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Drug education in schools: an update

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Contents

Introduction 3

Main findings 5

Drug education programmes 7

Drug policies 9

Support for drug education 13

Staff development 14

Monitoring and evaluation 15

Introduction

1. In 1998, the government published its 10-year strategy for tackling drug misuse, *Tackling Drugs to Build a Better Britain*. The aim is 'to help young people resist drug misuse in order to achieve their full potential in society'. Its four key objectives related to young people, communities, treatment and availability of treatment.

2. A statistical bulletin from the Department of Health published in July 2002 indicated that among 11 to 15 year olds in England in 2001:

- 12% had used drugs in the last month, and 20% had used drugs in the last year
- the prevalence of drug use increased sharply with age – only 6% of 11 year olds had used drugs in the last year compared with 39% of 15 year olds
- cannabis was the most frequently reported illicit drug used in the last year (used by 13%), with volatile substances being the next most frequently reported (7%)
- 1% had used heroin in the last year and 1% had used cocaine
- 42% of pupils had been offered one or more drugs
- the likelihood of being offered drugs increased with age – 18% of 11 year olds had been offered drugs compared with 66% of 15 year olds
- boys (44%) were more likely to have been offered drugs than girls (39%)
- pupils were more likely to have been offered cannabis than any other type of drug, with 27% saying they had been offered cannabis.

3. Changes made to the questions asked of pupils made it difficult to assess whether there has been any change in the level of drug misuse by young people. However, other recent surveys have indicated a decrease in the numbers of pupils misusing drugs.

4. Since the publication of the Ofsted report *Drug Education in Schools* (1997), schools and local education authorities (LEAs) have received further guidance on drug education. For example:

- new material from the Department for Education and Skills (DfES) on drug education in schools was issued in November 1998 and is currently under review in the light of responses

- the development of effective drug education programmes has been part of the work commissioned by a DfES advisory group on personal, social and health education (PSHE)

- schools seeking to meet the National Healthy Schools Standard (proposed in the Green Paper *Our Healthier Nation*), now adopted by all LEAs, are reviewing their drug education policies and their strategies for dealing with drug-related incidents

- the Department of Health is funding the development of drug education in primary schools.

The report

5. Ofsted provides evidence on drug education in schools through school inspections and special exercises. In April 2002, the DfES asked Ofsted to carry out a postal survey of school drug education programmes in a sample of LEAs. This was designed to update a similar survey carried out in 2000. A sample of 25 LEAs and 1200 schools was identified to give geographical coverage, a range of socio-economic conditions and a mix of types of school. This report is based on the survey and on evidence from Ofsted inspections and special visits.

6. The report includes evidence on the provision of drug education in primary, secondary and special schools. Such evidence is provided separately for each group of schools except where aspects of the provision in special schools are the same as that in other schools in that phase.

Main findings

- Pupils achieve adequate or better levels of knowledge of drugs and their effects in nearly all lessons at Key Stage 1 and in 80% of lessons at Key Stages 2, 3 and 4.
- Attainment in drug education is often too narrowly defined in terms of the acquisition of knowledge. At all key stages, the planning and the subsequent teaching are not always sufficient to help pupils develop their values and attitudes and the personal skills they need to make informed choices.
- At Key Stage 1 the quality of teaching about drugs is good or better in 60% of lessons and satisfactory in the rest. At Key Stage 2 the quality of the teaching about drugs is good or better in 50% of lessons but is poor in 10%. At Key Stages 3 and 4 the quality of teaching about drugs is at least adequate in all but a few lessons; it is good or better in 40% of lessons.
- The proportion of schools with a drug education policy has increased since the last survey in 2000. There has been a significant increase in the number of primary and special schools with policies on dealing with drug-related incidents.
- The quality of drug education policies continues to improve. Further guidance from the DfES and the take-up of the National Healthy School Standard scheme have been a stimulus.
- Most schools make good use of outside speakers and organisations in the planning and teaching of drug education. Such external contribution is most effective when the contributor is well briefed and, where necessary, advised on effective teaching strategies.
- In the last two years, although more schools have participated in training, competing pressures for staff development have affected the level of drug-related training in small primary and some secondary schools. In 11% of primary and 17% of secondary schools, participation in drug-related training has had no impact on the schools' drug education programme.
- A minority of schools continues to make no provision for monitoring and evaluating the effectiveness of their drug education programmes. The level of involvement of parents and pupils sought by schools in reviewing and developing the programmes remains disappointingly low, despite the evidence that such involvement has benefits.

Recommendations

- For more schools to provide effective drug education, the following matters continue to need attention:
    - the definition of achievement in drug education should extend beyond the acquisition of knowledge so that pupils can develop

their values and attitudes and the personal skills they need to make sensible choices

- secondary and special schools should consider involving drug and youth workers in teaching about drugs, as their different relationship with young people can enable them to provide advice and access to services not easily available by other routes in the school

- to meet the minimum criteria for drug education in the National Healthy Schools Standard, schools should ensure that there is a teacher and a governor with specific responsibilities relating to the provision of drug education

- schools should make sure that pupils have access to up-to-date information on local and national helplines and other drug services

- schools should ensure that arrangements for the training of staff on drug education are firmly established within their development planning and kept under review

- training organised outside the school should include support for the teachers attending in providing subsequent dissemination within their schools and should encourage evaluation of the impact of the training on teaching and learning

- the training provided by some LEAs for the agencies who can support schools in the planning and teaching of drug education could usefully be developed more widely

- schools should have effective procedures for monitoring and evaluating the provision for drug education

- secondary schools who employ all teachers in their role as tutors to teach drug education should monitor and evaluate the quality of the teaching with particular care

- when reviewing their drug education provision, schools should do more to find out the views of pupils and parents on the content and timing of the drug education programme.

Drug education programmes

7. In the majority of schools, drug education is defined as including education about alcohol, tobacco, volatile substance abuse and illegal drugs.

8. Drug education is usually provided through PSHE, as part of the National Curriculum in science and sometimes in other contexts, such as tutor sessions and assemblies. Pupils are rarely encouraged to make the links between the knowledge they are gaining from these different sources.

Achievement

9. In nearly all the lessons at Key Stage 1 and in 80% of lessons at Key Stage 2, pupils achieve adequate or better levels of knowledge of drugs and their effects.

10. At Key Stages 3 and 4, in 80% of lessons pupils achieve adequate or better levels of knowledge and understanding of drugs. In lessons where pupils' knowledge is weak, a major cause is poor teacher awareness of drugs and their effects. Another cause is lessons that are too short or not well enough planned to give pupils the opportunity to think through and consolidate what they have learned.

11. Although this still occurs in only a minority of lessons, pupils are increasingly involved in constructive discussion of their views, attitudes and values of the issues surrounding drug misuse. When presented with such opportunities to talk, they respond well.

12. Too many schools tend to judge achievement in drug education only in terms of gains in factual knowledge. At all key stages, but particularly at Key Stage 2 and Key Stage 4, the planning and the subsequent teaching do not always help pupils to develop their values and attitudes and the personal skills they need to make sensible choices.

Quality of teaching

13. At Key Stage 1 the quality of teaching about drugs is good or better in 60% of lessons and satisfactory in the rest. At Key Stage 2 the quality of the teaching about drugs is more variable than that of other aspects of PSHE; it is good or better in 50% of lessons but poor in 10% of lessons.

14. At Key Stages 1 and 2, where learning and teaching are less effective the problem is often a lack of clarity about what the pupils are expected to gain from the lesson in terms of improved knowledge, opportunities to reflect on their values and attitudes, and the development of personal skills. In addition, particularly at Key Stage 2, pupils are given too few opportunities to reflect on what they are learning.

15. At Key Stages 3 and 4, in all but a few lessons, the quality of teaching about drugs is at least adequate; it is good or better in 40% of lessons. At Key Stage 3 the quality of teaching about drugs is often better than that of other aspects of PSHE.

16. Effective teaching about drugs calls for teachers to have a secure and up-to-date knowledge of drugs and their effects. Increasingly, schools are recognising that it is unrealistic to expect that all form tutors, acting as teachers of PSHE, will have such knowledge or can readily be provided with it. As a consequence, 70% of secondary schools now employ specialist teachers to teach about drugs and other specialist aspects of PSHE.

17. When teaching about drugs is effective it ensures that all pupils are fully involved in the lesson. For example, considerable use is made of discussion, role-play and other methods that give pupils opportunities to explore their ideas and to improve their understanding, as well as helping them to develop skills and explore attitudes.

18. Special schools are particularly effective in using teaching assistants to support pupils in drug education lessons. By comparison, only 60% of primary and 55% of secondary schools employ teaching assistants in this way.

19. Assessment policy and practice on drug education, and in PSHE more generally, remain issues in many schools. There is little formal reporting to parents on pupils' work in drug education or other aspects of PSHE.

Drug policies

20. Schools are aware of the part that they have to play in reducing drug misuse by young people. The number of schools with a drug education policy has continued to increase since the last survey in 2000. Currently, 80% of primary schools have a drug education policy, compared with 75% in 2000. Among secondary schools, 96% have a drug education policy, compared with 93% in 2000. Almost 90% of special schools have a drug education policy.

21. There has been a considerable improvement in the number of primary schools with policies on dealing with drug-related incidents: 62% of primary schools now have a policy; the figure was 42% in 2000. Many primary schools were uncertain as to whether they needed to have such a policy in place. Guidance from LEAs and national bodies has helped schools to clarify both the need for such a policy and its possible content.

22. There has been no change in the proportion of secondary schools with drug-related incident policies: it remains at 95%. Almost 80% of special schools have such policies.

23. Governing body approval for drug policies has been gained by 90% of primary schools, 94% of secondary schools and 62% of special schools. The governing bodies of some schools have nominated a governor to link with PSHE programmes. This has the benefit of keeping the governors fully aware of the developments in the teaching of such issues and it offers a perspective which can be useful in monitoring and evaluating the programme. The minimum criterion for drug education in the National Healthy School Standard is that schools should ensure that there is a teacher and a governor with specific responsibilities relating to the provision of drug education. Currently, there are link governors in only 24% of primary, 39% of secondary and 43% of special schools.

24. The majority of schools have written or reviewed their drug policies in the last two years. Most drug policies are now subject to regular review. Schools are increasingly effective in using evidence from a range of sources when determining the extent of such a review. For example, those schools monitoring and evaluating their drug education programmes gain insights into the pupils' views on the effectiveness or otherwise of the programme. Some schools work with local youth and drug agencies which provide up-to-date information on the nature and extent of drug misuse in the community. National and local guidance on drug education policies and schemes of work are also available to schools.

25. Schools have consulted reasonably widely in the production or review of their drug policies. Nearly all schools have involved teachers in the review of the content and the teaching methods to be employed and in the writing of the subsequent policies and scheme of work. However, the involvement of parents and pupils in these consultations remains poor. Only about 40% of schools consult with parents about the content and timing of the drug education programme. Most disappointing is the lack of involvement of the pupils: this occurs in about 20% of primary and 45% of secondary schools. Very few special schools consult with their pupils.

26. The poor level of consultation with pupils raises two important issues. First, schools need to ensure that their drug education programme is appropriate to the needs of the pupils. Consultation with pupils prior to planning the drug education programme should identify what pupils already know and help to determine the appropriate time for elements of the programme to be taught. Second, policies on drug-related incidents are more likely to be better understood and effective in practice when pupil and parent opinion is sought.

Effective policies and programmes

27. The quality of drug education and drug-related incident policies are good or better in about 60% of schools but remain poor in 10% of schools.

28. The aim of a drug education policy is to clarify the school's role in drug awareness and prevention of misuse as part of its approach to a healthy school. Guidance to teachers should enable them to teach drug education with confidence and in a way that meets pupils' needs.

29. An effective drug education programme will enable students to make healthy informed choices by:

- increasing their knowledge and understanding of drugs and their effects
- challenging their attitudes
- developing their perceptions of self-worth and self-esteem
- helping them to develop and practise skills.

30. To achieve these aims, an effective drug education programme will seek to:

- give students accurate information about drugs and their effects
- encourage responsible behaviour in relation to drug use and misuse
- promote positive attitudes towards healthy lifestyles
- challenge and try to modify attitudes when they may lead to behaviour that could be harmful to health and relationships
- explore related health and social issues, such as HIV/AIDS and crime.

31. Effective drug education allows pupils to revisit topics at each key stage for reinforcement of what they have learned before and for coverage in greater depth. Effective drug education is also specific about what pupils will learn. The illustration below refers to pupils in secondary schools.

Objectives for drug education in Key Stages 3 and 4

Pupils will know and understand:

- *school rules relating to medicines, alcohol, tobacco, solvents and illegal drugs*
- *definitions of words: use, misuse, abuse, addiction, tolerance, dependence, overdose, withdrawal, adulteration*
- *different categories of drugs including stimulants, depressants, hallucinogens, analgesics*
- *different types of medicine (both prescribed and over the counter), legal and illegal drugs including their form, effects and risks. Information about drugs – appearance, effects, legal status (KS4)*
- *the law relating to the use of legal and illegal drugs*
- *the misuse of drugs in sport*
- *the effects of different levels of intake of alcohol*
- *people who can help students if they have concerns*
- *patterns of drugs misuse locally and nationally and the impact on community and wider society (KS4)*
- *dangers associated with particular drugs, mixing of drugs, particular moods and environments (KS4)*
- *drug policy in this country, including education, prevention, policing, penalties, treatment and rehabilitation (KS4).*

Pupils will be able to:

- *identify risks to health*
- *cope with peer influences*
- *communicate with adults, parents and professionals*
- *make decisions and be assertive in situations relating to drug misuse*
- *give and secure help (including basic first aid)*
- *manage conflict and aggressive behaviour (KS4)*
- *communicate drug advice to other young people (KS4).*

Pupils will have considered:

- *the attitudes towards drugs in different sections of society*
- *the impact of the media on young people's attitudes*
- *their attitudes towards drugs and the laws relating to them*
- *themselves as a role model, and acceptance of responsibility for their own actions*
- *taking responsibility for their own safety.*

Time allocated to drug education

32. Aspects of drug education appear in the National Curriculum for science. The non-statutory framework for PSHE refers to aspects of health education including drug education. Much of the teaching of drug education occurs in these subjects. The tables indicate the number of hours per year given to the teaching of drug education in these subjects.

Table 1. Number of hours per year spent on drug education in primary schools

Year	*R*	*1*	*2*	*3*	*4*	*5*	*6*
PSHE	3.0	3.0	3.5	3.5	4.0	4.0	5.5
Science	1.0	2.0	2.0	2.0	2.0	3.0	3.5

33. In the primary phase**,** PSHE remains the most common context in which to locate drug education. Since 2000, there has been an increase in the time allocated in PSHE to teaching about drugs. Teaching about drugs is also occurring at different times: in the most effective schools such changes have followed consultations with the pupils.

Table 2. Number of hours per year spent on drug education in secondary schools

Year	*7*	*8*	*9*	*10*	*11*	*12*	*13*
PSHE	5.0	5.0	5.5	4.5	3.5	2.0	2.0
Science	3.0	2.0	4.0	3.5	3.0	–	–

34. In the secondary phase, PSHE is again the usual context for drug education. The time allocations are relatively even, reflecting, in part, the fact that schools are developing drug education programmes where topics are revisited for reinforcement as well as coverage in greater depth. The range of drugs covered is also progressively broader.

Support for drug education

35. Schools are increasingly aware of the support available to them when planning and teaching about drugs. For example, 62% of primary, 87% of secondary and 44% of special school teachers receive guidance from the LEA or local drug agencies on recognising the signs of drug misuse.

36. Local drug agencies are also working very effectively with some schools to provide information to parents and pupils on the support and advice available to them from such local services. This information is available to over 20% of pupils in primary and special schools and to 84% of pupils in secondary schools. Some secondary schools give pupils work planners that have information on local and national advice services. A minority of pupils has access to school-based information and advice services. Such centres provide confidential advice to pupils and often serve as a very effective link to other services.

37. Most schools make good use of outside agencies or individuals in the planning and teaching of drug education. Such external support is most effective when the individual or agency is given advice on effective teaching strategies. Usually, such advice is provided by the school during the joint planning of the drug education programme. In a few LEAs, an adviser has provided a training programme for individuals and agencies who wish to support schools in teaching about drugs. This approach means that schools can more confidently use the support.

38. Almost 80% of primary schools use external support in teaching about drugs. The involvement of the school nurse (43% of schools) and the police (45% of schools) has increased since 2000. Primary schools are also making effective use of theatre-in-education groups (27% of schools) and ‘Life Education Caravans’ (11% of schools).

39. The use of external support in teaching about drugs in special schools is very similar to that of primary schools, with the notable exception of the lower level of involvement of the police (25% of schools).

40. Of secondary schools, 66% involve the police in teaching about drugs, although only 13% involve the school nurse. There has been a significant increase in the use of theatre-in-education groups in teaching about drugs: 44%, compared to 20% in 2000. About a quarter of secondary schools have been very successful in involving drug and youth workers in teaching about drugs. As such workers tend to have a different relationship with young people than teachers and others, they are often able to provide advice and access to services not available through other routes.

Staff development

41. In the last two years, 73% of primary schools (62% in 2000) and 78% of special schools have been involved in drug-related training. Small schools are most likely not to have participated in such training: in part this is related to the pressures on teachers who often carry other subject and aspect responsibilities.

42. For secondary schools, 61% have been involved in training about drugs in the last two years (75% in 2000). Competing pressures for staff development have reduced the level of participation in drug-related training.

43. LEAs, through their PSHE/drug education advisers, remain the most significant source of training for all schools.

44. In most schools, the drug education (or PSHE) co-ordinator was the most likely person to attend training. Focusing on one person to attend training is cost-effective, provided that the person concerned has the skills and opportunity necessary to brief and train colleagues effectively.

45. Schools in the survey were asked to indicate the impact of such training on their drug education provision. It is a concern that 11% of primary and 17% of secondary schools report that the training has not impacted on their provision. Where the training has made an impact:

- in 37% of primary, 19% of secondary and 29% of special schools, the training has raised teachers' awareness of drugs and improved their knowledge base
- in 57% of primary, 40% of secondary and 71% of special schools the training has resulted in more effective planning of the drug education programme
- in 21% of primary, 19% of secondary and 29% of special schools, training has resulted in the use of a broader range of learning and teaching styles
- in 11% of primary, 23% of secondary and 14% of special schools, there has been an improvement in the range and quality of resources used.

46. The major factors contributing to lack of impact are:

- the lack of expectation placed on those attending training, by the school's senior management team and/or the provider of the training, to carry out any review of provision following the training
- the lack of time for those attending the training to undertake planning or to disseminate the training to other teachers.

Monitoring and evaluation

47. A significant minority of schools continues to make no provision for monitoring and evaluating the effectiveness or otherwise of their drug education programmes. In only 69% of primary (75% in 2000), 85% of secondary (83% in 2000) and 88% of special schools are there mechanisms in place to monitor the quality of the drug education programme.

48. About a half of all schools monitor the quality of teachers' lesson plans. Monitoring through the observation of lessons takes place in about 25% of primary and special schools and in 34% of secondary schools. Secondary schools employing all teachers, in their role as tutor, in the delivery of drug education are those who are least likely to observe teaching. Without such monitoring schools are not in a position to know that their provision is meeting the needs of all pupils.

49. Formal and informal discussions with both the co-ordinator and with pupils are increasingly being used as a method of assessing the quality of the drug education provision.

50. In 66% of primary, 85% of secondary and 88% of special schools procedures are in place to evaluate the effectiveness of the drug education programme. Schools use a number of indicators to evaluate the effectiveness of their programmes:

- 38% of primary, 17% of secondary and 62% of special schools assess pupils' responses to the taught programme
- 33% of primary, 34% of secondary and 50% of special schools assess changes in the levels of pupils' knowledge of drugs
- 12% of primary, 30% of secondary and 37% of special schools record changes in the number of reported drug-related incidents. This is a relatively new but effective method of evaluation.