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# **Drug and alcohol education in schools**

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## Executive summary

This research is based on a detailed online survey of respondents from 288 schools, and 20 follow-up phone interviews conducted with respondents from a range of primary and secondary settings. It was commissioned to inform the development of the Alcohol and Drug Education and Prevention Information Service (ADEPIS) and its support for schools.

### Key findings

- Drug and alcohol education provision remains inconsistent in delivery across educational establishments within England.
- Primary school settings remain less confident in their ability to access effective resources and to provide best practice in drug and alcohol education provision. A fifth of respondents from primary schools (19%) felt they had little access to effective resources for teaching drug and alcohol education.
- Four-fifths (81%) of all respondents said they would like more classroom resources for drug and alcohol education.
- While elements of good practice exist throughout educational settings, assessment and evaluation, continuity in learning and quality assurance of resources and external support remain weaker areas.
- While there are numerous examples of excellent PSHE/drug and alcohol education teaching, overall many practitioners continue to feel constrained by a lack of curriculum time to build continuous learning, and gaps in finance for resources and staff training.
- Staying up-to-date on information and resources around drugs represents a particular concern for teachers, especially in secondary settings.
- Interview discussions reveal that practitioners continue to require advice on how to interact with parents around drug and alcohol education, particularly in primary settings.

# Full Report

## Background

The Alcohol and Drug Education and Prevention Information Service (ADEPIS) is a project funded by the Department for Education and run by the drug prevention charity Mentor, in partnership with DrugScope and Adfam. This report details research carried out by the PSHE Association, on behalf of Mentor, to inform the project's support for schools. It covers schools' current practice, how they choose and use resources for drug and alcohol education, the support that is currently available to them and perceived gaps. It will be of interest to all those working with schools around drug and alcohol education.

## Methodology

This research is based on a detailed online survey about drug and alcohol education consisting of both closed and open responses and completed by 288 participants between the 3<sup>rd</sup> June and the 24<sup>th</sup> June 2013. Respondents were sourced through the PSHE Association's mailing lists and other means: 16% of respondents were neither paid members nor subscribed to the Association's general mailing list. Respondents were based within a range of settings within primary, secondary and special educational needs institutions and were located nationally throughout England's regions.

In interpreting the findings, it needs to be remembered that this is not a random sample. There was considerable variation in schools' practice and how confident teachers were in providing drug and alcohol education. However, if anything the findings may give an over-optimistic picture of the resources schools commit to drug education within PSHE. It should also be noted that while the research covers provision within science lessons (where, unlike PSHE education, drug education is a statutory part of the curriculum), this is from the perspective of PSHE teachers rather than science teachers.

The research also draws upon twenty follow-up phone interviews conducted with respondents selected to reflect a range of primary and secondary settings including maintained schools, academies, independent schools and special educational needs institutions, as well as geographical diversity and confidence in current provision of drug education.

## Type of school in which participants were based

Participants were spread fairly evenly across a range of institution sizes from 1-200 pupils to 1400+ pupils. They were further based within a variety of settings:

- 156 respondents (55%) worked within secondary settings.

- 70 respondents (25%) were based within primary institutions.
- 16 respondents (6%) worked in primary + secondary schools.
- 9 respondents (3%) worked in infant schools.
- 6 respondents (2%) were based in middle schools.
- 6 respondents (2%) were based in further education colleges.
- 12 respondents (4%) were based in pupil referral units.
- 8 respondents (3%) were based in secondary SEN settings.

## Geographical distribution of participants

Asked to supply their postcode, 283 participants responded, facilitating a geographical breakdown of respondent location; as illustrated in the geocode map featured in Figure A below:



Fig. A

## School drugs policy and the teaching of drug and alcohol education

The majority of respondents (86%) said that their institution had a whole school drugs policy, compared with just 8% and 7% who answered 'No' or 'Don't Know' respectively. While this is positive, information from follow-up interviews suggests that such policies are frequently based on managing incidents. The majority of interview respondents suggested that their whole school policy was designed to assist teachers in understanding guidelines around drug behaviour and safeguarding, rather than providing a holistic scheme for all aspects of drug and alcohol, or PSHE education, throughout the school:

*“The school drug policy isn’t in the staff handbook...but it is on the online system if people want to look at it. In teaching they would only refer to it if there was a safeguarding issue.”*

In addition, where participants did suggest that the whole school policy influenced classroom teaching this process primarily rested on determining in which years or key stages specific drug and alcohol topics should be addressed.

When asked to indicate whether their school provided drug and alcohol education to their pupils 95% responded positively; while just 5% recorded that they did not support any provision. Of the 12 respondents who did not offer provision, 5 were based in infant or primary schools, 2 were based in primary and secondary schools, and the rest were associated with a range of settings including secondary, special educational needs, pupil referral unit and further education.

### **Constraints on teaching**

Participants identified three key overall constraints in providing effective drug and alcohol education:

Firstly, respondents noted that they lacked curriculum time to deliver effective provision often resulting in a fragmented topic-style approach, preventing continuous learning. The varying levels of importance placed on drug and alcohol education within schools often impacted on how many hours of teaching PSHE coordinators or other teachers were able to secure for drug and alcohol education provision. As one respondent noted:

*“The most important aspect which could be improved would be curriculum time. Resources aren’t really the problem and it’s not about staff competence, it’s about having enough time to build effective teaching and experience.”*

Secondly, some interview participants indicated that their schools lacked the financial capacity necessary to secure good external resources of support:

*“It is hard to find funding to bring in outside speakers and it is sometimes also hard to afford good resources. For example, we bought a drug box which has been really useful as it is hands-on and engages the children but it was also incredibly expensive.”*

Finally, respondents noted that drug and alcohol education, and PSHE more generally was often delivered by non-specialist teachers resulting in varying levels of confidence and preventing continuous learning for pupils and development of teaching experience for staff:

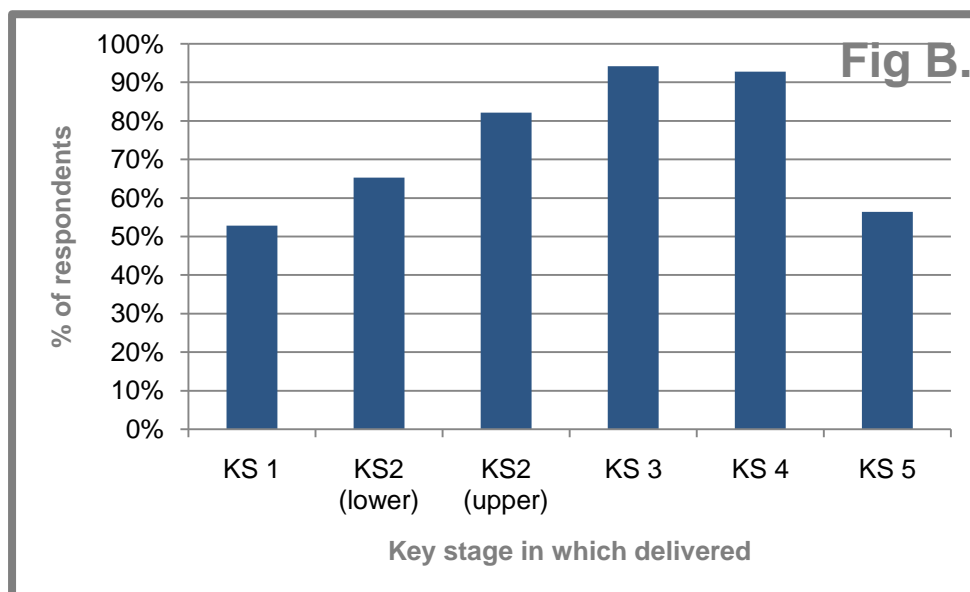
*“The real barrier that effective (drug and alcohol) teaching faces within the school is that it is not delivered through a PSHE team which leads to a huge variety in delivery. There are 8 tutors in a year team so the delivery can be varied even within one year. Also tutors move with the year group so every year they confront something new and have to teach a new topic.”*

## Drug and alcohol education by key stage

This section considers two key questions: in what key stages are alcohol and drug education most often delivered? And how is drug and alcohol education offered within these key stages?

### Key stage in which drug and alcohol education is delivered

Figure B shows the proportion of schools providing drug education at each key stage (excluding those who weren't catering for that key stage).



Unsurprisingly, during primary education, pupils are most likely to receive drug education during Years 5 and 6. However a quarter of schools surveyed providing education at Key Stage 2 did not provide drug education during these years. Looking in more detail at these 28 schools, they included four primary schools that had already provided drug education, 15 schools who waited until Key Stage 3, and one until Key Stage 4, to start drug education, and the remainder of schools did not provide drug education at all.

Data derived from open comment responses and follow-up interviews suggests that among primary school respondents drug and alcohol education was not expected to start until Key Stage 2, and particularly in the upper part of that key stage. There was a fear of teaching children more “than they already know” and consequently earlier drug and alcohol provision focuses on using medicines safely. As one respondent noted:

*“As a Key Stage 1 school, our provision is mainly concerned with keeping safe: e.g., safe use of medicines. Obviously this is a basis for building on at further key stages with drugs and alcohol education.”*

The majority of secondary schools provided drug education during both Key Stage 3 and 4. At both stages, the minority (around 10%) which did not teach drug and alcohol education were divided into about half which did not teach it at all and half which taught at one key stage but not the other. Drug and alcohol education is less prevalent at Key stage 5, however, where only half of schools offered pupils teaching in relation to this subject.

### Time spent on drug and alcohol education during each key stage

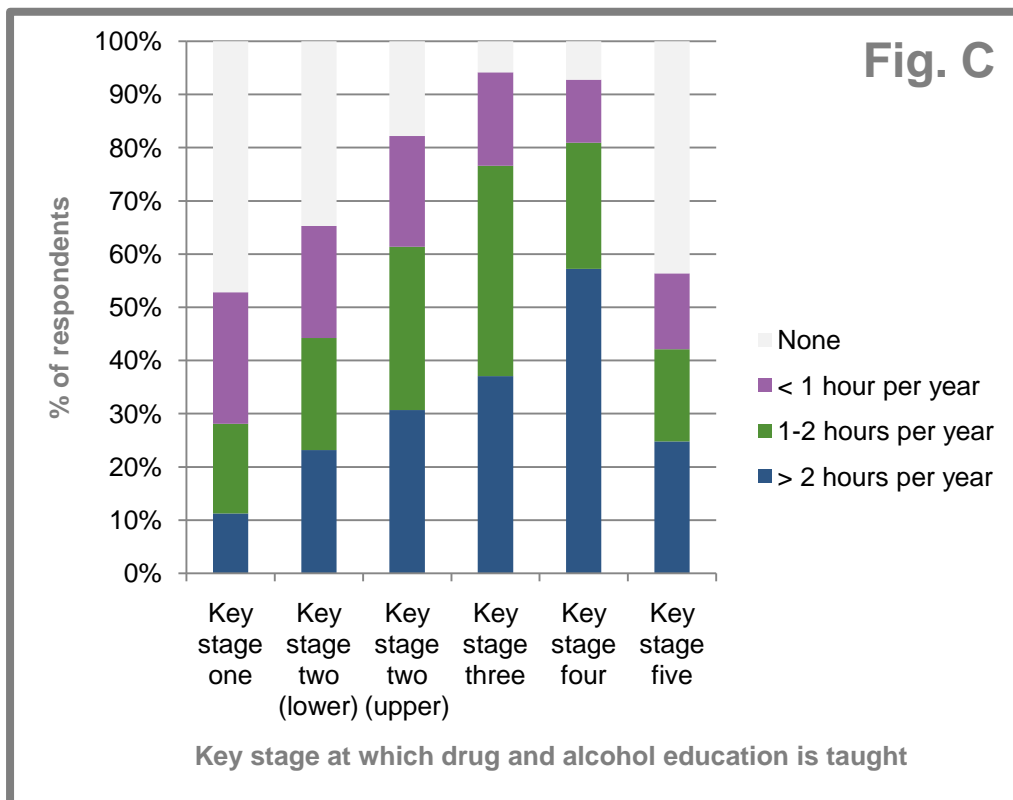


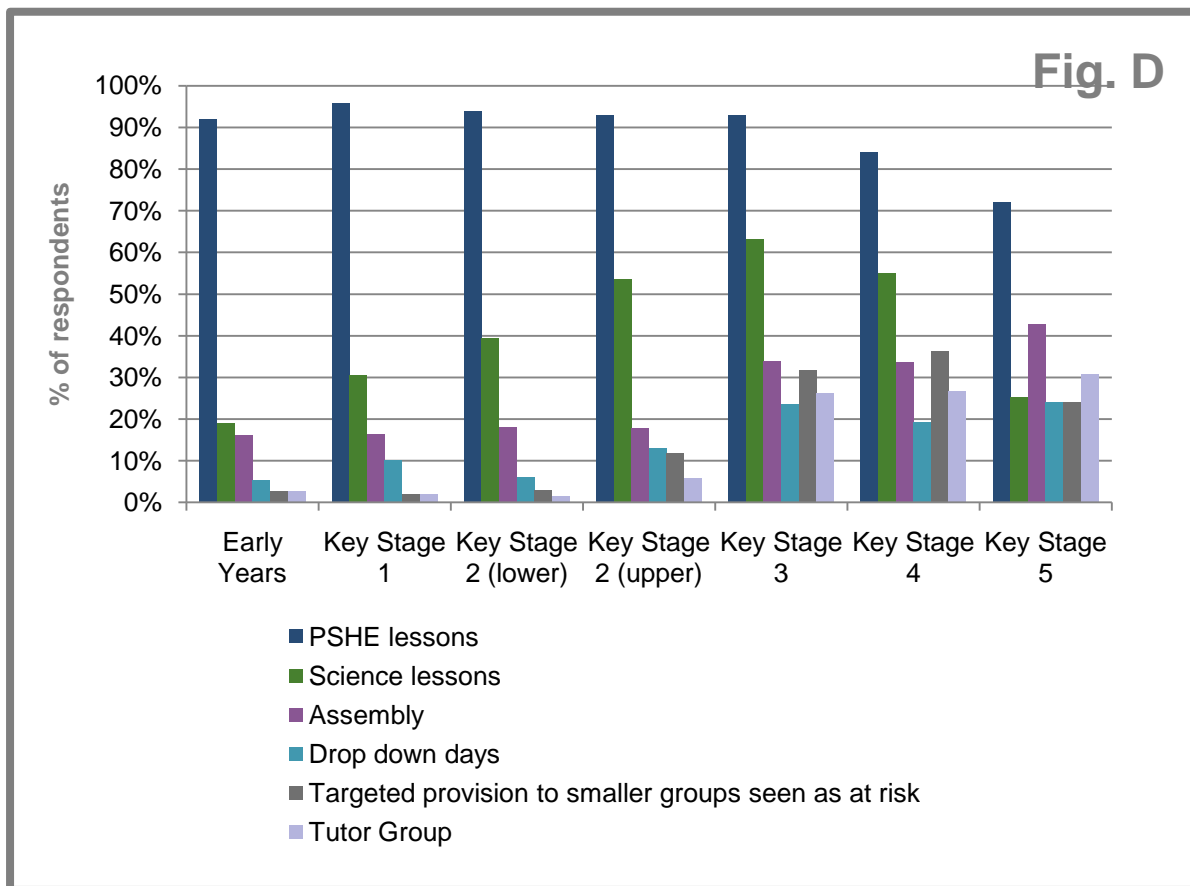
Figure C indicates how many hours were dedicated to drug and alcohol education within each key stage (excluding those who weren't catering for that key stage). It is clear from these data that the further students move up through the key stages, the more hours of drug and alcohol education provision they will receive each year up until Key Stage 5, where provision lessens. For example, at Key Stage 2 (upper) 25% of participants noted that pupils received less than 1 hour of provision compared to 18% of those teaching at Key Stage 3 and 13% of those teaching at Key Stage 4. Similarly, at Key Stage 2 (upper) 30% of respondents indicated that pupils would receive more than 2 hours of provision, as opposed to 37% at Key Stage 3 and 56% at Key Stage 4.

### How drug and alcohol education is delivered within each key stage

Analysis of data relating to this question reveals clearly that PSHE lessons are the primary form of delivery for drug and alcohol education throughout each key stage



and across all settings. Figure D below shows the percentage for those who answered this question at each key stage who used each form of delivery (so excluding those who provided no drug or alcohol education at that stage).

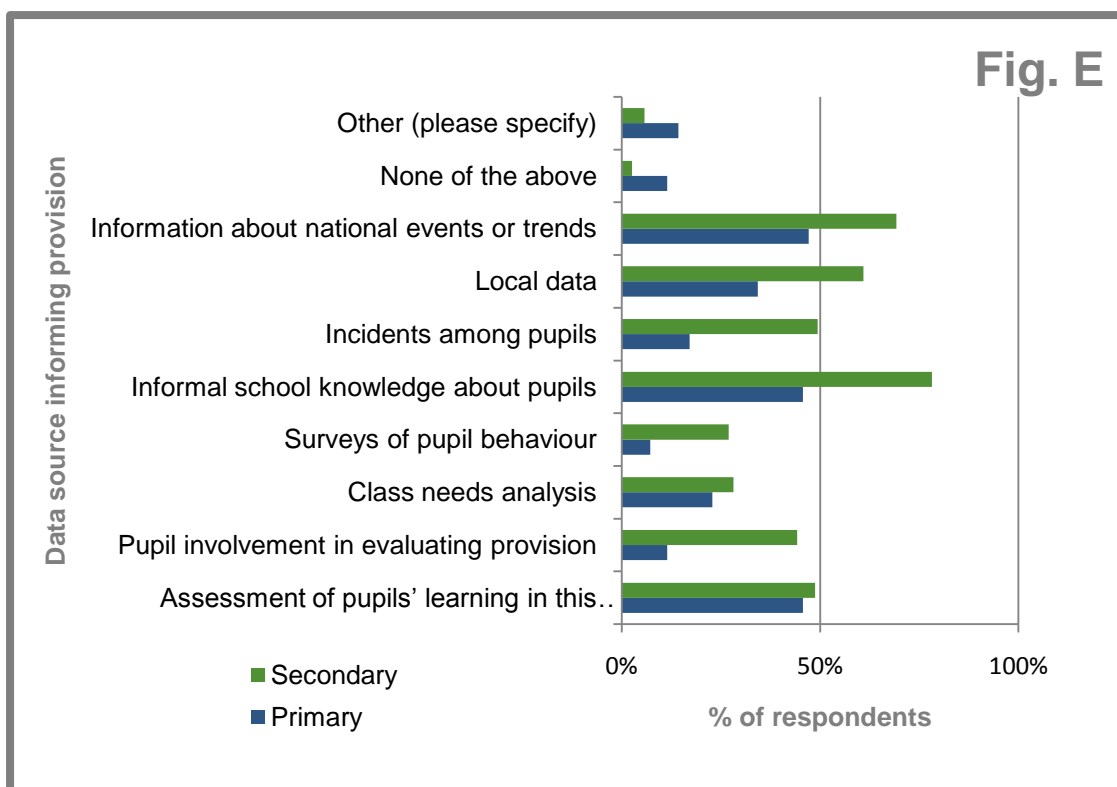


Science lessons remain the second most popular form of delivery for drug and alcohol education, while targeted provision, drop-down days and assemblies also offered participants opportunities to teach around the topic. With the exception of the oldest pupils, only a very small minority of schools choose to reject PSHE lessons and teach solely through other forms of provision at each key stage; other forms of delivery of drug and alcohol education are therefore used primarily to complement PSHE lessons.

The data also indicates that in Key Stage 3 and Key Stage 4 provision through drop-down days and tutor groups are currently the least popular forms of delivery with less than 30% of respondents selecting these criteria at each key stage.

## What informs schools' provision of drug and alcohol education?

Participants were asked to indicate what processes or information had informed their provision of drug and alcohol education. Responses are indicated in Figure E below:



Analysis of these data reveals that across primary and secondary settings informal school knowledge and information on national events are key sources of information when shaping drug and alcohol education. In secondary schools, informal school knowledge was the most important factor informing provision nationally (78%), and information about national events was the second most popular choice (69%).

In primary settings, by slight contrast, information about national events (47%) and informal school knowledge (46%) drew roughly the same number of responses. However, it is clear that both criteria remain significant across all key stages.

Local data was also viewed as an important source of information with 61% of secondary respondents and 34% of primary respondents selecting this option as informing provision.

Incidents among pupils were also essential in shaping provision of drug and alcohol education within secondary settings with 49% of respondents selecting this option, as opposed to 17% of primary participants.

While assessment of pupils' learning remained important across primary (46% of respondents) and secondary (49% of respondents), other targeted information such as surveys of pupil behaviour, class needs analysis, and pupil involvement in evaluating provision remained consistently less significant to participants in shaping their provision.

These data are revealing in underlining wider trends linked to the popularity of anecdotal evidence in informing provision. Anecdotal forms of information derived

from informal school knowledge and information about national events were consistently more popular with respondents in shaping provision than information gathered from assessments relating to their particular school; for example, evidence derived from best practice activities such as assessment of pupil's learning, pupil involvement in evaluating provision, class needs analysis, and surveys of pupil behaviour. Use of local data indicates some degree of engagement with localised issues and follow-up interviews reveal that drug and alcohol education is at times specifically informed by local events or information delivered to PSHE coordinators by police liaison officers or local authority advisors. For example, one interviewee noted that they would:

*“Work closely with local police to get local data and find out what is happening so that I know what needs to be addressed. I also get information through local councillors who feedback to the school and I can then update teaching as required.”*

In these instances extra lessons may be provided to tackle a specific topic. Local data is, however, predominantly used to address localised events or trends, rather than to build or assess pupils' decision making around risky behaviours as a whole.

While there are clearly excellent teachers across the country who are following best practice, overall these results seem to indicate that there remains a lack of importance attributed to assessment of pupil learning and pupil-led evaluation of drug and alcohol education. In addition, the widespread importance of informal school knowledge, raises the possibility that those providing drug and alcohol education are using erroneous and untested information in informing provision. For example, one follow-up interview participant suggested that rural schools did not need to focus on “hard drugs” as pupils would be more naïve and have less contact with drugs and alcohol. While, findings from the Crime Survey for England and Wales (released 25<sup>th</sup> July 2013; Home Office) indicate that drug use is lower in rural areas the discrepancy may not be as great as teachers assume with 3.1% of respondents to that survey having taken drugs regularly in urban areas as opposed to 1.8% in rural areas.

Questionnaire data combined with detailed analysis of follow-up interviews suggests that there is little consensus among practitioners regarding the importance and practice of assessment and evaluation in drug and alcohol or PSHE learning. For example, surveys of pupil behaviour were used to identify issues within school, rather than to assess learning; while assessment often took the form of informal feedback from students in lieu of monitored assessment.

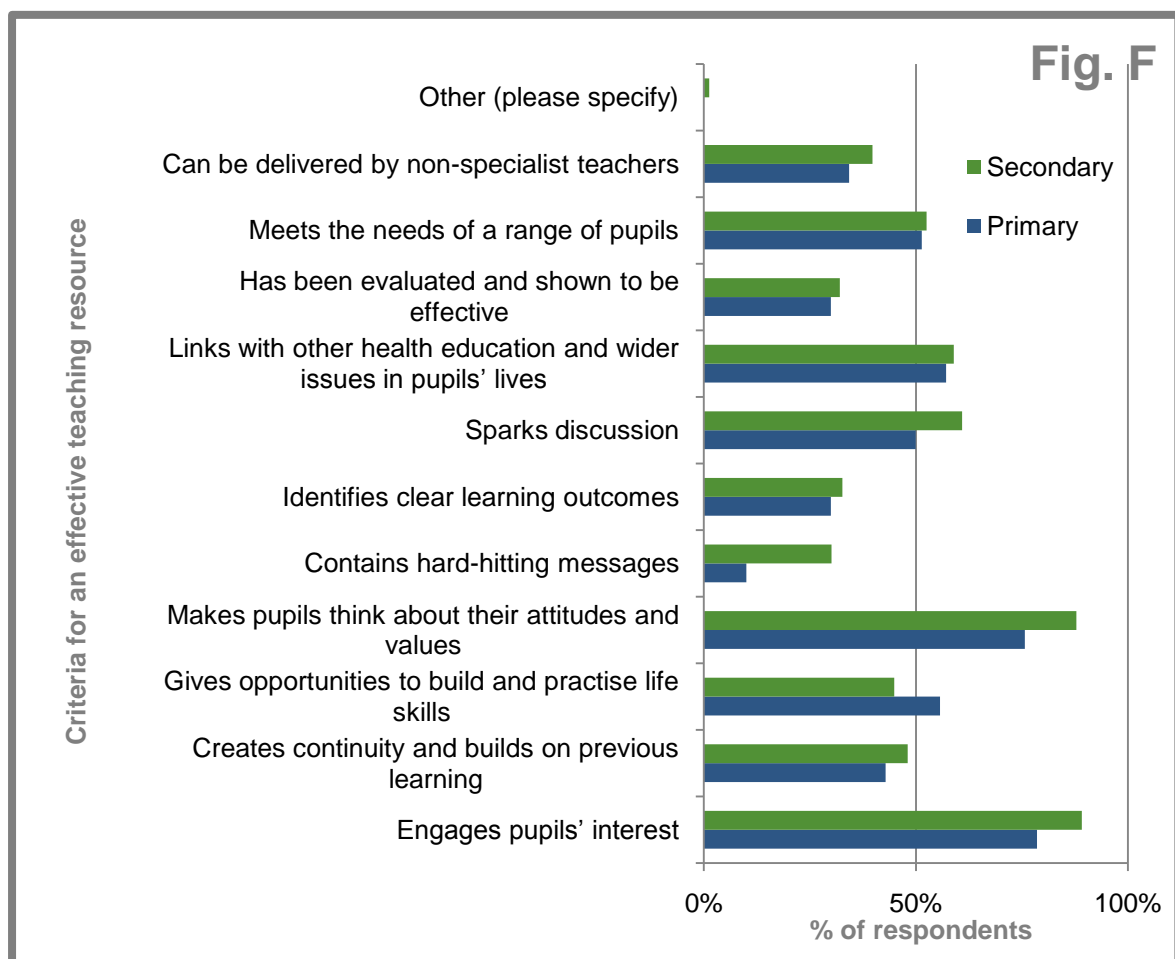
Finally, it is noticeable that primary schools draw on a much more limited information base, and 11% said their teaching was informed by “none of the above”.

## Teaching resources for drug and alcohol education

A key component of this research was to determine the current state of drug and alcohol education teaching resources within schools and educational settings. The research intended to discern: what were considered to be the criteria for effective resources; participant access to effective resources; on which topics practitioners most required new resources; what resources were already being used; and where and how resources were both sourced and quality assured.

### Criteria for effective teaching resources

Participants were asked to select up to five criteria that would identify an effective teaching resource. Data gathered indicates that practitioners understand several key themes to be important in determining an effective resource across both primary and secondary settings, as set out in Figure F below:



The two key criteria identified by participants within both primary and secondary settings were that teaching resources should both engage pupils' interest (79% of primary and 89% of secondary respondents), and make pupils think about their attitudes and values (76% of primary and 88% of secondary respondents).

In addition, participants across all key stages selected that resources should link with other health education and wider issues (57% primary/59% secondary), and meet the needs of a range of pupils' (51% primary/ 53% secondary).

The notion that a resource should spark discussion was marginally more popular at secondary level (50% primary/61% secondary); while, primary respondents were more likely to feel that a resource should give opportunities to practise life skills (56% primary/43% secondary).

For interviewees' the criteria that a resource should engage pupils' interest and spark discussion were also paramount, with primary respondents and some secondary respondents noting the need for resources to be tactile; for example, some respondents used a Drugs Box purchased from an outside agency or given by a local authority:

*"At a local LEA meeting I was also given a free Drugs Box. I have found this really useful because the kids get to visually see the drugs and read descriptions and the students find it really engaging and informative to be able to actually know what different drugs look like."*

While others wanted resources to be more interactive to encourage student-led participation:

*"It would be nice to have more interactive resources, especially for the whiteboards, but these would need to be affordable. These sorts of resources let students do their own research and make the whole process more engaging and effective."*

Fewer respondents (37% overall) opted for the criterion 'Can be delivered by non-specialists'. Nevertheless, interviewees and comments suggested that mixed confidence amongst teachers in delivering PSHE and drug and alcohol education remains a key issue within schools, and fears were raised in follow-up interviews regarding the provision of drug and alcohol education by non-specialist teachers. As one participant noted:

*"We need to provide a more streamlined approach that is mapped across the whole school from KS1 to KS5. We have some staff who are excellent practitioners, but others are very wary of having to teach PSHE and 'awkward' lesson materials."*

Three in ten respondents from secondary schools thought that an effective teaching resource should 'contain hard-hitting messages'. This is concerning because research has shown that, "fear arousal is...not very effective in changing behaviour, especially amongst the young." Young people may not have experienced ill-health for themselves or within their families and may also present 'optimistic bias' leading them to feel removed from hard-hitting scenarios presented to them; "this in turn can lead adults to exaggerate the magnitude of the problem, or to use scare tactics to emphasise the risks." (J. McWhirter, *Personal, Social, Health and Economic education: From theory to practice*: 2009: 13-14).

In addition, fewer than half of both primary and secondary respondents indicated that an effective resource should create continuity and build upon previous learning. Taken in conjunction with responses regarding provision of drug and alcohol education by key stage and the information used to inform such teaching, these data further suggest that drug and alcohol teaching remains fragmented within schools. Similarly, only a minority of participants indicated that key criteria for an effective resource would be that it was evaluated and shown to be effective.

### Access to effective resources to teach drug and alcohol education

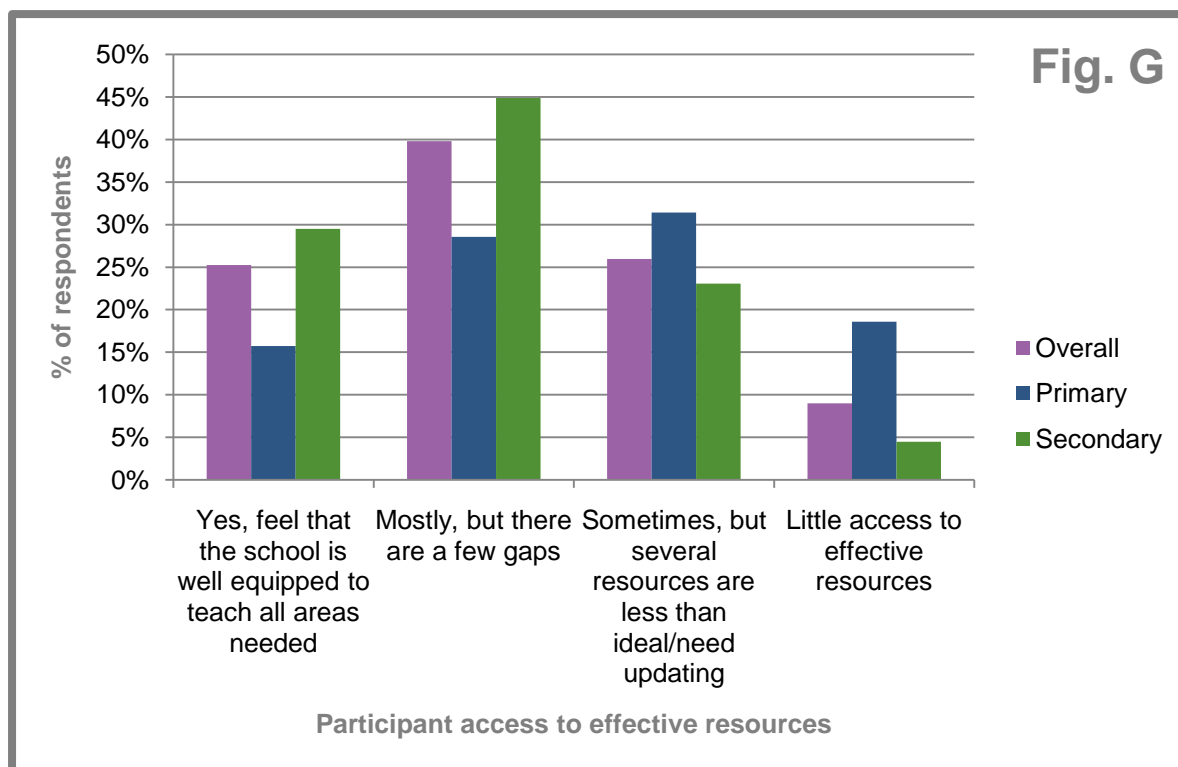


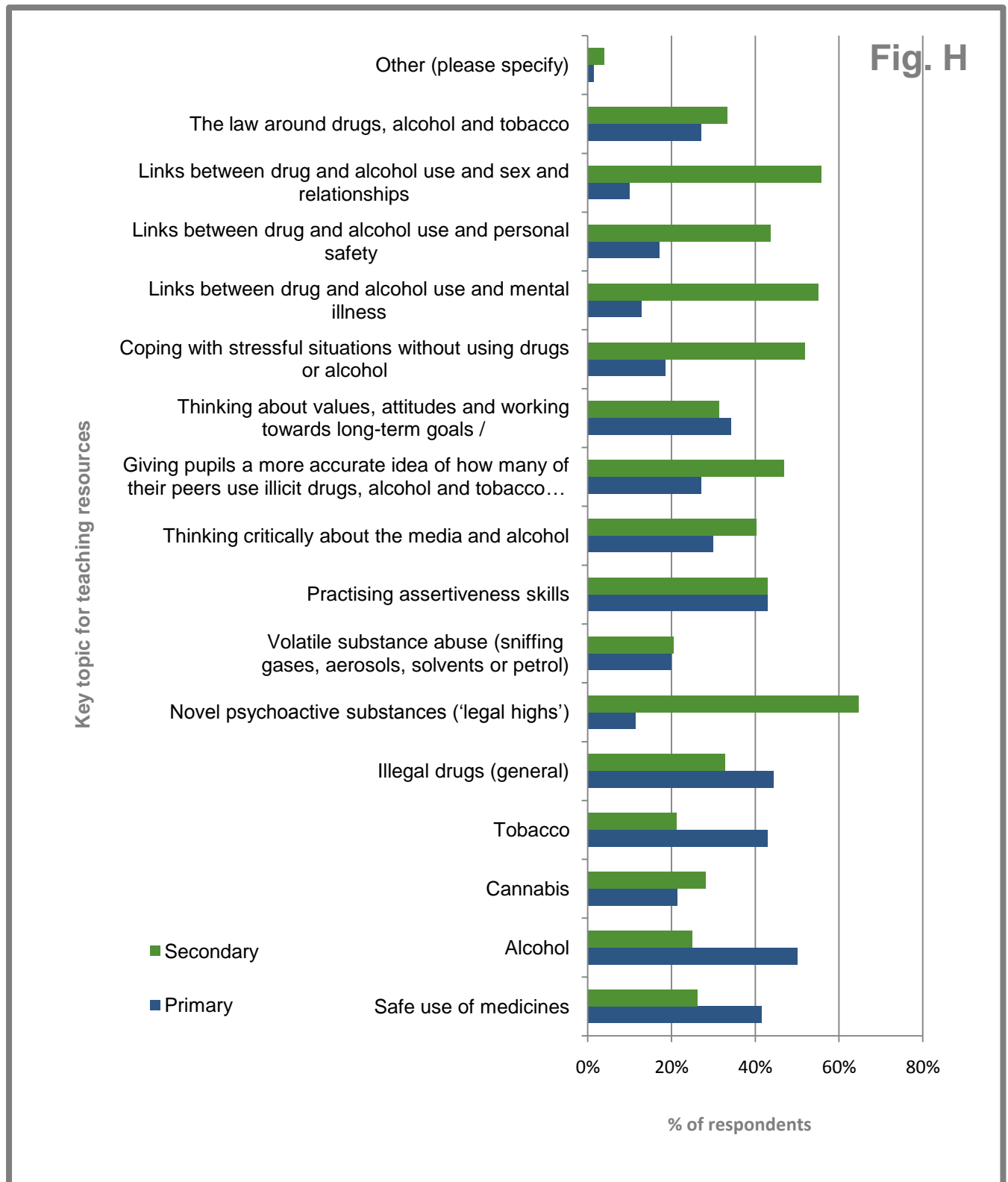
Figure G indicates that confidence across all key stages is mixed in terms of the ability to access effective resources with no single criteria attaining over 50% of selection from participants. It also suggests that secondary practitioners were more able to access effective resources than their primary counterparts, with three-quarters (74%) mostly or always able to access effective resources, compared to 45% of respondents from primary settings. As one primary respondent noted:

*“Lots of resources are for secondary schools. (We) need specialist resources for Key Stage 2 which inform without scaring.”*

Overall, these data reflect a key theme emerging from both survey and follow-up interview data, which suggests that primary respondents were less confident in their practice and in accessing effective resources.

## Key topics for teaching resources

Following on from identifying effective criteria for teaching resources, participants were asked to select topic areas on which they would particularly welcome drug and alcohol education resources. Here there were significant differences between primary and secondary schools (see Figure H below).



Primary school respondents generally wanted substance specific-resources: alcohol (50%), tobacco (43%), illegal drugs (44%) and safe use of medicines (41%), as well as resources which encourage pupils in practising assertiveness skills. These data seem to reflect information gathered through follow-up interviews which suggests that primary school practitioners remain less confident in their ability to find effective resources for drug and alcohol education than those in secondary settings. Secondary teachers, while noting the need for more up-to-date resources, were often more positive about their ability to source resources.

The greater confidence of practitioners in secondary settings in identifying sources around alcohol, tobacco and illegal drugs in particular, is perhaps also illustrated through a greater focus on issues such as novel psychoactive substances (65% of secondary respondents), links between drug and alcohol use and sex and relationships, (56% of secondary respondents) and links between drug and alcohol use and mental health (55% of secondary respondents and 13% of primary respondents). This latter criterion was also picked up by interview respondents who noted that there was a lack of effective resources within this area:

*“I am under-resourced on some topics across PSHE but we have good resources for teaching drugs and alcohol. One area where there are still gaps is in the link between mental health and drugs and alcohol.”*

The disparity in importance of different types of resources partially reflects the necessity of information targeted at different age groups. It also suggests, however, that while teaching within both settings utilises resources which consider decision making and assertiveness skills, primary drug and alcohol education remains more focused on information-led teaching, particularly around alcohol, tobacco and safe use of medicines. In secondary settings there remains a greater focus on linking drug and alcohol education to other behaviours and issues and around decision making. For example, 52% of secondary respondents would like more resources on coping with stressful situations without using drugs and alcohol.

Secondary respondents were also 20% more likely (47% of secondary respondents and 27% of primary respondents) to suggest the necessity for greater resources to assist in social norms approaches to drug and alcohol education in giving pupils a more accurate idea of how many of their peers use illicit drugs, alcohol and tobacco (countering the myth that ‘everyone does it’). For example, the recent publication of the Crime Survey for England and Wales suggests that drug use within those countries is now at the lowest levels since records began (Crime Survey for England and Wales, 25<sup>th</sup> July, 2013, Home Office).

### **What resources are schools using for drug and alcohol education?**

The clearest outcome of this research is that there remains a lack of consistency in where resources are sourced and how they are chosen. While participants and interviewees suggested the importance of the local authority (primary settings), the



FRANK website (secondary settings) and the PSHE Association (both settings) in finding classroom resources, only the FRANK website in secondary settings was selected by a clear majority of respondents. In comments and follow-up interviews it became clear that many teachers rely on open internet searches to source resources. While there are good resources available from different organisations on the internet, consistency of quality is variable and resources are not fully quality assured. In addition, many resources used have been produced in other countries. The making of resources in-school is also common by teachers who feel that they don't have time to search out up-to-date resources which fit their setting. For example, one interview respondent indicated that most of the resources used within drug and alcohol education within their school had been put together by the participant themselves because, "*what needs to be covered changes so much*", with a need for a new focus on issues such as legal highs and energy drinks. In order to build new resources the participant also made use of the FRANK website to gather factual information.

In other cases teachers rely on resources accumulated by the school over a number of years.

Key resources:

- At primary level the 'Jugs and Herrings' approach was cited by a number of participants. This method refers to a research activity developed at Southampton University in the 1980's aimed at discovering children's knowledge of drugs in primary settings through a 'Draw and Write' technique. It is unclear, however, whether this refers to the original resource produced by the Jugs and Herrings research - the Health for Life books - or local variations.
- At secondary level key resources cited were those provided by The Christopher Winter Project; the Alcohol Education Trust and Local Authority resources such as those provided by Islington Healthy Schools.

### **How are resources quality assured?**

The primary response among follow-up interview respondents noted that resources were predominantly quality assured through their own expertise and experience:

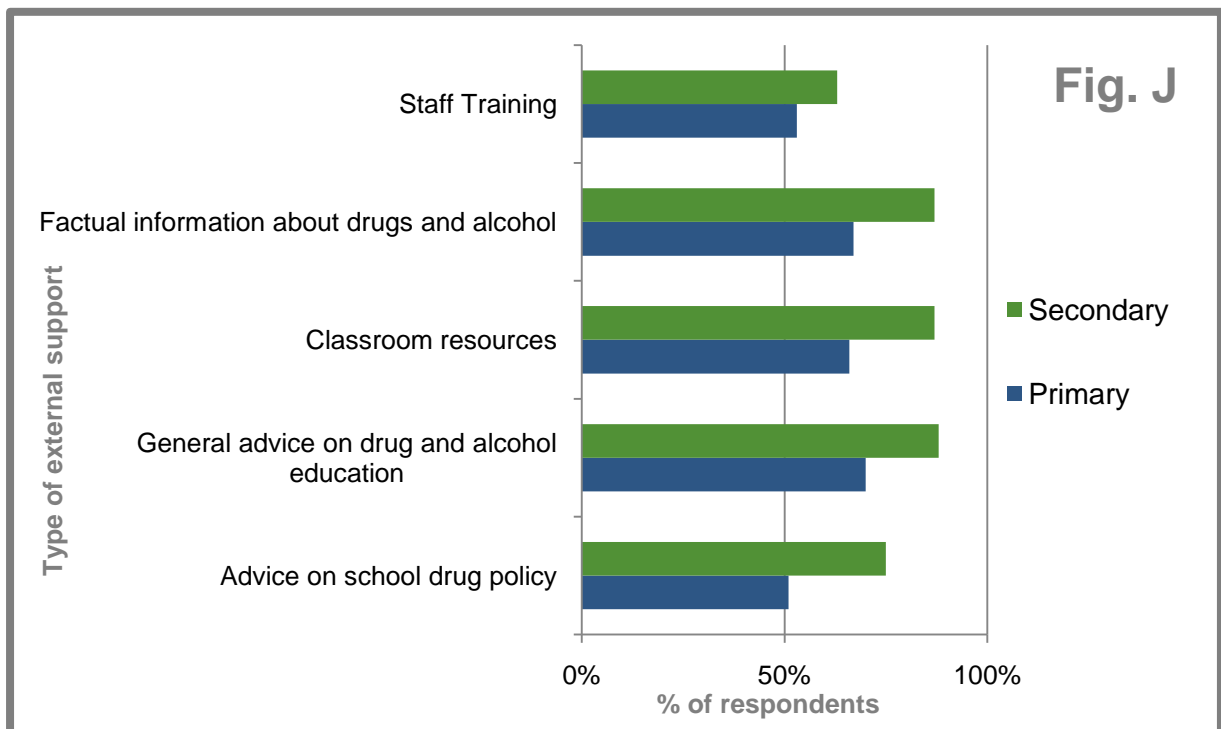
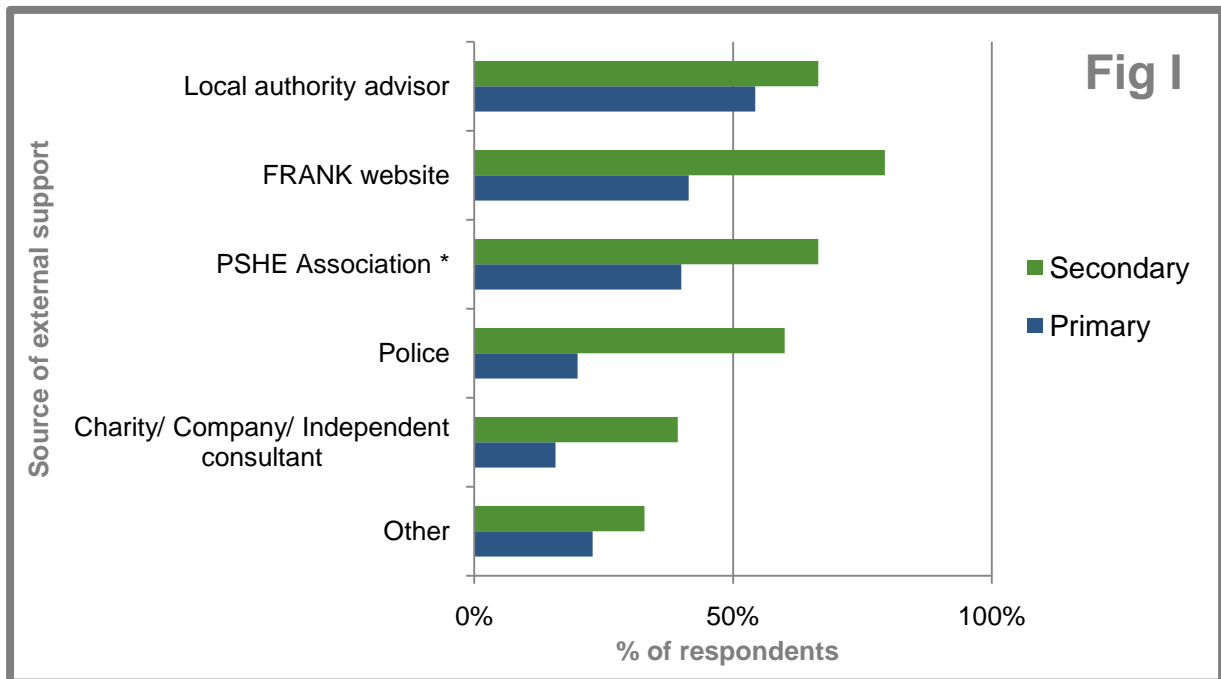
*"Yes, they (resources) would be (quality assured) through my own experience of what makes a good resource and what is appropriate for the children at the school."*

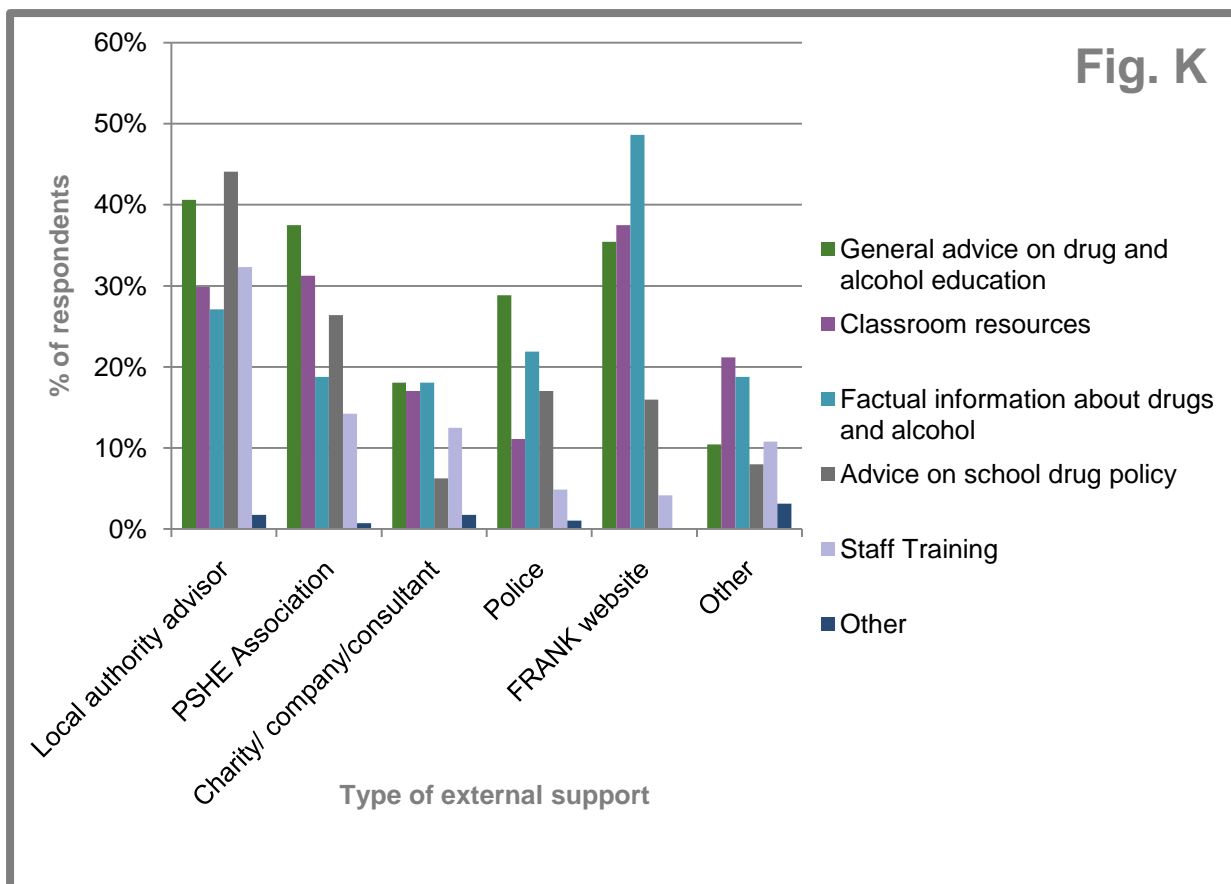
While experienced PSHE or drug and alcohol practitioners may be well placed to identify good practice, this overall response suggests that more could be done to provide teachers with simple guidelines to quality assure drug and alcohol resources to avoid inconsistency of efficacy. A number of participants also used the PSHE

Association to quality assure, although it is likely that this response is influenced by the percentage of respondents (55%) who were paid members of the Association.

## External support for drug and alcohol education

The majority of respondents (92%) accessed some external support for drug and alcohol education and prevention, and this came from a range of sources as indicated in the graphs below:





### Support from local authorities

Overall, the continued importance of local authority support across primary and secondary settings - where this still remains viable in a landscape of financial cuts - is striking. In particular, participants noted the role of local authorities in advising on school drug policy and training staff.

Local authority support was cited by a number of respondents who commented on both its various forms, from youth services, healthy schools, and PSHE and drug and alcohol advisers, and the loss of local authority support due to economic cuts in local government funding.

Interviewees often underlined the role, or prior role where cuts had been made, of local authorities in supporting drug and alcohol provision within their institution. Interviewees highlighted the part played by local authorities in providing resources and external visitors to school and noted their interaction with local authority advisers. For example, one respondent noted:

*“We have been using the Islington Drugs Ed pack for a number of years and updated it within Croydon. It has very practical advice and lessons that continue to be relevant”.*

Similarly an interview participant from Gloucestershire noted that their local authority provided an in-depth, anonymous online survey undertaken in year eight, year ten, and year twelve across the authority, giving schools access to detailed data which

can then be filtered down, *“nearly to the level of a tutor group to see if there are particular high incidences of any kind of drug and alcohol usage and identify trends which can then be addressed in teaching.”*

However, reliance on local authorities, particularly in primary settings, could cause a reduction in quality of provision once services were lost. One primary settings participant noted that Northumberland authority had in the past delivered drug and alcohol education through a “Life Education Centre” van which would visit schools and provide education around alcohol, illegal drugs and tobacco. Once this programme was removed due to economic cutbacks the school took over drug and alcohol provision but this affected provision:

*“Before students’ input was guaranteed because the programme was really effective, but now it has to be taught through science or circle time. The LEC van staff had more confidence in talking about sensitive issues than the teachers.”*

### **The PSHE Association**

The PSHE Association also offered the second most important source of advice on school drug policy across participants and was also a key external support with regards to general advice on drug and alcohol education and classroom resources; **these data must be treated cautiously, however, given that the majority of teachers were contacted through the PSHE Association** (55% were paid members of the Association, while a further 24% received emails from the PSHE Association).

### **FRANK**

The FRANK website was key to providing general advice and factual information in relation to drugs and alcohol. This was the case across settings with the exception of independent institutions which relied less heavily on Local Authority support and were 35% more likely to use other external providers to train staff around drugs and alcohol education.

In highlighting the role of the FRANK website, interviewees tended to underline its use as a repository for factual and up-to-date information on drugs. A number of respondents, however, also noted that use of the website was integrated into their practice by using FRANK as a platform to encourage student-led research. Students would be given a particular substance to research and then asked to present and discuss their findings with the rest of their class:

*“One of the big things that have helped to break down prejudices within the school is by encouraging independent learning about drugs rather than being told whether they should or shouldn’t take them. It is important to get them involved in their own research (often using the FRANK website) so they decide what is important and what is worth knowing so that they have highlighted the dangers for themselves”.*

## Data by category of external support given:

### **‘School drug policy’**

Across both primary and secondary based respondents, and throughout the majority of settings, the local authority was considered to be the most important source of external support in devising a school drugs policy with 44% of participants overall selecting this option as opposed to the 26% who choose the next most popular criterion, the ‘PSHE Association’.

The main exception to this trend lies in the relationship between independent schools and local authorities with only 18% of participants indicating that they utilise the local authority in this way. Independent school respondents were more likely to gain support from the PSHE Association (41%) (once more with the caveat that 63% of independent respondent were Association members) or from the FRANK website (27%). The small sample size for independent respondents should be borne in mind and these data treated as a cautious guide.

### **‘General advice on drug and alcohol education’**

For respondents in primary settings the local authority was also the most important source of information with 43% of respondents selecting this option. In secondary settings by contrast, participants were more likely to gather information from a range of sources, with FRANK the most selected external resource on 47%, the PSHE Association (44%), the local authority (41%) and the Police (40%), all remaining popular responses.

### **‘Classroom resources’**

Primary school based participants were again most likely to engage the local authority in provision of classroom resources, with 31% of respondents selecting this option as opposed to the 19% and 14% who opted for the PSHE Association and FRANK respectively. In secondary settings, by contrast, the FRANK website was the most popular source of external support on 49%, compared to the 38% of participants who opted for the PSHE Association and the 28% of respondents who selected local authority.

### **‘Factual information’**

It is in this category that the importance of FRANK to drug and alcohol provision in secondary settings is most apparent. Among primary respondents the local authority (27%) and FRANK (21%) were important sources of information; for secondary respondents, however, FRANK (62%) was more than twice as popular as a source of external support as the next most selected option of ‘Police’ (30%).

## **‘Staff training’**

In respect of staff training, respondents from primary (34%) and secondary (31%) settings relied on the support of their local authority, with the next most popular option overall being the PSHE Association on 14%. From the small sample available it seems possible that this trend is broken in independent schools where only 9% of respondents noted using their local authority for training, as opposed to 32% and 27% who had drawn on training support from the PSHE Association and other charities or company’s respectively.

## **Other sources**

In the questionnaire, participants were asked to specify other sources of external support, but tended to give further information about support around the categories already selected. Key findings from this and from the interviews included:

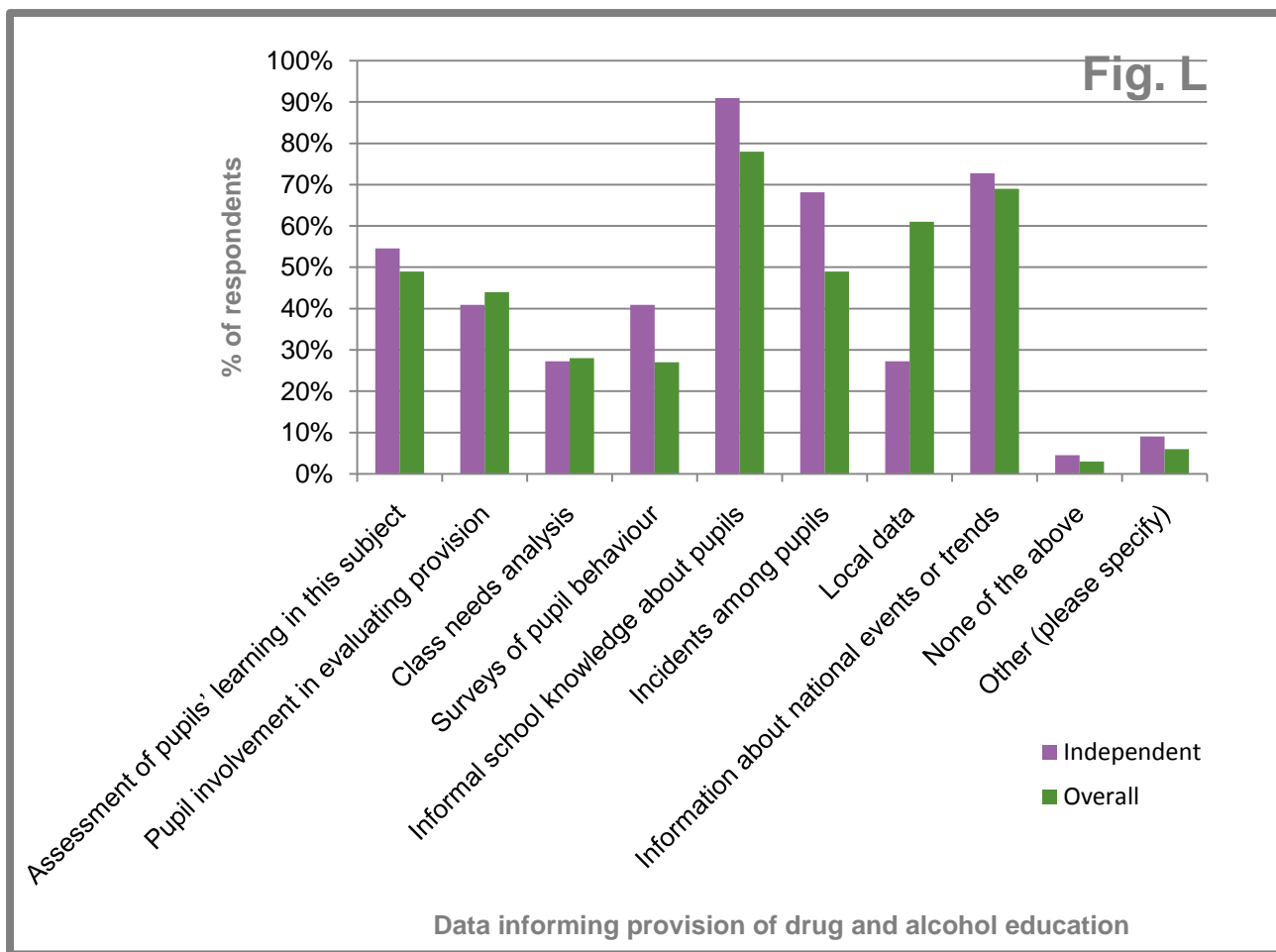
- The Alcohol Education Trust was cited by several respondents as an important external provider, with one participant noting that, *“The Alcohol Education Trust is brilliant and provides excellent and relevant resources which have proved to be very successful in PSHE lessons.”*
- Participants also noted using the internet for external support and in particular the websites of the TES and NHS.
- Participants also identified the use of external speakers, such as those from organisations like Alcoholics Anonymous, as well as local providers of drug and alcohol safety sessions and theatre groups. A number of interview respondents noted that they would welcome more external drama groups; there is some concern, however, as to whether all drama groups are quality assured as providing best practice with an adult playing key roles to ensure that children are not asked to identify with sensitive roles, such as the drug user.

## **Impact of setting on drug and alcohol provision**

The limited sample size of respondents from several settings ensures that the following analysis must be considered as providing only cautious insights rather than concrete conclusions on differences in provision in various educational settings for drug and alcohol education.

### **Independent schools**

Responses from participants from independent settings generally reflected overall trends identified within the survey data. For example, see Figure L below:



The main difference for this question was that independent schools were much less likely to use local data in planning their drug and alcohol education. Other areas where independent respondents differed from other interviewees included:

- An increased level of financial resources for staff training and less reliance on local authorities to provide that training; 9% of respondents from independent schools indicated local authority involvement in staff training compared with 31% overall.
- A focus on the requirement for teaching resources adapted to different institutional settings. Follow-up interview respondents noted that current resources were too heavily characterised by an urban aesthetic and focused on scenarios portrayed as occurring in areas of deprivation, leaving their pupils unable to engage with the resource.
- Greater popularity for resources which helped students in 'Coping with stressful situations without using drugs' (73% of independents; 52% overall).

Follow-up interview respondents also suggested that independent institutions have more curriculum time to devote to PSHE and it was therefore easier to implement a "spiral curriculum" that builds on learning and knowledge throughout the key stages and to take pupils' out of curriculum time for extra PSHE when required. Respondents also noted the lack of resources around other forms of stimulants and

steroids which were seen as constituting a particular concern in independent settings.

### Special Educational Needs Schools (SEN) and Pupil Referral Units (PRU)

The research incorporated responses from twenty SEN and PRU institutions. This is clearly too small a sample from which to make any detailed insights. The three points highlighted below are therefore meant only as a rough guide to issues which were highlighted by participants from these institutions, without any claims to wider universality.

1. Overall, participants from SEN and PRU units tended to reflect wider trends identified in other settings. For example, when asked to identify what criteria would make an effective resource, participants working in SEN schools or PRU, indicated broadly similar criteria to respondents from other settings.
2. There was an increased focus by participants on incidents among pupils in informing provision.
3. From the small sample available there was also an increased confidence in demonstrating best practice in supporting children and young people at risk.

Working in SEN and PRU settings also throws up other challenges depending on the needs of the pupils attending, which should also be considered. For example, one interviewee from an SEN setting for children with autism noted that resources had to be solid and robust due to the likelihood that they may be treated roughly:

*“We also need resources which are hardy because the children often have difficulties controlling their temper and resources can get destroyed quite quickly.”*

### Support for drug and alcohol education

A key aim of this research has been to establish what resources might best assist practitioners in delivering effective drug and alcohol education. The table below shows the most popular forms of support indicated by respondents as likely to improve their drug and alcohol education provision.

Support required by teachers	Overall	Primary	Secondary
Classroom resources	81%	79%	85%
Best practice guidance	57%	51%	56%
Updates on policy developments relevant to drug and alcohol education	53%	43%	56%
Case studies of good practice from other schools	50%	47%	53%
Updates on research about effective drug and alcohol prevention	45%	34%	50%



Advice on assessing pupils' learning and evaluating drug education provision	41%	30%	49%
Resources to help assess pupils' needs	40%	33%	44%
Advice on working with parents	40%	39%	44%
Targeted resources for working with pupils seen as 'at risk'	35%	20%	41%
Information on supporting pupils with drug or alcohol misuse in their families	33%	37%	30%
Opportunities to network with other practitioners and experts in the field	31%	20%	31%
Advice on selecting external providers of drug education	28%	14%	34%
Other (please specify)	0%	0%	3%

Across all settings there is a strong desire for more classroom resources with 81% of participants - rising to 85% for secondary settings - identifying these as the most important assistance that the new ADEPIS service would be able to provide.

Using responses to other survey questions, such as the criteria for effective resources, as well as discussions with follow-up interview participants, it is possible to indicate that this desire for more classroom resources seems to mask more complicated information. For example, while in all settings the importance of classroom resources undoubtedly represents a genuine need, in primary education the requirement for more resources may illustrate a lack of knowledge in relation to existing resources such as the 'Jugs and Herrings' Health for Life work schemes and the necessity for new and visible resources to be produced.

In secondary settings, survey data combined with qualitative data derived from follow-up discussions suggests that the key need for classroom resources more often rests on the requirement for them to contain "up-to-date information". As one respondent in a secondary academy noted, "*the hardest thing is to find up-to-date materials*". Indeed, all secondary respondents participating in the follow-up interviews used the term 'up-to-date' within the course of the discussion, frequently noting that they no longer had time to research 'up-to-date' resources or policies, and sometimes indicating a fear that the pupils would have greater knowledge than themselves around novel drugs trends. Secondary participants were therefore also more likely to require resources around new drugs such as novel psychoactive substances. In addition, they were more concerned that new resources should be targeted at specific settings; for example, resources targeted at pupils of independent schools may need to reflect the visual aesthetic of their audience or they may be unable to identify with scenarios presented.

Following classroom resources, the next three most popular responses within the survey were best practice guidance (56% overall; 56% secondary; 51% primary), updates on policy (52% overall; 56% secondary; 43% primary) and case studies of good practice (49% overall; 53% secondary; 47% primary). The focus on these resources appears to indicate a clear desire among respondent practitioners to offer students best practice teaching in drug and alcohol education, as well as implying a certain lack of confidence in remaining up-to-date with best practice trends and a changing drug and alcohol, or PSHE policy landscape. One follow-up interview respondent noted that laws around drugs and alcohol are often in flux and highlighted the recent discussions over the classification of Khat as an example of the need to be kept up-to-date with policy shifts:

*“I mean Khat is being banned, (but it is) hard to keep up with what is banned and what isn’t all the time.”*

The data produced by this research therefore seems to indicate that in a number of cases there remains a gap between the best practice that teachers would like to implement and the reality of practice under current constraints. This is further illustrated here by the smaller proportion of respondents from all settings selecting resources to help assess pupils’ needs, and help assess pupils’ learning, at 40% and 41% respectively; although secondary respondents were more likely to identify these categories. This disparity seems to further underline a lack of confidence in successfully implementing assessment of drug and alcohol education.

One further point that may be made in relation to these data is around the category, ‘Advice on working with parents’ which was selected by 40% overall: 39% of primary respondents, and 44% of secondary respondents. This issue was also raised by a number of interviewees. In primary settings a number of respondents noted that parents were often uneasy with drug and alcohol education being taught and required advice on how to mitigate these concerns; while in secondary settings two respondents noted that local external support, such as the local authority, had previously assisted in engaging parents with the PSHE scheme of work within schools, but that this support had now been withdrawn leaving the teachers themselves feeling less confident about working with parents:

*“The most important service that ADEPIS could provide would be on working with parents. The school used to offer workshops for parents using the local drug advisory service and parents used to really appreciate it but teachers don’t have the confidence to deliver these sessions (even if they are very experienced)...this is a need that is now sorely missed.”*

## Concluding remarks

This research provides valuable insights for both ADEPIS and others who support schools or provide resources around drug and alcohol education.

While excellent drug and alcohol education clearly exists in numerous schools across the country, variability in form and frequency of provision, as well as gaps in understanding around best practice, indicate that there is still significant work to be done in improving drug and alcohol education overall. This report highlights the needs of primary schools in particular in accessing resources and delivering effective drug and alcohol provision, while both secondary and primary settings have work to do in implementing clear evaluation and assessment of learning within teaching.

## ADEPIS: Meeting the needs of schools

Mentor's Alcohol and Drug Education and Prevention Information Service (ADEPIS) will help give teachers more confidence in providing effective drug and alcohol education to their pupils by providing good practice guidance and signposting to effective resources. To ensure this is grounded in wider PSHE education which gives children and young people the life skills they need, ADEPIS is working closely with the PSHE Association.

In a challenging financial context, schools' access to local support and advice varies widely. ADEPIS will work with key players such as Public Health England to raise the profile of drug and alcohol prevention among competing local priorities. Partnership with networks such as the Drug Education Practitioners Forum will help equip local advisors with the latest research and good practice, and raise standards among external providers of drug education.

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Mentor is a national charity working to protect children from the harms caused by alcohol and drugs.

The PSHE Association is the subject association for all professionals working in PSHE education.

Find out more about ADEPIS: <http://mentor-adepis.org>

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