

# Alcohol and drug education in schools

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## Executive summary

This report contains examples of good practice and policy, alongside a desire to improve PSHE, alcohol and drug education in schools and other educational settings. This ambition is shared by teachers and pupils, public health specialists and parents alike.

Improvements in PSHE provision, especially in alcohol and drug education, is essential. Key findings indicate there has been little change in the thinking of schools, students and other stakeholders since the report into the evaluation of Mentor-ADEPIS, completed in 2013.

Achieving the momentum required for change is paramount. Recommendations to ensure this include: continued engagement with those who responded to the survey; capturing the interest of those who did not respond through dissemination of findings; promotion of Mentor-ADEPIS and evidencing progress as it happens, which could also contribute to the Government's intentions to make PSHE statutory.

Both primary and secondary education settings share concerns about resources, support, time constraints and developing teachers' skills and confidence to deliver quality alcohol and drug education within a PSHE curriculum. There is also a conflict between non-statutory PSHE delivery and other (statutory) curriculum priorities. PSHE suffers as a result.

Secondary school-age young people are vocal about the emphasis put on academic achievement in schools and how this can have a negative impact on student wellbeing. They link management of the perceived pressure to achieve with incidences of alcohol and drug use. Primary schools have a more implicit approach to alcohol and drug education, which is viewed as a more age-appropriate response.

It must be noted that the response rate for this report, despite considerable efforts, was low (lower than the previous report). A number of teachers reported not having time to complete the survey or forgetting to complete it. This may be reflective of the non-statutory status of PSHE / alcohol and drug education in schools. Incentives to make time and remember to complete the survey may need to be explored. Likewise, input and engagement with parents and families requires further attention. School responses were not explicit about how they manage drug incidents, including supporting children at risk from alcohol and drug related harm in their homes. Students were vocal about these points during focus groups and so this report provides findings for schools to consider.

A key finding from the survey was the lack of awareness of Mentor-ADEPIS. Those with awareness of the resources and support available from Mentor-ADEPIS to help

schools safeguard pupils from alcohol and drug harm spoke favourably of the platform; those looking at the website and resources for the first time were encouraged by its content.

Many of the findings of this report can be addressed by Mentor-ADEPIS, possibly in collaboration with other credible national and local agencies. With Mentor's support, schools and other organisations can develop effective alcohol and drug education lessons and curricula. This will require a school-level needs analysis as well as training and CPD, pupil support, family engagement, policy and quality development, inter-agency working, openness and co-production to make the best use of resources and partnerships as a part of a whole community approach. Any such approaches should be based on the Mentor-ADEPIS Quality Standards for Effective Alcohol and Drug Education.

## Key findings

- Almost every school surveyed reported that they deliver some alcohol and drug education (95% of primary schools and 97% of secondary schools).
- Alcohol and drug policy is a weakness in many schools, even amongst those who responded to the survey. 3% of schools reported that they did not have a drug policy at all, while 33% of primary schools and 42% of secondary schools reported that policy had not been updated for 4 or even 5 years.
- Time constraints in secondary school, particularly at Key Stage 4, frequently eliminate any alcohol and drug education.
- Primary teachers frequently lack confidence in delivering alcohol and drug education.
- Poor knowledge of, and access to, resources for teaching Novel Psychoactive Substances and volatile substances mean this is frequently not taught.
- Teachers and young people identified the links between mental health and substance use as a key area where they would like more input.
- Interviews and focus groups identified many instances where good practice had been constrained or eroded because of reduced funding and/or support from local authorities.
- There is a widespread lack of consistency in the delivery of alcohol and drug education in both primary and secondary schools.
- CPD for alcohol and drug education is too often not easily accessible locally for schools. 80% of teachers don't know if their local authority can provide high quality CPD for alcohol and drug education; 70% feel the same about CPD for PSHE more broadly.
- Schools feel that the non-statutory status of PSHE education negatively impacts on the resources, time, quality and the importance given to these sessions within pressured school curricula, particularly at Key Stage 4.

- The lack of statutory status for PSHE education also impacts on attitudes towards CPD investment in PSHE; many teachers believe CPD for alcohol and drug education is not easily accessible.
- Although almost half the respondents reported using five or more sources of information to plan alcohol and drug lessons, 13% reported using none of the sources listed. Where additional information was supplied, the sources were listed as PSHE Association and local authority guidance. This suggests a reactive approach to alcohol and drug education, rather than planned approaches based on identified local needs.
- The planning of alcohol and drug education appears to be haphazard in many schools; the data suggests that assessment of learning and/or progress is equally inconsistent.
- There is no assessment of PSHE in 39% of primary schools and 33% of secondary schools who responded to the survey. Where assessment does take place, it most likely to be self- or peer-assessment.
- Addressing poor classroom resources and inadequate time for learning was raised as a priority by students.
- Students want to be actively involved in informing how alcohol and drug education is delivered.
- There is a need to use misconceptions about alcohol and drug use within the learning environment to dispel myths, challenge views and develop pro-health social norms, based on accurate local data.
- Primary teachers frequently report a lack of confidence in delivering alcohol and drug education; however, primary teachers using a PSHE scheme of work that includes alcohol and drug lessons feel more confident about their delivery of good quality lessons.
- Some teachers feel intimidated by PSHE alcohol and drug sessions and uncomfortable with the notion that the students may know more than they do. This has an adverse impact on their willingness to deliver these classes, as well as the quality of education that children and young people receive.
- Funding cuts and reduced service provision makes access to external support increasingly difficult for schools. One teacher even reported feeling so anxious about the lack of external support for their students, that they had to relinquish their role because their own mental health was suffering.
- Opportunities to develop co-learning models with students are being overlooked.
- Members of the Mentor Youth Panel felt that, though there was more information and signposting available at university compared to school, it was still insufficient.
- Mentor-ADEPIS resources and support are viewed very favourably by teachers and other professionals who are aware of Mentor-ADEPIS.

## Full Report

### Background

The Alcohol and Drug Education and Prevention Information Service (ADEPIS) is a project that is currently funded by Public Health England and the Home Office, developed by the prevention charity Mentor UK. Amongst PSHE and Alcohol and drug education specialists, Mentor-ADEPIS is acknowledged as the leading source of evidence-based information and tools for alcohol and drug education and prevention for schools.

This report details the research carried out by Healthy Attitude on behalf of Mentor-ADEPIS and builds on previous research that has been completed biennially. The report covers schools' current practice regarding the delivery of alcohol and drug education, support available from external sources and any perceived gaps in resources. The report will be of interest to those delivering PSHE and particularly alcohol and drug education.

### Methodology

The data that the report is based on has been drawn primarily from a detailed online survey consisting of both closed and open 'free text' responses. The survey was completed between May and July 2017 by 172 participants, 117 of which were based in schools. Respondents were sourced through Mentor-ADEPIS mailing lists and an independent school marketing company was engaged to increase coverage across the UK with the survey being sent to 19,000 school email addresses, including over 1,000 named PSHE leads. Respondents worked in a range of educational settings, including primary, secondary and special schools. The largest group of respondents (60) were PSHE leads, with others covering a range of roles within their school. Just over half (51%) of respondents were members of the PSHE Association. In addition, there were 55 respondents based in non-school settings. Respondents were based across most regions in England, with a greater concentration in London and the South East.

The response rate was low, despite engaging the services of a specialist school marketing company; this suggests only a small subset of highly motivated teachers completed the survey. There were no incentives offered for completion of the survey and this may also have had an impact on the response rate. The teachers who took part in focus groups had received the link to the survey; however, some did not complete the survey, despite being willing to give up time to provide their views on alcohol and drug education. Reasons given for non-completion included lack of time or forgetting to complete it.

In addition to the online survey, a range of interviews and focus groups were completed with teachers and others involved in delivery or provision of alcohol and

drug education. In total, 30 teachers and 4 professionals working with local authorities provided input and were located across the UK. As more respondents from London and the South East completed the online survey, this geographical location was not targeted for interviews and focus groups.

Children and young people, including a member of the UK Youth Parliament, took part in semi-structured focus groups. The groups represent a range of ages (from 8 to 18) and geographical locations. Findings from this group revealed the importance placed on an inclusive process for planning alcohol and drug education and this is discussed further later in the report.

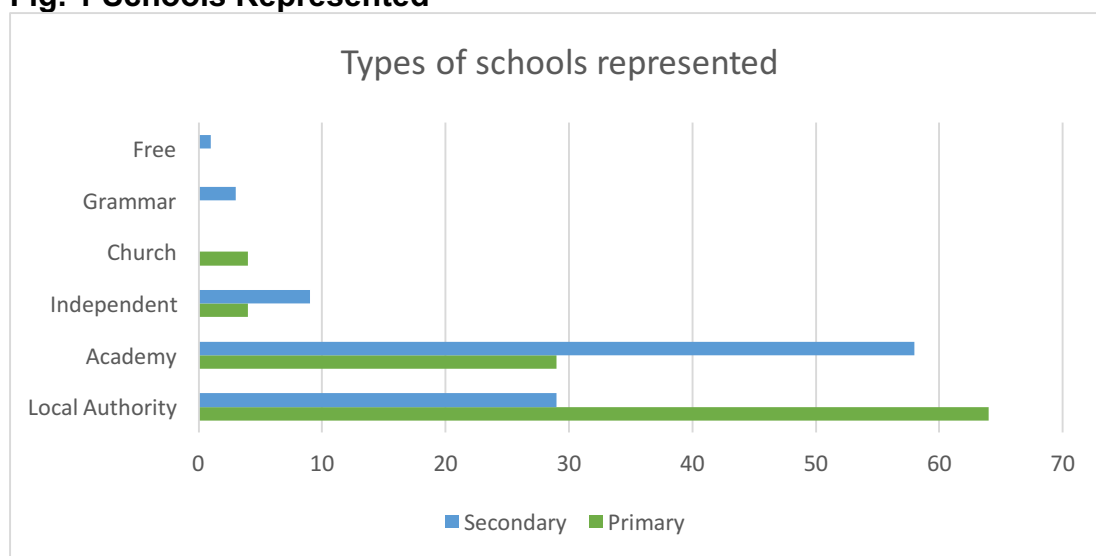
### **Type of schools in which participants were based**

The largest group of respondents were based in larger secondary schools with 1,000-1,500 pupils. The remaining respondents were spread evenly from schools of other sizes.

The largest group of respondents (71) were based in secondary schools; this represents 64% of school respondents. A further 23% of respondents were based in primary schools with the remaining 13% representing other educational settings, including special schools and pupil referral units. Due to the small number of respondents from special schools or other types of educational settings, comparisons are only made between primary and secondary schools. Results from special schools, where appropriate, were incorporated into primary and secondary results.

Most of the schools were either maintained schools (i.e. local authority controlled) or academies; however, there was also representation from a small number of independent, church, grammar and free schools, the data from which were included in the quantitative results.

**Fig. 1 Schools Represented**



### Settings other than school

Of the respondents from non-school settings, 75% were from local authorities; the others represented a range of organisations, including the voluntary sector, NHS, police and independent training consultancies.

### Geographical distribution of participants

All regions of England were represented within the schools; in addition, there were several non-school respondents from Scotland, Northern Ireland and Wales. Fig. 2 provides details of the location of respondents and concentration across the country. London and the South East provided the largest numbers of respondents.

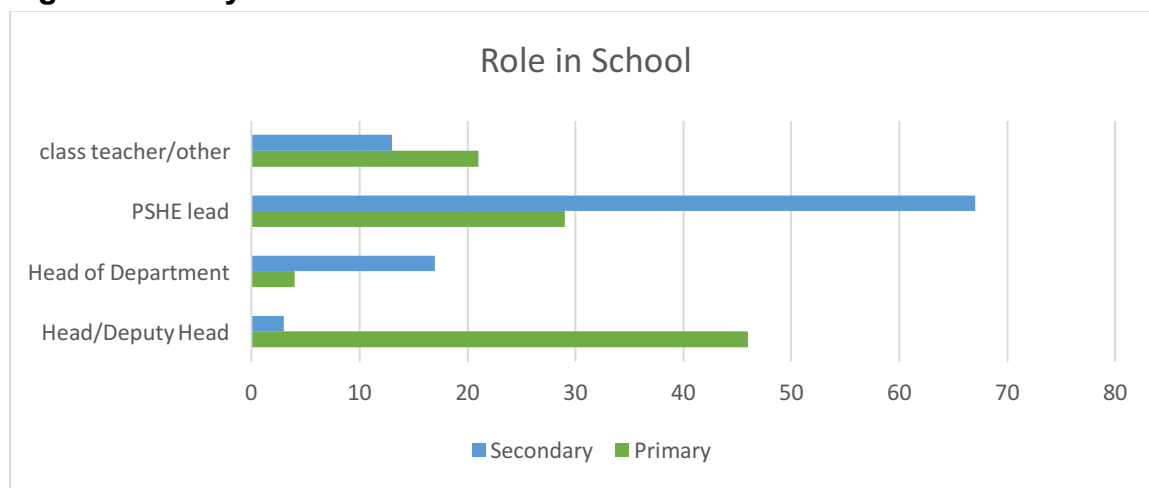
**Fig. 2 Geographical Distribution**



### Role of respondents

Within primary schools it was much more likely for a headteacher or deputy headteacher to respond (50%); however, from secondary schools, the majority of respondents were PSHE leads (67%); only 3% of respondents were in senior leadership roles. (See Fig. 3).

**Fig. 3 What is your role in school?**



### School drugs policy and alcohol and drug education

Most respondents reported a drugs policy in their setting, either as a specific policy or as part of a wider strategy. However, a considerable number of respondents (17% of primary schools and 28% of secondary schools) did not know if they had a drugs policy in place and 3% of schools reported that they did not have a drugs policy at all. With regards to updating their drugs policy, 67% of primary schools and 58% of secondary schools had updated their policy within the past two years, while 17% of primary schools and 38% of secondary schools reporting that they did not know if policy had been updated. The remaining respondents reported their policies had not been updated in four, or even five, years.

When asked if they were aware of the Psychoactive Substances Act 2016, 61% of primary schools and 75% of secondary schools reported that they knew about the Act and as a result, 18% of primary schools and 51% of secondary schools had updated their drugs policy.

Schools were also asked if they had a referral policy in place to support more vulnerable students. 47% of primary schools and 68% of secondary schools confirmed that they had a policy in place. In both primary and secondary settings, a similar percentage of respondents reported that they were unsure if they had a referral policy in place (26% and 28% respectively). Secondary schools were much more likely to have targeted alcohol and drugs lessons in place for students deemed to be “at risk” (58%, as opposed to 16% of primary schools).



Primary school respondents further commented that any referrals were generally made as part of safeguarding procedures, whereas secondary schools gave a range of referral processes, including self-referral and joint work with external agencies. A small number of schools reported having a trained professional on-site to work with students. This took the form of either a nurse offering one-to-one sessions or “tier 2” (skilled work visa) trained staff available to work with students experiencing problems with drugs or alcohol.

Interviews with secondary school teachers suggested that some of these services may have been reduced in the last few years as a result of funding constraints:

*“Until 2016 we had a qualified counsellor in school two days per week and we would refer students to him. The process was quick and effective, and in most cases the students benefited from this and were able to stay in school. Following budget cuts, we lost the counsellor and the pastoral lead now manages referrals to the local drugs service, but exclusions have increased. I know the picture is the same in other schools because they no longer use the counsellor.”*

(PSHE lead, secondary school)

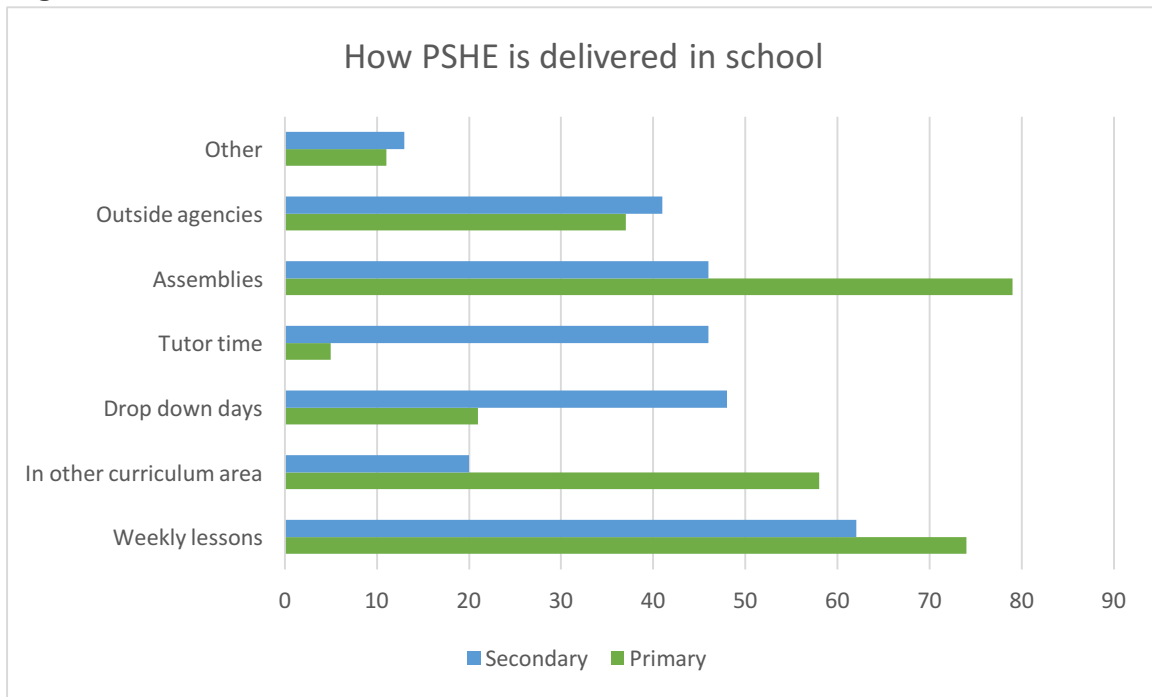
*“I was head of student services and PSHE lead for 6 years, and it was my job to make referrals and deal with safeguarding along with the deputy head. The process got increasingly difficult with waiting times for intervention increasing, especially if CAMHS were involved. I had to give up the role as my own mental health was suffering.”*

(Senior leader, secondary school)

## **Provision of PSHE/alcohol and drug education**

Almost all schools reported that they delivered PSHE lessons (95% of primary schools and 97% of secondary schools), with the majority of alcohol and drug education being delivered as part of the PSHE curriculum. Other delivery opportunities were identified in science lessons, the wider curriculum and via assemblies (Fig. 4). Only one school reported that they did not deliver any PSHE or alcohol and drug education at all.

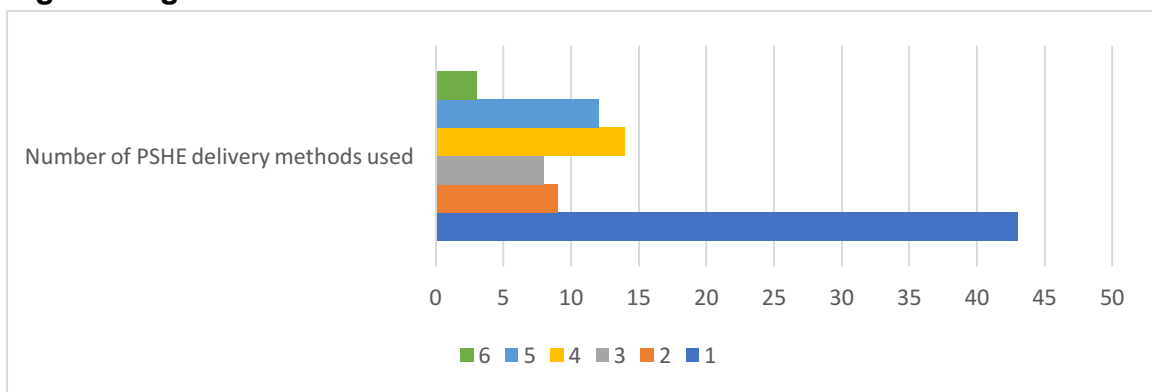
**Fig. 4 How is PSHE delivered in school?**



Where schools selected “other”, the most common delivery method was via fortnightly lessons. Many schools reported using a variety of delivery options, and where only one method of PSHE delivery was reported (43% of respondents, Fig. 5), most of those (31%) were in weekly, timetabled lessons. However, in a small number of cases the only method of delivering PSHE was via drop-down days (4%) or via assemblies, tutor time or using outside agencies. This group represented 10% of respondents.

Of the remaining 57% of respondents, the vast majority cited weekly or fortnightly planned lessons together with a range of other methods to support PSHE delivery. Fig. 5 shows that almost 30% of respondents reported using between four and six delivery methods for PSHE education.

**Fig. 5 Range of methods used to deliver PSHE**



Respondents selected all the PSHE delivery methods they used from the following list of options:

- Outside agencies
- Assemblies
- Tutor time
- Drop-down days (off-timetable sessions)
- Other curriculum areas
- Weekly lessons

The common practice of using a range of delivery methods for PSHE was further reflected in the focus groups.

*“We tend to use lots of different ways to deliver PSHE, but try to avoid drop-down days”*

(Secondary school)

*“Tutor time is used, but there’s not much time to get your teeth into anything. We also have themed assemblies throughout the year where external speakers come along. These are well-received by students but there is never enough time for any effective follow-up”*

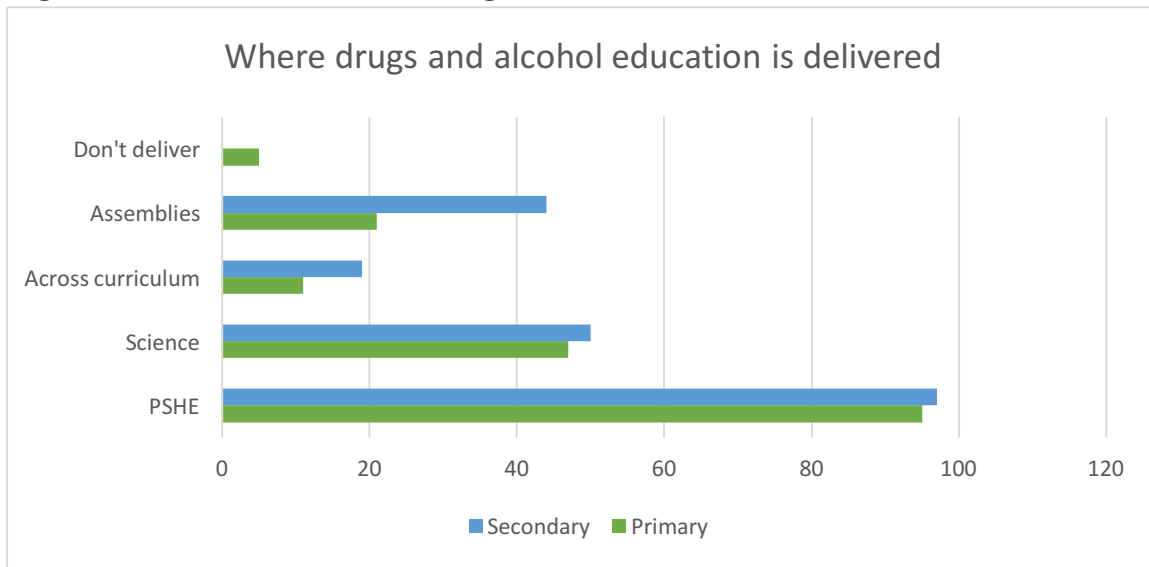
(Secondary school)

*“We have planned weekly lessons of around an hour with the whole school doing PSHE at the same time. We use a PSHE scheme of work that includes assemblies, so we feel that PSHE helps pull the whole school together.”*

(Primary school)

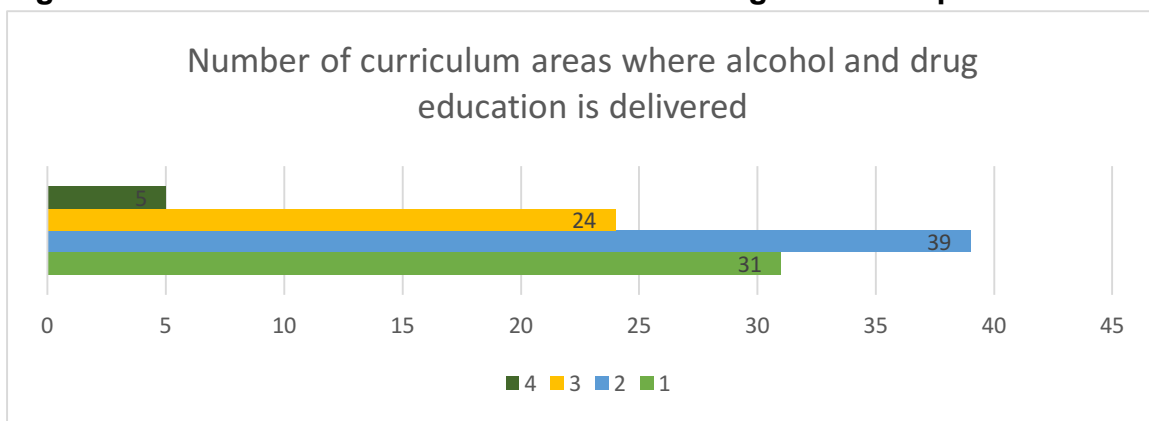
Respondents were also asked to identify specifically where alcohol and drug education was delivered; results were similar to those for PSHE education more generally. The key difference between primary and secondary schools was the use of assemblies for alcohol and drug education, with secondary schools citing this delivery method much more frequently than primary schools (Fig. 6). This could indicate that alcohol and drug education is not regarded as an appropriate topic for primary school assemblies, particularly as primary schools use assemblies to deliver broader PSHE education much more than secondary schools (Fig. 4). 5% of primary schools reported no delivery of alcohol and drug education at all.

**Fig. 6 Where is alcohol and drug education delivered?**



In most cases alcohol and drug lessons are delivered in only one or two specific areas of the timetable. This is most commonly timetabled PSHE lessons or science lessons. Only one respondent reported that science was the only provision of alcohol and drug education. In just under a quarter of settings, PSHE lessons, science and/or other curriculum areas were used for alcohol and drug provision, with only 5% of respondents indicating that alcohol and drug provision was provided across all 4 areas i.e. PSHE, science, assemblies and other curriculum areas. (Fig. 7)

**Fig. 7 Where in the curriculum is alcohol and drug education provided?**



Respondents selected where in the curriculum alcohol and drug education is delivered from the following list of options:

- PSHE lessons
- Science lessons
- Across a range of curriculum areas
- Assemblies

## Constraints on teaching alcohol and drug education

The foremost constraints on delivering good quality alcohol and drug education were a lack of confidence among primary school teachers and a lack of time among secondary school staff, due to conflicts with other priorities and time required for other subjects.

The comments below are reflective of many statements from both one-to-one interviews and focus groups. Primary schools were more likely to have both the time and flexibility to deliver PSHE education; however, respondents acknowledged that, when children were preparing for SATs or preparing for an event such as a school play, they would often use the time allocated to PSHE to focus on these areas. Coupled with the general reticence in many primary schools to include alcohol and drug education in their PSHE provision, this may explain the lack of provision in some primary settings.

*“I really don’t know anything about drugs and have no experience in this area. I’m not sure that alcohol and drugs are relevant to our children. They will get lessons at secondary school and that’s probably at the right age.”*

(Primary school teacher)

*“I enjoy leading on PSHE and it’s a very important area but not everyone sees it that way and I get very little time for planning our lessons. It is also the class that get used if students need to do something else, for example a music lesson or an extra class for another subject. I teach across two other subject areas, so I don’t have a lot of time for finding good resources.”*

(PSHE lead, secondary school)

Other constraints included: a lack of resources; less support from external agencies, particularly the local authority; and budgetary constraints.

*“There’s no support from our local authority unless we pay for it, and that’s mainly for specialist interventions”*

(Head of Department, secondary school)

Within secondary schools, PSHE leads reported being limited to what the non-specialist tutors who are responsible for delivering PSHE were prepared to teach:

*“The tutors point-blank refuse to deliver some lessons, mainly the sexual health ones, but some won’t deliver drugs education either. We want the right people to deliver good quality lessons and feel comfortable, but there doesn’t seem to be enough of them. I’ve suggested some CPD but that hasn’t been received well either, it’s very frustrating.”*

(PSHE lead, secondary school)

The non-statutory position of PSHE is clearly detrimental in trying to ensure quality lessons for students and the non-specialist nature of most teachers involved in delivering lessons means that quality is inconsistent or, in some cases, not happening at all. Teachers also acknowledged that they had often over-relied on local authority support, and that finding alternative provision or developing in-house resources had been challenging, particularly when there were other changes taking place in school that were perceived by school leaders to be of a higher priority.

## **Alcohol and drug education by Key Stage**

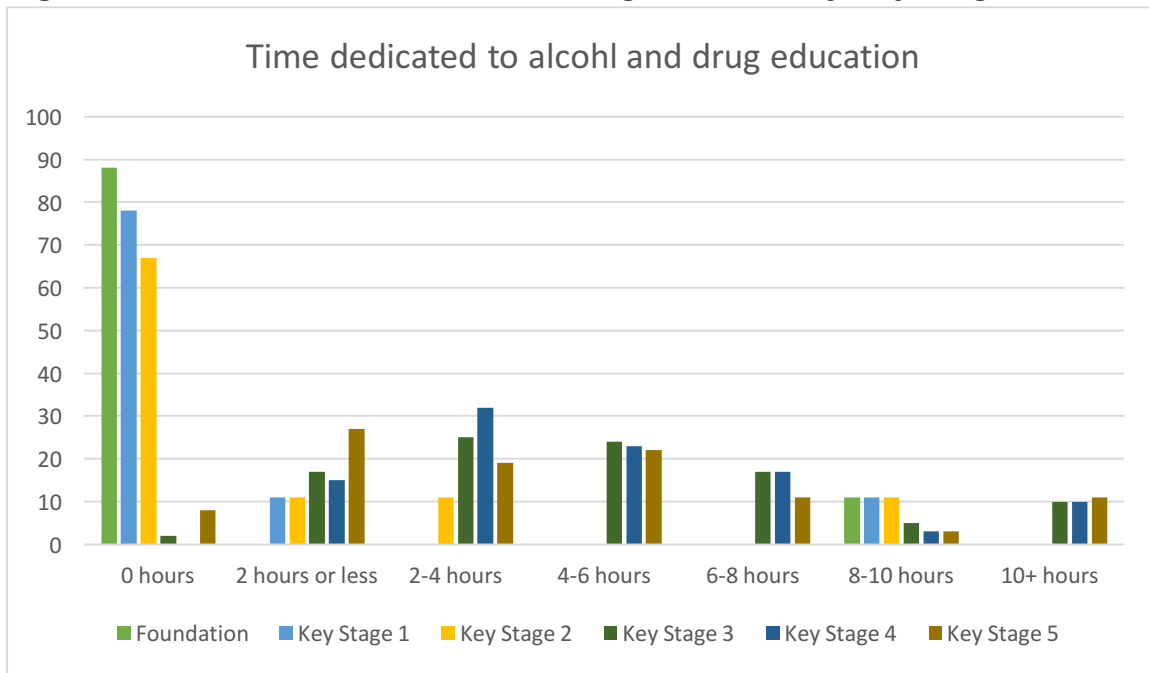
This section considers how much time is dedicated to alcohol and drug education in each Key Stage.

As shown in Fig. 8, most of the dedicated alcohol and drug education takes place in Key Stages 3 and 4, with the majority of schools continuing this into Key Stage 5. All schools provided at least some input, with the majority delivering between four and six hours of alcohol and drug education over the Key Stage. Only two secondary schools did not provide any alcohol and drug education at Key Stage 3.

In primary schools, most alcohol and drug education is delivered in Key Stage 2; however, 67% of primary schools responding reported that there was no alcohol and drug education in Key Stage 2. However, previous questions indicated that almost all primary schools were delivering some alcohol and drug education. The assumption is that, in many primary schools, alcohol and drug education is not given any dedicated lessons in PSHE but does feature on the curriculum. Focus groups and interview responses also suggested that in many cases primary schools either don't deliver alcohol and drug lessons or "gloss over" this area when delivering "safety" lessons.

There appears to have been a sharp increase in the number of primary schools delivering alcohol and drug education. In the 2013 report 48% of schools reported no alcohol and drug education at Key Stage 1 and 35% at Key Stage 2. This appears to have risen to 78% and 67% respectively. On the other hand, the numbers of students receiving no alcohol and drug education at Key Stage 3 has reduced to just 2% and at Key Stage 4 all schools reported delivering some alcohol and drug education. There was also greater reporting of alcohol and drug education at Key Stage 5 compared to 2013. However, the sample size in 2017 is smaller, so care must be taken interpreting these figures.

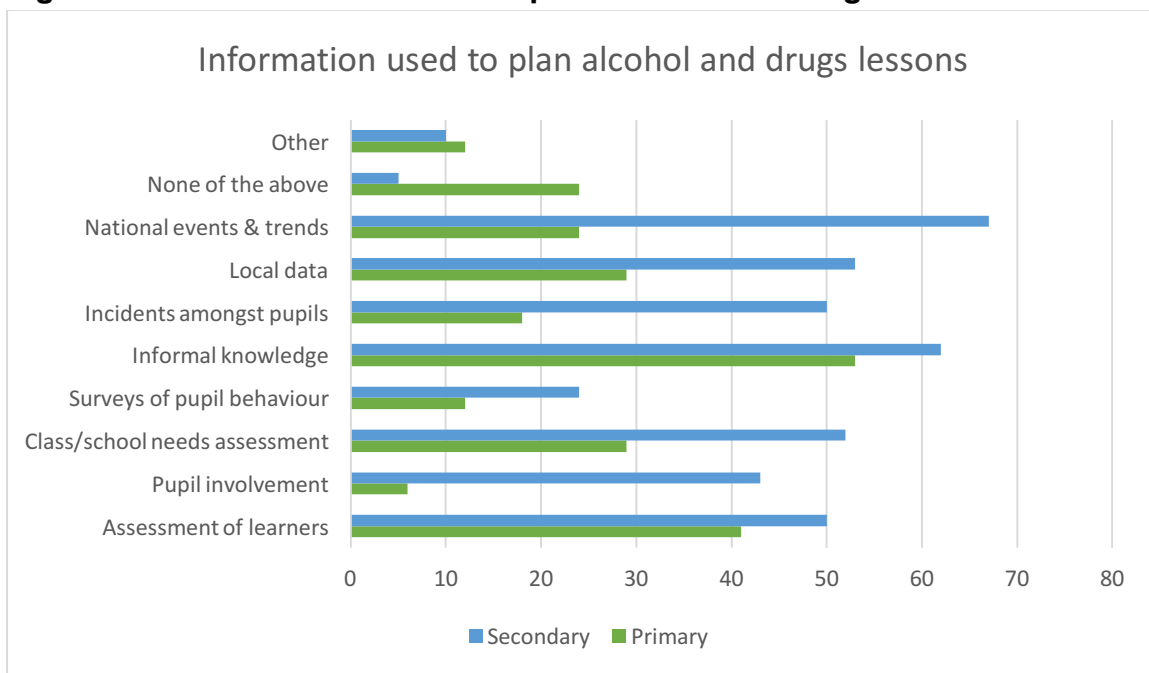
**Fig. 8 Time dedicated to alcohol and drug education by Key Stage**



**What informs schools’ provision of alcohol and drug education**

Respondents were asked to indicate which data they use to inform the content of alcohol and drug education (Fig. 9). Informal school knowledge is a common driver of delivery in both primary and secondary schools with only national events and trends surpassing this in secondary schools. In secondary school, class/school needs analysis and assessment of learners is used by 52% and 50% of schools respectively.

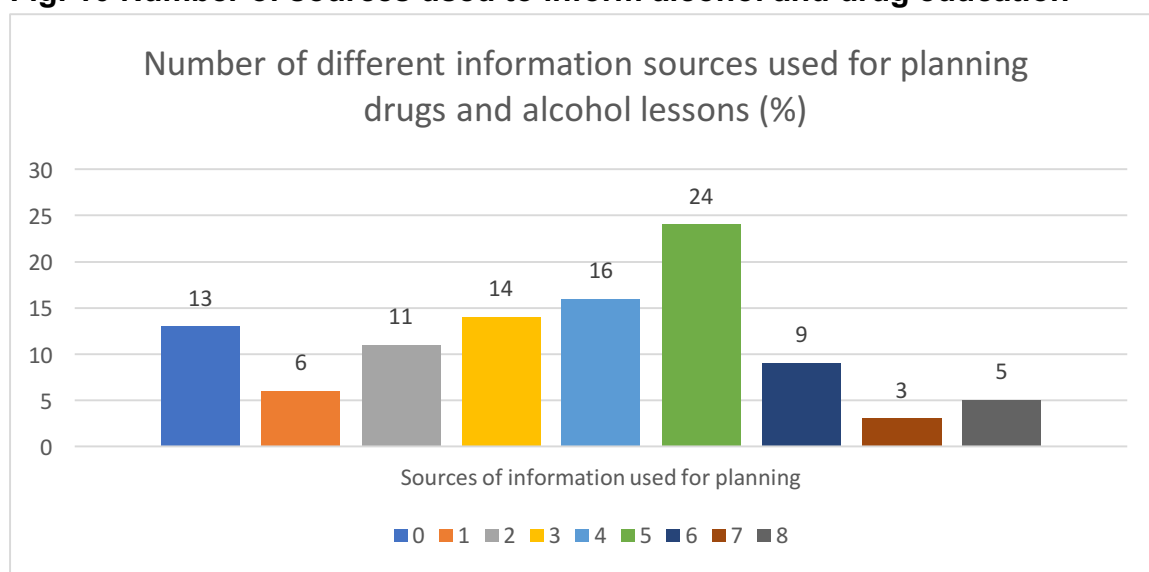
**Fig. 9 What information is used to plan alcohol and drugs lessons?**



The popularity of national events and trends (such as media reports) and informal knowledge informing provision of alcohol and drug education in secondary schools, suggests a “knee-jerk” or “fire-fighting” response to alcohol and drug education, rather than a well-thought-out and planned approach, based on identified local need. Still, some respondents used a range of data sources and other information to plan alcohol and drug lessons. Fig. 10 demonstrates that almost a quarter of respondents reported using five sources of information to plan alcohol and drug lessons, and a further 17% using more than five sources of data. At the other end of the scale, 13% reported using none of the sources listed. Where additional information was supplied, the sources of information were listed as PSHE Association and local authority guidance.

Where multiple sources of information were used to support planning of alcohol and drug education, no pattern emerged; informal knowledge and national trends were the most commonly selected information sources. Only two respondents reported that the only source of information they used was national events and trends, and no respondents relied solely on informal knowledge.

**Fig. 10 Number of sources used to inform alcohol and drug education**



Respondents selected from the following list of sources to plan lessons:

- National events and trends
- Local data
- Pupil incidents
- Informal knowledge
- Surveys of pupil behaviour
- Class/school needs assessment
- Pupil involvement
- Assessment of learners
- None of the sources listed were used



These figures are supported by some of the comments made by secondary school teachers, such as the following:

*“A few years ago it was all about cannabis, and now we seem to be jumping onto the ‘legal highs’ bandwagon. Drugs education is often at the bottom of the PSHE ‘to do’ list until a teenager dies at a festival and it’s drug related.”*

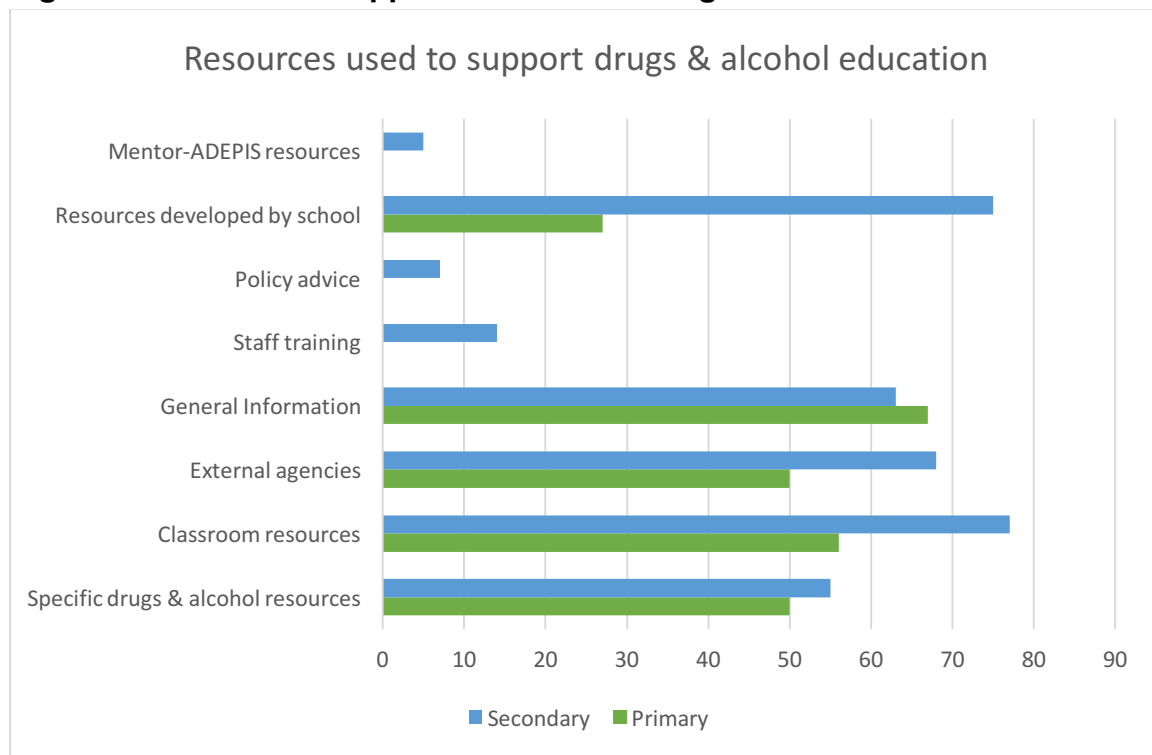
The planning of alcohol and drug lessons appears to be haphazard in many schools and the survey results and comments from teachers and pupils suggest that assessment of learning and/or progress is equally inconsistent. There is no assessment of PSHE in 39% of primary schools and 33% of secondary schools. Where assessment does take place, it most likely to be self or peer assessment.

## Teaching resources for alcohol and drug education

Identifying the resources being used within schools to deliver alcohol and drug education and ascertaining teacher’s and pupil’s views of these resources was addressed through a number of survey questions and further explored in interviews and focus groups.

The range of resources used by schools to deliver alcohol and drug education varies between primary and secondary schools. This is unsurprising given the number of primary schools reporting that they don’t deliver alcohol and drug education.

**Fig. 11 Resources to support alcohol and drug education**



Secondary schools reported using resources developed internally to deliver alcohol and drug education much more frequently than primary schools. When questioned further in focus groups and interviews, schools gave examples of resources provided by their local authorities, often via the Healthy Schools team. These included a resource called “Drugs and Stuff” that provided lesson plans across Key Stages 3-5. In addition, some schools had received class room resources to support alcohol and drug lessons including beer goggles, alcohol calculator wheels, drug boxes and films made by young people about smoking. Schools reported that many of the resources had been received many years ago and there had been no updates made available. For example, the “Drugs & Stuff” resource did not include information on new psychoactive substances. In some areas, there were online resources that schools could access, particularly where there was a healthy schools team or person in place at the local authority.

Several primary schools admitted that, since their local Life Education Centre was no longer freely available to them, they had not delivered any drug education as part of their PSHE provision and, in some cases, had not provided any teaching about alcohol. It was more common for primary schools to have included tobacco education as part of PSHE.

Lack of teacher expertise and confidence was cited as a reason for avoiding alcohol and drug education. Some primary school teachers also believed that alcohol and drug education was not a topic that they should be responsible for; an exception to this was the importance of medicine safety, which suggests a need to clarify what age-appropriate drug education should address through teacher training.

Teachers’ lack of expertise and confidence may be due to the belief that they do not understand the science related to alcohol and drug education, as some teachers felt that the Life Education Centre sessions took a scientific approach. In focus groups, there was also a tendency for teachers to reflect on their own behaviour and personal experience with alcohol and drugs; many expressed difficulties understanding that distancing techniques can be used in this area, as is the case with PSHE delivery more generally.

*“I do think (primary) children need to know about the risks associated with alcohol and most will see their parents drink. I suppose some will see drug use at home too. If we had some training it would give us the confidence to tackle these issues in the right way. At the moment, I wouldn’t know where to start.”*

*“I think if we tell children too much about alcohol and drugs they are more likely to try it. Better if we keep them innocent for a bit longer.”*

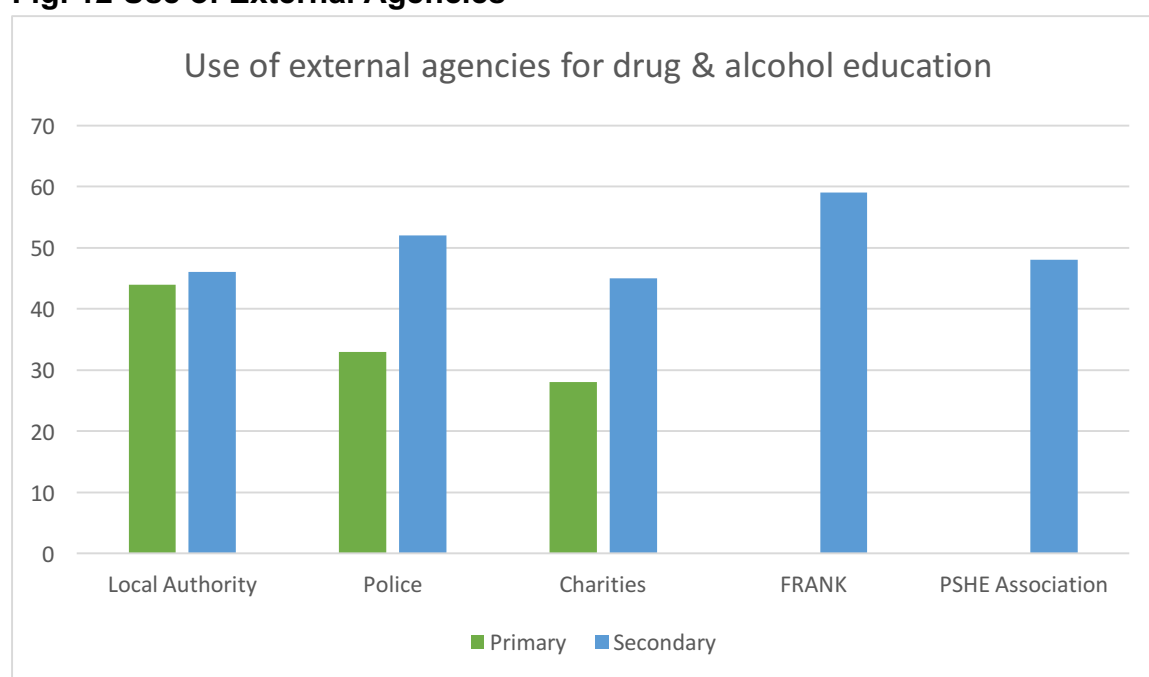
*“Smoking is easy to tackle; we have a strict no smoking policy in and around the school and our children were involved in designing a poster for smoke free play parks.”*

*“We have lessons in reception and early years and Key Stage 1 to make sure children know that they must not take medicine and that an adult must always do this. We tell them how dangerous taking too much medicine can be.”*

## Engagement of External Agencies

Primary and secondary schools were very similar in their use of local authority resources; however, in all other categories, secondary schools were much more likely to make use of external resources to support alcohol and drug education. Most notable was the popularity of the “Talk to Frank” website and the PSHE Association with secondary schools, and although “Talk to Frank” is targeted at older students the same cannot be said for the PSHE Association. Since collecting this data, Public Health England has launched “Rise Above”, which might help to address this need.

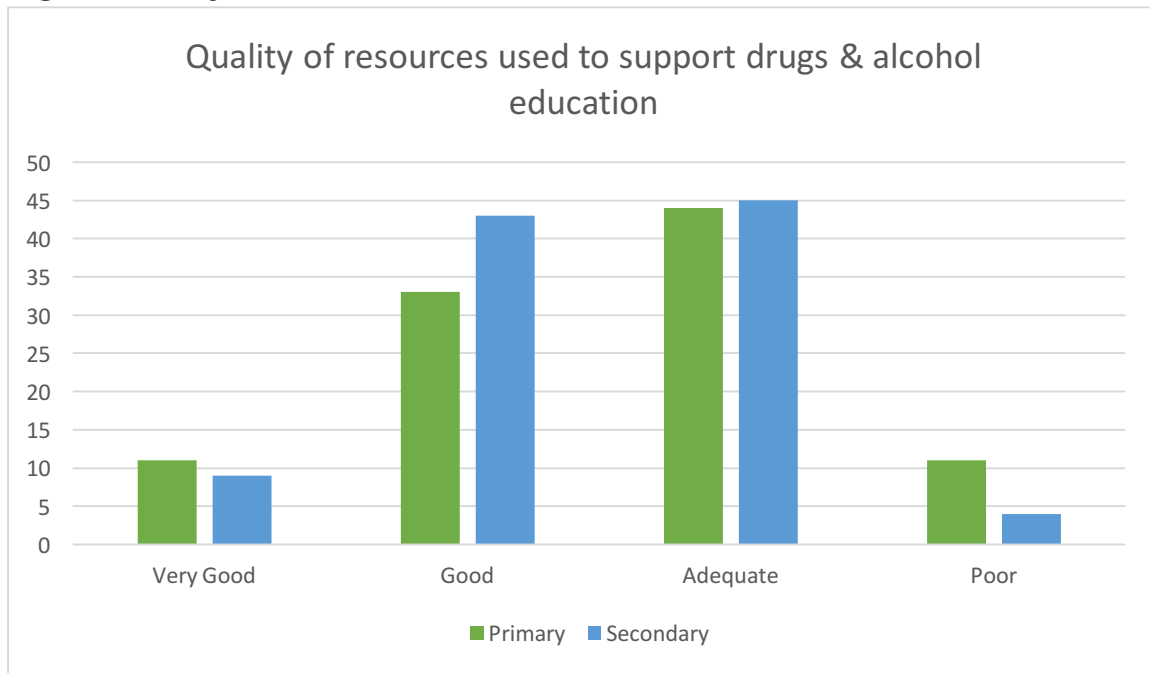
**Fig. 12 Use of External Agencies**



## Quality of Resources and Quality Assurance

Respondents were asked to rate the quality of the resources available to them to support delivery of alcohol and drug education. Responses were similar from respondents in both primary and secondary settings (Fig. 12); however, this is a rather subjective question with no benchmarking as to what is “very good” compared to “good” and consequently this data is of limited value.

**Fig. 13 Quality of Resources**



This question was discussed via interviews and focus groups with teachers. In general, there was no awareness, or prioritisation, of reliable quality assurance of resources:

*“If my tutors are delivering the material and the students are involved in the lessons we can assume that the quality is ok. We try to make sure we cover at least most of what is on the PSHE programme of study”*

*“We haven’t really thought about quality assurance when it comes to PSHE, because it’s not statutory and we don’t do any assessment so quality assurance hasn’t hit the radar”*

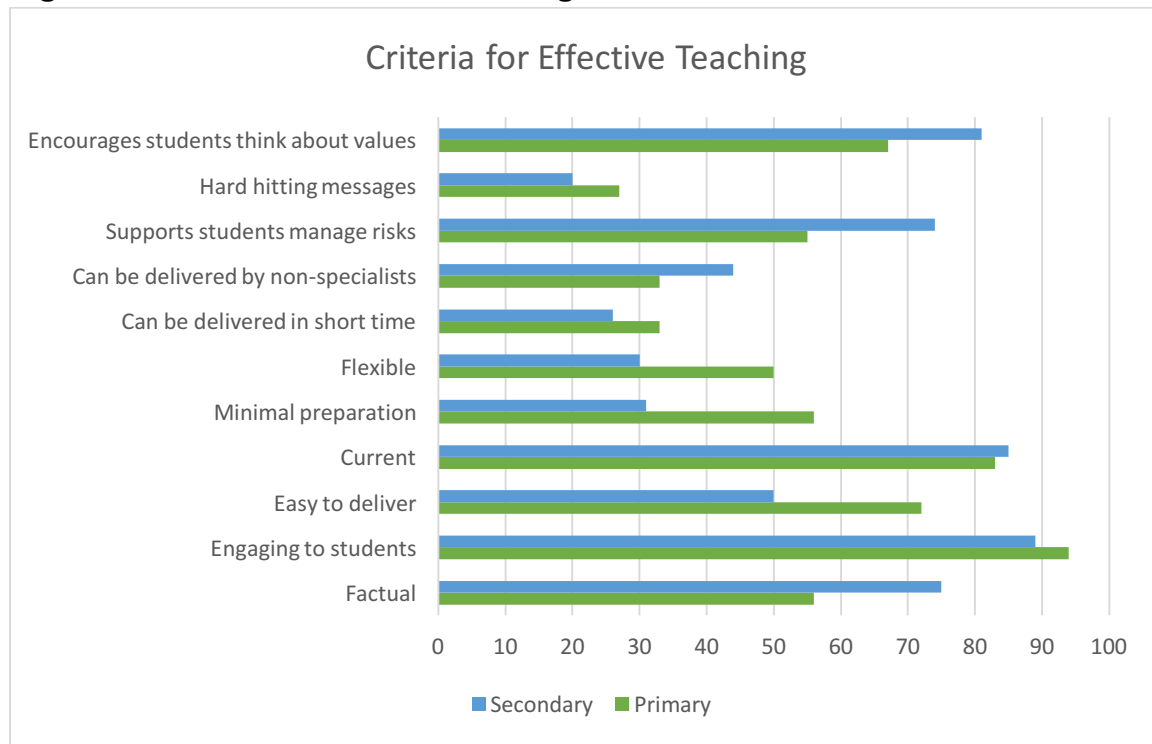
Where external organisations were used to deliver alcohol and drug education, such as theatre workshops, the organisations usually completed questionnaires both before and after; however, schools acknowledged that there was no evaluation of any medium- or long-term impact of these programmes. Feedback tended to focus on “before” and “after” knowledge and/or attitude of students and how students “rated” the performance or workshop.

Jigsaw PSHE resources, used by some primary schools, has achieved the PSHE Association’s Quality Mark. The Alcohol Education Trust’s materials have also been well evaluated and quality assured; however, only a few schools reported using the resources and were not very complimentary, specifically commenting that the resources feel dated and are not available online (to be used interactively with SMART Boards).

## Criteria for effective teaching resources

Participants were asked to comment on the criteria they believed to be the most important when delivering alcohol and drug lessons and Fig. 14 shows their responses.

**Fig. 14 Criteria for Effective Teaching**



Respondents from secondary schools identified the following as the top 5 most important for effective teaching:

1. Engaging to students
2. Current and up-to-date
3. Encourages students to think about attitudes and values
4. Factual information
5. Supports students with managing risk

Respondents from primary schools identified the following as the top 5 most important for effective teaching:

1. Engaging for students
2. Current and up to date
3. Easy to deliver
4. Encourages students to think about attitudes and values
5. Factual information/Minimal preparation

None of the responses identified behavioural outcomes as important, nor whether programmes had a theoretical or evidence-based approach. This suggests that there may be a lack of awareness or understanding of these concepts.

When looking at the most important criteria for effective teaching, primary and secondary respondents identify some shared priorities that the materials are: engaging for students; current and up-to-date; encouraging students to think about attitudes and values; and contain factual information. Secondary schools additionally identify 'supporting students with managing risk' as being a key criterion, whereas primary schools chose materials that are easy to deliver and require minimal preparation. This may be indicative of a perceived relevance for alcohol and drug education in secondary settings and, in the case of primary school teachers, further highlight a lack of confidence with the subject area.

*"Engaging lessons are key as otherwise they (the students) will switch off. This is where external speakers can help. I think they are often more credible than us."*

(Secondary teacher)

This comment about engagement is consistent with teachers lacking confidence in their own skills to deliver engaging lessons or an awareness of the importance of evidenced-based teaching as detailed previously.

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

In some parts of the country, including those where teachers took part in focus groups, large numbers of primary schools are using Jigsaw PSHE to deliver their PSHE curriculum, including alcohol and drug education, and rated this resource favourably because of its age-specific content and relevance across the PSHE curriculum:

*"We've been using Jigsaw for the past two years and there are lessons on drugs and alcohol at both Key Stages. The holistic approach means that drugs and alcohol are related to other parts of PSHE."*

*"It's good to have a resource that is specifically written for primary schools. Most drugs and alcohol resources are for secondary schools and not age-appropriate for our children."*

### **Areas where there are fewer resources available**

The area of drug education where staff report having the fewest resources New/Novel Psychoactive Substances (NPS). Where this topic was being taught, respondents were asked to comment on how they had referenced NPS in lessons. A wide range of comments were supplied ranging from input from the police or school nurse, assemblies combined with "Talk to Frank" signposting to more planned approaches.

Secondary school teachers made the following comments about their NPS resources:

*“The North Lincolnshire adolescent lifestyle study is completed every three years; 50% of pupils in the county take part. This is a great basis for planning for pupil need.”*

*“Feedback from Safer Schools partnership team and Met Police crime data.”*

*“Specific lessons on legal highs such as spice and the effects this is having on people.”*

*“Additional targeted session at holiday time, included brief outline of the law and the effects this is having on people.”*

*“We do lessons on them (NPS) in Year 8 and 9, include them in Year 10 and 11 and mention [them] in Year 7.”*

*“As part of planned programme – since 2014.”*

*“External drugs worker Years 8-13 every year.”*

There were also a few comments suggesting a lack of confidence in delivering lessons on New Psychoactive Substances or were taking a ‘fire-fighting’ approach:

*“In discussion we found they know more than we do.”*

*“Briefly via our PCSO visits; however, this is not for every year group and mostly via a one-off assembly when we realised this had become an issue in the local area in previous years.”*

Many of the comments included the use of external support from either the police or local drug workers with fewer taking a planned approach using local data to support the planning of input.

## **External support for alcohol and drug education**

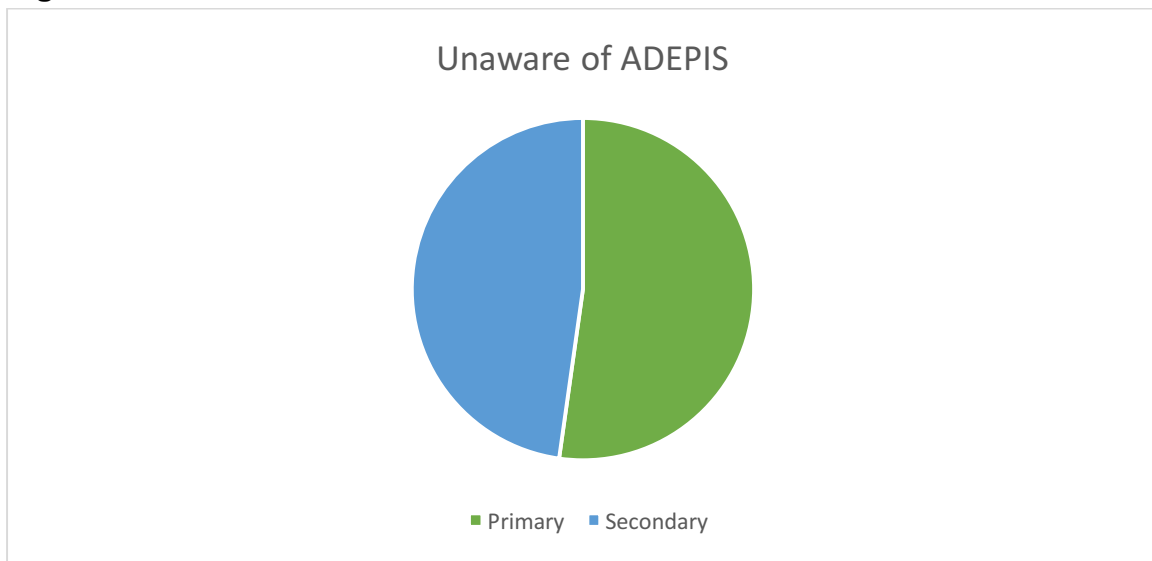
Most respondents had access to external resources; the most widely used is the “Talk to Frank” website (49%). Local authorities, the Police and the PSHE Association were used at a similar level.

Interestingly, only four primary schools reported that they had used their local Life Education Centre; the low rate of access to these centres was also raised in discussions with primary school teachers:

*“In the past we would have the Life Education Centre in school every two years. The children enjoyed it and we could deliver some additional lessons, picking up on the themes covered. The cost is now prohibitive for us, so we don’t use it at all.”*

When respondents were asked if they were using Mentor-ADEPIS resources, the majority 82% of primary schools and 75% of secondary schools were unaware of Mentor-ADEPIS. This lack of awareness was evident during both interviews and focus groups.

**Fig. 15 Awareness of Mentor-ADEPIS resources**



During focus groups with both primary and secondary staff, the Mentor-ADEPIS website was shared and, without exception, the groups were impressed with the resources available and the easy navigation around the site. There was some disappointment that they had been previously unaware of ADEPIS.

*“This (Mentor-ADEPIS website and resources) would be really useful to us. Could it be part included in the Healthy Schools website, so we have regular reminders?”*

*“I would have used the lesson plans, they could have enhanced some of the work we did with KS3, especially the social norms project with year 9”*

*“I’m always looking for new ideas, this would have saved so much time!”*

*“I was not aware of ADEPIS, possibly more publicity.”*



In the small number of cases where teachers had accessed Mentor-ADEPIS resources, feedback was positive; however, there was also an indication of the time and financial constraints facing teachers in the feedback.

*“We used the smoking, marketing etc. with Year 9; the PPTs (PowerPoint presentations) were a good starting point but we did not use any of the supporting resources because of cost and time of copying.”*

*“Mainly advice on policy writing as we have a parenting support team in school. I have shared some of your material with them. It is very difficult to read through lots of ‘good practice’ material in the current teaching climate – yours is great (I have a day I can do this in – my ‘AST day’) but for your average 5 day a week teacher/PSHE lead, it could possibly be shortened and made a bit more user-friendly.”*

### **In which areas do you need more resources?**

Respondents were asked to identify the areas where they felt that additional teaching resources would be helpful; respondents from both primary and secondary schools indicated that additional information on New Psychoactive Substances would be useful. In addition, respondents from both primary and secondary settings placed links between drugs (including alcohol) and personal safety and/or mental illness in their top five areas requiring additional resources.

Areas requiring additional resources	Primary	Secondary
1	New Psychoactive substances (76%)	New Psychoactive substances (76%)
2	Links between drugs/alcohol and personal safety (59%)	Links between drugs/alcohol and mental illness (67%)
3	Practicing assertiveness skills (53%)	Links between drugs/alcohol and personal safety (56%)
4	Thinking critically about media and drugs/alcohol (53%)	Accurate data about peer behaviour in relation to drugs & alcohol (55%)
5	Links between drugs/alcohol and mental illness (53%)	Links between drugs/alcohol and sex and relationships (47%)

When respondents were asked about the support they wanted from Mentor-ADEPIS, classroom resources were cited by 69% of primary schools and 81% of secondary schools, followed by staff CPD for primary schools and policy updates from both primary and secondary respondents.

These responses are somewhat arbitrary as both sectors are generally unaware of the resources that are currently available from Mentor-ADEPIS, which currently include classroom resources, policy updates and an online CPD course. In the case of CPD, the issue would be whether schools were prepared to pay for staff training or any other resources they identified as being required.

When asked about willingness to pay for resources the majority of schools responding didn't know if their settings would pay for resources. Secondary schools were more likely to state "yes" or "possibly" with regard to payment with classroom resources and CPD for PSHE leads received the most positive response.

### **Staff access to quality CPD for drug education**

To ascertain if schools were able to access CPD either internally or from their local authority, respondents were asked to provide feedback on any CPD they had received, specifically in relation to alcohol and drug education. They were also asked to say how and where they could access good quality CPD.

Fig. 16 demonstrates that just over half of respondents would know who to approach from their local authority to find out about CPD for alcohol and drugs education. Regarding the delivery of this CPD, it appears that the majority (80%) disagree or don't know if their local authority can provide quality CPD for alcohol and drugs education, and 70% feel the same with regard to CPD for PSHE more broadly.

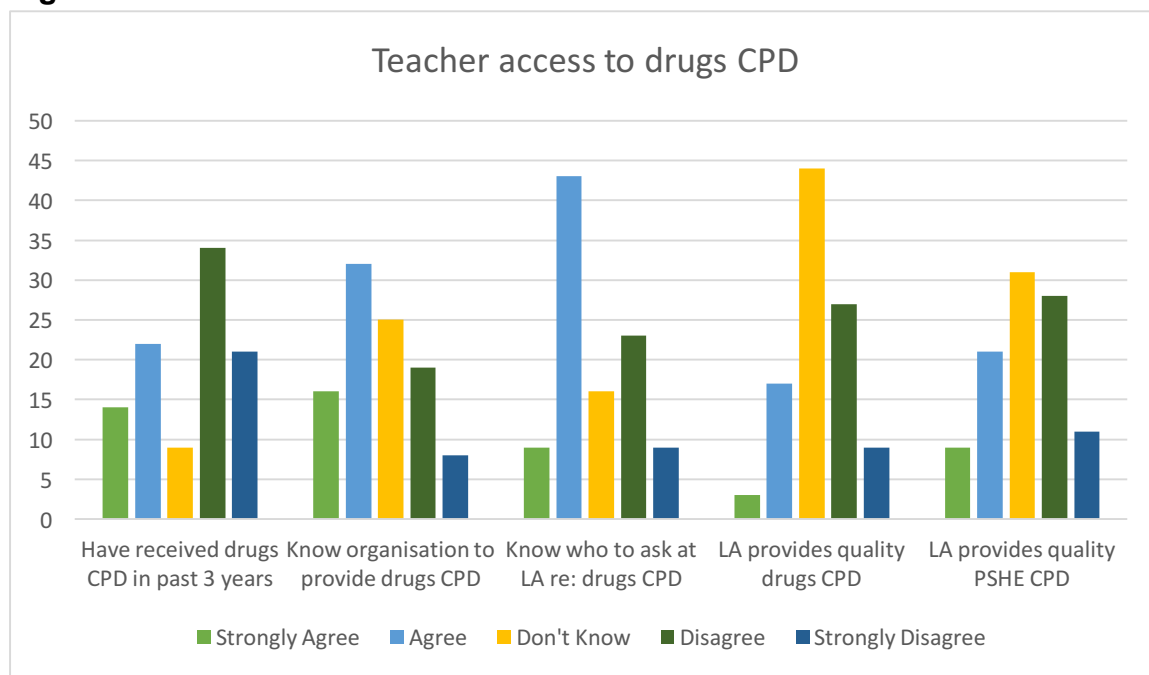
Only 36% of respondents reported that they had received any CPD within the past three years. Responses suggest the changing face of alcohol and drug support from local authorities had impacted the availability and/or quality of CPD:

*"A few years ago, we were able to regularly invite our local drug service into school to deliver lessons, the students enjoyed the sessions and got to know the team. Now, we can refer students with problems to the service, but there is no support or information provided more generally."*

*"Our local authority provided very good CPD on everything from eating disorders, to self-harm and of course drugs and alcohol. I think there are still safeguarding courses but everything else has stopped. We've looked for external courses, but most run in bigger cities and are expensive."*

*"We don't even have a healthy schools team anymore and that was always the main way we heard about local training courses. As a team we do our best to put together relevant lessons and rely a lot on what we can find online. I will be sure to look on the ADEPIS website."*

**Fig. 16 Teacher access to CPD**



### Future contact

Most secondary school respondents confirmed that they would like to receive the results of the survey (84%) and would be happy to be contacted in the future to complete another survey (90%). Almost all (96%) secondary school respondents requested updates from Mentor-ADEPIS. Primary school respondents were far less interested in either the survey results (53%) or being contacted in the future.

However, the number of primary school respondents was small, so care must be taken with interpreting the data.

### PSHE Association membership

Respondents were asked to state whether they were members of the PSHE association. Only 27% of primary respondents were members, with this figure rising to 54% among secondary school respondents.

### Feedback from non-school-based respondents

In general, the responses from non-school-based respondents were more positive in relation to alcohol and drug education and its relative importance than those based in schools. As a result, these settings seem to have addressed some of the areas of concern raised by schools, such as: accessing resources; feeling prepared and able to deliver sessions; and being confident in quality standards and evidence-based approaches.

Non-school-based respondents were also much more likely to be aware of, and have used, Mentor-ADEPIS resources. There were 52 non-school-based respondents, 35

of whom went on to answer the parts of the survey relevant to them. Half were involved in delivering PSHE lessons at both a universal and targeted level and 55% were involved in the referral pathways. In common with teachers, the majority cited 'national events and trends' as a key source for planning lessons. All were aware of New Psychoactive substances and 78% had updated their drugs policy to include this area. 89% referenced NPS in drug education lessons.

When asked to provide detail on the input they provided to schools in relation to drugs and alcohol, the following comments were recorded:

- "Targeted lessons as requested by school"
- "Hour-long session to all Year 11 students"
- "Part of overall drugs and alcohol delivery across school"
- "Use a social norms approach to deliver messages"

As with schools, this group reported that NPS and volatile substances were the areas lacking in resources; however, one respondent had delivered training on NPS and signposted trainees to the Mentor-ADEPIS resources on NPS. In line with schools, 35% of non-school-based respondents did not assess any learning or progress of students.

The most important criteria for effective lessons echoed those cited by schools. The key difference within this group was their awareness and use of Mentor-ADEPIS and as such they were in a better position to comment on additional support or resources required to support alcohol and drug education.

When asked to comment on the resources used, respondents made the following comments:

*"The [Mentor-ADEPIS] service is excellent."*

*"[We use] briefing papers to keep school and us up to date."*

*"I use the quality standards in staff training and always use the briefing papers to keep up to date."*

*"I have used multiple resources from the Mentor-ADEPIS website."*

*"I have used multiple resources from the Mentor-ADEPIS website to support schools in my local authority area. The resources are of a very high standard and linked to the best research in the field. CAYT is an excellent resource and the Quality Standards for Drugs Education have been integral to my role in training teachers."*

The areas where this group felt additional resources would be useful were:

1. Links between drugs, alcohol and mental health (81%)
2. Links between drugs, alcohol and personal safety (75%)
3. Links between drugs, alcohol and sex/relationships (63%)
4. Thinking about values, attitudes and long-term goals (56%)
5. Giving pupils a more realistic view of how many of their peers use illicit drugs, alcohol and tobacco (50%)

The group of non-school-based respondents also said more resources to use in school, as well as more frequent policy updates, would be useful. One respondent asked for “*more on harm reduction*”. Other comments included:

*“What we have found is that we can utilise best evidence, provide guidance, training etc. but still very ‘silo’ thinking – alcohol/drug/tobacco topic could be more mainstreamed into wider curriculum and not just within health/wellbeing or PSHE. This would require some real investment in time, energy and most important of all – confidence. We continually still see a lack of confidence in tackling this area due to perceptions of it being ‘specialist’ and complex. By demystifying some of this and looking at student attitude/values/skills it could be perceived to be simpler to deliver – but time within the curriculum is pressured – probably why schools rely so much on outside influence.”*

*“An important area of focus for me is to help schools understand the benefits and importance of evidence-based approaches for drugs and alcohol prevention.”*

There was some evidence of good practice in local authorities where support for schools was still in place. For example, the Borough of Poole is currently trialling an “all-through” PSHE scheme, providing comprehensive coverage of the PSHE programme of study for all children in schools across the borough from early years to age 16. This is further supplemented by offering schools support from local drug and alcohol services, training in mental health first aid and ongoing consultations with young people. There is also a dedicated local website signposting young people to local support services.

Leicestershire County Council work with commissioned services to support children and young people with universal provision of PSHE, through termly network meetings and specific training on Relationships and Sex education, coupled with targeted and universal mental health support. A young people’s hub and the online platform ‘Wellbeing Cloud’ also provide signposting to local services.

In both Poole and Leicestershire, there is a holistic approach to health and wellbeing and to PSHE education, with both universal and targeted support available. There is also a focus on consultation with young people. However, even where a good level

of local authority provision is in place to support schools, it does not always follow that schools will seek or access this support. Local authorities commented on the difficulties they experienced in engaging with schools:

*“Schools ask us to provide resources and then, when we do, they don’t use them, or they don’t give them the time required to be effective.”*

*“We are often called in to provide training when things have gone wrong. The training is the same training that has been available all along and, in all likelihood, could have prevented the current disaster if it had been taken up earlier.”*

The survey asked respondents if they had any resources they would be happy to share; two provided details:

*“Policy guidance – PSSHE section [www.surreyhealthyschools.co.uk](http://www.surreyhealthyschools.co.uk)”*

*“Curriculum for Excellence based local policy, NHS Grampian.”*

However, one respondent stated:

*“At the moment, no, all public health and local authority funding for prevention education has been cut off in Staffordshire since last year”*

This comment reflects the feedback from some teachers in relation to the changing level of support from local authorities and further emphasises the inconsistency in drugs and alcohol support available to schools across England.

## **What do children and young people think of their alcohol and drug education?**

To supplement and enrich the data collected from the online survey and from teacher interviews and focus groups, a number of further consultations were held with children and young people. In total, 64 school-age children and young people were involved in focus groups with a further nine members of the Mentor Youth Panel were consulted. Focus groups met in Oxfordshire, Wiltshire, Dorset and Birmingham, with attendees representing a range of schools, including a girls-only school, a faith school and both medium and large comprehensive schools. All students attended state schools in urban areas.

Fig. 17 provides a brief summary of the groups involved and some details of the methods used to gather insight on students’ experiences and views of drug and alcohol education.

**Fig. 17 Summary of Children & Young People Interviews**

Group	Age range	Activity/interview style	Areas addressed
1	Secondary Year 7-11 (KS3 & 4, age 11-16)	Semi-structured group discussion by key stage on set questions, followed by feedback to full group. Led by Youth leader.	Own experiences; lessons received; views on internal/external delivery.
2	Secondary Year 9 (KS3, age 13-14)	Semi-structured group discussion led by facilitator.	Own experiences; lessons received. Focus on drop-down delivery.
3	Primary Year 6 (KS2, age 10-11)	Transition workshop. Co-led by facilitator and secondary school students from Year 9.	Concerns about secondary school; perceptions of substance use; lessons received at primary school.
4	Primary Years 3-6 (KS2, age 7-11)	Semi-structured group discussion co-facilitated by PSHE lead.	Experience of drug/alcohol education as part of wider project.
5	Secondary Year 13 (KS5, age 17-18)	Semi-structured group discussion led by facilitator.	Experiences of drug alcohol education at KS5 compared to KS3/4
6	Mentor Youth Panel (aged 18+)	Group activity, working in pairs on questions (from online survey), followed by feedback to full group.	Reflections on own experiences using questions from on-line survey as focus.

Where there were mixed age groups the students were placed in groups according to Key Stage. Students were given questions to discuss and flip-chart paper to write comments. They were then asked to give feedback to facilitators, and further questions were asked if appropriate. In the case of group 4, the mixed primary school group, the PSHE lead in school led a discussion with students taking turns to answer, share views and give examples of their experiences of the project being run in school.

The feedback was mixed, with some examples of alcohol and drug education that children and young people find useful. Two key themes that emerged most strongly were the inconsistency across settings and the lack of consultation with young people about the content of the education they would find useful.

### **Group 1 – Secondary school, mixed group**

This focus group consisted of students from Years 7-11, conducted in four different primary schools. The group included a newly elected member of the UK Youth Parliament (from Year 10) who had been tasked with gathering feedback from peers

to feed into the session. The discussion was co-facilitated by a local authority employed youth worker responsible for student voice and the youth parliament members. The group was split by Key Stage (3 and 4) with both groups discussing a set of questions, making notes of their experiences on flip chart paper and feeding back to the wider group.

It quickly emerged that there was a significant difference in experiences of alcohol and drug education between schools, as well as between the attitude and maturity of the students.

In Dorset, for example, there is still an active local drugs team what work with schools providing both universal and targeted support. The young people were complimentary about this group and felt they were more useful than for example, theatre workshops or external speakers.

*“We’ve not had any drugs or alcohol education in Year 7. We were supposed to be doing something, but the teacher changed her mind and did something else instead.”*

(Year 7 student)

*“We’ve had a lot on smoking and also did this at primary school. I think it’s because so many Year 10s smoke, it’s a big problem in our school.”*

(Year 8 student)

*“I think most of the Year 10 boys smoke weed, [school] needs to do something about that.”*

(Year 7 student)

*“We had [an external provider] in school to run a session, it was awful.”*

(Year 10 student)

*“One to one is much better but hard to access unless you’re caught with drugs.”*

(Year 11 student)

*“There needs to be more focus on mental health, that’s what most young people are concerned about. We get to Year 10 and 11 and it’s all about exams and there’s not much PSHE. No-one seems to realise that’s when we need more information not less. I know of young people who are drinking because they’re stressed.”*

(Year 10 student)

*“We want to know more about how normal, average, students are feeling and how many are using drugs and alcohol and why. Scare stories where*



*someone dies are upsetting, but everyone soon forgets about it and thinks it won't happen to them."*

(Year 11 student)

*"Some of us have gone to festivals and it's very easy to access drugs, much easier than alcohol. We need to know more about these situations and what to do if we're tempted."*

(Year 11 student)

*"YADAS (Young Adults Drug & Alcohol Service in Poole) are good, they know how to talk to us."*

(Year 10 student)

The Year 7 and 8 students in the group reported that they had received very little teaching on alcohol or drugs as part of their PSHE lessons; however, they reported having done some work on smoking, as well as regular (weekly) PSHE lessons.

Students tended to have exaggerated perceptions of the number of students smoking tobacco and cannabis. When asked what they based their views on, it was usually anecdotal experiences rather than on any local or national data. This may be an example of how the informal knowledge used by teachers to plan alcohol and drugs lessons translates to student misperceptions of peers' behaviour. If schools were to engage with students to collect behaviour data, there would be an opportunity to challenge misperceptions more effectively.

By contrast, the Key Stage 4 students in the group, which included the member of the UK Youth Parliament, gave more balanced views and displayed a far greater level of maturity. They acknowledged that there had been some useful alcohol and drug education over their time at secondary school; however, it tended to be sporadic, without making connections to what they were going through in their lives. The Youth Parliament member's canvassing of peers highlighted mental health as a key concern, with some anecdotal examples of a few students attempting to manage stress by drinking alcohol. There was also a widespread assumption that alcohol and drug use is more prevalent among boys.

### **Group 2 – Year 9 students**

This group of Year 9 students (5 girls and 4 boys), reported that the only alcohol and drug education they had received since starting school was a full "drop-down" day where they were off timetable and a range of external agencies provided the entire year group with activities. The students were split into smaller groups which each watched a play and participated in various workshops. The students were fairly scathing of this type of activity and suggested that some students didn't come to school on the day, although most did, because of their previous experience of such events.

*“The main thing I remember was the scare tactics play. It was about a girl being exploited and they (the external organisation) said it was based on true story. She was given drugs and alcohol by an older man because she wasn’t happy at home.”*

*“The whole day was about the effects of alcohol on your future and how much it could be a problem.”*

*“Not much on drugs and I can’t remember what they said, just don’t use them, they will ruin your future.”*

*“Didn’t ask us for our views we were ‘talked at’ by the trainers.”*

*“There has been no follow up, would be better if spread out across the year.”*

*“We completed a questionnaire afterwards, it asked what we thought of the day.”*

*“No-one took it seriously.”*

*“We worked in friendship groups, so it was basically a day of mucking around.”*

The group were surprised that there was almost no drug education had been included in the day as there had been several drug-related incidents as early as Year 7 – including a small group of students regularly posting videos of their drug use on social media. Two members of the group in question were moved to alternative provision.

The students gave the impression that they were more aware of drug use in their setting and the need for some input to address, this than the school were.

The students confirmed that there had been no follow-up from the drop-down day and no subsequent drug or alcohol education since the one-day event. Additionally, there had been no feedback on the results of the questionnaire they completed, despite there being regular “social education” i.e. PSHE classes.

### **Group 3 – Year 6 students**

A transition workshop (to prepare students for secondary school) was completed with a group of 24 Year 6 pupils in the 2017 summer term. During the workshop, the group took a short quiz that tested their perceptions of the behaviour of secondary school students, including questions on alcohol and drug use, smoking and bullying. The pupils had shared their worries about starting secondary school with their

teachers; these included concerns about being bullied or coerced into smoking, as well worries about getting lost.

The workshop was co-facilitated with a group of Year 9 students from the secondary school where most of the Year 6 pupils would be going. The Year 9 students, all of whom had formerly attended the primary school, had completed a social norms project and, as such, were well informed on the behaviour of their peer group.

Interestingly, the primary school students had more accurate perceptions on the behaviour of Year 9 students than the older group did when they were previously surveyed as part of the project. The Year 6 students were able to discuss their concerns with the older students in small groups and, when asked about their own alcohol and drug education, it was clear that the school had invested some time in PSHE lessons, particularly in relation to alcohol and smoking.

*“We learned that smoking in the UK has gone down and less people are dying of heart attacks.”*

*“Smoking is very expensive, smokers could go on a cruise if they didn’t spend the money on cigarettes.”*

*“Alcohol is more dangerous than drugs.”*

*“The rules about alcohol are complicated, but young people shouldn’t drink at all until they are at least 16.”*

*“If we see anything unusual in a playground it’s important not to touch it.”*

The children were able to recite lots of safety and health related facts around smoking and alcohol, and knew a little about drugs and medicine safety. In terms of making their own choices around risk, they were less certain; some said that to be part of a particular friendship group, it may be necessary to smoke. Despite being aware of reduced levels of tobacco smoking, particularly amongst young people, the perception that significant numbers of secondary school age students smoke tobacco persists. The older students were able to confirm that in fact this is not the case and, through their social norms project work, had learned that 95% of their year group did not smoke.

The school had used resources held on the local authority’s Healthy Schools website to develop some lessons; however, the school reported that they had found it difficult to access age-appropriate materials about drugs other than medicine safety.

PSHE delivery more generally was based on lessons produced by school and the PSHE lead acknowledged that the lessons were predominantly learning about health

facts rather than developing the skills, values or attitudes necessary to successfully manage risk.

#### **Group 4 – Primary school, mixed group**

This session was co-facilitated by the PSHE lead and pupils ranged in age from 8 to 11. This Birmingham school promoted its values strongly which included “caring for ourselves and others” and “making good choices”.

The school followed the international primary curriculum, which doesn't include PSHE; however, the school had a planned programme of PSHE by year group throughout the year. A chart was displayed in the staff room detailing PSHE lessons being delivered each term. At a glance, everyone could see what was being delivered that week and if there was any theme for the term.

The school took a novel approach to alcohol and drug education in that they linked it to the fundraising they did for a local homeless charity. Linked to the values mentioned above, lessons were based around choices people made and the consequences this could lead to, but also considered the things that could go wrong in life and why poor choices resulted. Children were challenged to empathise with this and think about what they could do to support themselves when they had tough choices and also what they could do as individuals to help others.

*“We try to make good choices and look after our health, not eat too many sweets and my dad is trying to stop smoking, again.”*

(Year 3 pupil)

*“We can care for others by giving them money, we gave them (the charity) enough money for a new food cart.”*

(Year 5 pupil)

*“We learned that sometimes when people are very sad or lonely they can make bad choices. Sometimes it's drinking too much or taking drugs, but they can get better again.”*

(Year 4 pupil)

*“If I'm sad or annoyed I might want to eat a big bar of chocolate, but then I think, it's better to talk to [my friend]. We can share the chocolate.”*

(Year 3 pupil)

*“Our teachers volunteer to help at the homeless shelter, they tell us how good it feels to help others.”*

(Year 6 pupil)

This school's approach was interesting; rather than just providing lists of facts, it linked values to lots of areas covered by PSHE, including alcohol and drugs. From an early age, children were able to explain choices, risk and consequences in an age-appropriate way, and they were non-judgemental about themselves or others. The school are making subtle links between mental health and actions, by demonstrating that fundraising and volunteering can help you feel good, and that feeling sad can lead to poor choices around alcohol and drugs, which can have serious consequences for some people.

### **Group 5 - Key Stage 5 students**

The results of the online survey show that most schools provide some alcohol and drug education to Key Stage 5 students. A group of six Year 13 students (four girls and two boys) were invited to share their experiences of alcohol and drug education in Key Stage 5.

As part of "life skills" sessions, which they were expected to attend every fortnight, a range of topics were explored, including university applications (to which a considerable proportion of time was devoted) and personal safety. The main focus of their drug education was a talk, delivered by an addict in recovery who now worked for the external agency used by the school. Following the initial talk, the drug education worker was available for drop-in sessions on a regular basis throughout Key Stage 5. There were also some talks on alcohol use and sexual health. These were delivered by the head or deputy head of sixth form.

*"They (head/deputy head of sixth form) weren't so bothered about drinking. I think they thought everyone was drinking anyway. As long as it didn't stop us being in school they didn't care if there was a lot of drinking going on."*

*"The most ridiculous thing they did was having that drugs worker in school, the boys group (this was a group of boys regarded as 'cool') thought he was their mate and would go and see him whenever he was in school. I'm sure they took more drugs than ever before after that."*

The group reported that recreational drug use was common among Key Stage 5 students, particularly (but not exclusively) by boys. There were examples of significant drug use at festivals and weekend parties, where a range of substances would be taken. When asked about actual numbers engaging in regular recreational drug use, it was in fact a small percentage of the year group; however, as numbers in the entire Key Stage were fairly small (approximately 200), behaviour of individuals was apparently well known.

Alcohol use was reported as almost universal, with very few known non-drinkers. There was some indication that alcohol, and possibly other drugs, were being used to self-medicate a range of anxieties and other mental health issues. One group of

students, unflatteringly described as “the mental health group” but were, in fact, popular and well-liked, were expected to achieve at a very high academic level. A number of them were also suffering from a range of problems, including depression, self-harm and generally finding it difficult to cope. This particular group had generally been perceived as quiet, well-behaved students prior to sixth form, but were now regularly partying and drinking heavily.

*“I would never have believed that she would have ever got in such a state, if any of us had done that (i.e. being sick at a school organised Christmas party) we would have been in so much trouble. I guess [the head of sixth form] treats her differently because she’s so clever.”*

*“I feel sorry for him, but drinking until you pass out every weekend isn’t going to help, he’ll end up in hospital or worse.”*

The group described the strong push by school to achieve academically but felt that there was little support for managing stress. They acknowledged that their personal ability to manage emotional health varied greatly and on the whole, most were feeling some pressure.

This echoes the comments made by Key Stage 4 students (from a different school), and also reinforces a need for resources that make connections substance use and mental health issues, as identified by some teachers.

### **Group 6 – Mentor Youth Panel**

Mentor’s Youth Panel consists of young people between 18 and 24 years old. It was valuable to work with this group as they were able to reflect on their experiences of alcohol and drug education from the perspective of young adults. As such they are able to identify if the education they have received has been of use in their current young adult lives, or if there were gaps that have been detrimental to them and / or their peers.

The group were asked to consider some of the questions teachers answered in the online survey and the comments below reflect their feedback. The comments from this group were very similar to secondary school age students, suggesting that not much has changed in recent years with regard to alcohol and drug education. The group had greater knowledge of alcohol and drug education and commented more vociferously on the “marginalised” position of alcohol and drug education.

*“We didn’t get much PSHE but there was some. The bits that always got dropped when there wasn’t enough time was drugs education.”*

PSHE was delivered using a range of methods including assemblies, tutor time and occasionally weekly lessons; however, these would often be replaced by other subjects at the school's discretion.

Views on external agencies supporting alcohol and drug education were mixed, with some of the group feeling this was beneficial, while others were less convinced about the quality and impact of this kind of input (such as theatre workshops or talks from addicts in recovery). There was also a variation in views depending on the settings the group were familiar with.

*“Primary schools need drugs education too, I've worked with children of six years old who got into a violent argument over their mother's drug use.”*

One group member had not encountered, or had knowledge of, much drug or alcohol use in their school and therefore questioned the need for alcohol and drug education in all settings. This was followed by the suggestion that alcohol and drug education may be more important in more deprived areas, which given the pervasive nature of substance misuse across the country, suggests some worrying misinformation.

It is probable that many people are likely to have views in relation to alcohol and drug use that are both misinformed and stereotypical. It is therefore beneficial to recruit young people from a wide demographic to the Mentor Youth Panel, in order to better explore and understand common misconceptions.

None of the youth panel members could confirm that their experience of alcohol and drug education had been positive, well-planned and / or comprehensive. In addition, there had been no experience of being consulted on the content of alcohol and drug education, or being assessed on their knowledge or skills while at school.

Some members of the group felt that there was more information and signposting available at university compared to in school; however, many still felt it was insufficient.

In common with other student groups and teachers, youth panel members agreed that making alcohol and drug education engaging was a high priority; it should also be factual and up to date. This group was very aware of the links between mental health and substance use and agreed that this was important to include in PSHE lessons. Everyone agreed that all of PSHE should be statutory, including alcohol and drug education.

When asked about what would be most useful regarding alcohol and drug education, the group felt that being able to manage risk was important and also receiving sufficient signposting to other resources, so that additional advice and support could be accessed if necessary. It was also suggested that knowing what to do to support

friends if they had problems with drugs or alcohol, either as a result of on-going over-use or an acute one-off situation, would be very useful.

*“Knowing what to do in an emergency (with regard to drugs or alcohol) should be something everyone knows about from a young age.”*

## Recommendations

### **1. Discuss with stakeholders the key findings identified on page 2, 3 and 4.**

Given the forthcoming curriculum changes around relationships education, relationships and sex education and PSHE, there are a number of important messages for PHE, the Home Office, DfE and the PSHE Association.

### **2. Build awareness of the ADEPIS website and resources.**

Where teachers and other professionals were aware of Mentor-ADEPIS, they were very complimentary about the resources and acknowledged how useful they would be in their practice. It would therefore be useful to increase awareness of Mentor-ADEPIS within the target group. A useful first step may be to focus on secondary schools and professionals working within local authorities.

### **3. Build on the existing “fan base”.**

The respondents from secondary schools and non-school settings almost universally stated that they would like the results of the survey and to be kept up to date. It may be a good first step to start to build relationships with this group by thanking them for their input, feeding back how their input has been used, for example *“you said, we did”* and also give them some information on what young people told us.

Focussing on how you can solve the problems they identified (where possible) would show that Mentor-ADEPIS listens to, and acts on, feedback.

Targeting Healthy Schools and other local authority professionals to spread the message may be another useful strategy.

### **4. Offer a (virtual) networking service for the “fan base”.**

This could simply be a short group email with updates and a reminder that they can get in touch with questions.

### **5. Increase uptake of survey.**



Despite the survey link being sent to over 19,000 contacts, the response rate was disappointingly small; this made it difficult to interpret data with any degree of confidence. The involvement of a specialist educational marketing company led to more than doubling the original response rate, however, it still did not reach the target figure of 300 respondents. It may be worth considering incentivising respondents in some way to increase uptake.

#### **6. Begin planning for 2019.**

Consider what you would like to measure in the 2019 survey in order to put some actions in place now that can be built into the next survey.

## **Concluding Remarks**

This is the third evaluation report completed since 2013. There are some findings that are consistent with previous reports, including: teachers reporting time constraints; lack of support and (in primary schools particularly) a lack of confidence to deliver alcohol and drug education. Teachers also raised concerns about accessing high quality classroom resources and CPD.

Some additional and different insights have also come to light as a result of including young people, as well as consulting with more teachers in focus groups and interviews in this evaluation. Novel Psychoactive Substances is the area most commonly reported as being of lacking in teaching resources – this was not addressed in the 2013 survey. Teachers also report greater levels of concern regarding access to CPD, indicating the continuing reduction of support across many local authorities.

Young people echo teachers' concerns over the lack of resources, as well as a lack of provision around the connections between alcohol and drug education, mental health and other aspects of PSHE. Young people also report that they want to be more involved in the planning of their alcohol and drug education and to receive input that is relevant to them, including normative education that dispels the myths surrounding drugs and alcohol.