# FROM INFORMATION TO MORAL ISSUES: DILEMMAS IN DRUG EDUCATION

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SYNOPSIS

Notable proportions of school-age young people are misusing substances that have health-related effects and risks (alcohol, tobacco, toxic inhalants, and a variety of drugs - many of them illegal in different parts of the world). In the UK, most publicity is given to the harmful effects of illegal drugs (such as cannabis, cocaine, crack, ecstasy, heroin, LSD) and less attention is paid to the health risks associated with other drugs – tobacco and alcohol – partly because they are considered more socially acceptable than illegal drugs.

Drawing on their major research projects on drug and sexual health education since 1995, the authors explore some of the problems that teachers face and ways in which initial and inservice education could provide better support for teachers. Some of the dilemmas teachers face in drug education are common to other areas of the curriculum such as sex education that require sophisticated pedagogic skills and where teachers' personal values can be in conflict with those of pupils.

## THE UK CONTEXT

### PUBLIC IMAGE

In the UK, the term 'drugs' tends to be interpreted by the general public as referring to drugs that are generally illegal. As in most other parts of the world these include cocaine, crack, ecstasy and heroin. The possession of cannabis is also illegal although there are campaigns to have it legalised and most recently, trials have begun to use cannabis to relieve pain in certain chronic medical conditions. The official UK position is that cannabis is illegal and its use is likely to promote addiction to harder drugs. However, evidence suggests that smoking tobacco which is not illegal, is an indicator of later use of 'hard' drugs, of alcohol and other health risk behaviours (West and Sweeting 1992) and also as a 'marker' of disengagement from school and the academic track (Sweeting and West 2000). It is illegal for young people under the age of 16 to purchase tobacco and for those under 18 to buy alcohol. It is illegal to knowingly sell substances to someone under age 18 for inhalation. What is evident is that, although there is substance misuse by young people, the incidence of illegal drug use tends to be exaggerated in the media and therefore, by the public. At the same time, the importance of other substance misuse, especially alcohol, is less likely to make the headlines and the ill effects are underestimated.

### INCIDENCE OF DRUG USE

Despite the legal position, many young people clearly have access to all kinds of drugs. Most of the data are based on studies carried out at school and will therefore not pick up the approximately 10% of pupils likely to be absent on any one day.

#### *Tobacco*

Our drug surveys among pupils aged 10 - 17+ show that some of the youngest pupils are smoking regularly. In 1999, 3% of 10 year olds, 4% of 13 year olds, 13% of 15 year olds and 19% of 17 year olds reported smoking tobacco at least once week. These overall figures remained constant over two years 1997-1999. Among secondary pupils, 62% of regular smokers were girls compared with 38% boys in

1999 – a slight increase in the proportion of girls over two years. Access to tobacco is partly through shopkeepers ignoring the law and partly as young people told us in other studies (Lowden and Powney, 1994; Cartmel *et al* 1999) that they are given cigarettes by their friends, siblings and sometimes their parents.

*Alcohol*

Regular alcohol drinking among pupils far outweighs any other substance misuse. In 1999, 15% of 11 year olds, 17 % of 13 year olds, 47 % of 15 year olds and 75% of 17 year olds reported drinking alcohol at least once a week. These figures represent a slight decrease over the period 1997 to 1999,

*Solvent use*

ISDD trends (January 2000) indicate that between 6 and 20% of school children have used solvents depending on age and location. The same source records 73 solvent related deaths in 1997 compared with 11 ecstasy related deaths. Our surveys show that inhalant use peaks at the S3 age group with about 11% reporting use.

*Illegal drugs*

The majority of young people do not use illegal drugs and are against their use, even though most of the older pupils have been offered them. Older secondary pupils are more tolerant of cannabis use that is perceived as being less harmful than other illegal drugs. 23% of secondary pupils (predominantly those who are over 15 years old) reported misusing illegal drugs – almost always cannabis. As mentioned earlier, those pupils who claim to use illegal drugs are also far more likely to smoke than those pupils who do not use drugs (72% compared with 29%).

These figures broadly correspond with other UK studies (e.g. HEBS 1997, SHARE 1998, Todd et al 1999). They reflect the steady increase in the acceptance of certain drugs by users and non-users as 'a taken for granted facet of youth culture' (Coggans and Wason 1995).

The crucial period for becoming involved with drugs seems to be around the age of 13 to 14 when there is a steep rise in use. There is consensus among various longitudinal surveys (Balding 2000, ISD 1999, Lowden and Powney 1999, Goddard and Higgins 1999b) that about one per cent of 11-12 year olds will have used drugs in the last month. This increases to about 7% of 13-14 year olds and 29% for 15 to 16 year olds.

## DRUG EDUCATION IN SCHOOLS

Against this background of various substance use, Scottish schools offer a drug education that aims to both provide information and promotes pupils' decision-making skills. Drug education, in this context means school-based content that is systematically time-tabled into the curriculum and targeted at young people with the intention of having an impact on their health behaviours, attitudes and knowledge about the use of alcohol, tobacco, inhalants and illegal drugs.

Teachers have a variety of published materials at their disposal and most teachers tend not to follow these systematically but to use parts of them perceived to be most appropriate for the class and for the theme being addressed (Lowden and Powney 1999). This dependence on published materials indicates that drug education is currently driven by the resources available rather than an explicit health theory or approach.

Education specifically related to drug education is increasingly being provided for more younger pupils but many teachers feel uncomfortable about teaching children younger than 11 about drugs. Nevertheless we know that primary school teachers are

likely to talk about safety in relation to medicines and probably their unwillingness to teach younger children about drugs is that they are equating drug education with illegal drugs and less so with smoking, inhalants and alcohol.

In secondary schools, drug education occurs predominantly within the Personal and Social Education (PSE) curriculum. PSE lessons occur about once a week throughout the secondary school. Work is not assessed and the curriculum includes many other areas such as sexual health education, family and other relationships, career options and development, nutrition, hygiene and other topics related to life skills. This area of the curriculum is consequently in danger of being over-loaded.

Many schools in Scotland also invite outside agencies to support the drugs education programme by provide services with a training and teaching input into pupils' school drug education. In order of prevalence the agencies used are: the police, local health boards and drug agencies. An alternative policy taken by some health promotion departments in Scotland is to use external support to improve teachers' understanding and skills rather than to work with directly with pupils in classrooms.

## TEACHERS' PERSPECTIVES

Against the evidence of growing use of illegal drugs and of other substance misuse, teachers in drug education indicate they have two major areas of uncertainty. The first is whether or not they have sufficient knowledge of the drugs accessible to their pupils and understand the effects of these drugs on health. Without this knowledge they will not be credible teachers. The second area of uncertainty relates to the complex moral maze that confronts teachers in areas where personal values, professional responsibility and the law interact. There are external requirements and guidance from government and local authorities to support teachers in providing drug education (Audit Unit/ HM Inspectors of Schools 1999, King 1999, SCODA 1999 & 1998, DfEE 1998, SCCC Curriculum File No 9) and advice to deal with drug related incidents on school premises (SOEID 1999). Many teachers, however, lack confidence in their own ability to work in drug education and would prefer to draw on external support from the police and other agencies than to teach classes with whom they may have little credibility in drug education.

## CREDIBILITY

Teachers' lack of confidence in their own credibility and certainly feedback from pupils endorses this lack of teachers' credibility as drug educators (Lowden and Powney 1999). Most teachers lack detailed knowledge and experience of the illegal drug scene. Our evaluations of inservice training (Powney *et al* 1999) also reveal considerable ignorance of the law, of the effects of drugs and of effective methods of teaching in this area among primary teachers . This lack of knowledge was also evident among many secondary teachers participating in our Scottish wide survey of (Lowden and Powney 2000) .

Many pupils know more, or perceive they know more, than their teachers about illegal drugs – their effects, their cost and where they can be obtained. Of course not all pupils are well informed or all teachers ignorant about the topic. Nevertheless, there is inevitably a culture gap between adults and pupils if only due to age differences as well in many cases to different socio-economic status.

## TEACHING METHODS

Teachers' confidence may also be undermined by their perceptions of the teachers' role. If teachers believe they must be expert in the field they are teaching, they are severely disadvantaged especially if they use didactic methods. Our evidence

(Lowden and Powney 1994; 1996; 2000) indicates that providing information is only one aspect of facilitating informed decision making among young people. Pupils are more likely to respond to more flexible teaching methods that increase their own participation and interaction such as in role-play and discussion. Our studies show that relatively little active discussion or participative methods occur in Scottish drug education although pupils clearly enjoy these opportunities when they occur. Videos are often used in lessons with older pupils and not only are these often out of date with the current and rapidly changing trends in youth culture, they are not necessarily followed up with discussion or other activities. This seems a missed opportunity as experience from school based strategies in the USA. (Bosworth,1997; Tobler and Stratton, 1997) suggests that interactive techniques can be used as well in drug education as with almost any other classroom subject and are more likely to be effective than other non-participative approaches.

Where teachers have limited knowledge or skills or they perceive this to be the case then it is comforting to bring in external experts who will take the class and leave the teachers' own self confidence intact. Pupils, particularly those in S3 and older, would also often prefer experts on drugs to provide their drug education. They include in this definition not only health promotion workers, doctors and medical staff but also those with experience of using illegal drugs such as a 'reformed drug addict'. However, many schools are reluctant to use ex-drug addicts for fear that it glamorises the status of illegal drugs. Schools, therefore, are more likely to bring in police and health workers with an interest in working with young people. These external experts can provide helpful frameworks or specialised sessions but there are at least three potential long-term disadvantages in depending on external resources. There is the practical consideration that these services are funded outwith education budgets and are therefore vulnerable to changing priorities in the allocations of police and health education resources. The second difficulty is in maintaining control and coherence in the curriculum with people 'flying in' from outside to provide isolated lessons. The third problem that we have observed is that teachers do not necessarily extend their own teaching repertoires when external specialists visit the schools. This is partly because teachers often withdraw from the session ostensibly to allow a more frank discussion between pupils and experts that pupils appreciate. However, the disadvantage is that teachers do not enhance their own knowledge of drugs and drug related issues. This issue has now been recognised by a number of local authorities and health boards. The result has been an increasing level of training for teachers by health specialists to provide them with the knowledge and sometimes the resources and skills to teach more credible and appropriate drug education. Some of this training reflects what is known about effective approaches to teach drug education but we do not as yet have a comprehensive overview of the status of in-service drug education training for teachers or the impact it has on their skills and pupils' behaviours and attitudes.

### MORAL DILEMMAS

Even when teachers are well informed about drugs and associated social and health risks, dealing with the moral dilemmas involved in substance misuse can raise major difficulties. These are similar in many respects to issues concerning the teaching of sexual health education. Such issues may be based on legal (or quasi-legal) factors or be more associated with conflicts in values between teachers, schools, pupils and their families.

### LEGAL FACTORS

Teachers cannot be seen to promote illegal activities whether this is drinking alcohol

and purchasing cigarettes under age or possessing illegal drugs. Teachers are still regarded *in loco parentis* with responsibility for young people while they are at school. A recent example of the constraints put upon teachers was in the UK wide debate to repeal Clause 28 of the Education Bill that forbade teachers to promote homosexuality in their teaching. The proponents of the Clause seemed to envisage that its removal would mean teachers promoting homosexuality and other non-conventional forms of sexual activity. Our research (e.g. Lowden and Powney 1996) shows that it is more likely that many teachers prefer to avoid any active discussion related to sexual health. Rather than risk infringing the law, some teachers are reluctant to provide basic information – in case parents and others interpret this as encouraging illegal behaviours or sexual promiscuity.

Pupils are realistic about the legal constraints upon teachers and will not confide in them. *If I tell the teacher she will have to do something about it* (*op cit*.) seems to be the attitude of pupils who desperately want advice, such as pupils under 16 wanting contraceptive advice or needing help about their drug use.

## LEGISLATION, EXHORTATION AND ADVICE FOR TEACHERS

To counteract illegal drug use there was initially a JUST SAY NO campaign to encourage pupils to refuse illegal drugs. Education authorities have recognised that this policy has not worked, particularly for the most at risk groups of pupils, Drug education approaches have moved on to an informed decision-making approach that emphasises the provision of credible information and skills that facilitate choices that are likely to promote health. It is arguable that this broad framework still rests on the assumption that this form of approach will mean that the informed decisions pupils make will be to avoid drug use. Despite some common misperceptions, harm reduction approaches do not condone illegal drug use. However, because of such connotations references to harm-reduction teaching approaches are publicly avoided but there is a growing acceptance that some aspects of harm-reduction can be introduced where and when appropriate (for example, on courses targeted at groups of people known to be at high-risk of substance misuse).

Teachers may feel very isolated in their role as drug educators and yet have a lot of responsibility for the care of pupils and provision of health education. Until, relatively recently there has been little firm advice and guidance concerning dealing with drugs and the teaching of drug education. This has begun to change, In Scotland, there is now guidance about how to deal with drug incidents on school premises (SOEID 1999), and in Scotland and England and Wales there are a number of publications that provide guidance of teaching effective drug education.

Current Government advice on drug education is broadly similar across Scotland, England and Wales (Scottish Office 1996; Scottish Executive 1999 DfEE 1998;). Building on the previous government's strategy *Tackling Drugs Together,* the new strategy set out in *Tackling Drugs in Scotland: Action in Partnership* (May 1999) maintains the commitment to co-ordination of local strategies by Drug Action Teams (DATs) and to the task of examining best practice in all areas of the drug strategy including education. The whole strategy is underpinned by four key principles:

*Inclusion* – tackling the causes of social exclusion

*Partnership* – co-ordinated and collective work and partnerships across services

*Understanding* – accurate research and information to underpin all work

*Accountability* – set clear targets which can be properly evaluated

Ideally therefore teachers and education are part of a holistic approach to drug education, sharing responsibility with others in the community. Applying the

principles above to Scotland, the key objectives in relation to young people include establishing an evidence-based approach to education, prevention and harm reduction and ensuring that every child has effective drug education. The goal is to reduce acceptability and incidence of drug use in young people.

However, from our studies teachers' awareness of useful documents and guidance seems patchy. Many teachers are still uncertain about how to work with pupils who may be drinking quite heavily or using illegal drugs. If teachers perceive a pupil has a substance problem they can consult the Guidance staff in the school and the matter is likely to be considered in a' flexible way'. Teachers may of course imply a more or less judgmental stance in their teaching depending on their personal values.

### PERSONAL VALUES

Slightly different issues therefore come to bear when teachers' personal values and behaviours are in conflict with what they might teach or with those of their students and even students' families. Adults may generally consider that using illegal drugs is more 'wicked' or dangerous than smoking or drinking – the latter apparently being essential for 'a good time' in our pervading culture. To illustrate some of the potential difficulties let us consider some hypothetical examples of dissonances between home and school:

- a group of teachers celebrate the end of a hard week by going straight to the pub after school.
- parents give their young teenager cigarettes; the teenager's teacher disapproves of smoking, drinking and using drugs.
- a teacher smokes cannabis at the weekend and during the week at school must uphold the legal prohibition on drugs which neither he nor many of his pupils agree with.
- a parent under the influence of alcohol arrives at school to take her child home.

These examples provide some illustration of the variety of standards and values current in Scottish and wider UK society. An accepted goal for many drug education programmes is for schools to enable young people to make informed decisions. What should teachers do when young people make very informed decisions but which contradict the teachers' own beliefs or those predominating in society? In practice, teachers have to maintain their professional role and integrity but this can be at the cost of facing considerable moral dilemmas.

The question now arises about how teacher education can prepare new professionals to cope with such potential dissonances and how practising teachers can be supported in developing their knowledge, confidence and credibility in drug education.

### TEACHER EDUCATION

#### STAFF DEVELOPMENT AND SUPPORT

Only recently in Scotland did the school Drug Safety Team provide *Guidelines for the Management of Drug Incidents* (1999) to support schools in developing policies and procedures for dealing with illegal drug incidents. Now the same team comprising representatives from health, education and the police are turning their attention to wider issues concerning school-based drug education particularly promoting good practice.

In secondary schools, drug education is not taught systematically by any one kind of teacher. Those working in drug education may be health specialists or teachers

who began their careers as specialists in other subjects and may still be teaching these subjects as part of their timetable. The latter group have either opted or 'been volunteered' to join the pastoral team led by a guidance specialist who will be trained in a range of topics only one of which will be drug education. Primary schools are staffed by generalist teachers for whom drug education will be part of their science and personal and social education programme.

While most primary and secondary teachers value drug education training, the majority in our 1996-99 study (Lowden and Powney 2000) had not received such training in the last two years. This partly explains the tentativeness of many teachers in working in this area. In observing primary teachers who were undertaking basic drug education (Powney unpublished) it was clear that many were working from a very low knowledge base about the effects of drugs and the legal situation. There was also a time lag before they could put their new understanding into effect as schools' plans for the year were already settled and additional topics could not easily be introduced until the following year.

Secondary teachers would also appreciate further training especially about appropriate and effective ways to tackle drug education. (Participative and interactive methods are not common in all Scottish secondary schools.)

## MODELS OF DRUG EDUCATION

A major obstacle to effective drug education is the exaggerated expectation that it can be accomplished within the constraints of school timetables, and especially within the crowded PSE curriculum. Schools are not solely responsible for drug education. It is important to be realistic about what schools can do within the time available and in collaboration with other agencies, against the background of prevailing behaviours and values. Most pupils value their drug education although older pupils and those reporting drug misuse are usually more critical (Lowden and Powney 2000). Nevertheless, two thirds of those pupils misusing illegal drugs claimed their drug education had helped them reduce the risks associated with misuse. Teachers are therefore having some measure of success.

An innovative model developed in Glasgow for sexual health education depended on the partnership between the local health board and education division. Health promotion specialists worked in a team with teachers to plan a term's sexual health education programme. However, the longer-term implementation of this programme was hindered partly by resource issues and joint planning and teaching across agencies was complicated and expensive. Our evaluation (Lowden and Powney 1996) also showed that where health professionals were operating successfully with a class, teachers chose to withdraw rather than to develop their own knowledge and skills in this context. This suited the participants: teachers were not embarrassed by the ambiguities of their moral position; health professionals and pupils could be frank with each other without the constraints of school policies. If it could be guaranteed that agencies could work together with schools in holistic approaches to sexual health and drug education this would clearly be in the best interests of pupils. However, the pragmatics of interagency co-operation and budgeting suggest this may not be a reliable solution for schools.

## INITIAL AND INSERVICE TEACHER EDUCATION

What is essential is that teacher education should prepare teachers:

- to be realistic about their attitudes and drug related behaviours. Bosworth (1997) suggests that an essential feature of teaching about the use of alcohol, tobacco and other drugs is for teachers to examine their own history and current use patterns to identify any bias they may unintentionally convey

to students that would contradict the main message of the drug education programme.

- to have up to date information about the local and national use of drugs and about the effects on young people.
- with a wide repertoire of teaching techniques that include interactive methods that engage young people in discussion and debate that helps them to make informed choices.
- to identify pupils' needs in relation to drug education and adapt their teaching accordingly.
- to select appropriate resources consistent with an overall philosophy about drug education.
- to work closely with relevant services and organisations in the community and to raise pupils' awareness of local sources of information and support.
- to monitor and evaluate the effectiveness of the curriculum and methods of working with young people in drug education.

Are these components reasonable and sufficient to include in pre-service and inservice teacher education programmes?

## CONCLUDING COMMENTS

The changing nature of drug misuse means it will be necessary for teachers to renew their knowledge base periodically and to review new approaches to drug education within the changing mores of society. The question is how can teachers best be prepared to support all pupils in this complex area of drug education?

## NOTES

1 We use the term 'drug misuse' when referring to the use of illegal drugs. The term 'substance misuse' refers generally to the range of materials such as alcohol, tobacco, inhalants and illegal drugs that can induce changes of a mental and/ or physical nature.

2 ISDD (Now Drugscope) is designated by Government as the United Kingdom focal point for drugs information. This role involves the collection and dissemination of information about illegal drugs from primary and Government information sources in England, Scotland, Wales and Northern Ireland. For further information see: http://www.isdd.co.uk/trends/introductio1.htm

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