to not get you into too much bother.

277: §147 Interviewer

278: Right.

279: §148 Scott

280: Yeah, I would go along with that.

281: §149 Delivery

282: §150 *Messages*

283: §151 Balancing Views

284: §152 Interviewer

285: Okay. To what extent can you, when you say that you can tell them that people use drugs because they enjoy it and obviously present the other side as well. How restricted do you feel in doing that, because some schools have not really gone down that road, they tend to say, you know use all the technical terms like 'euphoria' and all of these terms but not actually straight up say like-

286: §153 James

287: It's good, they're enjoyin' it, they're gettin a buzz.

288: §154 Interviewer

289: Yeah, it's a buzz.

290: §155 James

291: I would say, you may as well, say it in language that the kids can understand. I think you've really got to take it beyond that and say you know fine, but with pleasure comes a consequence and you've got to weigh that you know is it a good thing in the long term or is it a bad thing. And you <284>

292: §156 Scott

293: And as an early exercise in drug education we say that, we often have a brainstormin' session for reasons why you take, why people take drugs. And you tell them why people take drugs.

294: §157 James

295: Peer pressure, <287>, risk, buzz, you know, it's fun or something, recreation, you know you'll get all the terms.

296: §158 Interviewer

297: And do they ever come up with the stereotype things of drug addicts as losers and they're just wasters or rejects or do they come up with any of that?

298: §159 James

299: We did sometimes get them to do a stereotype thing, one of the exercises is "whats your picture of a drug user? What do you see?", because one of the things I'd like to get across to them is it could be the guy next to you, it could be anybody fae a wealthy background it could be somebody from a very poor background. It goes right across the social spectrum, it's not confined to one person. So we do talk about stereotyping and try to get a broader viewpoint.

300: This illustrates the ad-hoc nature of things (flexible or ad-hoc?). They do this with some people, not with others. I suppose this reflects the fact that there is never enough time to cover all the issues and so inevitably some things get left out and which bits that is depends on the interaction in that particular classroom at that time.

301: §160 Interviewer

302: Do you cover things like, I suppose its human rights in a way, but seeing like- As a pharmacist, I work in pharmacies where we give methadone to patients and I've had to deal a lot with other customers being like you know "why is he getting that?" and you know just a really attitude towards them whereas we would be obliged to treat them equally and give them the same respect as all of our other customers. Is that something that would be covered as well, just the human rights side of not rejecting people who've used drugs or who are-

303: §161 James

304: Being honest it doesn't tend to be a, I wouldn't say it's something that we focus on strongly because we're more into, I think, trying to prevent them as opposed to- You know to take your example, I would say, that you know despite clause four- or twenty eight or fitever it is, if the kids ask about homosexuality you're supposed to pretend it doesn't exist or something. Now my attitude to that is say you really should be tolerant. I'm not saying it's a good thing or its a bad thing, I think you should just accept that maybe some people are like that and be tolerant about it. And I would just leave it at that. So I would say, where the drug use is trickier because I think it would depend on what they, I suppose if somebody held a knife to my throat and said I'll have your wallet, that probably wouldnae make me particularly keen on drug users who's doin' that. As opposed to somebody who's got into it through some circumstances and you feel they're damaging themselves, you know obviously you would feel sympathy towards them but I don't think it's really focused or come up with the kids on that. They don't ask on that line, it doesnae really come up. Maybe it would come out with more mature students, discussing that.

305: §162 Interviewer

306: It seems that pupils now have a lot less of these stereotypes than maybe certainly I feel like when I was growing up, you really did feel drugs are for losers, but perhaps its because there's more of them using the so-called softer drugs, that they just don't make that distinction between-

307: §163 James

308: I don't think they see it as being losers, I think they just see it as part of the scene. The pupils see drug use as a normal part of life for them or around them.

309: §164 Interviewer

310: It's just something that some people do and some people don't.

311: §165 Scott

312: And when they see drugs in sport, I mean, they're not losers then are they?

313: §166 ***Method***

314: §167 Differentiation

315: §168 Interviewer

316: Well, sometimes, it depends if they get caught I suppose. How do you cater for the pupils within the class who may have never used, may not be drinking even, and those who may be using or that you suspect could be using drugs?

317: §169 James

318: Differentiating, you mean?

319: §170 Interviewer

320: Yeah.

321: §171 Scott

322: It's a difficult one because one of the things when I did the national in-service guidance course, we did positives and negatives, you know do you stimulate an interest that's not there?

323: §172 James

324: I think we just, the lessons are really sort of broad based, one of the areas where we have a concern is we sometimes have kiddies who have almost special education needs and we've felt that that's something we've got to look at. And in some cases it's probably nae appropriate really to have them in the lesson because its flying straight over their heads and they're completely lost.

325: That's true in other things, but I'll be looking at that because we feel we've got to try and address that. Even though we've been happy with what we're doin there. But broadly the lessons are just really pitched as a mixed ability class lesson would be. And we dinnae have a kids range <357> so the rule really would be to promote discussion. So you can have em in groups so that's compensated a wee bit wi' able and less able in your groups or workin' in pairs or just as a whole class and bring it in as a discussion and just get the whole thing going from there. 'Course your more able kids are going to carry the discussion anyway.

326: As well as the pressure of looking after kids with special needs, inclusion policies also highlight the issue of differentiation. Of course, all kids have different needs for learning about drugs, but it is far more obvious in relation to special needs kids. It is hard to see how these kids can be included and also be catered for in terms of pitching the drug education. Equally, it is hard to see how any groups of pupils can be catered for individually - users, non-users etc. etc.

327: §173 Interviewer

328: But they do get the chance to just discuss in small groups like pupil to pupil and challenge each other?

329: §174 James

330: Oh yeah, aye, challenge views.

331: §175 Interviewer

332: Maybe a little bit more quietly than with everyone together.

333: §176 James

334: Ye sometimes play devils advocate, set a thing up saying well I'm going to argue this is a good thing, you've got to produce an argument against it. So you do that a wee bit just to stimulate interest.

335: §177 Interviewer

336: And in pairs as well.

337: §178 James

338: In pairs aye.

339: §179 Interviewer

340: And would that be throughout the course, from first year up?

341: §180 James

342: Well, we develop this, there's some, the discussions develop a wee bit with age, but certainly we use a variety of approaches first to fifth year, obviously if you're talking about fifth year, you're talking an entirely different level because you know I think they're more mature at that stage that they can present their arguments better so your approach in fifth would be a bit different obviously than say in second or third year.

343: §181 Interviewer

344: How exactly would it be different?

345: §182 James

346: Well, you could say to them "right c'mon, what's the real scene here, what would you be doin' if it was offered?" and they're at the stage of saying "well, you might get or you mightnae, doesnae mean to say you're gonnae take it".

347: §183 Interviewer

348: So you don't have to encourage and pull the discussion out of them as much?

349: §184 James

350: Well, we've had them fae first year so by the time you get them to fifth year you've a pretty good relationship with them.

351: §185 Interviewer

352: And they know you.

353: §186 James

354: They know you pretty well. They know if you're pullin' their leg or that. But on the whole, as I say the kids are reasonably open so you can- Fourth year are, they're quite good and if you choose your questions carefully you can get a lot of dirt. <laugh>

355: §187 ***Messages***

356: §188 Openness

357: §189 Interviewer

358: Yeah?! <laugh> Do you think that there is, that it is practical at all to think that there would be a situation at some stage where pupils in the small groups or whatever would be able to say to each other "well, I've used this" and actually argue, saying straight up what they have and they haven't done or saying "well, actually I don't think there's anything wrong with that" or "I'm going to do x"

359:

360: <End of Tape 1, Side A>

361:

362: <Tape 1. Side B>

363: §190 James

54: discuss among themselves what they thought, I think it wouldnae come to that.

365: §191 Interviewer

366: And is that just because the confidentiality issues and legally that its just not a runner.

367: §192 James

368: I think they feel <3> maybe grass somebody up. They're not gonna drop that in, unless that there was a <?> I'd be surprised if you got it just as "that's a good idea, I'm gonna go and do that". I don't think they would <4> even if they felt they were gonna do that.

369: §193 Interviewer

370: Okay. So they're just, they can give their opinions or whatever, but it's better if they don't be specific about what they've done because that means that you have an obligation then to take action on that.

371: §194 James

372: That's right you would, aye.

373: §195 Interviewer

374: I'm just trying to get, because one of the things in the School Drug Safety Team report that you were saying is that they talk a lot about the kids being able to be honest, which they can be about their opinions but in a way, I think they're trying to pretend that you can have a situation where everybody says I do this or that and I'm not sure that that's really realistic.

375: §196 James

376: I think in reality, the kids draw a distinction between you as a teacher and them as a group and we need that space I think to be honest and they need that space as well. I think he means by this that though the teacher knows how things are with the pupils, and they kind of know that he/she knows what they get up to, its not acknowledged openly by either side on any kind of individual basis. And I think, I would some kids if they had a definite worry about something, would probably approach you. And they might approach it say in the third person or whatever but they would do that but I think to upfront say you know "I'm doing this or that". I mean I've known parents who wouldnae admit their kid was solvent abusing and I knew that their kid was solvent abusing but they wouldnae admit that their kid was solvent abusing which I think is even mair (more) worrying. You know. But you know, there's image.

377: §197 Harm Reduction

378: §198 Interviewer

379: Right. Do you actively tell them what they can do to help somebody who is really drunk or also say if they have taken drugs?

380: §199 James

381: Aye, say in terms of their physical wellbeing?

382: §200 Interviewer

383: Yeah, first aid.

384: §201 James

385: Well, they do first aid in the school as part of things so they know recovery positions and airways and things like that. I think it depends on the situation with drugs, if somebody took an overdose, I've found, I think with most kids the best thing they could do is dial 999 as fast as they can. They can obviously try and keep their airways open, I mean the airways are the first thing aren't they? But I think if our kids were out as a group and somebody was drinking and somebody got bad, I think they would try to look after them. Now the danger of that is they might be doing all the wrong things, you know maybe the best thing is to get them home as quick as they can. But you know there's lots of statements, I took some of the things for you on alcohol where its saying that if the police find you they'll take you home to your parents etc. which is true unless they need to be stomach pumped and that's to the hospital. But I think our kids would be responsible enough to try and look after anybody that's drunk. The risks of harm reduction, in case of alcohol - but this doesn't stop them giving the information.

386: §202 Interviewer

387: And so would they be given information like, its obviously easier with alcohol but taking that first are they given information are they given specific information like drink water and that sort of thing.

388: §203 James

389: For drugs?

390: §204 Interviewer

391: Well, for alcohol first?

392: §205 James

393: For alcohol you could do it, well, I would say, we dinnae specifically go into, you know recognising the risks involved that somebody could choke on their own vomit, if they pass out they could die of hypothermia so be responsible if there's somebody in that position.

394: §206 Scott

395: It would tend to be immediate action until they can get specialised help. That would be the message.

396: §207 James

397: Dealing with drugs is difficult because depending what they've taken, I'm not sure I would know what to do <36> and there is conflictin' Two of the three main worries about harm reduction - lack of teacher knowledge, conflicting information. The third is a worry of encouraging use.

398: §208 Interviewer

399: It depends if they know I suppose what the person's taken.

400: §209 James

401: The guidelines are really difficult, <38>, is that a leading question? Say if anybody is sick, well, I'm sure somebody is going to be delighted mopping that up, you know, but you can see why.

402: §210 Interviewer

403: And with the older age-groups do you cover responsible drinking?

404: §211 James

405: Aye well we do, there's a programme in there, it's on binge drinking and the consequences of binge

drinking, so we do try to express that, the dangers-

406: §212 Interviewer

407: So at that stage even though it would be illegal technically but you would cover things like okay, it's okay to have, when you're eighteen to have a few drinks but not to binge.

408: §213 James

409: Sensible drinking, yeah. I mean one of the things I do, I'd be challenging them on cannabis because a lot of the time you get the people who say, you're okay taking cannabis, <46>. Because I think, in one state in America one third of the road accidents people had been smoking cannabis prior to it.

410: §214 Interviewer

411: Australia, I think it's quite high as well.

412: §215 James

413: so you know it does nae stop <47>, it does alter your spacial awareness, it does slow your reactions. So you know I keep telling them, you're charged by police under drink and drugs. It's not drink. You're charged under drink and drugs or drugs. So it's a mythical thing that you can have a puff of cannabis and its not going to affect your driving or your health maybe in the long run. Equally, I mean, we'd a police officer who was telling us about one guy who is regularly arrested for being on alcohol and fighting, and who has recently switched onto cannabis and he'd say to the inspector "what are you picking me up for? I havnae battered anybody." He says "two or three years ago you were picking me up for mayhem". And they could put a rational argument to that. But I mean, we dinnae put that to a pupil, you know, do nae have a pint, have a cannabis joint or something. But you know the police, they do say with ecstasy and that, that they would be happier, that it's an easier job policing a rave than where a lot of drink is involved.

414: §216 Scott

415: In alcohol I talk to them about units and, you know, sensible drinking and basically trying to get across the message to older pupils that there are certain pleasures, definite pleasures that you can get from drinking but you control the alcohol and not let alcohol control you. That must be the message.

416: §217 Interviewer

417: And if we were to move on then to the illegal drugs, can you give any harm reduction information for that? If there is such a thing as sensible drug-taking.

418: §218 James

419: I think we've tended to- well, personally, I think <63>, because, basically, harm reduction has its place but it depends who is, you know our message has really got to be educate away from rather than harm reduction. Because we had Paul Betts in, and he's very anti-harm reduction because of the experience of his daughter. Now, I mean, within these walls, we had some reservations about Paul Betts but having said that he has a tremendous presentation. He <?> the kids, he's got them there and he's very frank. But I mean we know that most of the research says if you just have a simply "don't use" it works for some kids but for the majority it certainly doesnae. But his real anti-harm reduction comes from the message his daughter got which was apparently at a drop-in, if you dinnae take more than one ecstasy and if you dinnae drink alcohol you'll be okay. Now according to her PM, she'd taken one 'E' and she'd drunk water instead of alcohol so of course her kidneys failed. So he's very anti-harm reduction on that basis. Calton Athletic are very anti-harm reduction whereas Crew2000 are very much, you know, minimise the risk. A few years ago we got things on solvent abuse <76> tell em the right way to use it and reduce the risk. Now the current swing is dinnae use it at all because there's worry over how of 'em are dying possibly on first experience. It's a difficult statistic because it just says new evidence was found but that doesn't mean to say it was the first experience. But you know obviously more kids die from solvent abuse than, you know, young kids die from solvent abuse in the UK than drugs. So that's a worry as well. Conflicting advice to

schools - the different messages received tend to reinforce the gut feelings of the teachers, which tend towards the conservative, less controversial actions. This happens until the 'controversial actions' become recognised and agreed best practice, and to do less then is controversial!

420: §219 Interviewer

421: So do you actually, can you actually give that kind of information, to drink water? I mean, personally I would see that, I'm not sure that it would have a place in schools but if it did, I would say that the way to do it would be to say "you're never safe. The only way to be completely safe is not to do it. There's always a risk but you can minimise the risks, but it's never zero." I don't know if you can emphasise that enough to still-

422: §220 James

423: I think that would be difficult because at one time there was leaflets going around saying do nae take more than one ecstasy because the chances are one of them <?> anyway. And you know and it turned out the guy that died in <87> had been getting MDA as opposed to MDMA and it had been fairly weak and he'd been taking four or five. Went out one night and got genuine stuff, popped four and so that's my worry about harm reduction is that you could give honest advice and it might backfire and you know I think the counselling agencies and addiction services, I think fine if they're workin with people, I think that's okay. I would still be pretty wary about, I don't know what it is, I just feel uncomfortable about it. Total confusion about what is the advice on ecstasy. Is there any advice that can help? Is there any evidence that deaths can be prevented by doing the right things, or is it a case of if you get a reaction like Lorna Spinks or Leah Betts that that's just it, even if you were going to drink the right amount of water etc., you'd still have this problem? Need to check this out. Usefulness/validity of harm reduction information on ecstasy.

424: §221 Interviewer

425: I suppose what I would say with that though is that when you get to the addiction services and the counselling agencies-

426: §222 James

427: You're already in trouble.

428: §223 Interviewer

429: They've already got a problem whereas they need to know this from the very first time they're going to use. And that, but yet are you going to encourage people if you give them the information so-

430: §224 James

431: The problem with using is that they do nae know in all cases what they're buying. I mean okay you could advise them on things like idiots who are melting jellies and then inject them and then get leg amputations, if you're gonna take them, for God's sake swallow them, but would I want them taking temazepams anyway?

432: §225 Interviewer

433: Yeah.

434: §226 James

435: And the fact that if heroin users are, I always tell them it does nae matter whether you swallow heroin, sniff it or inject it, it's equally addictive. But obviously it's a lot more dangerous if you're injecting it than if you're sniffing it or swallowing it. You know, I mean so if you're gonnae do it at all you'd be better swallowin' it or sniffin' it than you would be injecting it because of the adulteration thing, and the risk of injection anyway. But I would nae like to <106> injectin' neat vodka. You know, I mean, I don't want to tell them how to do that. Of all the things to do, gee whiz. <108>

436: §227 Interviewer

437: So would you say to summarise on that, that you can give them the facts on the risks and that it's up to them then to make the connection if they need to, how to minimise them if they know the risks but that you can't really give them that connection? How would you summarise them?

438: §228 James

439: I really think the harm reduction is taking it- I think the Leah Betts one is more of an example where advice that 99 times out of a hundred is probably correct, can be wrong. As above, this is a very valid point, that I perhaps have rejected as ignorance before. I was assuming that the HR advice does reduce risks but does it? Or is it just likely to be sensible advice to reduce your hangover?

440: §229 Scott

441: I think it's worrying.

442: §230 Interviewer

443: How would you?

444: §231 Scott

445: I would go along with that.

446: §232 ***Delivery***

447: §233 Outside Agencies

448: §234 **Paul Betts**

449: §235 Interviewer

450: You said you had some reservations about Paul Betts, what was that?

451: §236 James

452: I wouldnae question the man's sincerity and he has a good tongue. He's worked on something, he delivers it and he holds an audience and he held the kids attention but I mean he uses language that we wouldnae use and I don't think that's good. You know, a couple of statements he came up with, he said "teachers know nothin'" which annoyed me, because I've done a couple of national in-services which I'm not brilliant at so I dinnae, I'm not brilliant, I've got some knowledge and I wouldn't like to be portrayed as someone who doesnae know anything. Not impressed with Paul Betts' portrayal of them as knowing nothing. From PB's perspective he's probably educated himself to the point of being a drugs expert, which means he most likely does know far more than the teachers, but that doesn't mean that they are not more clued in than a lot of professionals, and certainly than parents.

453: §237 Interviewer

454: Probably know more than most parents so-

455: §238 James

456: So I got a bit annoyed about that. It's not what he says that is wrong but the, I believe you can be pretty honest with kids and give them accurate information and that's it. And I'm not saying his information is no accurate but the emphasis can be totally different. Now he's talkin about, is it TCH in cannabis, I always forget

that?

457: §239 Interviewer

458: Yes, that's the active.

459: §240 James

460: saying well, it's now up to 60%. Well, in a sense, that's irrelevent. It's how much you use and abuse it in a sense. It doesnae matter if it's sixty or thirty. And if you want to get full well, you'd swallow it but how many's gonna do that? Naebody's gonna do that. He was makin' a big thing on LSD. "It's in your body for life." Well, it is in your hair but if you did a blood or urine test in two days you wouldnae find it. Now what is important is you can get a flashback. Now a flashback to me is maybe memory ingrained as opposed to the drug. So, I mean, I would say, I've told them they can get a flashback. He'd a big thing about amphetamines and Nazi crank saying that the longest that somebody has gone without sleep, this was something like forty days and I thought "who the hell timed that in the middle of a war?" You know it may be true, it may be not, I don't know. I thought it was a bit unlikely.

461: §241 Interviewer

462: Do you think he held the kids' attention because it was kind of extreme rather than educational?

463: §242 James

464: I think he just, I dinnae ken, what do you feel? <to R2> He certainly has their attention and he's certainly "dinnae use drugs". He didnae want them usin' drugs and to that I'll gie him credit you know. But he uses the slide, this is me ten years ago, his head up his bum. But you can get that message across without that. You know, to be honest. If you do it with the parents fair enough, he did it with the parents, and fair enough the parents took it and thought it was funny. Okay. With kids, we'd no put that in front of them as an image. He was usin' a lot of language of the coarse sort, which of course the kids are quite delighted but we're not gonna stand.

465:

466: They have many issues with Paul Betts - not just style but also the kind of information he is giving them. Though I can't help but feel the information complaints would not be noticed if they hadn't already disliked his style so much!

467: §243 Scott

468: When he comes into our place of work, I think he's got to abide by our standards and he fell.

469: This is a very fair point about the standards, but I feel that if he is being paid by the school (even if its a donation) then its up to the school to set out to him what those standards are in advance. Schools just invite in people and then complain afterwards when they do not do what is expected - this has come up in other interviews - where?

470:

471: §244 Interviewer

472: And do you think that there's a certain entertainment value to it that's perhaps not educational?

473: §245 James

474: Well, he came out with one statement which I think worried me greatly. He was speaking to <name> and she asked him how he found the kids and he said they were well-informed. Now I'd have been disappointed if they were nae well-informed and then he said "you've a lot of users there". Now the fact that somebody said "Rolls Royces and Es" whatever, means that they know, and they might well mean it when they're through in there but how could, you couldn't stand in front of two hundred kids and say "you've a lot of users". I couldn't stand in front of two hundred kids and say "you've a lot of users".

475: §246 Interviewer

476: No, I mean, okay, if they know, they're more likely to be but it still would only be a proportion of the ones that know, who would actually be using.

477: §247 James

478: Well, going statistically, is to say that only 10% of the population are regular users of drugs, 90% are not.

479: §248 Interviewer

480: I would question if it's even ten, I don't think it's even that high.

481: §249 James

482: <155>. It doesnae really matter, it's who is usin it and why are the usin it rather than any kind of figure. That was my, I'd reservations <158> I mean I could go into class and I could entertain the troups no problem, with twenty-odd years experience by being flamboyant and throwin a bit and havin a great laugh and you know it's magic. But you know-

483: §250 Scott

484: It's easy for him to come in and entertain them, he's not in front of them every week. I mean he was crude and rude and I don't think it's the place. If he's got to do that to get their attention I think it's rather sad. These two comments hit on an important point. It IS easy to make an impact with sensationalism and large group presentations, but those sorts of things are simply not practical on a daily basis with a smaller group. Perhaps schools need to think about combining the two more effectively. For really high quality learning, you'd want the PSE programme to resemble a well-thought out, prepared for conference, planned in advance and considering the needs and wants of the target population. This should really be done on a yearly basis. But teachers are not really given the time to do this kind of developmental work - nor is it necessarily what they are skilled to do. So what do teachers consider to be their niche skills? Refer to Making Sense of Teaching book.

485:

486: §251 James

487: His predicted thing was that the next epidemic would be cocaine. Now I would have thought crack rather than pure cocaine because you can produce crack cheaper, can't you? It's more addictive anyway.

Project: Drug Education in Northeast Scotland User: Niamh Date: 20/04/2003 - 08:04:15

NODE CODING REPORT

Node: /Interview Study/Drug Education Delivery/Medium/Outside Agencies

Treenode address: (1 16 1 18)
Created: 21/01/2002 - 12:31:40
Modified: 01/02/2002 - 11:38:31
Documents In Set: Interview Study
Document 1 of 13 School 1 - First Visit
Passage 1 of 4 Section 8.1.1, Paras 177 to 178, 599 chars.

177: §92 Outside Agencies
178: We also have had speakers in, the police have for several years now, come in and spoken to first years, for a forty minute period. And usually what he brings in is a box of, they're all fake, but it looks very convincing, samples of drugs and needles and all the rest. And the kids get an opportunity to, they come and look at them, they're made of, plastic containers and they pass them around the kids. And of course the policeman tells them entertaining tales, all true of course, but its a different voice from the teacher and its the real thing when the policeman tells you.

Passage 2 of 4 Section 8.1.1.1.2, Paras 181 to 182, 615 chars.

181: §94 Mary
182: We have had the police in to come and speak to all of the pupils but it tends to be in connection with the use of drugs when driving including alcohol because as they come into fifth and sixth year they're thinking about getting their own driving licence. But we're also about to start arranging for a police officer who came to us really and asked if we'd like to have someone speak to the senior pupils about the real raw nitty-gritty about the drugs, what their experience of drugs is as law enforcement officers. So I hope that that will develop because I think it's something to grab the kids attention.

Passage 3 of 4 Section 10.1.1.1.1, Paras 200 to 201, 239 chars.

200: §105 Mary
201: When this, I suppose about four years ago, when this whole issue became much more public, we had a forum one night where we had the police in speaking to parents, social work department and health promotions and the drug action group.

Passage 4 of 4 Section 10.1.1.1.1, Para 201, 1140 chars.

201: And of course they were, they had everything thrown at them. It wasn't <427> discussion. I'm not saying this very well. What my concern was that at the end, I had already been on a couple of courses that health promotions did and I have been very impressed by them but of course health promotions just speaking to an audience from all of the different disciplines. But when this person came in, and when the Drugs Action person came in and spoke to parents as a first shot. They definitely got, they picked up on, the parents picked up on the risk minimisation aspect of things and they then started holding that type of thing at a distance because I thought they'd think they were going to come in -. I think they thought they were going to come in and say to kids well, you know if you're going to do this make sure that you do that, and I said it many times but I don't think anybody

was convinced that if you ask these people to come in and speak to us, they will ask us what you want us to tell them. They won't come in with that message. And I still think that there are some people either not prepared to listen to that or -.

Document 2 of 13 School 1 - Second Visit
Passage 1 of 1 Section 9.1.1, Paras 129 to 144, 2213 chars.

129: §72 Outside Agencies

130: §73 Mary

131: Where I'm at the minute, I don't know if I mentioned before, <other school name> have been in touch with Paul Betts the father of Leah Betts - you know the lassie that died from ecstacy a few years ago and he's moved into the area, he lives near <place name> and he was into <other school name> just last November or beginning of December and spoke to, I believe a whole year group for three hours. If he kept the kids attention for three hours, I mean he's doing a marvellous job but I have the number and I'm going to get in touch with them and see if I can get something from him. You know he- that wouldn't be speaking to the person that's used the drugs but it would be speaking to someone who has suffered all the consequences of his daughter using drugs. And he also gives presentations I understand to parents as well, so I want to look into the possibilities of using him.

132: §74 Interviewer

133: I was in Glasgow, and he's done quite a bit of work there.

134: §75 Mary

135: Yeah, I think he's quite busy doing this sort of thing. The video that was produced after his daughter died, "Sorted", have you seen it?

136: §76 Interviewer

137: I've heard of it, I haven't seen it.

138: §77 Mary

139: I must have shown it a dozen times now to classes, and I always am moved by it and there has not been any class whether its a high, if you like a naughty class, there hasn't been any class that I've used it with where there hasn't been absolute silence at the end of it. It really hits home and I usually use it at the end of a lesson so they go away with their thoughts.

140: §78 Interviewer

141: I haven't seen the video but is it because it emphasises how normal she was, and that she thought it would never happen to her and?

142: §79 Mary

143: Yeah, she was not a- Yeah, I just think it- Of course it reflects the impact that not only did it, well, did it have on the family and how unfortunate the whole thing was, it could all have been avoided so easily if everyone had known and ...so just the effect of that video which was the parents working with the television company that got the video made, I think to have Mr. Betts come and speak to pupils I'm sure, I really feel we should get that organised as quickly as possible. I think its important.

144:

145: §80

Document 3 of 13 School 2
Passage 1 of 2 Section 5.1.1, Paras 34 to 37, 552 chars.

34: §19 Outside Agencies

35: §20 Angela

36: Now we often get the local school police liaison officer, she comes in to just give a general chat, introduce herself, in second year and she goes to each SE class. Will give a chat and its quite good for the children just to see the local police or just any police person, I mean the schools liaison police, she's actually based at <place name> and she's just newly appointed. But its good for the children to see somebody in uniform coming in. So they give a talk but they usually are there to answer questions as well.
37:
38: §21

Passage 2 of 2 Section 21.1.1, Paras 322 to 326, 1140 chars.

322: §178 Outside Agencies

323: §179 Bob

324: And what has worked particularly well is, we bring into the fifth year, Narcotics Anonymous and we have an hour session at a whole year group assembly, cause we can't take them in eight, nine times. And that elicits a great response from the kids because we're bringing in kids who have been users who can talk from experience. We recently had one, a lady who had been a user herself, and her daughter had become addicted and her daughter had died. And you know the kids are so intently listening to this and to me that's the best kind of message they can get. We've also used some of the drama groups that go around the country. They've done a variety of things for us. They've done drugs, use of narcotics. They've done alcohol. And that kind of message is better than what's taught. Its a different kind of approach. You've got to be factual but you've got to have the interactive approach as well, try and have a variety of all these things.

325: §180 Interviewer

326: And how do you make sure that when using different groups that the message is a consistent one? Do you sort of vet what they're doing beforehand or?

Document 4 of 13 School 3
Passage 1 of 2 Section 15.1.1, Paras 151 to 165, 2043 chars.

151: §85 Outside Agencies

152: §86 Interviewer

153: All the kids want to speak to addicts. Ex-addicts?
154:
155: <laughter>

156: §87 Paul

157: All singing, all dancing! Yes! We've toyed with the idea of Calton Athletic and I was at the point of saying yes, but I've always backed off, I don't know why. I feel it's a sort of a, quite aggressive approach to-

158: §88 Interviewer

159: Well, one of the schools I did the pilot in, it was down in Glasgow and Calton Athletic have done a lot of work down there and I think the problem the health education co-ordinator I was talking to had with it was that they very much discourage having teacher in the room when they're giving the drug education because they say that that affects it, the kids won't tell us anything or whatever, but he was concerned that can you really leave people from outside alone with the kids, even for the beginning, they didn't want you in there at all. I don't know if that is still the case.

160: §89 Paul

161: We deal with health promotions, they're keen that that happens but most of their staff are teachers who have been involved in education and we said 'yeah'. And our school nurse, I've managed to make sure that our school nurse is involved at least and we sit down and plan the programme beforehand, so we clearly know what's going to happen. And again, with Calton Athletic, I would be, a feeling of loss of control in some way.

162: §90 Interviewer

163: It's a difficult one. Actually I think you'd find that school drug safety team document really useful. I was quite impressed with it because I thought it would be just another distillation of "these are all the recommendations on drug education" but it's actually quite practical and just it pulls from lots of different documents, but fairly concise, it's all in point form and it does have recommendations on external agencies and everything like that. It could be quite useful.

164: §91 Paul

165: Yeah, that's what we feel about the health promoting school because it's always been a case of reinventing the wheel, things coming from different directions, and the idea of "here we go again".

166: §92

Passage 2 of 2 Section 25.1.1, Paras 464 to 478, 983 chars.

464: §251 Outside Agencies

465: §252 Paul

466: And the police are quite good, our educational liaison officer is excellent so he does, and they've used footage from Aberdeen, the police cameras in Aberdeen, Saturday night in Union St. in Aberdeen and some situations inside clubs and so on and things that will, that could happen-

467: §253 Interviewer

468: blotted out faces would it have been?

469: §254 Paul

470: Yes, yeah.

471: §255 Interviewer

472: I was wondering how they would use them, poor people!

473: §256 Paul

474: So that's <131>, it's real and we use that as part of our programme in sixth year, those going to university about moving on, we look at aspects of finance, students accommodation, healthy eating and so on. They get hands-on experience of cooking, many of them for the first time.

475: §257 Interviewer

476: That's really good actually, we never had that in my school. It's amazing all the things that the schools do now where before it was just academic subjects, it's just absolutely amazing.

477: §258 Paul

478: Six years and away, so right what do I do now?!

479: §259

Document 5 of 13 School 4
Passage 1 of 2 Section 19.1.1, Paras 383 to 409, 3272 chars.

383: §197 Outside Agencies

384: §198 Doug

385: I just read this this morning, I should really have called you last week, because we had Calton Athletic in on Friday morning. Friday was our last of the sessions and we hadn't really done much on drugs with our current fifth and sixth year. In the past we've had say a panel, we would invite in professionals, you know people from Drugs Action -

386: §199 Interviewer

387: Do you mean that you hadn't done much with them while they were in fifth and sixth year or would they have also missed out further down?

388: §200 Doug

389: No, no, they'll have had all the stuff further down the school, but we hadn't had a big focus on drugs for that particular group. They'll have had all of that further down the school, but the current sixth year didn't do much in fifth year on that. Just you know the availability of people and such thing. So we managed to get Calton to come up. I don't know if you've seen them.

390: §201 Interviewer

391: I've not seen them do their presentation, I've heard of them.

392: §202 Doug

393: Their presentation is wonderful. And again because they can say and do things which we could never, ever do. And also because they're real people and they are all reformed addicts and they are basically telling their own story.

394: §203 Interviewer

395: Which is what the kids want to see.

396:

397: R - Which is what the kids want. They were there for about an hour and a half. The session lasted, they do their three workshops - "From cannabis to chaos" is the first one, the second one is "the life of a drug addict", the third workshop is "the effect on the family" and each workshop as they call it is just one individual telling their story.

398: §204 Interviewer

399: And then is it followed by questions and discussion.

400: §205 Doug

401: Yeah, and they're able to ask questions afterwards and so on. And their approach a lot of the local authorities don't agree with their approach because it is very hard hitting. You know its just in your face reality.

402: §206 Interviewer

403: One of the schools in Glasgow weren't sure whether to get Calton in or not because they were under the impression that they didn't like to have any staff at all in the room while they were doing their-

404: §207 Doug

405: Yeah, they don't mind at all. No, Calton have done, they've been on the go for fifteen, sixteen years now I think and one of the chaps who was up was actually one of the founders and he said that in the years that they've been doing this they've never had a single complaint from parent pupil or teacher, so all those people can't be wrong. You know their approach is very effective. And they've done talks to teachers' groups, to parents' groups. They were up in <place name> at our own school about four years ago and did talks to our fourth, fifth and sixth years and also to our parents that evening and we threw it open to the parents of the primary schools associated as well. And everybody who saw it at that point thought it was fantastic.

406: §208 Interviewer

407: And they are quite happy for staff to sit in on it.

408: §209 Doug

409: Absolutely, on Friday all the guidance team were there, I was in there myself, the school nurse and the trainee nurse came in, one of the local community workers came up. And if I had thought quicker I would have let you know they were coming because that would have been quite a good experience for you to see them.

410: §210

Passage 2 of 2 Section 19.1.1.1.15, Para 415, 1 chars.

415:

416: §213

Document 6 of 13 School 5

Passage 1 of 2 Section 5.1.2, Paras 104 to 106, 490 chars.

104: §56 Outside Agencies

105: §57 Fiona

106: Another thing we've done in the past but not for two or three years; we've had Calton Athletic in speaking to the kids and that's very hard hitting. And they're very much you know "you just have to cold turkey. That's it, you can't". It's either one thing or the other. It is black and white. And the people they sent in were

very, very good and I know again there's been disquiet about the methods they use but my goodness, it fairly got the message through.

107: §58

Passage 2 of 2 Section 19.1.1, Paras 330 to 350, 2031 chars.

330: §179 Outside Speakers

331: §180 Interviewer

332: And how much of that happens?

333: §181 Fiona

334: More in senior school, there's a lot of outside speakers in the fifth and sixth year programme. But, we have first year for example - its nothing to do with drugs - but the fire brigade come in and talk to all the classes individually about safety. So it would happen, first and second year maybe once a term, once you get into the senior school, speakers maybe once a month.

335: §182 Interviewer

336: And how many of those would be drugs speakers then?

337: §183 Fiona

338: I couldn't honestly say, you know as I say, we've had the odd big push here and there, when we get the Buzz video delivered I'm sure there'll be a big interest in that.

339: §184 Interviewer

340: And who initiates an outside speaker?

341:

342: R- Well, we'll have a guidance meeting every week on a Friday and it would be initiated at that meeting, somebody would suggest it, we would look into it, discuss it.

343: §185 Interviewer

344: Just say, okay, maybe we'll think about getting someone in to cover that aspect or?

345: §186 Fiona

346: A-hah. Yeah. We're also looking at the moment, there's quite a lot of independent companies doing drama workshops on these topics so we're currently looking to book one to do a thing, LiveWire I think they're called, they're going to do an alcohol thing called Snow Ice and the Seven Shorts. It's going to cost us three hundred pounds but we're hoping to be able to fund that. That'll be done for all first and second years and there's also a drugs workshop that I've just sent away for the information. And if it looks good-. It seems to follow the same kind of format. They have an assembly in the morning where the whole issue is discussed. A small chosen group of pupils are taken away by the company for the day to work on a play and then we have another assembly last period again when the group come together and they actually perform it for other kids.

347: §187 Interviewer

348: Okay.

349: §188 Fiona

350: So I think we're hoping to get. We're definitely going to do the alcohol one, and I think we're going to get the drugs one as well.

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Project: Drug Education in Northeast Scotland User: Niamh
Date: 11/04/2003 - 21:20:50

NODE LISTING

Nodes in Set: **All Nodes**
Created: **17/01/2002 - 16:33:06**
Modified: **17/01/2002 - 16:33:06**
Number of Nodes: **382**

INTERVIEW STUDY

INTERVIEW STUDY/LOCAL ENVIRONMENT
Interview Study/Local Environment/Demographics
Interview Study/Local Environment/Local Substance Use
Interview Study/Local Environment/Local Substance Use/Alcohol
Interview Study/Local Environment/Local Substance Use/Smoking
Interview Study/Local Environment/Local Media

INTERVIEW STUDY/WHOLE SCHOOL FACTORS
Interview Study/Whole School Factors/Ethos
Interview Study/Whole School Factors/Other school factors
Interview Study/Whole School Factors/Other school factors/School Links
Interview Study/Whole School Factors/Other school factors/New Community School
Interview Study/Whole School Factors/Policies
Interview Study/Whole School Factors/Policies/Incident Policy
Interview Study/Whole School Factors/Policies/Education Policy, Key Messages
Interview Study/Whole School Factors/Policies/At-Risk Pupils

INTERVIEW STUDY/DEVELOPMENT
Interview Study/Development/Pupil Feedback
Interview Study/Development/Pupil Feedback/Formal
Interview Study/Development/Pupil Feedback/Informal
Interview Study/Development/Pupil Feedback/Observational
Interview Study/Development/Staff Feedback

INTERVIEW STUDY/DRUG EDUCATION DELIVERY

Interview Study/Drug Education Delivery/Medium

Interview Study/Drug Education Delivery/Medium/Outside Agencies
Interview Study/Drug Education Delivery/Medium/Outside Agencies/Paul Betts
Interview Study/Drug Education Delivery/Medium/Outside Agencies/Health Promotions
Interview Study/Drug Education Delivery/Medium/Outside Agencies/Other Agencies
Interview Study/Drug Education Delivery/Medium/Outside Agencies/Calton Athletic
Interview Study/Drug Education Delivery/Medium/Outside Agencies/Police

Interview Study/Drug Education Delivery/Medium/Variation

Interview Study/Drug Education Delivery/Medium/Teacher Characteristics
Interview Study/Drug Education Delivery/Medium/Teacher Characteristics/Training
Interview Study/Drug Education Delivery/Medium/Teacher Characteristics/School Nurse

Interview Study/Drug Education Delivery/Medium/Peer Involvement

Interview Study/Drug Education Delivery/Medium/Peer Involvement/Peer-Led Programme

Interview Study/Drug Education Delivery/Timetable

Interview Study/Drug Education Delivery/Timetable/Flexibility
Interview Study/Drug Education Delivery/Timetable/Frequency, Duration
Interview Study/Drug Education Delivery/Timetable/Which subjects include drugs~
Interview Study/Drug Education Delivery/Timetable/Timing

Interview Study/Drug Education Delivery/Method
Interview Study/Drug Education Delivery/Method/Materials Used
Interview Study/Drug Education Delivery/Method/Materials Used/Health Promoting School
Interview Study/Drug Education Delivery/Method/Materials Used/Entertainment
Interview Study/Drug Education Delivery/Method/Open Discussions
Interview Study/Drug Education Delivery/Method/Differentiation
Interview Study/Drug Education Delivery/Method/Initiatives
Interview Study/Drug Education Delivery/Method/Teaching Methods

Interview Study/Drug Education Delivery/Messages
Interview Study/Drug Education Delivery/Messages/Decision Making
Interview Study/Drug Education Delivery/Messages/Balancing Views
Interview Study/Drug Education Delivery/Messages/Harm Reduction
Interview Study/Drug Education Delivery/Messages/Scare Tactics

INTERVIEW STUDY/PRACTICAL ISSUES

Interview Study/Practical Issues/Time
Interview Study/Practical Issues/Time/Pupil Time
Interview Study/Practical Issues/Time/Curriculum Time
Interview Study/Practical Issues/Time/Staff Time

Interview Study/Practical Issues/Resources
Interview Study/Practical Issues/Resources/Space
Interview Study/Practical Issues/Resources/Facilities & Equipment

INTERVIEW STUDY/OUTCOMES/
Interview Study/Outcomes/Measurement
Interview Study/Outcomes/Wishlist
Interview Study/Outcomes/Perceived

INTERVIEW STUDY/INFLUENCES
Interview Study/Influences/National
Interview Study/Influences/Headteacher
Interview Study/Influences/Parents
Interview Study/Influences/LA Level

INTERVIEW STUDY/ROLE OF RESPONDENTS

CASE STUDY

CASE STUDY/LESSON OBSERVATIONS

Case Study/Lesson Observations/Summary

Case Study/Lesson Observations/Content

Case Study/Lesson Observations/Content/Specific Drug Content
Case Study/Lesson Observations/Content/Specific Drug Content/Drugs Covered/
Case Study/Lesson Observations/Content/Specific Drug Content/Smoking discussion/
Case Study/Lesson Observations/Content/Specific Drug Content/Alcohol discussion/
Case Study/Lesson Observations/Content/Specific Drug Content/Cannabis Discussion/
Case Study/Lesson Observations/Content/Specific Drug Content/Ecstasy/
Case Study/Lesson Observations/Content/Specific Drug Content/Heroin/
Case Study/Lesson Observations/Content/Specific Drug Content/Cocaine/
Case Study/Lesson Observations/Content/Specific Drug Content/Solvents/
Case Study/Lesson Observations/Content/Specific Drug Content/LSD/

Case Study/Lesson Observations/Content/Categories of Information

Case Study/Lesson Observations/Content/Other content
Case Study/Lesson Observations/Content/Other content/Exaggeration, Sensationalism/
Case Study/Lesson Observations/Content/Other content/Presenting the fun or alternative si/
Case Study/Lesson Observations/Content/Other content/Decision-making/
Case Study/Lesson Observations/Content/Other content/Reasons for Use/
Case Study/Lesson Observations/Content/Other content/Peer Pressure/
Case Study/Lesson Observations/Content/Other content/Date Rape/
Case Study/Lesson Observations/Content/Other content/Entertainment Value/
Case Study/Lesson Observations/Content/Other content/Harm Reduction/
Case Study/Lesson Observations/Content/Other content/Alternatives to drugs/
Case Study/Lesson Observations/Content/Other content/Attitudes/
Case Study/Lesson Observations/Content/Other content/Speak to your parents/

Case Study/Lesson Observations/Content/Persuasion
Case Study/Lesson Observations/Content/Persuasion/Exaggeration, Sensationalism/
Case Study/Lesson Observations/Content/Persuasion/You don't know what you're getting/
Case Study/Lesson Observations/Content/Persuasion/Drugs' Mystical Powers/
Case Study/Lesson Observations/Content/Persuasion/Can happen locally/
Case Study/Lesson Observations/Content/Persuasion/Normal people take drugs/
Case Study/Lesson Observations/Content/Persuasion/Real Life Scare Tactics/

Case Study/Lesson Observations/Content/Social Awareness
Case Study/Lesson Observations/Content/Social Awareness/Drug Scene in Pubs, Clubs/
Case Study/Lesson Observations/Content/Social Awareness/Drugs in Prison/
Case Study/Lesson Observations/Content/Social Awareness/Effects on Community/
Case Study/Lesson Observations/Content/Social Awareness/Drug Dealing and Dealers/
Case Study/Lesson Observations/Content/Social Awareness/Drug Dealing and Dealers/Mixing~Cutting Drugs
Case Study/Lesson Observations/Content/Social Awareness/Drug Dealing and Dealers/Trafficking

Case Study/Lesson Observations/Content/Consequences
Case Study/Lesson Observations/Content/Consequences/Medical Consequences/
Case Study/Lesson Observations/Content/Consequences/Medical Consequences/Addiction Discussion
Case Study/Lesson Observations/Content/Consequences/Legal Consequences/
Case Study/Lesson Observations/Content/Consequences/Legal Consequences/Classification
Case Study/Lesson Observations/Content/Consequences/Legal Consequences/Sentencing
Case Study/Lesson Observations/Content/Consequences/Legal Consequences/Police Powers
Case Study/Lesson Observations/Content/Consequences/Social, Personal Consequences/

Case Study/Lesson Observations/Content/Drug Information
Case Study/Lesson Observations/Content/Drug Information/Use of Medicines/
Case Study/Lesson Observations/Content/Drug Information/Prices/
Case Study/Lesson Observations/Content/Drug Information/Names/
Case Study/Lesson Observations/Content/Drug Information/Definition of a drug/
Case Study/Lesson Observations/Content/Drug Information/Forms, Origin/

Case Study/Lesson Observations/Content/Drug Information/Usage methods/

Case Study/Lesson Observations/Other Issues
Case Study/Lesson Observations/Other Issues/Complexity

Case Study/Lesson Observations/Delivery

Case Study/Lesson Observations/Delivery/Teaching Method
Case Study/Lesson Observations/Delivery/Teaching Method/Group Type Summaries/
Case Study/Lesson Observations/Delivery/Teaching Method/Class Discussion or lack of/
Case Study/Lesson Observations/Delivery/Teaching Method/Type of Materials Used/
Case Study/Lesson Observations/Delivery/Teaching Method/Use of Drama/

Case Study/Lesson Observations/Delivery/Specific Resources
Case Study/Lesson Observations/Delivery/Specific Resources/Sorted/

Case Study/Lesson Observations/Delivery/Pupil Input
Case Study/Lesson Observations/Delivery/Pupil Input/Correcting misconceptions/
Case Study/Lesson Observations/Delivery/Pupil Input/Missing Opportunities/
Case Study/Lesson Observations/Delivery/Pupil Input/Openness/
Case Study/Lesson Observations/Delivery/Pupil Input/Sharing Opinions/
Case Study/Lesson Observations/Delivery/Pupil Input/Pupil Feedback/

Case Study/Lesson Observations/Delivery/Teacher Factors
Case Study/Lesson Observations/Delivery/Teacher Factors/Dealing with Pupil Questions, Comments/
Case Study/Lesson Observations/Delivery/Teacher Factors/Guidance delivery changeover/
Case Study/Lesson Observations/Delivery/Teacher Factors/Sixth years coping/
Case Study/Lesson Observations/Delivery/Teacher Factors/Using Outside Speakers/

Case Study/Lesson Observations/Delivery/Pupil Discipline
Case Study/Lesson Observations/Delivery/Pupil Discipline/Smart ass pupils/

Case Study/Lesson Observations/Quality

Case Study/Lesson Observations/Quality/Accuracy
Case Study/Lesson Observations/Quality/Accuracy/Teacher Knowledge or lack of/

Case Study/Lesson Observations/Quality/Lesson sequencing, structure
Case Study/Lesson Observations/Quality/Lesson sequencing, structure/Organisation/
Case Study/Lesson Observations/Quality/Lesson sequencing, structure/Lesson Time/
Case Study/Lesson Observations/Quality/Lesson sequencing, structure/Disjointed Lessons/

Case Study/Lesson Observations/Quality/teachers perceptions of their teaching

Case Study/Lesson Observations/Quality/Overall Impression of Lessons

Case Study/Lesson Observations/Quality/Relevance to pupils experiences

CASE STUDY/PUPIL FEEDBACK

Case Study/Pupil Feedback/Pupils' Overall Impressions
Case Study/Pupil Feedback/Sources of Information

Case Study/Pupil Feedback/Peer Press, Reasons for Use
Case Study/Pupil Feedback/Peer Press, Reasons for Use/Reasons for stopping

Case Study/Pupil Feedback/Medium
Case Study/Pupil Feedback/Medium/Teachers
Case Study/Pupil Feedback/Medium/Sixth Years
Case Study/Pupil Feedback/Medium/Paul Betts

Case Study/Pupil Feedback/Medium/Police
Case Study/Pupil Feedback/Medium/Ex-Users

Case Study/Pupil Feedback/Prevalence
Case Study/Pupil Feedback/Prevalence/Other drugs
Case Study/Pupil Feedback/Prevalence/Smoking, Drinking

Case Study/Pupil Feedback/Pupil Individuality
Case Study/Pupil Feedback/Pupil Individuality/Prior drug education
Case Study/Pupil Feedback/Pupil Individuality/Pupil Knowledge

Case Study/Pupil Feedback/Content
Case Study/Pupil Feedback/Content/Desired Content
Case Study/Pupil Feedback/Content/Messages
Case Study/Pupil Feedback/Content/Drugs Covered or Omitted

Case Study/Pupil Feedback/Delivery

Case Study/Pupil Feedback/Delivery/Pupil Discipline

Case Study/Pupil Feedback/Delivery/Process

Case Study/Pupil Feedback/Delivery/Teaching Method
Case Study/Pupil Feedback/Delivery/Teaching Method/Worksheets/
Case Study/Pupil Feedback/Delivery/Teaching Method/Videos/
Case Study/Pupil Feedback/Delivery/Teaching Method/Leaflets/
Case Study/Pupil Feedback/Delivery/Teaching Method/Other/
Case Study/Pupil Feedback/Delivery/Teaching Method/Small Group Work/
Case Study/Pupil Feedback/Delivery/Teaching Method/Discussion/

Case Study/Pupil Feedback/Delivery/Desired

Case Study/Pupil Feedback/Delivery/Specific Resources
Case Study/Pupil Feedback/Delivery/Specific Resources/DWDF/
Case Study/Pupil Feedback/Delivery/Specific Resources/Danny Video/
Case Study/Pupil Feedback/Delivery/Specific Resources/Sorted/
Case Study/Pupil Feedback/Delivery/Specific Resources/Off Limits, Ch 4/
Case Study/Pupil Feedback/Delivery/Specific Resources/David's Story/
Case Study/Pupil Feedback/Delivery/Specific Resources/Think Twice - Drugs can Kill/
Case Study/Pupil Feedback/Delivery/Specific Resources/Buzz/

Case Study/Pupil Feedback/Delivery/Openness
Case Study/Pupil Feedback/Harm Reduction
Case Study/Pupil Feedback/YAP

Case Study/Pupil Feedback/Organisation
Case Study/Pupil Feedback/Organisation/Frequency, Duration

Case Study/Pupil Feedback/Other
Case Study/Pupil Feedback/Consultation

Case Study/Pupil Feedback/Outcomes
Case Study/Pupil Feedback/Outcomes/Perceived
Case Study/Pupil Feedback/Outcomes/What they learnt

CASE STUDY/THE COMMUNITY
Case Study/The Community/Can happen locally

CASE STUDY/THE SCHOOL
Case Study/The School/At-risk Pupils

CASE STUDY/POLICY
Case Study/Policy/Messages

CASE STUDY/PREVALENCE
Case Study/Prevalence/Other drugs
Case Study/Prevalence/Smoking, Drinking

CASE STUDY/DEVELOPMENT

Case Study/Development/Frequency, Duration

Case Study/Development/Lesson sequencing, structure
Case Study/Development/Lesson sequencing, structure/Organisation
Case Study/Development/Lesson sequencing, structure/Lesson Time
Case Study/Development/Lesson sequencing, structure/Disjointed Lessons

Case Study/Development/Planning

Case Study/Development/Consultation

CASE STUDY/PROCESS

Case Study/Process/Process

Case Study/Process/Teaching Method
Case Study/Process/Teaching Method/Worksheets
Case Study/Process/Teaching Method/Videos
Case Study/Process/Teaching Method/Leaflets
Case Study/Process/Teaching Method/Other
Case Study/Process/Teaching Method/Small Group Work
Case Study/Process/Teaching Method/Discussion
Case Study/Process/Teaching Method/Group Type Summaries
Case Study/Process/Teaching Method/Class Discussion or lack of
Case Study/Process/Teaching Method/Type of Materials Used
Case Study/Process/Teaching Method/Use of Drama

Case Study/Process/Pupils' Desired Delivery

Case Study/Process/Specific Resources
Case Study/Process/Specific Resources/DWDF
Case Study/Process/Specific Resources/Danny Video
Case Study/Process/Specific Resources/Sorted
Case Study/Process/Specific Resources/Off Limits, Ch 4
Case Study/Process/Specific Resources/David's Story
Case Study/Process/Specific Resources/Think Twice - Drugs can Kill
Case Study/Process/Specific Resources/Buzz

Case Study/Process/Openness

Case Study/Process/Pupil Discipline
Case Study/Process/Pupil Discipline/Smart ass pupils

CASE STUDY/MEDIUM

Case Study/Medium/Teachers
Case Study/Medium/Teachers/Guidance delivery changeover
Case Study/Medium/Sixth Years
Case Study/Medium/Paul Betts
Case Study/Medium/Police

Case Study/Medium/Ex-Users
Case Study/Medium/Dealing with Pupil Questions, Commen
Case Study/Medium/Using Outside Speakers

CASE STUDY/CONTENT

Case Study/Content/Pupil Reports of Content

Case Study/Content/Specific Drug Content
Case Study/Content/Specific Drug Content/Smoking discussion
Case Study/Content/Specific Drug Content/Alcohol discussion
Case Study/Content/Specific Drug Content/Cannabis Discussion
Case Study/Content/Specific Drug Content/Ecstasy
Case Study/Content/Specific Drug Content/Heroin
Case Study/Content/Specific Drug Content/Drugs Covered or Omitted
Case Study/Content/Specific Drug Content/Cocaine
Case Study/Content/Specific Drug Content/Solvents
Case Study/Content/Specific Drug Content/LSD

Case Study/Content/Categories of Information
Case Study/Content/Pupils' Desired Content

Case Study/Content/Other content
Case Study/Content/Other content/Exaggeration, Sensationalism
Case Study/Content/Other content/Presenting the fun or alternative si
Case Study/Content/Other content/Decision-making
Case Study/Content/Other content/Reasons for Use
Case Study/Content/Other content/Peer Pressure
Case Study/Content/Other content/Date Rape
Case Study/Content/Other content/Entertainment Value
Case Study/Content/Other content/Harm Reduction
Case Study/Content/Other content/Alternatives to drugs
Case Study/Content/Other content/Attitudes
Case Study/Content/Other content/Speak to your parents

Case Study/Content/Persuasion
Case Study/Content/Persuasion/Exaggeration, Sensationalism
Case Study/Content/Persuasion/You don't know what you're getting
Case Study/Content/Persuasion/Drugs' Mystical Powers
Case Study/Content/Persuasion/Can happen locally
Case Study/Content/Persuasion/Normal people take drugs
Case Study/Content/Persuasion/Real Life Scare Tactics

Case Study/Content/Accuracy
Case Study/Content/Accuracy/Teacher Knowledge or lack of

Case Study/Content/Correcting misconceptions
Case Study/Content/Missing Opportunities

Case Study/Content/Social Awareness
Case Study/Content/Social Awareness/Drug Scene in Pubs, Clubs
Case Study/Content/Social Awareness/Drugs in Prison
Case Study/Content/Social Awareness/Effects on Community
Case Study/Content/Social Awareness/Drug Dealing and Dealers
Case Study/Content/Social Awareness/Drug Dealing and Dealers/Mixing~Cutting Drugs/
Case Study/Content/Social Awareness/Drug Dealing and Dealers/Trafficking/

Case Study/Content/Consequences

Case Study/Content/Consequences/Medical Consequences

Case Study/Content/Consequences/Medical Consequences/Addiction Discussion/

Case Study/Content/Consequences/Legal Consequences
Case Study/Content/Consequences/Legal Consequences/Classification/
Case Study/Content/Consequences/Legal Consequences/Sentencing/
Case Study/Content/Consequences/Legal Consequences/Police Powers/

Case Study/Content/Consequences/Social, Personal Consequences

Case Study/Content/Messages

Case Study/Content/Drug Information
Case Study/Content/Drug Information/Use of Medicines
Case Study/Content/Drug Information/Prices
Case Study/Content/Drug Information/Names
Case Study/Content/Drug Information/Definition of a drug
Case Study/Content/Drug Information/Forms, Origin
Case Study/Content/Drug Information/Usage methods

CASE STUDY/PEER-LED PROJECT

Case Study/Peer-led project/S6 Feedback
Case Study/Peer-led project/S6 Feedback/Expectations
Case Study/Peer-led project/S6 Feedback/Class Reaction
Case Study/Peer-led project/S6 Feedback/Process
Case Study/Peer-led project/S6 Feedback/Content
Case Study/Peer-led project/S6 Feedback/General

Case Study/Peer-led project/Recipient Feedback
Case Study/Peer-led project/Practical Issues

Case Study/Peer-led project/S6 Training

Case Study/Peer-led project/S6 Training/Drug Information
Case Study/Peer-led project/S6 Training/Drug Information/Definition, actions/
Case Study/Peer-led project/S6 Training/Drug Information/Alcohol, Tobacco/
Case Study/Peer-led project/S6 Training/Drug Information/Cannabis/
Case Study/Peer-led project/S6 Training/Drug Information/Heroin/
Case Study/Peer-led project/S6 Training/Drug Information/Forms, Origins/
Case Study/Peer-led project/S6 Training/Drug Information/Amphetamine, MDMA/
Case Study/Peer-led project/S6 Training/Drug Information/LSD, Mushrooms/
Case Study/Peer-led project/S6 Training/Drug Information/Medicines/
Case Study/Peer-led project/S6 Training/Drug Information/Cocaine/
Case Study/Peer-led project/S6 Training/Drug Information/Volatile substances/

Case Study/Peer-led project/S6 Training/Goals of Training
Case Study/Peer-led project/S6 Training/S6 feedback onTraining
Case Study/Peer-led project/S6 Training/Teaching training
Case Study/Peer-led project/S6 Training/Social Awareness
Case Study/Peer-led project/S6 Training/Legal Consequences
Case Study/Peer-led project/S6 Training/Medical Consequences
Case Study/Peer-led project/S6 Training/Quality of Training

Case Study/Peer-led project/Expectations of S6

CASE STUDY/PRACTICAL ISSUES

Case Study/Practical Issues/Time
Case Study/Practical Issues/Resources
Case Study/Practical Issues/Pupil Individuality

Case Study/Practical Issues/Pupil Individuality/Prior drug education
Case Study/Practical Issues/Pupil Individuality/Pupil Knowledge
Case Study/Research Issues

Case Study/Outcomes
Case Study/Outcomes/Perceived
Case Study/Outcomes/What they learnt

The School of Pharmacy
The Robert Gordon University

Drug Education Case Study: <School Name>

Information for Participants & Ethical Commitments
(draft for discussion)

Niamh Fitzgerald, 11 September 2001

Drug Education Case Study: <School Name>

Information for Participants & Ethical Commitments

This document describes the background and aims of the research that is to be carried out. It also explains what the case study in <School Name> will involve and lays out the expectations and roles of the researcher and participants involved with the study. It is a statement of commitment that the researcher will endeavour in good faith to keep to the principles laid out and to anticipate and discuss in advance should this become impossible for whatever reason.

Background

This case study is being carried out as part of work for a doctoral thesis that I am undertaking in the School of Pharmacy at The Robert Gordon University. This doctorate involves two stages: the M.Phil. (masters) stage, and then the Ph.D. (doctoral) stage.

I spent the first twelve months of my studies (Oct '99 to Sept '00) looking at the literature on drug education in schools, both in Scotland and internationally. There is a huge volume of information on what works in drug education and the effectiveness of various approaches and programmes. In Scotland, many surveys of drug education have been carried out by the government, independent bodies and universities. The most recent of these showed that 97% of schools provide drug education.

These surveys, while they provide an overview of drug education provision, offer little insight into what actually happens in schools. There is very little published on the reality of drug education in school, how it is planned and taught in schools, the difficulties and pressures that schools face, and the factors that affect the drug education that is ultimately provided. By interviewing and working with staff directly in schools in Grampian, I hope to shed light on these issues in the secondary school setting.

For the M.Phil. stage of my research I have completed an interview study with representatives of secondary schools across Grampian. This case study will therefore fulfil the Ph.D. stage of the research.

Aims of Research

- To investigate the current status of secondary school-based drug education in Grampian (this means looking at what currently happens in schools, best practice and comparing to existing theory on drug education from the literature)
- To carry out an in-depth study of drug education in selected secondary schools using various methods (looking in greater depth at how drug education is organised, how it fits in with everything else that happens in the schools, how it is delivered and received from the perspectives of both teachers and pupils)
- To study the factors which have an impact on the quality and effectiveness of drug education in the selected schools (looking at how decisions are made in relation to drug education, what level of priority is assigned to it, what decides that priority, what happens on the ground in schools that impacts on drug education provision)

The case study will provide information under each of the above and will allow me to observe first hand what happens in one of the schools that has been studied. There is also another important motivation for choosing to do a case study in addition to the interview study. While the interview study offers a structured account of the area of interest (in this case drug education in schools) and may provide 'reliable' data, it gives information from only one perspective, that of the interviewees in each school who were involved with drug education. The 'validity' of such an account can be greatly enhanced by combining this approach with field observations which may more accurately portray the informal and sometimes unanticipated aspects of the topic being investigated.

As such using first-hand observation allows me to examine how people interact in the school, how other teachers may have different perspectives and how pupils view the drug education (compared to the interviews, where I was asking the teachers how they thought the pupils felt). Having more than one source of information is therefore an essential tool to verify what has been said in the interviews.

Accordingly, by combining research methods (i.e. interviews and observations) the research will not just 'listen' to what people say they do and why, but rather observe actual behaviour. Further, the 'combined approach' allows for discussions and interviews with a range of people about what happens in the school, and coupled with reviewing relevant documentation promotes a fuller understanding of the issue of drug education in school.

It is important to understand that this study is not an evaluation of <School Name> . Rather, it is an exploratory study which aims to investigate an important area which has been little researched. The reason that I selected this particular school to be the focus of the case study is because practice here is already innovative compared to other schools elsewhere. Though the case study is focusing on this school, the aim is to enhance understanding of drug education in ways that might be relevant in schools in general.

What will the Case Study Involve?

- Observation
- Discussion
- Reviewing documents

Initially, I would like to spend time observing lessons with each guidance teacher. I will arrange in advance what days I will be present in the school and arrange with each teacher individually when I will spend time with them. On the days that I spend in the school, I will normally link up with one teacher who has drug education to deliver that day. I will meet with them for a short period (say ten minutes) before the lesson, sit in on the lesson, and then meet with them for feedback (say twenty minutes) at some stage after the lesson. On these days when I am observing a lesson, I will endeavour to spend the full day in the school, so that the feedback could be done at any time after the lesson. I do not envisage being in the school on more than two or three days in any one week.

The key aim of the case study is to understand the dynamics of the school and the job of a guidance teacher who delivers drug education. Accordingly, I will also take the time to attend guidance meetings, and I may need to meet with individual teachers for brief periods to discuss or explain any incidents or conversations that have happened previously. Again, these meetings would be arranged in advance, to suit the guidance teacher.

As I spend more time in the school and understand better how things operate, I will plan interviews with a selection of pupils and perhaps more formal interviews with each guidance teacher, or other members of staff.

Finally, I will also be reviewing any documents that might be relevant to how the school operates in relation to guidance and drug education.

Ethical Commitments

- **Freedom Not to Participate.** Each guidance teacher or member of staff is free to choose not to be directly observed or interviewed as part of the study, either at the beginning or at any stage while I am present in the school.
- **School Confidentiality.** The school will not be named at any stage in the reporting of the case, and will only be disclosed to members of my supervisory team (who will also be committed to the principles laid out in this document) and to administrative staff at RGU in order that I can obtain permission to be absent, and recoup expenses. The school will be described however, and it is possible that those who are already familiar with the area (e.g. those who know that this school provides peer education) may read published work and would be able to deduce what school is involved.
- **Participant Confidentiality.** No participant in the research will be named at any stage in reports. Each of the guidance staff will be identified only by an alias/number known only to me. In cases where members of staff other than the guidance team are participants and there is a risk that they would be identifiable from reports, prior arrangements for reporting information will be discussed with each person.
- **Pupil Involvement.** The above commitments will also apply to any pupils who may participate in the research. All parents will be informed of my presence in the school by means of a form

letter. All arrangements for involving pupils will be discussed and agreed with the relevant guidance teacher in advance.

- **Observation Protocol.** I will endeavour to meet with each guidance teacher in advance of observing any lessons to discuss arrangements both practical and ethical.
- **Information Provision.** At all stages during the research, participants who feel that they have any information or ideas that are important for me to know in relation to drug education at <School Name> , are invited make them known to me. It is important that those involved with the research do feel that they are participants rather than subjects, and that they feel they can direct me towards relevant information, concepts or questions.
- **Openness.** I will be open for any participant to contact me or come to see me to view my notes (in confidence), to ask questions, make comments and give or receive information. Any written accounts made by me will be open to participants for review and challenge if necessary to improve accuracy, fairness or relevance. Glaring inaccuracies aside, however, participants will not be entitled to 'veto' findings. In return, I ask that all participants are honest, forthcoming and open with me while I am in the school, and seek to provide me with as much relevant insight and information as possible.
- **Publications.** I will make available to you any journal publications in advance of submission for publication. Reports (oral or written) will also be prepared for other audiences but will adhere to the confidentiality and ethical principles stated above.
- **Thesis.** A copy of my doctoral thesis will be made available to the school after my final examination.
- **Risks & Benefits.** The risks involved in the study are that my presence in the school will involve a time commitment from participants and a certain amount of invasion of privacy. It is hoped however that the final report will be of benefit to the school and to all participants and that any risks will be outweighed by the increase in understanding which the study will provide. I will be happy to present a summary of findings to the school staff at a later date.

Contact Details

Please feel free to contact me at any time now, during the case study, or in the future:

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Mrs. Sandra Hutchinson
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August, 2001

Dear Parent/s,

Drugs Awareness Courses Research Project

As part of social education throughout the school, pupils are given courses in Drugs Awareness. This year, our drugs awareness education is to be studied as part of a research project being carried out by The Robert Gordon University. The project is looking at the quality and implementation of drug education in schools across Grampian, and <School Name> has been selected as a case study school because of its innovation in providing peer-led drug education.

To carry out this research, Niamh Fitzgerald, a researcher from the School of Pharmacy at RGU will be present in the school during the first term, observing lessons and carrying out interviews. She will be looking into policy, planning, development, and involvement of pupils in drug education.

Should you have any queries about this research, please contact your child's guidance teacher at the school.

Yours sincerely,

Thursday 13th September 2001

I arrived in the school at approximately 10.30am. I entered by the door from the courtyards beside huts one and two and so I didn't pass the reception area and didn't sign in until later in the day. I went straight to the office and was just looking over some book chapters when one of the guidance team arrived and we went up to the staff room for tea/coffee.

The staff room was very crowded and there was a queue for tea/coffee. We got ours and then went to sit down. While in the queue a number of people spoke to RM about various things. One woman handed her a copybook of a pupil, open at one page and just asked her to have a read of it when she could. When we were sitting down, JY asked "now what's this". She read through the open page and looked back through the copy. The writing was in places difficult to read, on the open page there was a story of the Maiden stone.

OC: I wasn't particularly sure whether it was better or worse than the standard expected of 1st years, but I guess it must be worse because: RM then explained that it belongs to a pupil who was not flagged up by her former primary school as someone in need of support. "You, see if the primary schools do not communicate with us." I asked if the classes are graded at all. She explained that the classes are not graded but that they do have classes in each year that are in need of extra support. There would be some "normal" (her emphasis) pupils in those classes too and the classes would have an extra teacher. It's actually an advantage but some parents don't see it that way. I asked if the pupils are aware that they are divided up in that way - she said that it is explained to the parents. She explained that it is just luck that this girl (who owns the copybook) is in a supported class, though she might not have been.

As the first bell went, she asked if it was the second - we looked at the clock, it said 11am, it is five minutes fast, as this was only the first bell. OC - I can't help but wonder if this is deliberate.

Appendix 2.18 - Extract from Lesson Observation Notes

Observation - 6.9.01 - 4K - Period 3 Sorted video

On arrival at the door of the classroom, a grey, prefabricated building, known as hut 2, we intercepted two adults dressed in lab-coats who were pushing a trolley with a tv and video on it out of the hut. Jim Cameron enquired as to where they were taking it and they said that they had been told to move it to hut 12. That's okay he said, but I need it now. Could you leave it here just now and move it later? Am I messing up your day?". "No, problem, no you're not messing up our day at all! It's a good job you caught us". So Jim repossessed the trolley and made his way with it, in the door of the classroom. "That could have been a total disaster!" he said to me as he set things up.

His own words dictate there, what happens. There is clearly an issue of resources here in relation to the use of TV/Video for the drug education lessons. In the absence of sufficient resources not to require movement of equipment, it then becomes an issue of forward planning and organisation. Who knows where the video is *supposed* to be at any given time? It would seem that the video's should be timetabled in the same way that people and classrooms are, so that everyone knows where it should be at any time, and it can be clearly seen if there are enough for everyone or not.

After a few minutes searching for a power point, he started. He introduced me "We have a guest in the classroom today. This is Niamh Fitzgerald, someone who like yourselves is a student, though Niamh is a postgraduate student. She is studying for a doctorate at the Robert Gordon University, on drug education - am I right (looking at me)?" I just said "hi!" and smiled.

Inside the classroom, there were thirteen kids sitting at desks that were set up in three columns two desks wide, facing towards the front. Four boys sat on the right hand side and one boy sat at the front on the left. Behind him, leaving one row empty, four girls sat. The remaining four pupils (also girls) sat towards the front in the middle column. I sat myself down in the gap on the left hand column where I could see most of their faces, though not the girls behind me so well.

He started the lesson by asking "have any of you ever heard of a young woman called Leah Betts?". "Yeah, you told us last week" came the reply. He didn't seem to notice this though, and continued to say "Yeah, you've heard of her? Who was she?". A girl towards the front centre of the classroom said "she died the first time she took drugs for her 18th birthday". This was not true, but Jim did not try to correct the error. One boy on the right asked "when was it?". Jim wasn't sure, around 1993, maybe 1996, looking at me, I didn't know either. "You'll see on the video anyway" he reassured them. "There's a lot in this tape, you'll see a bit about her family etc.".

He started the tape. There was some shuffling initially but it didn't take long before silence descended. I was able to look around without the pupils being aware of my gaze, and they seemed to be watching intently.

The tape begins with members of Leah's family and friends speaking about what kind of person she was. It goes on then to tell the story of her 18th birthday party. It struck me that the parents were more concerned about "the kids getting drunk". It was pretty sad, and I was bracing myself to make sure that I wouldn't get weepy! The pupils were quiet all the way through and when it finished, they remained quiet and waited for Jim to initiate any discussion. Can clearly see the effect of the video on the pupils - its easy to see why the teachers value it. It's powerful (I was affected too) and it keeps them very quiet. It's hard to imagine watching it and then going out to take E the next weekend. Does it work? Very short term, maybe. More than a month? I doubt it.

He began by describing the Betts as a normal family - he was a policeman, she was close to her brothers and sisters, they lived in a country area. "The "problem" was that she decided to take an "e" and "not drink". He asks if parental pressure might have had an effect on their behaviour since it would have been much more obvious if they had taken alcohol. A boy on the right hand side of the room spoke up to ask "what effect does 'e' have?". "a rush, a feeling of energy, wanting to dance all night" replied Jim. Jim's reply is quite honest, and there is a risk that it would sound like quite a lot of fun. He doesn't explain that it makes you feel lovey dovey with everyone. nor does he explain the downside. the comedown, clenched teeth etc.

Jim asks why she died. The same girl at the front, says "she drank too much fluid with it". Jim then asks and answers his own question - "did she take alcohol with it? We don't know. And combining drugs and alcohol would be absolutely fatal in many cases". This is a sensationalist statement. The truth is that most clubbers combine E with other drugs and most commonly alcohol. And only a very small proportion die. It may be more dangerous than taking E alone (though that is not necessarily the case, since it is believed that it is the specific effects of ecstasy that cause the fatalities) but it is still not fatal in the vast majority of cases.

He says "we're told she had taken doves before. Now that confused me a bit, what are doves. She had a different effects from a different tablet, why would that be?". The kids offered a number of options on the kinds of things "they" mix with "it" - dog wormer (a boy on the right), talcum powder (the front girl). "rat poison, washing powder" Jim adds, before enquiring of the front girl how she knows so much. "My mum is a youth worker" comes the reply. Here I would love to ask "which is dangerous, is it the ecstasy or is it what is mixed with it?". Such a question does not come. This is a classic example of a grave misconception that is promoted in relation to ecstasy. It is true that you don't know what you're getting, but its likely to be ephedrine or amphetamine; not rat poison or washing powder. No dealer wants to kill his clients. It doesn't make sense. Plus ecstasy is a tablet, it is often manufactured by reasonably able scientists.

Now Jim refers to a booklet that has been lying on the desk beside him during the lesson, that the boy in front of me has picked up and started reading. He says he will bring them in and show them to the class some time. He reads out some of the names for ecstasy from the booklet - they're kind of old-fashioned ones to my ears, but I guess I'm not with the scene. One of the boys on the right, suggests that they are also called "elephants". "I've never heard of that" says Jim. "They come in tablet form" he goes on, and asks "when do people take it?". "nightclubs", "to come down off other drugs" come the suggestions. "I don't think it is used to come down" he explains "it speeds you up. What did Leah's father say about her on the night of her birthday?". No-one knows. "He said "she looked good, excited, her eyes were smiling". No further discussion of the smiling eyes follows, it's just thrown in there, like a practice fisherman, not sure what fish he's trying to catch, but casting about anyway. I guess at this point he means to explain that she was excited, speeded up, not slowed down. But it sounds like good fun to me. And it probably is good fun, but he can't say that? Can he?

Next he discusses the classification of drugs - three classes A, B, and C. He asks what the difference is. "You get longer sentences for class A drugs", comes the reply. From youth-worker's daughter at the front. It strikes me that he makes no attempt to say that the classification is based on how dangerous the drugs are. He asks them if they can name any class A drugs. Cocaine is quickly mentioned by the boy on the right again. "What's the other name for that?" "Coke". "Do you know any other class A drugs?" Silence. he tries to prompt them "what's in the papers every day?" No response. "People die from using it.". "It's a particular problem in Aberdeen, in the Northeast". Eventually the other girl at the front mumbles heroin. "Yes, where does it come from?". Boy on right replies "fae abroad". "Do you do modern studies?" he asks him. "No". "How do you know so much?" "My mum's a nurse". "Oh, have you discussed these things with her?", "naw, not really, you just hear".

He goes on to try to get them to tell him where heroin comes from, they suggest all sorts of countries and at the end of it, he doesn't really seem to tell them which one is the correct one. He does say that it works its way from the East, and mentions the small farmers that are dependent on it. It comes from a plant they say, but don't know which one, even with heavy prompting. The poppy he tells them - it's made out of poppy seeds.

Post-Lesson Meeting with three 4th Year Pupils – 4L, 4M- 13.9.01

After the lesson, RM asked three pupils to stay behind. When everyone else had left they wanted to know what they had done! She explained that to them that they hadn't done anything and asked them if they would mind speaking to me for a few minutes about the video and the lesson. She told them that she picked them because they had spoken quite a bit during the discussions that had taken place. She also explained that they didn't have to do it if they didn't want to. They all agreed and we went to the interview room.

I started by explaining that I didn't need to know their names but that it would be easier if they could give me other names to use when I am writing what is written. They laughed at this, and then chose the names Anna, Greg and Gary.

OC - I suspected that they had just given me their real names.

I then asked them if they would like me to explain again why I was in the school and what I was doing and they said "yes". I gave them a brief summary of the work I had completed and the case study work in the school. Then I asked them if what their first impressions after the lesson were.

"Great video", was the general consensus. Anna felt that it was very hard-hitting particularly to see Leah's Dad crying, and the fact that her sister and friends also appeared on the video. "It was good because it explained some of the bad effects and all you really know is the good effects before this." I then asked them if there was any way it could be improved. They felt that they need more in-depth information about the effects of the drug. They explained that in first year they are asked to write down all of the names that they know for different drugs and they are made aware of the different names for them but they are not told at any stage what the effects are, in any depth. I asked if they were given written materials with this information on them, but they said, "no - we were only given worksheets to fill in". "The teachers don't know a lot themselves," they said. I asked them where they get their information from on drugs, if its not in school. "stuff you've heard," came the reply. Greg said that he reads the papers and that he was aware from them of the sequence of events that came about after the girl in Aberdeen died from ecstasy use.

I asked them if they thought what happened to Leah Betts happened to many people who took ecstasy. "Not many", they said. "It's not the most commonly used drug." "I would class E with heroin", said Anna. I asked her if she felt it was as dangerous as heroin. "Heroin is worse because you inject it. Heroin is probably not more dangerous than E but you wouldn't go injecting it in clubs, but you can take E in a club", she replied. I asked them if they thought it was the E itself that was dangerous, or if it was what it is mixed with. "Oh, it's mixed with all sorts of things" they answered. They questioned the sister's assertion on the video that the ecstasy Leah Betts took was pure. "How do they know it was pure?" they asked, "the dealer probably told them it was pure, oh yeah". "She (the sister) looked gullible anyway, she would have believed anything". I asked them "what is ecstasy?" "It's a mixture", said Anna "there could be rat poison or anything in it". Gary said "its got a chemical name". Greg: "yeah, something amphetamine, I can't remember". Gary: "dealers can put anything in it to bulk it up and make more money". I explained to them that it was probably from the post-mortem (autopsy) that the family knew that the tablet Leah Betts took was pure. I also told them that ecstasy itself is a chemical compound.

I asked them what percentage of people they thought died from taking ecstasy. Greg suggested "about 5%". "No" said Gary "just a couple of percent".

They were discussing how it was stupid that they (Leah and her friends) had planned to take it in advance. Gary said "if there's a group of people and they're all taking it, then you don't think anything when it comes around to your turn". "You could take it without knowing" one of them said. "yeah, you could be drunk, and do it, not intentionally". I said "but even if you're drunk, don't you still have to decide to do it?" "Well, it is intentional" admitted Gary "but you're under the influence of alcohol". Anna: "If you sat down for a few minutes and thought about it, you'd say "no". It's very surprising that they planned it in advance. It's the same with drink, you just have one at the time, but you might regret it the next day". Gary agreed "yeah, and once you have one drink you don't stop". Greg: "She said (in advance) she would take it and that's stupid. Very stupid. She should have been already high because it was her birthday. She shouldn't have needed it."

I asked them if they had studied the Drugwise programme last year. "Yes, it was stupid" they said "it was just all these worksheets to fill in and when you asked a question and the teacher didn't really know, they tried to tell you themselves but then looked in a book." "I think we probably know more than the teachers" "Yeah, I think they should be trained more". "It was just a regy teacher and they didn't know anything. Mrs. Mackay and Mr. Morrison know what they're talking about, they're much better."

"Don't tell me about yourselves or who it might be, but do any of you know anyone who has taken ecstasy?" I asked. They said "no", tentatively at first. Then Gary told us about the weekend. "There was a [local disco] and we were all going and two of the guys said that they were going to take it (E). I was with them and I just said "you can if you want". "You weren't interested" I asked him. "No, I wasn't interested." "But they didn't actually do it" Greg reported, "folk are always talking about it but they don't actually do it". But they then told me about an incident with one girl. She was part of a group who they seemed to think that there was a high chance were using some drugs. Greg explained "we were just talking about the price of ecstasy and we were saying it was £4 a tablet. She was sitting beside us and she interrupted us to correct us immediately and tell us that it was £5. It was just funny how quickly she corrected us". "Oh yeah, she would know" said Gary.

Gary then explained that ecstasy was not really the drug that was common in school. It was more likely to be dope or vallies. "Are they popular?" I asked. "Dope is" replied Anna. "yeah, they are, dope is popular, vallies are popular. The whole of [a nearby town] is on them - they're all junkies" said one of the boys. "I don't even know what vallies are, what are they?" asked Anna. I explained that vallies is a name for valium, which is a tranquilliser. "I don't know why they would want to take them" I admitted, "they would just make you sleepy. And they're very dangerous especially if you mix them with alcohol". "That's what they do," said Gary.

In the end I asked them if before they watched the video they would have believed that if you got away with taking an E a few times that you would be okay to take it again. "Yes. We thought, everyone thought that she died the first time she took it. We didn't know it had been her second or third time".

I explained that I might want to speak to them again in a few months time if they were willing. That would be no problem they said. I also said that I would be writing this up, and that I wouldn't let anyone know what they had said. I also said that I suspected that they had given me their real names and they didn't deny it, they just laughed.

After the chat, they came with me into the office to get absence slips from Mr. Morrison to explain their absence from their next class. I thanked them and they replied "you're welcome. Anytime!".

Case Study - Interview with Rector - 11/1/02

Interviewer

The first thing that I wanted to ask you generally was what is your vision for the school in terms of PSE and broadly drug education?

Rector

I do think that society is very complex today and that what we really have to do in schools is try and play our part in educating people so that they make choices in life which are informed by that education rather than making choices in ignorance so that is what I think the role of an effective PSE programme is to do, it is to make people aware of the choices they face and to give them the information they need to make those choices. I don't think schools can do it alone, I think is has to be part of what parents do, part of what perhaps employers do in the future, we all need to be part of that raising awareness, constantly reminding people, making sure they know what's happening, government plays a part clearly in advertising campaigns and so on. So to me that's what an affective PSE programme does, people become informed about a particular topic, or a particular subject and then they are aware that they have choices to make, and that they should make those choices based on knowledge of what's going on. Along with that however I do think that the PSE programme has to promote at all times, really this is across the school at all times, its not just in the PSE programme - self confidence, self awareness. It has to promote the kind of personal skills and qualities that will, I think will allow people to make the decision for themselves, or encourage people to make the decision for themselves rather than go along with the peer group. Now that's something, that's a wee bit like what you were saying about the government's agenda for drugs education - that's something that we may never totally achieve but we have to strive towards that, I suppose it's about making them more thoughtful and independent citizens.

Interviewer

And in terms of say more specifically drugs education would you see it as being the same, as giving them the information?

Rector

Yes, I mean I think that would be the basic starting block. We do in schools have however, a real almost moral dilemma about drugs education because we do know that there will be youngsters that take drugs, many of them will in particular try cannabis, but others will try other things and we do know also that there is a message that we can give out, perhaps say about things like substance abuse, that could reduce the risk involved in those activities, but we are always left feeling as if we are slightly in between, if members of the public or parents heard that we were advising the harm reduction route if you like, they could perhaps legitimately complain to schools about it. So we have to work closely with other agencies, we have to be realistic about the kind of activities young people get up to, of course it's not just young people, it's a bit like saying only young people drop litter, that's just patently not true so we have to be careful about that. But it is I think one that we would appreciate a lot more guidance on from government.

Interviewer
The harm reduction side of things you mean?

Rector
Yes, whether or not harm reduction is something that Government would sanction - that kind of approach. At the moment, we would tend to work with outside agencies and bring them in when necessary to try and advise youngsters who perhaps we knew for example were involved in substance abuse.

Interviewer
So it would be more at an individual level at the moment, but you would appreciate maybe having more guidance about it in terms of lessons

Rector
That's right, although clearly what we would really, really want is for the demand to reduce. And that stands to reason.

Interviewer
Okay. And so in terms of then, well, one of my questions is, do you think the drug education works, I mean, in terms of giving the information, I suppose if you're giving it

to make choices then its easier to say whether its working in that sense rather than whether its actually helping to make healthier choices, whether it changes their minds.

Rector

I think it works to an extent. It's difficult to say the extent to which it works based on hard solid evidence because we don't really have that evidence at our fingertips if anybody does, but I do think that for a few years now there is a generation coming through school who do know more about it. They probably know more about drugs and the effects that drugs have simply because they are exposed to it more, I think, in society, but along with that goes of course a whole set of myths and a whole set of disinformation or just the wrong information and I do think that schools have begun to really tackle that issue and alongside I think that in the wider sense school are also maybe aware that it is about making young people self-confident and having high self-esteem. It depends what criteria you apply to this. If do I mean that fewer people are smoking cannabis as a result of drugs education in schools the answer is probably no but I do think that perhaps people are slightly more aware of the kind of decisions they have to make or the kind of impact that taking drugs or being involved in the drugs scene can have on your life.

Interviewer

Right, Okay. What kind of levels of use would you say there are among pupils of everything, all substances, I mean alcohol and smoking as well?

Rector

I would think in terms of alcohol, probably a very, very large number. A huge proportion of our youngsters will be involved in underage drinking. I wouldn't say-

Interviewer

From first year up or?

Rector

I wouldn't have thought too many in first and second year but I would think in third and particularly in fourth, fifth and sixth year, a huge number, probably approaching something like eighty or ninety percent.

Interviewer

Okay, because I had three third year pupils today, and I asked them, out of ten people in your class, how many you would say, an average ten, smoke or drink? And one of them said three, the other said four or five and the other said seven. And they said the same for alcohol and as for smoking. And even after, say the first person said three, I said, well do you still say three after, you know, she said seven and they still said yeah, I still think its three so it obviously depends who they're hanging around with, but would you sort of think its in the middle or?

Rector

Aye, I think its pretty high. I think maybe by the time they're getting to this stage of third year, I would say its over the fifty percent and certainly into fourth year I would say its getting up towards maybe seventy percent and then fifth and sixth year, its just what they do. In terms of drug-taking, its still very, very difficult to say because in one way taking alcohol isn't done so secretively and people are more, they don't like to be caught or whatever, but they're more open that its happening. We do know that a number of youngsters are heavily involved in the drugs scene in and around Allandon and I would think that by the time people leave school they will all have had the opportunity if they want to take it of trying cannabis. But I think, I can't put a figure on it, I can't put a figure on it. But I would think a fairly high proportion would have tried cannabis, not anything else. A reasonably small proportion will have gone on to the so called harder drugs and will have tried them.

Interviewer

And the people that you know are quite heavily involved, is that mainly cannabis as well?

Rector

It is, but not exclusively so.

Interviewer

They would be dabbling in other things as well?

Rector

Yeah.

Interviewer

What would you see as your role as the rector in the development of the PSE, how do you, what's your input?

Rector

Well, my input is limited because, we, in a sense what we do, is as a senior management team we manage different parts of the curriculum and the school. Having said that, I would always discuss each year, maybe four or five times over the year, with my senior management colleague who has a responsibility for the guidance team, how the PSE programme is going, you know, what the strengths and weaknesses are and I do have a job in terms of trying to assure quality, to evaluate the success of the programme, but more across the whole school, being informed by the kind of evaluation, that you're in fact carrying out here. I do think however that if you like I almost have a figurehead role too which is to be seen to be trying to promote healthy lifestyles to encourage people not to become involved in those kind of things. But not in a necessarily kind of nagging way, but just in terms of being positive about people, promoting the kinds of skills and qualities in people that we've just talked about so that kind of approach. Because I do think that if schools, if teachers don't provide reasonably good role models for pupils, you know that's one part of what schools should be doing.

Interviewer

So, as an example?

Rector

That's right. I do have another role, unfortunately, which is a disciplinary role if people are involved in taking drink or drugs around the school then I have that role to play too and I think there what we always try and do is say, we don't try to overreact we just try to deal with things firmly and also fairly and it seems to me that in this day and age when so many youngsters do get involved in say something like cannabis, you know we can't be seen to be tolerating drug taking or drug selling, particularly drugs selling, in or around our schools but we also have to be even handed in how we approach applying

sanctions. Very often at that stage, that's when we will bring in outside agencies as well as parents

Interviewer
-to speak to the pupils

Rector
And part of our job is to educate parents as well because they very much still feel there's a stigma attached to it - my son's done this, my daughter's done this and we often have to try and ensure that they understand, where the, how could I put this, but really what the reality is in terms of the number of people who are involved and what their son or daughter has actually done.

Appendices to Thesis

POSTER ABSTRACT FOR FIP – WORLD CONGRESS OF PHARMACY AND PHARMACEUTICAL SCIENCE SEPTEMBER 2000.

With latest European figures showing increasing numbers of schoolchildren reporting use of illegal drugs, the need for drug education may never have been greater. For this poster, the author has reviewed the drug education literature to consider potential roles for pharmacists in the education of young people and possible barriers to fulfilment of these roles.

Most such education currently takes place in a school setting but programmes vary widely in content and delivery. In the UK, drug education is generally incorporated into the normal health curriculum taught by the relevant schoolteacher, whereas involvement of police and outside agencies or professionals is more common in the United States. Although many pharmacists have become involved in treatment services, very few have ventured into the role of educator in this area.

This relative lack of involvement may be largely due to historical factors, however the education of pharmacists in many countries leaves them ill-equipped to deal with questions on substance misuse. While the issue of who is best equipped to educate young people about drugs continues to be the subject of discussion the opportunities still exist for pharmacy to get involved. At the present time, we are not even in the debate.

EUROPEAN SOCIETY FOR SOCIAL DRUG RESEARCH

12TH ANNUAL CONFERENCE

Venice, Italy; October 4th to 6th, 2001

(A) TITLE

Is Effective Practice Feasible? A Qualitative Study of School Drug Education in Scotland

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(D) ABSTRACT FOR ORAL PRESENTATION

Background and Objectives

School-based drug education has been shown to be capable of improving knowledge about drugs, but far less able to translate such knowledge into any behaviour change such as a reduction in drug use. Previous research indicates that intensive, interactive programmes, based on life-skills and involving families and communities are more likely to be successful, however much work is needed to investigate to how such findings may be translated into effective practice in schools on a broad scale.

Previous studies of drug education in Scotland which were based on school questionnaires did not allow for in-depth analysis of policy and management structure, ethos, the abilities of different teachers, planning and decision-making, teaching methods, pupil involvement,

programme intensity and so on. The work reported here is part of an ongoing research project that aims to shed light on these issues by making use of qualitative interviewing and data analysis techniques.

Methodology

Theoretical sampling was used to select secondary schools for the study. Each school was then asked to make available for interview the person(s) best able to describe the school's drug education policy and provision. A semi-structured interview guide was developed, refined with input from independent experts and piloted with respondents in three schools outside the main region of study. The transcribed interviews were analysed on an ongoing basis using grounded theory procedures, further developing each theme in subsequent interviews until theoretical saturation was reached. Nine schools in the North East of Scotland took part in the main study.

Significant Findings

It is clear from the interview data that the planning process for drug education in most schools is largely haphazard. There is a worrying lack of consistency in the teaching of drug education between different schools, between different teachers in the same school, and even among pupils with the same teacher. Although discredited by research, scare tactics are still widely employed by schools and are justified by basing them on the real-life stories of one-time drug users. Most schools still do not provide harm reduction information as part of their programme and many of them felt that it would be inappropriate to do so. This is worrying given that all of the schools felt that there were significant numbers of their older pupils already using drugs. Despite these negatives, drug education is a priority for all the schools, some of whom were innovative in their teaching and pastoral care.

Abstract for Annual Symposium of the Society for the Study of Addiction, 2001
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School-Based Drug Education in Northeast Scotland - Policy, Planning and Practice.

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Short Title: School-Based Drug Education in Northeast Scotland

The research described in this presentation aimed to examine current practice in the planning, development and delivery of school-based drug education in the Northeast of Scotland. To do this, a qualitative study using semi-structured interviews was carried out. Schools were selected for inclusion in the study by means of theoretical sampling for maximum variation. Each interview was transcribed in full, annotated, analysed and validated using established procedures in grounded theory and qualitative methodology. In total, nine secondary schools were selected and thirteen participants interviewed. The interviews focused on: 1. Policy, planning and development of drug education; 2. Messages, teaching method and delivery of lessons; 3. Feedback, evaluation and monitoring; and 4. Innovative practices. The study found that none of the schools had a written policy on drug education, and programmes, priorities and lessons constantly evolved on an ad-hoc basis. Participants were not sure if/how pupils used drugs, and found it difficult to match provision to pupils' needs. Messages, teaching method and delivery varied enormously and scare-tactics were still widely employed and valued. Evaluation and monitoring were largely considered unnecessary bureaucracy. Despite this, there were signs of innovation including peer-led teaching and pupil consultation. In conclusion, the research has shown that current practice in school-based drug education is well below what is considered best practice. If such education is considered essential and appropriate then it needs to be organised in a way that acknowledges this. The philosophy, theory and aims of drug education programmes must be made explicit and delivery must then be monitored and evaluated accordingly. This would require fundamental changes to current approaches both locally and nationally.

Selected References:

1. Lowden, K. and Powney, J., (2000). Drug Education in Scottish Schools 1996-1999. Edinburgh: The Scottish Council for Research in Education.

2. Donaldson, S.I., Sussman, S., MacKinnon, D.P., Severson, H.H., Glynn, T., Murray, D.M. and Stone, E.J., (1996). Drug abuse prevention programming: Do we know what content works? American Behavioral Scientist, 39(7), pp 868-883.

3. Dorn, N. and Murji, K. (1992). Drug Prevention: a Review of the English Language Literature - ISDD Research Monograph Five, London: Institute for the Study of Drug Dependence (now DrugScope).

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A Qualitative Study of Drug Education in Secondary Schools in North-east Scotland: background and methodology

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ABSTRACT *Previous research indicates that intensive, interactive drug education programmes based on social influence theory and involving families and communities can be effective in reducing drug use among young people. Although there have been a number of recent developments in drug education in Scottish schools, much work is needed to investigate how closely it matches the above criteria for effectiveness and to illuminate the factors that hinder or assist the provision of drug education of high quality. This paper describes how a recent study used qualitative in-depth interviews to study current practice in drug education in secondary schools in north-east Scotland. The choice of methodology and the strengths and weaknesses of the procedures used in the study are discussed in terms of their impact on the reliability, transferability and truthfulness of findings. In particular, issues such as the position of the researcher, the selection of schools and the experience of respondents are considered, together with the strategies used to deal with them. These include the use of theoretical sampling, studying the leading edge of change, careful complete transcription, independent experts and a pilot study. The paper concludes with an indication of future work.*

Introduction

This paper describes a recent study of policy and practice in drug education in secondary schools in north-east Scotland. Firstly, it reviews existing information on drug education in Scottish schools and discusses the factors found to be critical in the success of drug education programmes elsewhere. Secondly, it describes the method and procedures used in the recent study. Finally, it discusses the appropriateness of the methodology used, and how it may influence the results of the study. The results themselves will be presented in a subsequent paper.

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'Appropriate' Drug Education

In recent years, tackling illegal drug use in Scotland and the UK has become a high priority for previous and current governments. Initiatives in Scotland include the setting up of a ministerial drugs task force, the publication of a drugs strategy for Scotland (Scottish Office, 1999), and the announcement in September 2000 of £100 million extra government funding for drugs work (Scottish Executive, 2000). One of the four cornerstone objectives of both the UK and Scottish strategies is as follows:

> to help young people resist drug misuse in order to achieve their full potential in society.

More concrete targets known as 'Scotland's action priorities' have been set in order to achieve these objectives. One of these, under the above objective is to ensure that:

> ... Every school provide[s] appropriate drug education for all pupils in line with national and education authority advice.

These targets seem unambiguous, but just what is 'appropriate drug education'? There is a wealth of literature and successive reviews on approaches to drug education and the effectiveness of various programmes, much of which concerns the search for the 'holy grail': a programme or approach that has a proven impact on drug use (Coggans & Watson, 1995; Plant & Plant, 1999). Most commonly, programmes have been shown to be capable of improving knowledge about drugs, but far less able to translate such knowledge into any behaviour change such as a reduction in drug use (Bangert-Drowns, 1988; Dorn & Murji, 1992; White & Pitts, 1998).

Nonetheless, some programmes have been successful and a picture has begun to emerge of the factors that appear to contribute to such success. The meta-analysis made by Tobler & Stratton (1997) found that interactive programmes had a significantly greater effect on drug use than non-interactive programmes. Interactive programmes are those that involve communications based on face-to-face *peer* interactions, with planned activities to stimulate active participation. Non-interactive programmes involve a passive approach where content is introduced by teachers in a didactic instructive manner in a lecture format, and activities are mainly between teacher and pupil, and not pupil to pupil (Black *et al.*, 1998). Although the effects of programmes tend to decrease over time, an increase in the intensity of a programme and the inclusion of booster sessions have been shown to bring about a more sustained reduction in drug use (Kumpher, 1997; White & Pitts, 1998). There is some evidence that interventions that combine school-based programmes with an array of community-wide and family activities are more likely to be effective and to sustain that effect for longer periods of time (Donaldson *et al.*, 1996; Flynn *et al.*, 1994; Kumpher, 1997). Finally, although there is still much work to be done to isolate the specific programme content areas (and combinations of areas) that mediate a reduction in drug use, there is evidence that social influence approaches are more effective than others. In particular, lessons emphasizing social norms (teaching about the actual prevalence of drug use among young people, and reducing perceived peer approval of use) are most likely to be effective (Botvin *et al.*, 1995; Donaldson

et al., 1996). Provision of 'appropriate' drug education would sensibly include consideration of the above factors.

Current Practice in Scotland

So is such appropriate drug education being provided in Scottish schools? The most recent survey of drug education in schools by the Scottish Executive Education Department (2001) reported that 100% of secondary schools provide drug education, and that 86% of them do so 'in line with current national advice'. These are impressive figures but, on closer inspection, one finds that this information is based on self-reports by schools. They provide no indication of schools' understanding of the details of local and national advice, nor how they interpret such advice and put it into practice.

In the late 1980s, Coggans *et al.* (1991) carried out a national evaluation of drug education in Scotland. This was a wide-ranging study that included a comparison of groups of pupils who differed in their exposure to drug education and it found that drug education had an effect on only two of the outcome variables, both of which were aspects of drug-related knowledge. No effect on pupil perceptions, attitudes or self-reported drug use was found, although why this was the case was not apparent from the research. The study described in detail four individual schools and how they approached drugs education and drugs issues. These descriptions revealed that school policy and management structures significantly influenced the development and implementation of drug education. More recently, in their national study of drug education, the Scottish Council for Research in Education (SCRE) (Lowden & Powney, 2000) found that the actual content and style of lessons in schools was influenced by a number of factors including

(i) teachers' perceptions of the pupils' needs and abilities,
(ii) teachers' attitudes and understanding concerning the aims of drug education,
(iii) awareness and availability of resources and support,
(iv) local authority policies and
(v) staff skills and staff development opportunities.

While these indications are helpful, both of the above studies noted that the level of detailed information that they were able to gather in primarily survey-based work was limited. In the USA, a national study into school health policies and programmes was carried out in 1994, which included extensive qualitative interviews of health education teachers across the country. The factors that facilitated and prevented the delivery of quality school health programmes were discussed and six issues emerged from the research (Pateman *et al.*, 1999):

(i) the value placed on health education in the school curriculum,
(ii) qualifications and opportunities for health educators,
(iii) programmes, curricula and teaching method,
(iv) assessment, evaluation and accountability issues,
(v) resources and support and
(vi) communication and collaboration.

While some of these factors are similar to those found by Lowden & Powney, there remains a lack of information on exactly *how* or *why* the factors impact on the ability of schools to provide appropriate drug education.

Recent Developments

In recent years, many school health promotion initiatives have been dominated by the concept of the 'health promoting school'. This initiative emphasizes the importance of environmental change and personal development, as well as classroom-based activities. The 12 criteria developed by WHO for schools to work towards in order to become a 'Health-Promoting School' include the active promotion of the health and well-being of school staff, the provision of stimulating challenges for all pupils through a wide range of activities, and the development of good links between the school, the home and community (Parsons *et al.*, 1996). These criteria are reflective of the factors found to enhance the success of drug education in schools, as described above.

The UK joined the European Network of Health Promoting Schools in 1993. Particpating schools may focus on just one (or more) of the 12 criteria and target one or several health needs. Thus there is considerable flexibility in the ways in which schools work towards becoming health-promoting schools. In Grampian, a range of support packs, including one on drugs, has been prepared to help schools. A recent systematic review of the health-promoting school initiative found that, while the approach is promising, there have been few quality evaluations carried out in participating schools, and therefore little is known about how effective it may be in the long term (Lister-Sharp *et al.*, 1999).

In 1999, the Scottish Executive set up the School Drug Safety Team to provide appropriate guidance for Scottish schools on handling drug incidents and on effective drug education. Having studied recent reports and following a consultation process which involved the commissioning of a number of papers and presentations, the Team published their final report in January 2001 (School Drug Safety Team, 2001). This report identifies some factors thought to impact on the quality of drug education in secondary schools, particularly teacher characteristics, career progression for health education teachers and a limited allocation of time for coordination of drug education. In addition, a number of recommendations are made in relation to drug education including aims, content, management, quality assurance and the involvement of external agencies. Although the report is comprehensive, it was not distributed directly to schools and it is not known to what extent individual schools have taken on board its conclusions. At the time of writing, funding has been made available for the implementation of this report, although exact details have not been made public to date (Scottish Executive, 2001).

Despite these efforts, the numbers of young people experimenting with and developing problems with drugs continues to rise (DrugScope, 1999; Hay *et al.*, 2001). Current approaches to drug education and the quality of such education vary widely between schools and even between individual teachers in the same school (Lowden & Powney, 2000). Indeed, even though there are indications of more successful strategies, it is by no means clear that schools in Scotland are prepared or even able to change practice in each individual classroom where drug education is taught. There is a dearth of published studies focusing on how

or why schools make particular decisions about drug education, decisions on teaching method and interactivity, pupil involvement, programme intensity, choice of teaching packages, lesson planning, and the factors that impact on practice in schools.

In truth, it remains to be seen whether it is realistic to expect schools to be able to deliver the kind of intensive, controlled programmes of drug education that might lead to a genuine measurable reduction in drug use among young people.

Methodology

Aims

The following aims were identified for this research:

1. to investigate the current status of secondary school-based drug education in Grampian, north-east Scotland;
2. to carry out an in-depth study of policy and planning of drug education in selected schools;
3. to study the factors which have an impact on the quality and effectiveness of drug education in the selected schools.

The study reported here is the first stage of the research and makes use of qualitative interviews with staff in selected secondary schools in the Grampian region to address the above aims. The following narrative describes how these interviews were planned, organized and carried out. For the purposes of the study, drug education was defined as all lessons and activities which deal with illegal drugs or legal drugs used illegally, and alcohol, tobacco or solvents where included in these lessons and activities. In the course of the fieldwork, discussion of other aspects of health education was encouraged where it was relevant to the research questions.

Access, Rapport and Interview Guide Preparation

Permission to carry out the study was initially obtained from the directors of education in each of the three local authorities in the region. The research aims outlined above were subdivided into more focused 'mini-research questions' (Figure 1), as recommended by Mason (1996). From these mini-questions, an initial interview guide was developed using questions and prompts following a semistructured format. An initial draft of the guide was sent to 'independent experts' (Appleton, 1995) for comment, including one of the authors of the SCRE report (Lowden & Powney, 2000) and a local health promotion advisor. Before approaching schools in Grampian, pilot interviews were carried out in a convenience sample of three schools outside of the region.

Selection of Schools

Initially, schools were selected by theoretical sampling for maximum variation, that is schools were purposely chosen in a way most likely to shed light on the research questions and to provide a comprehensive range of perspectives. Thus, a range of schools from the most to the least active in drug education, and varying in terms of rurality and size, were contacted. After interviews had been carried

Aim 1: *To investigate the current status of secondary school-based drug education in Grampian, north east Scotland*
Subquestions:
- What is currently taught in the classroom drug education?
- What messages are promoted?
- Who delivers the education?
- What teaching methods are used?
- What family and/or community involvement is there?

Aim 2: *To carry out an in-depth study of policy and planning of drug education in selected schools*
Subquestions:
- What policies exist at the school and local level for drug education?
- How does the school handle reports of drug use or drug-related incidents?
- How is drug education planned and organized?
- How are decisions about drug education made?
- Who is involved in the planning and decision-making process—teachers, pupils, parents etc?
- How is drug education monitored or evaluated by the school?
- What feedback mechanisms are in place in relation to drug education?

Aim 3: *To study the factors which have an impact on the quality and effectiveness of drug education in the selected schools*
Subquestions:
- What training do deliverers of drug education receive?
- What facilitates and hinders good drug education?
- What would need to happen or to change to improve drug education?
- What influences the school's decisions on drug education—internal, local, regional or national influences?

Figure 1. Major research questions and subquestions.

out with willing schools from this initial sample, it became clear that the research issues would be further illuminated by the selection of the most progressive schools in terms of drug education, as they had experience of overcoming some of the issues and difficulties identified by the less innovative schools. It also became clear that rural schools were somewhat under-represented in the data. Further schools were therefore selected in accordance with these criteria. Interviews were arranged until the researcher felt that new key themes were no longer emerging and that the resultant descriptions and explanations of drug education in schools would be sufficiently detailed to address the research questions. The selection of schools at all stages was based on discussions with representatives of each of the three local authorities in the region.

Procedures for Interviews and Data Management

In each school, the head teacher was initially contacted by post to inform him or her of the study and to request permission to interview staff. If permission was granted, the head teacher was asked to identify the person(s) in the school who would be best able to discuss the topics of the interview. When the interview had been arranged with selected staff, they were provided with a short guide listing both the topics to be discussed and any documents that would be helpful to the research. On the day of the interviews, the background, aims and purpose of the study, how the data would be recorded and used and arrangements to protect the identity of the respondents were discussed, prior to any questions being asked.

They were then asked to sign a consent form, stating their understanding of the research and the above arrangements.

Each of the interviews, which lasted one to two hours, was audiotaped and subsequently carefully transcribed in full. The transcripts were then 'tidied' to remove redundant words and phrases, although the content was maintained in the vernacular and no attempt was made to 'correct' the language. Efforts to protect the confidentiality of the information included the secure storage of original tapes and paperwork, and the protection of electronically stored documents with passwords. A second 'anonymized' version of each transcript was prepared, with all identifying information (except for a code number) removed.

Data Analysis

Where possible the interviews and data analysis were carried out in what Creswell (1998) has described as a 'zigzag' process. This process involves the researcher carrying out an interview, analysing data and how it contributes to themes and then going back to the field for another interview to develop the themes further. Thus, the interview and therefore the interview guide (and interviewer) continue to adapt to the themes that are emerging. The transcripts and any accompanying documentation were initially analysed using a variation on the procedures used in grounded theory research (Glaser, 1992; Strauss & Corbin, 1990). Each transcript was read several times as recommended by Agar (1980) 'to immerse [the researcher] in the details, trying to get a sense of the interview as a whole before breaking it into parts'.

As this reading was done, annotations were made consisting of short phrases, ideas or key concepts that occurred to the reader. These notes were added to each transcript using the 'Comments' function of 'Microsoft Word' and loosely fell into three categories: emerging themes (code notes); the researcher's thoughts about the data, possible interpretations and questions (theory notes); instructions to the researcher about methodology, sampling and future plans (action notes). As the transcripts were subsequently reread, phrases and sentences were highlighted where they discussed various themes and were later grouped together under broader headings or categories. These categories were developed into a framework of themes and subthemes, which went on to form the basis of the results of the study.

Discussion

Drug education programmes have historically shown little success in preventing drug use among young people. Despite this, there are indications that successful programmes share some common characteristics: those of interactivity, intensity, community involvement and a social influence basis. In Scotland, while most schools provide drug education, little is known about how provision compares with these criteria. This research study was designed to investigate this issue in Grampian.

Selection of Methodology

A qualitative research design was deliberately chosen for the study. Qualitative methods have been recommended to deal with research questions that begin with 'how' or 'what' so that initial forays into the topic describe what is going on (Creswell, 1998) and to uncover and understand what lies behind any phenomenon (Strauss & Corbin, 1990). In this study, finding out what was going on in relation to drug education in schools and understanding what lay behind that were exactly the focuses of the investigation. A survey method was considered unlikely to illuminate the complex processes and social realities that influence the provision of education on this often-controversial topic. This conclusion is supported by the recommendations of Coggans *et al.* (1991) and Lowden & Powney (2000) above. Lowden & Powney also noted that schools in the UK are increasingly being surveyed by various organizations, especially on health-related projects, leading to growing research fatigue, with response rates for surveys falling. Interviews involve face-to-face interaction, thus building rapport, allowing in-depth consideration of issues and the flexibility to be adapted to any school circumstances. For these reasons, qualitative interviews were selected as the primary means of data collection in this study.

Transferability of Results

There are a number of disadvantages to the use of qualitative interviews, however. It is time consuming to arrange and conduct interviews, and transcription is a long tedious process. These factors limited the number of schools that could be involved in this study, which may give rise to questions about the generalizability of the results. Generalizability in qualitative research is not addressed empirically, by means of random sampling and statistical significance. Rather, a range of strategies is used to consider how the results of the study may be generalizable or *transferable*, in this case to other schools in Grampian or elsewhere.

One of the issues on which the transferability of results depends is how typical the schools studied are of other schools in Grampian and elsewhere and how easily that may be judged from the study report. When results are presented, the research subjects, schools and the contexts in which they deliver drug education will be described fully. This will allow the reader to consider similarities to and differences from elsewhere, and thus to judge how well the results may transfer.

The study used theoretical rather than random or convenience sampling. It is suggested here and elsewhere (Slevin & Sines, 1999) that theoretical sampling is superior to either of the other two methods as it allows the selection of a sample likely to provide the broadest perspective. Random sampling in this region would not be guaranteed to include any rural schools in the sample, and convenience sampling could bias the results in any number of ways. Theoretical sampling also allowed the researcher to continue to generate data until she could be confident that additional interviews were no longer adding new themes or furthering the research questions beyond the existing body of data, that is the point of theoretical saturation. In this study, it was found that, while the provision of drug education was in some ways very different across the region, the same broad themes emerged in interview after interview. Although this will be discussed

further when the results are presented, it clearly increases confidence in the typicality of the results.

The method of theoretical sampling is not without fault. As the researcher was not entitled to access certain confidential information on individual schools that would be necessary for theoretical sampling, it was necessary to ask key personnel at the local authorities to select the schools according to the criteria discussed above. The possibility arises therefore that the particular interests of these representatives would in some way bias the sample. This potential bias was minimized by asking them to identify more schools than would be approached in total, and by making it clear that they would not be provided with feedback on any individual school. Of the 12 schools approached, three refused to take part on the grounds of lack of time. Whether or not this was the real reason for non-participation, it raises the possibility that the results obtained reflect those schools that may have more time and resources, or interest in drug education issues. This is exacerbated by the purposeful selection of innovative schools in the latter stages of data collection (for reasons explained below) and means that the results are likely to paint a rosier picture than typical. This was borne in mind during data analysis and ought to be remembered when the emergent results are considered.

Finally, transferability also depends on how the passage of time may change the circumstances studied. In this study, the selection of the most innovative and progressive schools is in line with the recommendation of Schofield (1993). He recommends studying what is termed the 'leading edge of change' in a field of practice, to act as a means of enhancing the transferability of findings beyond the time span of the data collection. If research focuses on new or innovative practices, it can provide early indications of the issues to be dealt with and overcome in implementing those practices in the future.

Reliability

Conventional measures of reliability are more comfortably associated with quantitative research where standardized 'research instruments' are used. Nonetheless, reliability in qualitative research can be conceptualized in terms of how thorough, careful, honest and accurate the data generation and analysis have been (Mason, 1996). In this study, the interviews were audiotaped and transcribed in full so that all that was said in each interview was fully represented in the body of data that was analysed. In transcription, any words or phrases that were unclear were not guessed at but rather marked with the number of the tape count at which they occurred, for subsequent checking either by the researcher themselves or by an independent colleague. In addition to the care taken when transcribing each interview, one of the transcripts was checked by an independent researcher by listening to the original recording. He was able to identify a small number of minor innacuracies in the 20-page transcript, only one of which altered the meaning of the sentence in which it occurred in the interview. This was not thought by him to change significantly the themes emerging from the interview.

Truthfulness

Validity in quantitative research generally means that the data collection instrument measures what it claims to measure. In qualitative research, however,

validity is more usefully seen as the extent to which the findings represent reality so issues of credibility and truth take prominence (Perakyla, 1997; Slevin & Sines, 1999). In considering how true findings are, the researcher is forced to consider how his or her own position or background may have influenced data collection and interpretation, how effectively the questions asked can actually illuminate the research issues and the likelihood that individual respondents can, and will, answer the questions asked, truthfully and accurately.

In the study described here, the interviews were conducted by one of the authors who was not a member of the secondary school community and who had not attended school education in Scotland. Although this had the advantage that the researcher had few preconceived ideas about what would emerge from the study, the position of 'outsider' can affect the ability of the interviewer to seem sympathetic and unthreatening to the respondents and thus increase the likelihood of them providing incomplete, inaccurate or misleading information. The pilot interviews allowed some insight to be gained into the secondary school setting in Scotland and thus a degree of empathy with respondents to be established as well as allowing the interviewer to gain in confidence and experience in guiding a semistructured interview of this kind. The issue of *threat* more commonly arises if the interviewer is in a position of power, or working for someone who is perceived to have power over the respondent in some way (e.g. the local authority). In the case of this study, every effort was made to explain to each respondent the background to the work, how the results would be used and the independence of the research from the schools and local authorities.

As the respondents were chosen by the schools themselves, there was some variation in their ability to answer the questions asked. This was because the issues considered broadly fell into two categories: that of planning, namely issues of policy and direction; and that of practice, namely what actually happens in the classroom during teaching. Not all the respondents had current experience of both areas; if they were a classroom teacher, they were not always aware of the schools future plans and direction for drug education and, if they were an assistant head teacher, their knowledge of policy was comprehensive but they were not always fully aware of the details of classroom practice.

Four of the nine schools selected two respondents to be interviewed either together or separately, so that both of the fields were covered. In the other schools, it was not possible to obtain a clear picture of both areas from every respondent. Early in the interview, each respondent was asked to explain their own role and experience in relation to drug education and this later gave an indication of how well prepared they were to answer questions about the different areas. In many cases, having been sent details of the interview topics in advance, the respondents had made efforts to speak to their colleagues so that they could give a more complete account. In all cases, care was taken to put respondents at their ease, to look interested in what they were saying and to reassure them of the confidentiality of the interview at sensitive moments. Despite all these efforts, during data analysis it was important to consider how sure the respondents were of their responses, whether they were saying what they felt that the researcher wanted to hear, or whether they were being in any way evasive or misleading. The independent researcher, who had carried out the transcript check, also performed his own thematic analysis and his results were compared with those of the research team, which he had not seen. There were no major themes identified by him that were not noted by the research team or vice

versa. While he did detect some evidence that the respondent softened her position on some issues over the course of the interview, he felt that the themes from the interview were still clear and unaffected by this. Overall, he considered that his work did not highlight any major weaknesses or bias in the data analysis for that interview.

As all the interviews, data management and analysis were carried out by the same researcher, the potential for the focus of the interviews to be biased by the perspective of that person was greater than if the interviews and analysis had been carried out by a team of researchers. In the pilot interview guide, the questions and prompts were based on the researcher's initial study of the topic, informal discussions with those working in the field, her own perspectives as a pharmacist and knowledge of educational issues through prior work (Fitzgerald *et al.*, 1999). The feedback of the 'independent experts' and pilot respondents was used to adapt the guide for the main study interviews. This ensured that it would cover the issues most likely to be relevant to the schools, whether or not they had been previously considered by the researcher, thus mimimizing the effect of any bias. The pilot work also allowed any irrelevant or poorly worded questions to be identified and the length of the interview to be tested, as well as allowing the interviewer to discuss with the pilot respondents how the interview was arranged and carried out.

Despite all these efforts, any study of something as complex and diverse as the social world is subject to the interpretations of the researcher. This had to be borne in mind particularly in the data analysis stage of the research, where each theme and topic had to be considered carefully, to ensure that it was grounded in the interview data. Nonetheless, achieving the 'truth' in research is an ongoing process and, as Hammersley (1990) argues, absolutely certain knowledge is impossible:

> I believe that we can *never* be certain about the truth of anything, not even in the natural sciences or in our personal lives. On the other hand, there are many things about whose truth we are very confident and about which we have every right to be confident. (Hammersley, 1990, p. 59 (original emphasis).)

Thus, while validity of findings may never be established beyond doubt, there are means by which the likelihood of error can be assessed and confidence in the results enhanced. The precautions and procedures described in this study are an attempt to do just that.

Conclusions

This paper provides a background to the study of policy and practice in school-based drug education. It goes on to describe how qualitative methodology was used in a recent study and discusses the strengths and weaknesses of the methods used and how they may impact on the findings produced. At each stage of the research, the researchers chose to be self-critical, questioning why each course of action was taken and how that may impact on the transferability, reliability and truthfulness of the findings. This discussion clearly illustrates the practical issues that arise when seeking to carry out rigorous qualitative research.

This interview study is now complete and results will be presented in a subsequent paper. One of the schools has been selected as the subject of a case

study and extensive fieldwork was being carried out in that school at the time of writing, observing drug education lessons first-hand and carrying out interviews with pupils and staff.

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References

Agar, M.H. (1980). *The Professional Stranger: an informal introduction to ethnography*. San Diego, CA: Academic Press.

Appleton, J.V. (1995). Analysing qualitative data: addressing issues of validity and reliability. *Journal of Advanced Nursing*, 23, pp. 441–7.

Bangert-Drowns, R.L. (1988). The effects of school-based substance abuse education—a meta-analysis. *Journal of Drug Education*, 18, pp. 243–65.

Black, D.R., Tobler, N.S. & Sciacca, J.P. (1998). Peer helping/involvement: an efficacious way to meet the challenge of reducing alcohol, tobacco and other dug use among youth? *Journal of School Health*, 68, pp. 87–93.

Botvin, G.J., Baker, E., Dusenbury, L., Botvin, E.M. & Diaz, T. (1995). Long-term follow-up results of a randomised drug abuse prevention trial in a white middle-class population. *Journal of the American Medical Association*, 273, pp. 1106–12.

Coggans, N., Shewan, D., Henderson, M. & Davies, J.B. (1991). *National Evaluation of Drug Education in Scotland*. ISDD Research Monograph 4. London: Institute for the Study of Drug Dependence (now DrugScope).

Coggans, N.S. & Watson, J. (1995). Drug education: approaches, effectiveness and delivery. *Drugs: Education, Prevention and Policy*, 2, pp. 211–24. (Health Education Board for Scotland (HEBS) Working Paper Number One. http://www.hebs.scot.nhs.uk/research/pd/index.htm (8 June 2000).)

Creswell, J.W. (1998). *Qualitative Inquiry and Research Design: choosing among five traditions*. Thousand Oaks, CA: Sage.

Donaldson, S.I., Sussman, S., Mackinnon, D.P., Severson, H.H., Glynn, T., Murray, D.M. & Stone, E.J. (1996). Drug abuse prevention programming: do we know what content works? *American Behavioral Scientist*, 39, pp. 868–83.

Dorn, N. & Murji, K. (1992). *Drug Prevention: a review of the English language literature*. ISDD Research Monograph 5, London: Institute for the Study of Drug Dependence (now DrugScope).

Drugscope, (1999). *UK Drug Report* 1999. London: DrugScope.

Fitzgerald, N., Sousa pinto, G. & Kos, K. (1999). *Pharmacy Education: a vision of the future*. The Hague: European Pharmaceutical Students' Association and International Pharmaceutical Students' Federation. http://come.to/pharmacy-education (16 October 2001).

Flynn, B.S., Worden, J.K., Secker-Walker, R.H., Pirie, P.L., Badger, G.J., Carpenter, J.H. & Geller, B.M. (1994). Mass media and school interventions for cigarette smoking prevention: effects 2 years after completion. *American Journal of Public Health*, 84, pp. 1148–50.

Glaser, B.G. (1992). *Basics of Grounded Theory Analysis*. Mill Valley, CA: Sociology Press.

Hammersley, M. (1990). *Reading Ethnographic Research*. New York: Longmans.

Hay, G., Mckeganey, N., & Hutchison, S. (2001). *Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland*. Executive Report, September 2001. Glasgow: Centre for Drug Misuse Research, University of Glasgow & Scottish Centre for Infection and Environmental Health.

Kumpher, K. (1997). What works in the prevention of drug abuse: individual, school and family approaches. In *Secretary's Youth Substance Abuse Prevention Initiative: resource papers* (pp. 69–106).

Washington, DC: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

LISTER-SHARP, D., CHAPMAN, S., STEWART-BROWN, S. & SOWDEN, A. (1999). Health promoting schools and health promotion in schools: two systematic reviews. *Health Technology Assessment*, 3, pp. 113–14.

LOWDEN, K. & POWNEY, J. (2000). *Drug Education in Scottish Schools 1996–1999*. Edinburgh: The Scottish Council for Research in Education.

MASON, J. (1996). *Qualitative Researching*. London: Sage.

PARSONS, C., STEARS, D. & THOMAS, C. (1996). The health promoting school in Europe: conceptualising and evaluating the change. *Health Education Journal*, 55, pp. 311–21.

PATEMAN, B., GRUNBAUM, J.A. & KANN, L. (1999). Voices from the field—a qualitative analysis of classroom, school, district, and state health education policies and programs. *Journal of School Health*, 69, pp. 258–63.

PERAKYLA, A. (1997). Reliability and validity in research based on tapes and manuscripts. In D. Silverman (Ed.), *Qualitative Research: theory, method and practice*. London: Sage.

PLANT, E. & PLANT, M. (1999). Primary prevention for young children: a comment on the UK government's 10-year drug strategy. *International Journal of Drug Policy*, 10, pp. 385–401.

SCHOFIELD, J.W. (1993). Increasing the generalisability of qualitative research. In M. Hammersley (Ed.), *Naturalistic Inquiry*. London: Sage.

SCHOOL DRUG SAFETY TEAM (2001). Final report of the school drug safety team. http://www.scotland.gov.uk/library3/health/sdst_final_report.pdf (16 October 2001).

SCOTTISH EXECUTIVE, (2000). Mackay's £100 Million Drive to Beat Drugs. Press Release. http://www.scotland.gov.uk/news/2000/09/se2581.asp (16 October 2001).

SCOTTISH EXECUTIVE, (2001). *Annual Report on Drug Misuse*, November 2001. http://www.drugmisuse.isdscotland.org/publications/local/ardm.pdf (19 December 2001).

SCOTTISH EXECUTIVE EDUCATION DEPARTMENT (2001). *Drug Education in Schools*. 2000/2001. http://www.scotland.gov.uk/stats/bulletins/00102-00.asp (16 October 2001).

SCOTTISH OFFICE (1999). *Tackling Drugs in Scotland: Action in Partnership*. Edinburgh: HMSO.

SLEVIN, E. & SINES, D. (1999). Enhancing the truthfulness, consistency and transferability of a qualitative study: utilising a manifold of approaches. *Nurse Researcher*, 7, pp. 79–97.

STRAUSS, A. & CORBIN, J. (1990). *Basics of Qualitative Research: grounded theory procedures and techniques*. Thousand Oaks, CA: Sage.

TOBLER, N. & STRATTON, H. (1997). Effectiveness of school-based drug prevention programs: a meta-analysis of the research. *Journal of Primary Prevention*, 18, pp. 71–128.

WHITE, D. & PITTS, M. (1998). Educating young people about drugs: a systematic review. *Addiction*, 93, pp. 1475–87.