CHILDREN, YOUNG PEOPLE AND HEALTH-RELATED DECISIONS:

A Review of the Research Literature and Discussion of the Implications for Health Education of Children and Young People

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FOREWORD

At Life Education we are committed to ensuring that all our work in schools, for parents and engaging the community, is firmly rooted within the evidence for what works most effectively.

During the last two years we have consulted with a wide range of national and local organisations working in the fields of personal, social, health and citizenship education (PSHCE) about the direction of our work. We have undertaken a strategic review of our mission, placing much greater emphasis on maximising the value we can add as a community based charity in helping to build partnerships with Government, schools and other agencies to promote and deliver effective health and drug education.

An important step in this exercise has been to commission a detailed literature review of evidence which underpins a multi-faceted life skills approach to health education, which is most likely to impact on children's and young people's health related decisions. Therefore I am most grateful to Educari, an established independent consultancy specialising in the fields of health and drugs education and prevention, for preparing this report, and to Louise O'Connor, Senior Research Fellow in the School of Education Studies, Roehampton University of Surrey, who prepared the commissioning brief and completed editing for publishing.

This review will be presented for consultation with a wide audience of those with experience in health and drug education at the Portcullis House on 21st July 2004.

We hope that the results of this work will not only inform the further development of our programmes and projects, but also become an important source for others interested in developing health and drug education programmes on their own or in partnership with Life Education.

Following the consultation, a report will be sent to all those that have participated.

Stephen Burgess
National Director
Life Education

CONTEXT TO THE REVIEW – LIFE EDUCATION'S REVIEW OF STRATEGIC MISSION, POLICY AND PRACTICE

Aim of the Literature Review:

- To critically review relevant literature which examines the significant influential factors on children's and young people's health-related decisions, drawing mainly on UK sources, but with additional key selected sources from the USA, Australia and Europe

Outcomes of the Literature Review:

- The production of an independently produced and scrutinised report which will assist in the revision and adaptation of Life Education's strategy, programmes and provision
- To inform an expert consultation event (Portcullis House, 21st July, 2004) which will examine the findings and implications of the review, for Life Education and potential strategic partners to explore possible collaborations on areas of mutual interest*.
- The report is also intended to inform the national debate on effective health education policy and practice for children and young people; and support national and local organisations and individuals working within the PSHCE fields.

Scope and limitations of the Literature Review

A preliminary search of the literature to inform the brief for this review, suggested that a number of factors are instrumental in influencing the health careers of children and young people.[1] These factors broadly fall within the following categories:

- Family/parents/carers
- Social/Community (peers/friendships, neighbourhood, statutory/voluntary agencies)
- School - informal and formal curriculum
- Media

Such influences on children and young people will vary in their importance depending on the developmental stages and life experiences of individuals.[2]

However, there are several evidence sources in the literature which allow some generalisation of findings which have implications for policy makers and practitioners in health education. Given that this is an extremely broad and extensively researched area, a decision has been made by the authors to concentrate on key papers and seminal reviews which draw on meta-analysis of the relevant research studies.

*A similar expert consultation event for Life Education Parent Programmes/Provision was held at the BMA (London) on June 24th.

However, other indicative and recent research is also included where relevant. The focus is on UK literature, but research from other English-speaking countries is used to support and enhance topic areas discussed. UK government reports and policy guidance are also examined in relation to the national policy context and impetus for health education practice within the United Kingdom.

In attempting to draw out the critical factors to inform health education policy and practice, this review has limited itself to the key areas of young people's health related behaviour of most concern to public health policy (see Sections 3 and 4) and where national and local resources are most concentrated.

Thus this review focuses on the following aspects of Children and Young People's health:

- Legal and illegal drugs
- Sexual behaviour
- Overweight and obesity
- Exercise
- School disaffection and exclusion

Space precludes an exhaustive examination of all the relevant literature, therefore aspects such as gambling, and accidents and road injuries are not included. However, they are acknowledged here as worthy of additional research to further inform the debate.

The review is also weighted in favour of a drugs perspective, to reflect the research which indicates that smoking, alcohol and drug misuse are correlated most clearly with less healthy lifestyles and problem behaviour (see Section 4).

In summary, the Introduction leads into the following Sections:

- Section 1: Health Behaviours and Health Education Models
- Section 2: Definitions of Health and Related Terms
- Section 3: Mapping Health Behaviours of Children and Young People
  - *a) Drug and Alcohol use*
  - *b) Sexual Health*
  - *c) Overweight and Obesity*
  - *d) School Disaffection and Exclusion*
- Section 4: Risk and Protective Factors
- Section 5: Public Health Priorities: Government Reports
- Section 6: School Health Education – Effectiveness Research
- Section 7: BME Communities and Diversity Issues
- Section 8: Commentary, Discussion and Conclusions

HEALTH BEHAVIOURS AND HEALTH EDUCATION MODELS

Influences on health behaviours

In any discussion of health behaviours, it is important to acknowledge that there are factors outside the control of the individual, for example, social deprivation/poverty, pollution and chronic illnesses such as diabetes and asthma[3, 4] (see also **Sections 5 & 7**). Nevertheless, for the purposes of this review, it is pertinent to recognise the debate around individual choice, and health education models which are most likely to impact on health-related decision making of individuals. Keith Tones[5] has critically reviewed the Medical, Educational, Radical and Self-Empowerment models of health education, which have influenced school and community education approaches from post-2nd World War to the present. A very brief explanation of these models follows:

- **Medical Model** (developed from a belief that modern medicine and medical practitioners hold the answers to ill-health, and scientific, rational explanations of the causes will result in avoidance of "un-healthy" behaviours, and adoption of "healthy" behaviours)
- **Educational Model** (based on the premise of "voluntarism" - that for an endeavour to be truly educational, the student must have an element of freedom and choice in participation and come to her/his own decision on health behaviours based on neutral and accurate information – Informed Choice)
- **Radical Model** (based on the belief that the root causes of ill health should be tackled through social and public policy which addresses health inequalities and business interests in contributing to ill health – for example smoking and alcohol abuse)
- **Self-Empowerment Model** (an attempt to make informed choice a genuine reality for individuals, through enhancing personal skills, and development of improved decision making – Life Skills).

Much of the debate around health choices relates to social and environmental factors which impact on the degree of choice realistically available to individuals, and the rationalisation of behaviours which are well known to cause health damage, for example smoking and poor diet.[6,7,8]

The development of the models described above recognise increasing understanding that health behaviours are influenced by values and attitudes which interact with knowledge about health effects and skill levels of individuals to exert decision-making for positive health. Developmental factors are also known to be particularly influential in health related decision-making, for example risk taking behaviour peaks at adolescence.[9]

An understanding of the above factors provides the context for definitions of health, health promotion and health education in the next section, as a necessary precursor to a review of the relevant literature.

DEFINITIONS OF HEALTH AND RELATED TERMS

The World Health Organisation defines 'health' as follows:

> *'Health, is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and … the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.'*[10]

The WHO definition acknowledges that "health" is a positive concept, "not merely the absence of disease or infirmity" but rather a state of holistic "well-being". It is also recognised as a human "right" which requires social and economic action to bring this about. However, some educationalists have argued that health education needs to recognise that individuals start from very different "health positions" and that realistic and effective approaches will begin from this premise:

> *"By health I mean…….I want to be all that I am capable of becoming".*
>
> (Katherine Mansfield)[11]

The above definition quoted in Wetton and Moon (1987) refers to the personal dimension to health, acknowledging that the capacity to fulfil personal potential, varies between individuals for a variety of reasons, some within and some without personal control. For example children may not be able to influence the quality of housing they live in, but have the capacity to refuse an offer of a cigarette from a friend.[12]

Definitions of health will inevitably relate to personal understandings of health, and Wetton and Moon (above) have argued that good health education will start from individual perceptions of health, acknowledging prior knowledge and experiences.

Definitions of health promotion, health education and prevention

The WHO further defines health promotion as:

> *'… the process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being."*

Within this definition, the WHO defines health education as a specific component of Health Promotion, 'Education that increases the awareness and favourably influences the attitudes and knowledge relating to the improvement of health on a personal or community basis.'[13] It comprises: '…consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health.'

The first World Health Organisation International Conference on Health Promotion, held in 1986, led to the Ottawa Charter.[14] The Charter gave a framework for the delivery of health promotion programmes*. Five principal areas for health promotion action were identified:

- Building healthy public policies
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Re-orientating health services.

These actions (and associated methodologies†) provide a basic framework for the delivery of health promotion programmes, and are reflected in the models of health education presented in Section 1.

The belief that health is not only a matter of individual choice but also affected by public health policy, is further recognised in the following definition of Public Health set out in the Wanless Report (2004):

> *'Public Health' is: 'the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations public and private, communities, and individuals'.*[15]

National policy guidance (UK Department of Health) has also set out how the aims of Public Health policy may be addressed through a combination of *Universal* and *Targeted* Prevention programmes designed to address general and specific populations, the latter requiring specialised educational and other interventions to meet their needs. The differences in approach are described in the following terms:

> *'A broad or universal prevention programme aims to reach the general population or smaller sections of society such as individual communities or schools in order to promote health or to prevent the onset of drug use. Children and young people are usually the focus of universal prevention and activities associated with universal prevention include campaigns to raise awareness of the dangers of drug misuse, school drug education programmes and multi-component community initiatives.'*[16]

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*The Declaration included the idea that all people are entitled to minimum standards of health, and these cannot be achieved at the expense of one individual for another.

†Three methodologies were also identified through which people could begin to take control of their own health: Mediation; Enablement; Advocacy.

And

> *'A targeted prevention programme singles out the recipient of the intervention and is aimed at groups at risk such as children of drug users, students with poor academic achievement or people facing difficulties as a result of poverty or financial hardship. Targeted prevention programmes aim generally to reduce the influence of risk factors and to prevent or reduce drug misuse by building on strengths such as coping strategies and other life skills. Children from difficult environments are often targeted to receive such prevention interventions.'*[17]

The relationship between the health education terms, models and definitions described above, and programmes and interventions designed to impact on children's and young people's health related behaviours, is examined in detail in Section 6. The next Section (3) examines the patterns and trends in young people's health behaviours, to provide a context for the examination of pertinent influences.

MAPPING HEALTH BEHAVIOURS OF CHILDREN AND YOUNG PEOPLE

To identify appropriate preventive actions, it is a necessary prerequisite to have an understanding of the nature of young people's health behaviours.

A recently published report from the World Health Organisation (WHO)[18] from a survey of 162,000 young people aged 11, 13 and 15 years in 32 European countries, and Canada, America and Israel found that:

- Weekly drinking among 15-year-olds in the UK was "especially high", with one in two 15 year olds drinking every week, a figure matched only in the Netherlands
- A third of UK 13-year-olds drink alcohol once a week, the highest anywhere
- Cannabis use amongst-15-year-olds is near the top end for all countries (46%) in the survey
- UK teenager diets are amongst the worst in the developed countries
- Fewer than 20% of UK young people surveyed met guidelines for physical activity per week
- UK 15-year-old girls report amongst the highest for levels of sexual intercourse, with Wales at 40%.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reported in their Annual Report for 2003[19] that drug use among young people has risen steadily in the 15 EU Member States over the last decade. Of particular concern, was the rise in "binge" drinking and drug use of vulnerable young people, and the increased access to a range of illegal substances, which are used in combination with alcohol.

A UK national survey using a representative sample of more than 14,000 students in English, Scottish and Welsh secondary schools (Years 7-11) assessed young people's levels of involvement in crime, drug and alcohol misuse and other antisocial activities.[20] The survey confirms the prevalence of "binge" drinking, with more than four out of ten students in Year 10, and over half in Year 11 admitting to five or more drinks in a session. Cannabis use was also reported by three out of ten boys and one in four girls in Year 11, and 8.5 percent of boys and 10 per cent of girls in Years 9 and 10 reported solvent abuse (see also Section 4 below).

The patterns and trends in young people's health behaviours are further illustrated by research findings presented under the key behaviours sub-headed below: Drugs and alcohol, Tobacco, Sexual Health, Overweight and obesity, and Exercise.

Drug use

A school-based questionnaire survey of young people's (aged 11 to 15 years) drug use is conducted annually by the National Foundation for Educational Research (NFER) and the National Centre for Social Research (NatCen) for the Department of Health. In the 2002 survey, the NFER/NatCen survey [21] found that:

- about a fifth (18%) had taken drugs* in the last year (a slight decrease from 20 per cent in the 2001 survey), and 11 per cent had taken drugs in the last month
- about a quarter had drunk alcohol in the previous week (little changed from the 2000 and 2001 surveys)
- a tenth of school students aged 11 to 15 years were regular smokers (unchanged from 2000 and 2001).

Illegal drugs

As in previous years of the survey, a larger proportion of boys took drugs both in the past month (12% of boys and 9% of girls) and in the past year (20% of boys and 17% of girls). Drug use increased with age: six per cent of 11-year-olds had taken drugs in the past year compared to 36 per cent of 15-year-olds.

Cannabis was the most-used drug: 13 per cent had taken cannabis in the past year. Six per cent reported misusing volatile substances in the past year, and one per cent of these 11- to15-year-olds had taken heroin, and one per cent cocaine, in the past year.

Respondents to this survey were also asked about the drugs they had ever been offered. Almost two-fifths (38%) had ever been offered one or more drugs.

Alcohol

Almost a quarter (24%) reported drinking alcohol in the past week. Boys (25%) were slightly more likely than girls (23%) to have drunk alcohol. Prevalence of drinking increased with age: five per cent of 11-year-olds had had a drink in the past week compared to almost half (47%) of 15-year-olds. The average weekly consumption (among pupils who drank in the past week) was 10.5 units.

Concerns about alcohol-related problems have been summarised in the Government's alcohol strategy, issued in March 2004. One area highlighted is 'binge drinking'. 'Binge drinkers' drink to get drunk. They tend to be aged under 25, and male, although binge drinking by young women is increasing. Binge drinkers are more likely to have accidents and suffer alcohol poisoning. They are more likely to be victims of violence and sexual assault, and to commit violent offences. A government survey published in Mach 2004 found that young women aged 16 to 24 had doubled their

*The individual drugs or categories of drugs covered in the questionnaire were: amphetamines, anabolic steroids, cannabis, cocaine, crack, ecstasy, heroin, LSD, magic mushrooms, methadone, poppers, tranquillisers, volatile substances such as gas, glue and other solvents, and 'other' drugs (not obtained from a doctor or chemist).

consumption of alcohol over the past ten years, and were now drinking 14.1 units a week on average; and almost half of young men aged 16 to 24 had exceeded four units of alcohol in any one day during the previous week.[22]

The Government's strategy to combat alcohol problems is education and communication, including: 'providing alcohol education in schools that can change attitudes and behaviour',[23] reflects increasing concern about the levels of teenage drinking (see also Section 8).

Tobacco

There is a sharp increase in prevalence of smoking with age – one per cent of 11-year-olds in the NFER survey smoked regularly compared with 23 per cent of 15-year-olds. Girls (11%) were more likely to be regular smokers than boys (9%). Smoking was reported by 18 per cent of 14-year-old girls and 26 per cent of 15-year-old girls, compared with 13 per cent of 14-year-old boys and 21 per cent of 15-year-old boys. Research has also indicated that regular and dependent smokers are also more likely to use illegal drugs.[24]

Young women are now more likely to smoke than young men. A Government survey published in March 2004 reported that 34 per cent of women aged 16 to 24 were smokers compared with 31 per cent of men in the same age group. Since the year 2000 there has been a sharp drop in smoking among teenagers aged 16 to 19 but little change among teenage girls in this age group.[25]

Drug-related deaths in the teenage years are low – because, for example, the dangers of tobacco and tobacco smoked with cannabis are long-term, and heroin and cocaine deaths tend to occur to people in their twenties.[26] However, alcohol is significantly related to death and accidents in some teenagers and a particular cause for concern in the early teenage years are VSA-related deaths – around 60, mainly teenage, deaths every year in the UK.[27]

Sexual health

The 2000 National Survey of Sexual Attitudes and Lifestyles (NATSAL) provides valuable information about early sexual behaviour in Britain. Over 11,000 participants aged between 16 and 44 years were interviewed about first heterosexual intercourse, communication about sex, pregnancy and STIs (sexually transmitted infections). The Survey found, among those aged 16 to 19 at interview, the proportion reporting first intercourse before age 16 was 30 per cent for men and 26 per cent for women.[28]

'Sexual competence' is an important concept for understanding adolescent sexual health. Sexual competence may protect adolescents' sexual health by ensuring that sexual intercourse is not coerced and that contraception is used to help prevent unwanted pregnancy or the transmission of STIs. The NATSAL Research used four variables relating to circumstance (regret, willingness, autonomy, and contraception) to construct a measure of sexual competence.

Although sexual competence, particularly the use of contraception, can help to protect the sexual health of adolescents, no sexual intercourse is risk free. Condoms provide the best protection against STIs but can be an unreliable method of protection, especially among people who lack experience. At least one survey of pregnant teenagers (13- to 19-year-olds) found a large proportion (up to 80%) claimed to be using contraception at the time of conception. Many of the condom users knew why the contraception had failed, attributing conception to the condom splitting, coming off or leaking. An Office for National Statistics survey found that 23 per cent of 16- and 17-year-old women are using a contraceptive pill. But 12 per cent of 16- to 17-year-old young women had used emergency contraception at least once.[29]

STIs are the commonest group of infections in the UK after chest infections. Recorded cases are rising rapidly, and they are a significant cause of morbidity. Although substantial declines in STI incidence were observed throughout the 1980s and early 90s, new diagnoses of STIs have risen continually since 1995. Diagnoses of chlamydia, gonorrhoea and syphilis have all more than doubled over the past five years.

The highest rates of gonorrhoea and chlamydia occur among teenage females. Over 40 per cent of the 6,313 females diagnosed with gonorrhoea in 2000 were under 20 years old, and among 12- to 15-year-old females diagnosed with gonorrhoea, almost a quarter will return with another episode of gonorrhoea within a year.

Several studies have shown particularly high rates of bacterial STIs, especially gonorrhoea, among the Black Caribbean population. In London, gonorrhoea rates are thought to be 10 times higher in black ethnic groups than in whites.

The rise of STIs in the youngest sexually active population is of particular concern, and it is estimated that cases diagnosed in GUM (genital-urinary medicine) clinics may represent only 10 per cent of the total. Many sexually transmitted diseases are asymptomatic in the early stages. Genital chlamydial infection is an important reproductive health problem, because 10 to 30 per cent of infected women develop pelvic inflammatory disease (PID).

The National Strategy for Sexual Health and HIV aims to:

- reduce the transmission of HIV and STIs
- reduce the prevalence of undiagnosed HIV and STIs
- reduce unintended pregnancy rates
- improve health and social care for people living with HIV
- reduce the stigma associated with HIV and STIs.

Overweight and obesity

In 2002 the World Heart Federation warned that obesity would shortly overtake smoking as the world's biggest killer. According to the Federation, 22 million children under the age of five worldwide are severely overweight. In the UK, there are 1 million obese under-16s. This 'epidemic' is due to eating too much saturated fat, sugars and salt and too few fruit and vegetables (the rising consumption of 'fast food' is an important factor); and a reduction in activity levels.

An HDA review of reviews by Mulvihill and Quigley in 2003[30] found that since 1980 the prevalence of obesity has nearly trebled in the UK and is continuing to increase. Combining the overweight and obese groups, in 2001 nearly two-thirds of men and over half of women were either overweight or obese. Age, education, social class and prosperity have an important influence on the risk of becoming obese. The prevalence of obesity is also rising in children. In 2001 8.5 per cent of six-year-olds and 15 per cent of 15-year-olds were obese*. Between 1996 and 2001, the proportion of overweight children (aged 6 to15 years) increased by seven per cent; and of obese children by 3.5 per cent.

Obese people are likely to suffer from a number of serious chronic diseases many of which are life-limiting. Some conditions – notably diabetes – are increasingly affecting children. Diseases normally associated with adult life have their roots in poor eating habits during childhood. Rising rates of obesity in children are a particular concern because they pose significant risks for the health of the future adult population, increasing the risk of death, coronary heart disease, type 2 diabetes (the research charity, Diabetes UK estimates diabetes costs the NHS around £5.2 billion each year[31]), some cancers and osteoarthritis in later life.

Besides the physical effects, there are also considerable psychological and social effects, including low self-esteem, being perceived as being unattractive, depression, bulimia, and body dissatisfaction.[32]

Exercise

Physical activity is an increasingly important focus for health promotion. As a key determinant of energy expenditure, physical activity is fundamental to energy balance and weight control. It can help to prevent and reduce the risk of coronary heart disease, stroke, high blood pressure, non-insulin-dependent diabetes mellitus, osteoporosis and cancer of the colon. It can also improve psychological well-being by reducing symptoms of depression and anxiety and enhancing self-esteem (See below, Our Healthier Nation (1998).

In 1997 the Health Education Authority (HEA) recommended that all young people should participate in one hour of moderate physical activity every day and that young people who currently do little activity should participate in physical activity of at least

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*These findings were based on a body mass index (BMI) over the 95th percentile to represent the obese and a BMI over the 85th percentile to represent those overweight.

moderate intensity for at least half-an-hour each day. The rationale for adolescents to take part in physical activity includes:

- optimising fitness, current health and wellbeing, and growth and development
- developing an active lifestyle that can be maintained throughout adult life
- increasing bone mineral density and thereby reducing the risk of osteoporosis
- reducing the incidence of overweight and obesity and the risk of chronic diseases of adulthood.

Measuring physical activity is difficult since, in addition to organised activities, it includes walking and other less ‘formal’ physical effort. Account needs to be taken of the frequency, duration and intensity of an activity.[33]

The 2000 British National Diet and Nutrition Survey estimated that 40 per cent of boys and 60 per cent of girls surveyed were failing to meet the HEA recommendations. From an early age, boys were more active than girls, and were significantly more likely to engage in vigorous activity during adolescence.

The Health Survey for England 1997 found that, overall, participation rates in four categories of activity declined with age after the age of about eight to 10 years. The decline was steeper among girls, so that, from the age of 12, fewer than half of all girls participated in physical activities for at least 30 minutes on most days. By the age of 15, only just over a third (36%) of girls undertook 30 minutes of physical activity on most days, compared with almost three-quarters (71%) of boys. Rates of adolescent participation in physical activity are similar for Scotland. The 1997 survey showed that inactivity increases with age among both boys and girls.

In summary, the data from international and national surveys, support the contention that the health behaviours of young people require positive interventions in the form of public health policy and educational programmes (see Sections 5 & 6 below). However, before a review and discussion of the issues, an analysis of the risk and protective factors related to young people’s health behaviours, will further inform the debate.

RISK AND PROTECTIVE FACTORS

Social scientists and Medical Researchers investigating the influences on what might, on the one hand, predispose people to use drugs or other unhealthy behaviours, and on the other, what might prevent them from drug misuse, and predispose towards healthy behaviours, have coined the terms of risk and protective factors. Hawkins, in a lengthy and influential review, identified the issues in relation to drug and alcohol misuse.[34]

The factors associated with a greater potential for drug use are labelled 'risk factors' and those that inhibit or reduce the probability of drug use are commonly called 'protective factors'. The role of risk and protective factors is complex. Their influence may be additive or interactive; they may mediate or moderate drug use; and, because they may not always precede drug involvement, their presence may be the result of earlier drug use. Most definitions of 'at-risk' youth include either the presence of early involvement in alcohol and other drugs or the presence of a range of behavioural factors that have been shown to be closely linked to future drug use.[35]

The evidence points to a variety of genetic, biological, emotional, cognitive and social risk factors that interact within social contexts to increase vulnerability, and these have typically been organised into categories that represent broad contextual, social and environmental factors and a wide range of individual, family and social risks:

> *'Understanding of the genetic and environmental risk and protective factors that may determine vulnerability to substance use is crucial to the development of effective prevention programmes'(HAS[36]).*

Elliman and Hall (2003) have produced a wide ranging analysis of the influences on children's health, from birth to secondary school, which points up the complexity of the interaction of the positive and negative factors for long term health, and the implications for children's public health policy.[37]

> *"In the twenty-first century, social, economic and environmental factors are more important than biological disorders as causes of poor health in children. There is growing evidence that experience and environment in early infancy affect the formation of neural pathways.'*

The following points adapted from a 1997 report on Community Prevention Programmes by Communities That Care (CTC) summarise the issues raised in this discussion.[38]

Risks

1. Risks exist in different areas of life

Risk factors can be found in every area of young people's lives and at different stages in their development. Tackling just one risk factor in one domain - family, school, community or friends - may not significantly reduce the problem behaviour.

2. The more risk factors, the greater the risk

Risk factors often cluster together in children's backgrounds and are interrelated. For example, young people living in run-down, disorganised neighbourhoods come, disproportionately, from low-income homes with poor parental supervision and erratic discipline. Exposure to a greater number of risk factors results in a disproportionate increase in the level of risk. This underlines the importance of targeting multiple risks.

3. Risk factors: consistency across different social groups

While the levels of particular risk factors may vary in different ethnic, cultural and socio-economic groups, research suggests that the ways in which they influence children's development are the same. Likewise, although surveys suggest that young men are more likely to use drugs and commit crime than young women, a similar set of risk factors applies to both sexes.

There is a separate – and more usual – use of the concept of “risk”. This is in the sense that young people, especially boys, tend to take more risks with their health than older people. The reasons for this are complex, but may be related to a sense of the “invulnerable”[39].

4. Protective factors and the impact on risk reduction

Children exposed to risk factors during their early years do not necessarily become involved in youth crime, drug misuse and other problem behaviour when they are older. Research has shown there are protective factors that – in potentially adverse circumstances – help to buffer children against risk and successfully navigate their way towards adulthood. Understanding and identifying risk factors will help communities to focus on what they should do to prevent problem behaviour. Protective factors hold the key to understanding how to reduce those risks and how to encourage positive behaviour and social development.

Common risk factors apply to different behaviour problems. Different youth behaviour problems share many of the same risk factors. This is a source of strength in a preventive programme. Reducing a particular risk factor is likely to affect a number of different problem behaviours.

5. Individual characteristics

Some children, from babyhood, share characteristics that help protect them against problems as they grow older. For example:

- *Gender*: Given equal exposure to risks, research shows that girls are less likely to develop health and behaviour problems in adolescence than boys.
- *Resilient temperament*: Some children adjust to change or recover from disruption in their lives more quickly than others.
- *Outgoing nature*: Children who are outgoing, enjoy company and elicit positive attention from others are at reduced risk.
- '*Intelligence*': 'Bright' children are less likely to perform poorly in school or commit crime during adolescence. However, 'intelligence' on its own does not appear to reduce the risks of drug abuse, and definitions of intelligence are the subject of many theories, outside the scope of this review.

Personality characteristics are arguably difficult to change, particularly the characteristic that is known as the Locus of control in Social Learning theory which describes a generalised expectancy of an individual's beliefs in his or her personal control over a situation.[40]

A further report from CTC (2003, Section 3) presented a model of risk and protective factors which was derived from first hand research and an analysis of secondary sources of mainly longitudinal studies. It describes seventeen major risk factors and six protective factors which are reproduced below:

RISK FACTORS

Family

- Poor parental supervision and discipline
- Family conflict
- Family history of problem behaviour
- Parental involvement / attitudes condoning problem behaviour
- Low income and poor housing

School

- Low achievement, beginning at primary schools
- Aggressive behaviour, including bullying
- Lack of commitment, including truancy
- School disorganisation

Community

- Community disorganisation and neglect
- Availability of drugs
- Disadvantaged neighbourhood
- High turnover and lack of neighbourhood attachment

Individuals, friends and peers

- Alienation and lack of social commitment
- Attitudes that condone problem behaviour
- Early involvement in problem behaviour
- Friends involved in problem behaviour

Protective factors

- Strong bonds with family, friends and teachers
- Healthy standards set by parents, teachers and community leaders
- Opportunities for involvement in families, schools and the community
- Social and learning skills to enable participation
- Recognition and praise for positive behaviour

The CTC model presumes that children may start life with certain predispositions, but that patterns of behaviour are learnt through modelling/interaction with the environment. The model also assumes that community based interventions can reduce risk and enhance protective factors, enabling children to fulfil potential and reduce the probability of involvement in problem behaviour.

A report by the Department of Criminology and Criminal Justice at the University of Maryland, arrives at similar conclusions to the CTC model. The report, *Preventing Crime: What Works, What Doesn't, What's Promising (2003)*[41] was prepared for the United States Congress and carries particular weight due to the methodology employed and the mandate from the United States Congress. The report uses a meta-analysis of reports and research evaluations in the United States, of interventions, policies and programmes designed to impact on family, school, community and economic factors which affect crime in neighbourhoods and communities.

Beyond those factors identified in the CTC report, the authors – Lawrence Sherman and Colleagues, note the importance of schools interacting with their communities in a range of multi-faceted, long term, broadly based interventions and programmes which are embedded in endeavours to strengthen the school as an organisation. Such endeavours are linked with the capacity to initiate, implement and sustain strategies to ensure goal consensus and coherence in prevention work. The report points out that knowledge of "what works" in the literature does not inevitably result in faithful

implementation of effective principles and practice elsewhere. This point is returned to in the review of effectiveness research in school health education (Section 6).

The problems of targeting at-risk groups

The reports discussed above point out that risk behaviours such as drug and alcohol misuse are not uniformly distributed through the general population. Some groups are at greater risk. They include out-of-school and unemployed young people, runaways, those in Local Authority care, homeless young people and those involved with the youth justice system. Such groups may be under-represented in school and household surveys, and therefore not identified early enough to enable effective intervention.

Early identification of, and intervention with, vulnerable, 'at-risk' young people in the school, can help. But there are difficulties with targeting interventions. Targeted interventions require screening and selection of candidates for intervention. This may lead to 'false positives' – that is, wrongly identifying people as being at risk who are in fact not. 'False negatives' can also be a problem in screening – that is, missing those who are at risk. The former error means wasting resources and possibly stigmatising those wrongly identified. The latter error means not reaching the target group.

This is a serious problem for early identification because it is extremely difficult to predict who will most benefit from the intervention. As was seen in the previous section, there are so many risk factors that to include them all would be to cast the net very widely indeed. There is also the difficulty that, since early intervention, by definition, is a long-term strategy it is difficult to measure the results.

However, as the sources above show, there is evidence that targeted prevention programmes and projects can impact to some degree on those factors which predispose towards problem behaviours. To this end a number of projects have been funded by Health Action Zones and Education Action Zones across the UK.

The evidence so far indicates that appropriate programmes aimed at young people and their families or at vulnerable communities may be helpful. The HAS report [42] described two targeted studies. In the first, a six-year follow-up showed a reduction in a range of antisocial behaviours including substance misuse. The second study did not use drug use as an outcome measure, but it did show a reduction in general antisocial behaviour and drug misuse is correlated with this. This programme (High-Scope) is presented below.

High-Scope

The pre-school education of children from vulnerable families was among the earliest type of evaluated prevention programme. Probably the most celebrated prevention and early intervention programme was the 'High Scope Perry' pre-school in the USA. Through pre-school programmes, High Scope aimed to help children from poor families make a better transition from home to community. The programme intervened with 58 three- to four-year-olds at high risk of psychosocial difficulty in adulthood, coming from areas of low socio-economic wellbeing where children had generally performed badly in school. With the goal of enhancing cognitive and social

skills, teachers worked with the children individually as well as in groups in the two years prior to mainstream school on a high-quality, active-learning programme. Half-day sessions every working day were given during school term-times; and the teachers visited the child's home once a week, encouraging parents to take an active role in their child's education.

High Scope was rigorously evaluated. The 58 children on the programme were matched with 65 children deprived children who did not receive any special intervention. Although, at first, the children in the intervention group did not fare any better; by age 15 they had lower levels of involvement in crime, and at both 19 and 27 years they had experienced significantly fewer arrests than the control group. For example, the proportion of 'chronic offenders' (defined as those arrested five or more times) was seven per cent for the High Scope graduates compared with 35 per cent for the controls.[43] The High Scope Programme influenced the UK 'Sure Start' Programme, which has now become an important component of Public Health Policy relating to families (see Section 5).

The factors which influence positive health promoting decisions of children and young people, which draw on this section, are summarised in Section 8: Summary and Conclusions. The influences of the theories and research presented above, in the priorities for UK Public Health policy and guidance, are reviewed in Section 5.

PUBLIC HEALTH PRIORITIES: GOVERNMENT REPORTS AND GUIDANCE

Health policy

As discussed in previous sections, the evidence suggests it is possible to improve children's health by a range of actions targeted at families, schools and communities. Government and local policies mainly targeted at adults (for example, concerned with alcohol misuse, reducing poverty, or increasing employment) may have significant effects on children's health. Positive health outcomes for children may also result from targeted health policies. This is the rationale for interventions such as the National Service Framework (NSF) for Mental Health (because of the risk of mental health problems for a child of a parent with mental illness) and the NSF for Coronary Heart Disease in promoting early establishment of patterns of healthy eating and positive physical activity.

Policy and children's issues

The Green Paper, *Every Child Matters*, is focussed on the range of issues and services which impact on children's life chances. It outlines the Government's proposals for reforming the delivery of services for children, young people and families. It aims to improve outcomes for children and their families, to protect them, to promote their wellbeing and to support all children in developing their full potential. It focuses on four main areas:

- Early intervention and effective protection
- Supporting parents and carers
- Accountability and integration – locally, regionally and nationally
- Workforce reform.

The recently-proposed reforms of local children's services will create Children's Commissioners in every local authority and will, in most cases, combine social services and education departments*.

The Green Paper (2003) and Children Bill (2004) clearly see schools as a central focus for coherent, joined up services which are at the heart of child support in the most holistic sense. Extended and Full- Service schools, designed to provide a range of activities to help meet the needs of pupils, their families and the wider community, are envisaged as the means of translating a vision into reality.[44]

*The Children Bill, introduced in Parliament in March 2004, is the first part of the government's reform of child protection following the public inquiry into the murder of eight-year-old Victoria Climbié. The Bill will implement the main proposals of the Green Paper, Every Child Matters, (September 2003). A longer Bill, including proposals for reforming children's social work and providing more support to parents, will follow later. The government will set out a fuller description of the outcomes it wishes children's services to achieve in autumn 2004, taking account of the targets and funding in the Treasury's next comprehensive spending review.

There are several such schools already in existence, many located in areas of multi-deprivation, and also involved in Safer School Partnerships (SSP) and Behaviour and Education Support Teams (BEST).[45] Such schools demonstrate awareness of the multi-faceted elements of child support, and have embraced the philosophy of multi-agency collaborations across a range of innovations. However, the effectiveness of partnerships is often compromised in schools which struggle with a number of the social issues found in socially and economically deprived neighbourhoods (See again Sherman et al and FitzGerald and O'Connor[46]). Nevertheless, the Healthy Schools policy (see below) has become part of DfES efforts to address pupil achievement and welfare in an integrated way.

Health education policy

The National Healthy School Standard is jointly funded by the DfES and the DoH and hosted by the HDA. The Standard aims to help schools become healthier by providing guidelines for a whole-school approach. The overall aim is to help schools become healthier places to be, and to provide an environment conducive to learning and to raising pupils' achievement. It is part of the Government's drive to reduce health inequalities, promote social inclusion and raise educational standards through school improvement. Drug education is one of ten specific themes identified by the National Healthy School Standard*, but has a separate policy dimension with accompanying guidance issued in 2004 (see overleaf).

Drug education policy

Drugs are a major concern for Government, presenting real challenges for public health policies, and related resource issues and the serious effects on individuals and communities of drug-related crime. The Government's updated Drug Strategy (2002) aimed to:

> *'Prevent young people from using drugs by maintaining prohibition which deters use and by providing education and support: targeting action on the most dangerous drugs and patterns of drug use and the most vulnerable young people'.*[47]

Specifically, the Strategy committed the Government to expand and improve the quality of drug education. One target was that, by March 2002, all primary and secondary schools had drug education policies. Another was that by March 2006 no drug education lessons would be described as 'poor' by Ofsted.

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*The National Healthy School Standard (NHSS), jointly funded by the Department for Education and Skills (DfES) and the Department of Health (DH), is part of the Government's intention to: 'reduce health inequalities, promote social inclusion and raise educational standards. … The overall aim is to help schools to become healthier'. A healthy school is: '…successful in helping pupils to do their best and build on their achievements. … it promotes physical and emotional health by providing accessible and relevant information and equipping pupils with the skills and attitudes to make informed decisions about their health. A healthy school … recognises the need to provide both a physical and social environment that is conducive to learning.'

The NHSS is based on evidence that healthier children perform better academically and education plays an important role in promoting health, especially among the socially and economically disadvantaged.

An Ofsted survey of drug education in 2002 found that 96 per cent of secondary schools said that they had a drug education policy – but that this was no guarantee of quality. The inspectors found drug education generally adequate but less than good in 60 per cent of lessons. Lack of interactivity was a major failing: the facts were taught, but pupils were usually not involved in constructive discussion of their views, attitudes and values and only rarely were they or their parents consulted about the overall programme.[48] As Section 6 below, on effectiveness research reveals, this is an issue in terms of positive impact on pupils.

However, drug education in the school curriculum is part of the statutory (Science) National Curriculum. It is also included in the PSHE curriculum. Several guidance documents now summarised in the DfES (2004) drugs guidance described below, have been issued by the DfES since 1995, which suggests that drugs prevention and education is a priority for national health policy (but see Section 8: Commentary and Discussion).

In 1995, the first major guidance for schools on drug prevention and education was issued by the DfES (then the Department for Education and Employment). Their Circular said that the 'essential aim' of a programme of drug education: 'should be to give pupils the facts, emphasise the benefits of a healthy lifestyle, and give young people the knowledge and skills to make informed and responsible choices now and later in life.'[49] This aim is incorporated and developed within the 2004 Guidance, discussed below.

2004 DfES Guidance on drug education

In 2004, the DfES published updated drug education guidance, which states:

> *'Drug education should enable pupils to develop their knowledge, skills, attitudes and understanding about drugs and appreciate the benefits of a healthy lifestyle, relating this to their own and others' actions.'*[50]

Other key points of the 2004 Guidance are:

- drug education should cover all drugs and, when appropriate, should focus on drugs of particular significance such as alcohol, tobacco, cannabis, volatile substances and Class A drugs.
- drug education should be delivered through personal, social and health education (PSHE) and citizenship and fulfil the statutory requirements of the National Curriculum Science Order.
- it should start in primary schools and develop through each of the Key Stages to ensure continuity and progression
- drug education in the classroom should be supported by a whole school approach that includes the schools' values and ethos, staff training and the involvement of pupils, staff, parents / carers, governors and the wider community

- drug education should take account of pupils' views so that it is both appropriate to their age and ability, and relevant to their particular circumstances.[51]

The 2004 DfES Guidance on drug education recommends that: 'Teaching in drug education should reach the same high standards as for other subjects and focus in particular on establishing a supportive learning environment and using active and participatory teaching methods.'[52] It refers to quality standards for drug education developed by DrugScope.[53]

The DfES Guidance goes on to state the importance of delivering drug education 'within a safe, secure and supportive learning environment'.

The Guidance is not only relevant drug education; it also provides links to the PSHE Guidance and evidence from Ofsted reports on drug education. As such, it puts drug education in a health education context, and the lessons from drug education are applicable to a broader health agenda.

Furthermore, through the emphasis on effective teaching and learning, and the clear links made with all aspects of the school curriculum; the schools policies on behaviour management, inclusion and pupil welfare; and effective partnerships with parents and external agencies; the guidance appears to send clear messages to schools that drugs prevention is central to the core functioning of the school.

In summary, public health priorities in relation to children's health and health related decisions, are demonstrated in key policy documents discussed in this section. Two important aspect of these policies are firstly, the recognition that schools are central to achieving policy aims, and secondly, that effective interventions require school partnerships with a range of agencies on agreed goals and procedures. A review of the school health education effectiveness literature, in the following section, will return to these themes.

SCHOOL HEALTH EDUCATION AND EFFECTIVENESS RESEARCH

Context to a review of effectiveness research: General School Issues

School Climate and the Informal Curriculum

Previous sections of this review have discussed how schools can make an important contribution to the life chances of their pupils, through measures which go beyond the lessons taught through the formal (organised) curriculum. The philosophy of National Healthy Schools Standards (Section 5) underpins the notion of a health promoting school, which addresses health through organisational policies, for example, school inclusion measures, smoke-free environments, and "healthy" diet choices in school canteens. Thus, many aspects of health are not just covered within particular school subjects, but are communicated and taught through the whole climate of the school. This will include (informal curriculum) issues such as the degree to which children and young people are empowered to make decisions and choices; and opportunities for physically energetic play.

Schools facilitation of "healthy" behaviours

For example, in a summary of research into the area, Wolf[54] reported that although the Government has funded many sports schemes in the community, there is less commitment to physical activity as part of the "crowded" school curriculum. Moreover, many children find PE alienating, and there needs to be a more sympathetic approach which takes account of the difficulties for some children in obtaining and keeping PE kit. Wolf suggests there should also an increase in physical activity across the whole school – not just during PE lessons.

School disaffection and exclusion

Section 4 on Risk and Protective Factors, identified that school disaffection is positively correlated with problem behaviours. Young people excluded* from school may miss aspects of their education (and perhaps become more vulnerable to drug misuse). A significant but unknown number of exclusions are related to drugs, but poor record keeping by schools make accurate judgements difficult. There are also many young people not formally excluded, jailed or hospitalised but who are self-excluding; this is estimated to include between 50,000 and 100,000 pupils of all ages who are missing from schools in England and Wales according to a report by NACRO.[55]

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*'Exclusion' is a formal procedure for removing young people from school either temporarily or permanently. This word replaces the older term, 'suspension'.

Charities working in the field – NACRO, Kids Company, NCH and NSPCC – have found a multiplicity of problems amongst such children including bullying, drug misuse, family breakdown, violence, sexual abuse, low educational attainment and poor social skills. Boys are overwhelmingly the most likely to go missing, although the number of girls is fast rising. Children from Local Authority care or Caribbean backgrounds appear to be at particular risk. Poverty appears to interrelate with many of these issues, and schools and the inflexible structure of the education system is held responsible in Nacro's report, for many of the problems identified. The report calls for a more flexible and vocationally-orientated National Curriculum to reduce the school drop-out rate.

CEDC/DrugScope have set out some principles to address pupil disaffection, and support school inclusion:

- *Setting good habits early*: primary schools need to help pupils establish regular punctual attendance and good behaviour, involving parents in the process
- *Early intervention*: prompt intervention is needed where there is poor behaviour or unexplained absence, so it is clear that these will not be tolerated
- *Rewarding achievements*: positive recognition of individual pupil, class or year group achievements in good attendance and behaviour
- *Supporting behaviour management*: behaviour management techniques, such as 'The Whole School Quality Circle Time' model, `Assertive Discipline', and 'Circle of Friends'
- *Working with parents*: encourage parents to support good attendance and behaviour through home-school agreements, parents' meetings and newsletters
- *Involving pupils*: involve pupils in formulating and reviewing anti-bullying policies, and contribute ideas through Schools' Councils and in class discussions
- *Commitment to equal opportunities*: parents and pupils should know that the school has an equal opportunities policy and is committed to it. Schools should monitor the impact of their policies and procedures on different groups. The effectiveness of policies should be assessed at governors' meetings
- *Identifying underlying causes*: poor behaviour may be linked to pupils' problems, and require additional literacy or numeracy support to address them effectively
- *Study support: many activities* - from homework clubs to thinking skills workshops - help reinforce school work. Family support services may help parents support their own children with school work.[56]

The role of external agencies in health education

A DfES review (2004) of the role of external contributors to school drug education illustrated the range of statutory, voluntary and commercial bodies involved in school health education. The review authors concluded that external contributions can be valuable, where the content and delivery is based on good practice principles, but that more research into measuring outcomes was needed, particularly regarding children's perceptions of effectiveness. Training for external contributors was seen as essential, and the report makes recommendations for improving training both for teachers and external contributors.[57]

A 1999 collaborative report between The Association of Chief Police Officers (ACPO) and Roehampton Institute (now Roehampton University of Surrey) found that police officers were the main external contributors to school drug education, but their inputs were rarely designed to fulfil school aims and objectives, and were seldom evaluated. The report recommendations that police officers should input only into teacher led and supported programmes, and be restricted to areas of police expertise, appear to have been partially implemented, at least in some Forces.[58]

Whilst the 2004 DfES Guidance on drug education states that:' Teachers should be the main providers of drug education and External contributors, if used, should be involved in a planned way, and where they can add value to the school's programme;'[59] the ACPO/Roehampton report findings reflect those of Sherman et al (Section 4) that school organisational issues work against coherent and co-ordinated planning in terms of the lack of school based leadership and co-ordination.

The DfES Guidance (2004) acknowledges the difficulties busy schools have in ensuring external contributors have the necessary skills and expertise:

> *'Schools are strongly encouraged to liaise with LEAs and their local Healthy Schools Programmes on the range of individuals and agencies who can support drug education programmes. Many have devised quality standards and protocols for the use of external contributors and provide training to those supporting schools to ensure quality and consistency.'*[60]

The research evidence suggests that the qualities of health educators have an important role in effectiveness, together with programmes based on evidenced best practice. The research evidence presented below, identifies the components of best practice, as far as available evidence allows.

Health and drug education effectiveness: Research Evidence

Much of this section presents evidence for the effectiveness or otherwise of drug education, but the lessons are applicable to health education generally, given that both must address knowledge, skills and attitudes (see again, Health Education models, Section 1). In addition, drug misuse is correlated with other problem behaviours which affect young people's health, but which space precludes an in-depth examination. However, within this section, there is a particular focus on 'lifeskills'-based education, which are also used within sex education programmes.

The 'LST' and 'Project Star' approaches from the USA have informed part of the basis for the UK 'Blueprint' drug education programme, which is currently being piloted and evaluated.

In a consideration of the research evidence base, the 2004 DfES Guidelines on drug education states that:

> *'Research shows that certain models of drug education can achieve modest reductions in the consumption of cannabis, alcohol and tobacco, and delay the onset of their use. There are also indications that drug education has a role in reducing the risks associated with drug use, reducing the amount of drugs used and helping people to stop.*
>
> *Although not yet thoroughly tested in Britain, the best available worldwide research identifies effective drug education programmes as ones which:*
>
> - *address knowledge, skills and attitudes*
> - *provide developmentally appropriate and culturally sensitive information*
> - *challenge misconceptions that young people hold about the norms of their peers' behaviour and their friends' reactions to drug use. This 'normative education' is important because young people often overestimate how many of their own age group drink, smoke or use illegal drugs*
> - *use interactive teaching techniques such as discussion, small-group activities and role play*
> - *involve parents/carers as part of a wider community approach. Parents/carers should have access to information and support in talking with their children about drugs.' (paragraph 2.3)*[61]

However, it is necessary to examine the sources of the evidence which underpins the above statements.

At least in relation to drugs, there is emerging evidence that the life-skills approach to drug education is rather more effective than others. A UK study conducted for the Drug Prevention Initiative (DPI), the forerunner of the Drug Prevention Advisory Service (DPAS), found that a life-skills approach implemented in the primary school did have some positive impact.[62] This finding supports other research, mainly from the USA, which has identified the life-skills approach to drug education as having the most promise of success.

Lifeskills education

The WHO (World Health Organisation) defined life skills as:

> *'Abilities for adaptive and positive behaviour, that enable individuals to deal effectively with the demands and challenges of everyday life… [they are] those abilities that help to promote mental wellbeing and confidence in young people as they face the realities of life.'*[63]

Thus, the WHO suggests, life-skills education will develop the skills of:

- decision making and solving problems
- creative and critical thinking
- communication and interpersonal skills
- self-awareness and empathy
- handling emotions and dealing with stress.

Life-skills education is practical and activity oriented, therefore, part of the life-skills approach involves creating a safe environment where young people can practise and develop these skills. Having the right classroom atmosphere is therefore an important component of the life-skills approach.

'Life Skills Training' (LST) is a particular (USA –originated) implementation of life skills education. It was first developed and tested among mainly white, middle-class pupils from suburban and rural intact families. Life Skills Training can result in lasting reductions in regular smoking; the evidence of a positive effect is strongest in relation to heavy smoking and drinking to intoxication. However, the findings are insufficiently consistent with regards to reduction in illegal drug use and reducing problem drug use.

The reasons for the programme's success seem to be its:

- intensity
- use of booster sessions
- interactivity
- emphasis on skills
- and its potential for delivery by peer leaders.[64]

A review of the research on Life Skills Training drug education programmes by Coggans *et al* found:

- LST can have durable preventive effects on cannabis use if delivered relatively completely, but these effects are small in scale (effects on tobacco and alcohol, while not covered in detail in the review, can be positive, although relatively modest)
- LST had positive effects in reducing the numbers of those who used more than one of: cigarettes, alcohol and cannabis

- in a six-and-a-half-year follow-up study, there was some evidence of preventive effects on a wider range of drugs
- the impact of LST is maximised when programme delivery is faithful to the original programme design and when students complete the programme.

However, LST impact is *not*, on the available evidence, achieved in the expected way, that is, by enhancing the social and psychological factors believed to promote substance misuse.

Coggans *et al* concluded that although LST had some effects, LST promotional material overstates the programme's effectiveness and it was questionable whether the costs and resources required for LST training and implementation were justified, given its limited impact.[65]

Project Star

LST is one of the models of drug education that partly inform the basis of the UK Home Office drug education *Blueprint* Programme. This relatively large-scale action research programme commenced in 2003. Another model from which the Blueprint Programme is drawing inspiration is Project Star. This has as its core a school-based programme, but it also involves parents and the wider community.

Project Star was implemented in Kansas City and in Indianapolis as 'I-Star'. The project was trialled among first-year secondary school pupils in Kansas City and Indianapolis. The results were:

- a reduction in tobacco, alcohol and cannabis use
- some evidence of long-term impact through to early adulthood and reductions in other form of illegal drug use.
- impacts were most consistent and more impressive for cigarette smoking.

However, critics point out that the studies are not robust enough; non-random allocation of schools in Kansas and incomplete reporting of the randomised Indianapolis evaluation leave doubts over the validity of the findings.[66]

Reviews of drug education effectiveness

The HDA (Health Development Agency) have produced Drug *use prevention: a review of reviews (Evidence briefing summary)*[67] which summarises the evidence on drug prevention from 21 reviews. They have also published a short document entitled *Preventing and reducing drug use*: *what works?*

White and Pitts[68] conducted a systematic review of the effectiveness of interventions directed at preventing, reducing, or reducing harm of young people's drug use. (This review is the only 'Category 1' (i.e. reaching a high standard) review in the HDA's review of 21 reviews.) They found that the impact of evaluated interventions was small, with dissipation of programme gains over time. They also reported that interventions targeting hard-to-reach groups have not been evaluated adequately.

Tobler (2001) suggests that evaluations of 120 school drug prevention programmes in the USA aimed primarily at adolescents, shows that interactive programmes were more effective than non-interactive programmes. Successful interactive approaches are characterised by pupil-to-pupil communication facilitated by small group activities including practice of interpersonal skills. Successful programmes focus on interpersonal competence and challenge overestimations of the extent of drug use among pupils' peers (normative education). Delivering such programmes requires a paradigm shift from 'instructing classes' to 'facilitating groups'. Implementing interactive programmes requires support from policy makers and education administrators and training to give teachers the skills and the confidence to work in what may be unfamiliar ways.[69]

DARE (Drug Abuse Resistance Education) police led programmes in the USA have been subjected to a number of evaluations which have differed in terms of methodological rigour (Sherman *et al – Section 4*). Whilst Sherman et al state that such evaluations conducted in the mid 1990s, have been generally negative in terms of impact on behaviour, attitudes or knowledge gains, they also point out that revised DARE programmes, including DARE PLUS should be subjected to further rigorous evaluation.

However, the first randomised trial of DARE in US Secondary Schools for 12-14 year olds, is reported as finding some positive impact where the programme was supplemented by interactive elements involving parents and the community, in addition to pupils. Police Officers leading the programme were trained in interactive teaching, a parental involvement strategy (partly led by pupils) was set up, and extra-curricular activities, and neighbourhood action teams led by community workers were established. The DARE – plus (not DARE PLUS programme) elements significantly retarded growth in boys' smoking, alcohol and cannabis use and reduced cases of physical victimisation. There were no significant effects for girls. The DARE only programmes had no significant impact on any of these factors.[70]

Effective programmes

A general consensus in the research literature on drug misuse prevention, suggests that some school-based programmes can achieve at least modest reductions in adolescent drug use. There is also agreement that certain kinds of prevention programmes are not effective: these include information dissemination or knowledge-based programmes. Dusenbury and Falco[71] carried out a literature review of school-based drug misuse prevention programmes in the USA; they also interviewed a panel of 15 leading experts in prevention research.

Effective prevention programmes were found to be based on a sound theoretical or research foundation. They included developmentally-appropriate information about drugs, social resistance skills training and normative education. Broader-based personal and social skills training appeared to enhance programme effects. Effective programmes used interactive teaching techniques and teacher training and provided adequate coverage and sufficient follow-up. Cultural sensitivity to the target population was found to be critical to programme success (see also Section 7).

UK examples of evaluated drug prevention programmes are in short supply. An example is 'NE Choices', a major drugs prevention programme in North-East England, carried out between 1996 and 1999, targeting 13- to 16-year-olds. It had explicit drug use prevention, prevalence reduction and harm minimisation behaviour change objectives. The intervention had many of the right elements: strong theoretical underpinnings; a multi-component design, combining a schools intervention with community, media and stakeholder activity; extensive long-term resources (the programme lasted three years plus a one-year pilot and an additional year of follow-up). But it did not change behaviour.

Hastings *et al*[72] found that NE Choices' apparent inability to produce behaviour change may reflect weaknesses in the outcome evaluation (changes may have happened, but not been recorded). Lack of confidence amongst the teachers, competing priorities and difficulties of involving parents were given as some of the problems with the programme. These problems were further exacerbated when local political pressure led to the programme being delivered in more than twice as many schools as was originally intended. Despite successful efforts to extend the budget with private sector sponsorship and public partnerships, it may be that the resources were inadequate to the task.

In a systematic review, Cuijpers[73] found that most research has concentrated on the effectiveness of school drug prevention programmes but relatively few studies have examined *which characteristics* are related to the effectiveness. By reviewing research on effective characteristics of school-based drug prevention programmes, Cuijpers developed several quality criteria for prevention programme:

- *proven effects*. The effects of a programme should have been demonstrated in well-designed scientific research
- *interactive delivery methods*. Universal school-based drug prevention programmes should use interactive delivery methods
- based on the '*social influence model*'. Based on the idea that 'inoculation' in the classroom against active or indirect social pressure to use drugs will help prevent substance use
- *focus on norms, commitment not to use, and intention not to use*. As part of the social influence approach, prevention programmes should focus especially on norms (social prevalence knowledge, social acceptability knowledge, normative expectations, friends' reactions to drug use), commitment of students to not use substances, and intentions not to use
- *adding community interventions to school-based interventions*. This strengthens the effects of school-based interventions. Community interventions include family interventions, mass media campaigns, and community mobilising committees

- *use of peer leaders*. This may strengthen the short-term effects of prevention programmes
- *adding life-skills training to social influence programmes*. This may strengthen the effects of prevention programmes (although there is insufficient evidence from research on whether this works).

Midford *et al*[74] identified the principles that underpin effective school-based drug education:

- drug education should be evidence-based, developmentally appropriate, sequential, and responsive to student needs
- a whole-school approach is important, as are parental involvement and community support
- programmes should be initiated before drug use commences
- strategies should be linked to goals and should incorporate harm minimisation
- teaching should be interactive and use peer leaders
- the role of the classroom teacher is central
- information on normative drug use and relevant harms is important, as is social and resistance skills training.
- community values, likely drug use and the social context of use are issues that have to be addressed
- coverage needs to be adequate and supported by follow-up.

Blueprint Drug Education Research Programme

The Blueprint Programme was developed from a research evidence base that incorporated many of the components above. Essentially these are:

- Research driven
- Developmentally appropriate
- Broad skills base
- Social resistance skills
- Normative education
- Interactive teaching styles
- Adequate lesson coverage
- Culturally sensitive
- Added components (Parents, media, community)
- Evaluation

The programme has set out to test the evidence-based rationale, by designing a school based programme (Years 7 & 8) which incorporated the research recommended components (see previous page). The evaluation report is due in 2007.

However, much of the evidence underpinning the Blueprint programme has also informed UK strategy on drugs prevention and education.

The UK's Cross-Departmental Government Strategy on Drugs stated that:

> *'…the evidence points to certain key principles:*
>
> - *purely fact-based and / or 'shock'-based education is not as effective as a lifeskills-based programme, fully integrated into a school's curriculum*
> - *schools which deliver drug education in a broad PSHE context with a trained teacher responsible for co-ordination and delivery tend to have more coherent and effective programmes than those where education is delivered in a tutorial context.…no matter how drug education is approached, the importance of suitable training and support for teachers can not be overstated. Parental involvement is also a crucial factor in success*
> - *external inputs, such as visiting speakers, can be useful, but are not a substitute for a comprehensive drug education programme…'*[75]

While acknowledging that: 'much of the research into the effectiveness of drug education and prevention in schools has been short-term and local'; the Strategy emphasised the importance of planned and integrated programmes of drug education.

Some educationalists argue that for drug education to attempt to achieve abstention or even reduced consumption goals is unrealistic, and that it is more sensible to focus on harm minimisation outcomes. As McBride puts it:

> *'The presumption that school drug education should or could have a continued long-term effect after young people leave school, or even after the immediate delivery of a programme, needs to be questioned.'*[76]

Anderson suggests:

> *'In general, it has been concluded that educational programmes on their own are unlikely to deliver large or sustained benefits in preventing the harm done by alcohol to young people.'*[77] '

These two authors go on to argue for a focus on harm minimisation in relation to alcohol. Correcting unrealistic beliefs about how normal it is to drink alcohol is a feasible way for school programmes to reduce excessive, or otherwise problematic, alcohol use. The USA Alcohol Misuse Prevention Study (AMPS) aims to reduce alcohol problems rather than use. It begins in Grade Six (ages 11-12) with eight lessons primarily intended to improve pupils' ability to resist peer influences, followed over the next two years by nine 'booster' sessions. Comparison of AMPS and matched

control schools suggested that the lessons curtailed the development of alcohol problems, but only among the minority of pupils who had already drunk without adult supervision. Findings from AMPS suggest that, while refusal skills have a role, correcting normative beliefs is the more powerful way to affect adolescent over-indulgence in alcohol, and is easier to achieve through school lessons. School drug prevention programmes should incorporate teaching which corrects inaccurate beliefs about the normality and acceptability of drug use.[78]

However, while, as McBride and Anderson suggest, harm minimisation might be all that could be hoped for with certain groups of older teenagers, it is reasonable – at least in the absence of conclusive evidence *against* the effectiveness of properly planned programmes – to pursue preventive goals with younger children.

In summary, the research evidence suggests that there are defining characteristics of school-based interventions which are most likely to be effective. Nevertheless, in Sherman *et al* terms (Section 4) many approaches come under the heading of "what looks promising" rather than "what works".

The next section (Section 7) is devoted to the particular issues for health education of young people raised by the specific needs of BME communities. The research has indicated that targeted approaches hold out the best chance of success, in a diverse society, the implications of this need to be addressed.

BME COMMUNITIES AND DIVERSITY ISSUES

Modern-day UK society is made up of diverse ethnic and multi-cultural communities. Health and drug educators need to understand and incorporate this diversity into their programmes. Despite the fact that the UK has long been a multi-cultural society, there is little research about ethnicity in relation to health and drug education. This section focuses on work in this area.

There have been some reports in the UK, for example a Home Office-funded report on drug prevention with diverse and multi-cultural groups,[79] and a series of needs assessments of black and minority ethnic (BME*) groups in relation to drug services.[80,81,82] Because there is limited research in the UK (particularly concerning primary school-aged children) this section draws on literature from the USA,[83] Australia,[84] and Canada[85] and covers adolescents.

The 2001 Census reported that ethnic minorities made up 12.5 per cent of the population in England and Wales[86]. London had the highest proportion of people from ethnic minority groups (apart from people of Pakistani origin; there is a higher proportion of this group in Yorkshire and Humber and the West Midlands). In the London Boroughs of Lambeth, Lewisham, Brent and Hackney over 10 per cent were Black Caribbeans and in Southwark, Newham, Lambeth and Hackney over 10 per cent were Black African. Looking at religion, there were 37.3 million people in England and Wales who stated their religion as Christian. In England 3.1 per cent were Muslim, 1.1 cent were Hindu, 0.7 per cent were Sikh, 0.5 per cent were Jewish, and 0.3 per cent were Buddhist. There is enormous regional variation in terms of both ethnic group and religion.

The needs of particular ethnic groups

It is important to understand the range of needs that BME groups have; to consider their experiences and their attitudes; and take these into account in the development of health and drug education programmes. If programmes fail to do this, they risk being ineffective and irrelevant for these groups.

Minority ethnic communities share the needs of the majority population, but also have specific needs in relation to drugs issues. For example:

- many BME groups have a poor knowledge of drugs and their effects
- alcohol and tobacco are often not considered to be ‘drugs’
- there is often stigma associated with the use of illegal drugs
- spoken and written language may present a challenge to educators
- cultural-based attitudes to health and drugs may need addressing.

*‘BME’ is a generally accepted ‘short-hand’ term for referring to the multiplicity and diversity of groups in the UK

In addition, minority ethnic communities are more likely to experience economic and social deprivation, have limited access to health care and education, and, as a result, have poorer health status and be more at risk of harmful drug use.[87]

In general, in relation to drugs issues, BME groups may need:

- better access to information
- more confidence in dealing with drug-related issues
- the ability to put drug issues in context and in perspective
- parents, in particular, need to be well informed about drugs in order to:
  - bridge the gap between parents and youth
  - help parents spot the warning signs in their children
  - provide support for the parents and equip them to support their children
  - enable parents to be more effective and have the confidence to talk to their children about drugs
  - help parents understand what their children are being taught in schools.[88]

The research suggests that the needs of BME groups are, in general, poorly served in these respects.

Epidemiological research into substance use is sparse. Without solid data, racist stereotypes are more easily formed, for example, a common stereotype is that 'black people use drugs more than others'.[89] However, this is not the case; research suggest that drug use is more widespread among 'whites' than any other ethnic group.[90] The British Crime Survey[91] found that, amongst 16- to 24-year-olds, levels of drug use were lower for black people than those from a white background. In particular, around 10 per cent of 'white' people and eight per cent with mixed backgrounds had used a Class A drug in the last year, compared with two per cent of black people. There was, however, variability in the types of drugs used. For example, black people have similar levels of cannabis use compared to the white population. In relation to more problematic use, the more recently established minority communities and refugees, in particular, have higher levels of drug misuse.

It can be difficult to find out the extent of drug use in some ethnic groups because of the stigma associated with drug use. For example, obtaining an accurate picture of Asian drug use is difficult partly because of the concept of 'izzat' (or 'respectability') that is important in the lives of many Asians. This means that drug use is often concealed and not discussed.

Whilst broad survey data are informative for a general picture, the needs of ethnic minorities must be understood from more localised small-scale studies of the communities where health education programmes are implemented.

Risk and protective factors associated with minority ethnic groups

Ethnic and cultural background and religious affiliation have an important influence on individuals' health (including drug use, diet, and sexual health, for example) and in use of health services[92]. Understanding the role of ethnic and cultural differences in predicting health outcomes is necessary for developing culturally sensitive health education programmes.

Although levels of drug use are lower among BME people, some research suggests that some ethnic minority communities are more vulnerable to drug use than others[93]. Research on family risk and protective factors finds that there are more family risk factors in minority ethnic communities. Young people are more at risk of drug use when:

- family ties are weakened
- where there are communication problems
- where stress and conflict resolution strategies are poor.[94]

While family tension exists everywhere, intergenerational conflict within ethnic communities may be more extreme. For example, young people in minority ethnic communities tend to belong to peer groups with markedly different social and moral codes, which can increase conflict in the relationship between parents and their children.

It has been suggested that ethnicity *per se* is not an inherent risk factor.[95] Risk is more to do with social and environmental conditions such as poverty, prejudice, unemployment and low educational levels. Minority ethnic groups frequently live in areas of deprivation and, as problematic drug use is associated with deprivation, these groups may be at greater risk. In this way, it is these factors – not ethnicity or minority status – that put these communities at heightened risk of health and drug problems.

The vulnerability of ethnic communities is aggravated by lack of knowledge about drug services and barriers to utilising them. Information is not easily available, which adds to the risks. Some members of ethnic minority groups are less able, and can be less willing, to utilise existing drug services.

Despite BME communities being deemed more at risk of health problems, there is also evidence that minority ethnic groups might be at lower risk of drug misuse. Since many such groups are less likely than 'whites' to use drugs, ethnicity can be a 'protective factor'. There is evidence that young people with multicultural competencies, in particular those who are proud of their cultural heritage, bonding and identification (and therefore develop 'cultural competencies') are less likely to use drugs.[96] In addition, BME parents may have a greater influence on their children; for example, black parents are more likely than white parents to believe they have an influence on their children's behaviour and are more likely to be proactive and set and reinforce rules about drug use.[97] It is therefore important to understand the risk and protective factors associated with ethnicity and to incorporate these in programmes.

Health education programmes with ethnically diverse communities

There are two main strategies adopted by health education programmes working with minority ethnic communities. The first is based on the assumption that the causes of ill-health or drug use are different for different populations. This results in targeted, population-specific interventions. The second is a generic approach, based on the assumption that health issues are similar across ethnic populations and therefore interventions should be designed to address a broad range of individuals from different populations.

The targeted approach, which focuses on the particular cultural issues of an ethnic group, is very resource intensive.[98] Although it is recognised that it is important to develop culturally sensitive programmes, targeting communities can lead to ethnocentrism,[99] whereby an individual's perspective revolves around, and is limited by, their cultural identity. An ethnocentric approach can lead to marginalisation, stereotyping and bringing shame on a community.

Whilst there is diversity between (and within) ethnic groups, there are also similarities between them. Furthermore, schools generally include children and young people from a range of ethnic groups and it would be difficult to implement separate interventions for all such groups in a classroom context. Rather, therefore, than develop a programme entirely for a minority ethnic group, an approach that draws on both the generic and targeted approaches is possible. This should hold constant key aspects of a mainstream and tested health education programme, tailoring it for a particular ethnic group:

> *"Genuine recognition of diversity can lead to incorporation of a variety of different groups under one umbrella focusing on shared values and common needs"*[100]

Botvin's Life Skills Training (LST) is a generic life skills approach* that has been adapted to two main ethnic groups in the USA (Hispanic and African American youth). One study compared the generic LST programme with the culturally-tailored version and found that the two programmes were equally effective in reducing the intention to use drugs. They concluded that a single drug education programme can be used with multi-ethnic populations.[101] Despite this, a follow-up two years later found that the culturally-focused intervention had a greater impact than the generic LST. Thus, it seems that the most effective health and drug education programmes are sensitive to, and incorporate, the particular cultural meanings of different ethnic minority groups.

*This programme is discussed in an earlier section of this report.

Developing culturally sensitive health education material

If cultural characteristics of health understandings are not taken into account, culturally inappropriate messages could be conveyed, resulting in programmes that are meaningless and ineffective for minority ethnic groups.

Much health promotion is delivered in the medium of print. It is often translated into a range of minority ethnic languages. However, translating such material is by no means straightforward; subtle cultural meanings and differences between particular groups have to be taken into account. It is helpful if materials include pictures and images from particular cultural groups, as well as providing the material in more than one language so they can be used by family members of different generations together.[102]

Although there will be common components among programmes for different populations, it is unrealistic to think that a generic programme can simply be transferred across ethnic groups as there are important and vital differences that characterise minority ethnic groups. There can be issues in relation to, for example nutrition and diet (such as kosher foods for Jewish people). In drug education, it is crucial to ascertain not only the extent and types of drugs used in particular communities, but to understand the potentially complex cultural social and personal meanings surrounding drug use. Drug use might serve very different functions for different ethnic groups. For example, as Resnicow *et al* suggest, some people might use drugs to anaesthetise the emotional effects of racism, poverty oppression and lack of opportunity.[103]

A further aspect of cultural sensitivity is whether the educators themselves have an understanding of the cultural diversity of the participants attending the programme. The Home Office evaluation of a series of drug prevention initiative projects found that many professionals in drug prevention work were ignorant of minority cultures and community priorities. As a result, the Home Office researchers suggest that all staff need to be adept at cross-cultural working and understand the issues concerning ethnic minority groups.[104] In Australia, an approach to this issue has been to recruit staff to match the particular ethnic minority groups being targeted. The drug education programme for parents of 12- to 18-year-olds in minority ethnic communities found that bilingual health workers from the same ethnicity group could be specifically trained to deliver the drug education.[105] Suitably skilled and trained staff are crucial in developing culturally sensitive programmes for ethnic minority groups.

Health educators must be sensitive to the values and beliefs of children and families from different cultures. Focus groups are useful in the development of culturally sensitive health education programmes to understand the target population's perceptions and experiences in relation to health and drug use, as well as during a programme both to inform further developments and evaluation of a programme.[106]

Health education with ethnic diverse groups should avoid instructional methods and adopt participative methods as such methods can be useful in the integration of individuals' perspectives and experiences, including ethnic and cultural diversity, within the education process. Information should be presented with openness to different

cultural, religious and ethnic groups' beliefs and experiences. In addition to the participative methods adopted in wider health education, traditions from different cultures such as songs and stories can be used to teach and pass on traditions.[107] Role-playing, vignettes and acting out real life situations are valuable methods of learning with ethnic diverse groups.

A number of drug education programmes have made use of participative methods to facilitate cultural sensitivity in working with ethnic minority populations. For example, the Midwestern Prevention Project (MPP) is a multi-component drug abuse prevention programmes for adolescents widely implemented in the USA.[108] This programme has been adapted to diverse ethnic groups through the use of participative methods. A further programme, *keepin' it R.E.A.L*, which is designed for 7th graders in South-Western USA, has been developed into three multicultural versions.[109] Ascertaining and incorporating participating children's own meanings, knowledge and experiences is an effective way of creating culturally sensitive health education programme curricula.

Culturally sensitive health education programmes need to:

- be carried out in relevant languages
- be sensitive to cultural values, beliefs and practices
- have suitably trained health and drug educators who understand ethnicity and diversity in relation to health and drug use
- involve the active participation of members of the ethnic minority community.

Through emphasising the value of diversity it is possible to encourage real multi-cultural learning where pupils, parents and educators can learn from each other.

Involving parents

Because parents have a big influence on their children's health, involving them in health education can increase the effectiveness of programmes. In many ethnic minorities the family is a strong unit and an important protective element from drug use. A needs assessment in Canada within four main ethnic groups (Chinese, Indian, Latin American and Vietnamese) found that communities wanted programmes that focus on youth and parents within the family context.[110] Drug education for young people from ethnic minority groups (as for any other group) should involve parents.[111] In the USA in recent years drug prevention efforts have focused on involving parents alongside children in family interventions.

Most parenting programmes have not been culturally adapted; however, more recently programmes have been revised to be more culturally sensitive. Some of these programmes involve parents working alongside school-based education and include parent-child homework, family skills training and parents programmes in the community. Multi-component drug education family programmes such as *Strengthening Families Programme* (SFP) have been shown to be effective with high-risk ethnic populations.[112]

Accessing ethnic minority communities

'Official' organisations may have difficulty in accessing members of some ethnic minority groups to health and drug prevention programmes. Ways of successfully involving members of minority ethnic communities include:

- developing partnerships and work alongside existing agencies within local minority ethnic communities
- employing workers from ethnic minorities
- training key workers within the community about drug issues
- educating community leaders to make them aware of drug issues in the community
- raising the profile of drug organisations within community.
- disseminating drug information widely throughout the community.
- building trust by making the work long-term and sustained.[113]

Effective strategies

Although there are disagreements about what are the most effective strategies for developing interventions (and a lack of detailed information both about the extent and characteristics of drug use) with BME groups, there are also clear lessons. Any organisation addressing diversity issues in health and drug education needs to bear these in mind and make the most appropriate choices according to ethnic diversity within the local community, paying particular attention to the perceptions and needs of the community, as well as the resources and programme materials and staff available to implement a programme.

COMMENTARY AND DISCUSSION, AND CONCLUSIONS

Involving parents, the community and children and young people in health related decisions

Parent involvement in children's school achievement

In a report for the DfES (2003) Desforges (see below) has shown that successful school experiences are more probable with increased parental involvement, and that involvement has a significant impact throughout the years of schooling.[114] There is also evidence that parental involvement in a child's schooling for a child between the ages of 7 and 16 is a more powerful force than family background, size of family and level of parental education.[115]

Desforges (2003) also found that family influences have a much more powerful effect upon children's attitudes and achievements than either school or neighbourhood factors- even when these are added together, and when similar schools are compared, those with strong home-school links have consistently fewer problems related to pupil work and behaviour.

It is evident that a health education programme involving parents in their children's learning and encouraging more participation in school life may have impact both on children's achievement in school, and protective factors relating to school success.

Parent education prior to children's drug experimentation

As Section 3 described, the age of initiation into drug use has been decreasing (NIDA, 1997) and a strong association has been found between early initiation into drug use and later problematic misuse (HAS, 1996 and below). This underlines the importance of involving parents while their children are still young enough to be influenced in a positive preventive manner.

In summary, the research suggests that drug education aimed at parents should take account of the factors outlined above i.e.

- Knowledge and skills to provide a stable, caring home environment for children with appropriate behaviour management strategies.
- Knowledge about drugs and the skills and confidence to communicate effectively with children and young people
- Knowledge and skills to maintain their own and their children's physical and mental health and wellbeing.

Thus, much evidence points to the importance of involving the parents and the communities to which they belong. For example, a literature review on the evidence of substance use and parent-child relationships by Velleman *et al*[116] found that family factors impact not only on initiation into substance use but also on problematic use. Family-centred intervention was particularly important in steering young people away from a drug-using career.

In doing so, a range of parenting skills and attributes are important. A close parent-child bond may discourage drug use both directly and through choice of non-drug using friends (while low family cohesion may predispose children towards deviant behaviour which parents then lack the influence to control).

However, Velleman's report included a literature review on the difficulties of engaging parents in drug prevention activities. This found that most projects attempt to recruit parent via schools, as many parents are involved to some extent with their children's education. But some parents have little involvement with schools: particularly fathers, parents from minority ethnic groups (especially those uncomfortable with the English language); and families of low socio-economic status. In response to low recruitment rates, an assertive approach has been developed in parts of the USA, including: home visits; meetings at the family's convenience; written contracts; and incentives such as free transport, crèche facilities, meals, and prize draws. A recent report sponsored by Mentor UK also found innovative projects designed to access "hard to reach" parents (See again Sections 4 and 7) and Marshall, Y.[117]

Parents influence both the views and the subsequent behaviour of their children towards substance use, and therefore have a major role to play in drugs prevention. DPAS (the UK's Drug Prevention Advisory Service) evaluated five drug prevention programmes for parents and reported that:

- parents reported a number of sustained effects of participating in drug prevention activities. These included: talking with friends about drug-related issues, continued participation in education or skill-raising activities; and further involvement with schools or the community
- at one secondary school, the majority of children whose parents had participated in drug prevention activities, welcomed this participation, had confidence in what parents said, and felt this would affect their own drug-related decisions. Of one group of 62 children whose parents had attended drugs prevention sessions, 30 said their parents spoke about drugs in a more useful way than before, and 24 said that, following parental attendance, their parents spoke to them about drugs for the first time.

The research also found that parents' involvement in project activities was hindered by:

- social difficulties (including the extra financial and organisational difficulties of single parents)
- the location of the event and worries about personal safety
- lack of engagement with the school or community
- lack of self-confidence
- fear of being stigmatised as a parent of a drug user
- lack of perceived need
- lack of project resources.

Desforges[118] reviewed the English language research literature to identify research findings on the relationship between parental involvement, parental support and family education on pupil achievement and adjustment in schools. The research shows that parental involvement takes many forms, including:

- good parenting in the home (including the provision of a secure and stable environment, intellectual stimulation, parent-child discussion, good models of constructive social and educational values and high aspirations relating to personal fulfilment and good citizenship)
- contact with schools to share information
- participation in school events
- participation in the work of the school
- participation in school governance.

In summary, the literature review suggests that investment in parenting support, education and skills training, will have the most impact on influencing children's and young people's health related behaviours. However, the review also suggests that if this is combined with school practices and health education programmes associated with positive impact, than the chances are improved. It is worth noting again, that effectiveness is clearly correlated with the involvement of young people themselves in the aims, content and delivery of health education.

Involving children and young people in health related decisions

Research by Barnardos[119] involving consultations with young people about health issues found that they related their standard of social life directly to their well-being in health terms. Forty-five males and 46 females took part in the Barnardos' research. 'Boredom' was cited by the young people as the main reason for doing things that had a negative influence on their health. It was more often given as a reason why they took drugs, drank alcohol, or smoked.

Some of the findings suggested that there was a hierarchy of unhealthy habits among young people; with a greater likelihood of drug users also smoking, and drinking alcohol*. On the other hand, a young person's decision to smoke did not mean that they would necessarily use drugs or alcohol. Nevertheless, drinking alcohol, smoking or drug use was associated with taking less exercise. It seems that these habits also impact on motivation to exercise and perhaps engage in other activities.

While it is difficult to measure the effectiveness of some health policy interventions, it is plausible to argue that listening and responding to young people's priorities when framing health policies will increase the acceptability and therefore take-up of services. Involving young people in decisions can enable resources to be targeted more effectively and ensure that programmes are related to young people's concerns and experiences, a condition of effectiveness.

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*Of those young people who drank alcohol, 44 per cent of the males and 31 per cent of the females also used drugs; and 88 per cent of male and 65 per cent of female alcohol

Broader Social factors

Some health researchers and educators argue that, in the face of unhealthy environments and the pressures in a consumer society to live unhealthily, the role of health education in changing attitudes and behaviour is, at best, limited. Furthermore, some people have very intractable problems that are not easily susceptible to change.

For example, an important finding from 1998-99 CAMHS Innovation Grants-funded projects across England, addressing improving mental health through early intervention, was that the needs of children who were considered 'at risk' of mental health problems, such as those excluded from primary school, were already often longstanding and complicated by significant family difficulties. The projects found that they could not achieve positive change with many – up to a third – of the children referred to them.[120] Nevertheless, these findings support the view that health education must involve parenting skills, and early intervention programmes which address the multiplicity of psycho/social factors which affect children and young people (Section 4).

Moreover, the research findings presented in Section 4 – Risk and Protective Factors, identified those factors which positively influence the health behaviours of children and young people, and the interaction of school and effective education interventions in partnership with parents, can make a difference.

Media and legal drugs

In relation to tobacco and alcohol advertising, Reid[121] makes the point that it has a pernicious influence on young people. He highlights evidence that alcopops advertising is targeted at young people. He also points to the awareness of very young children of the most-advertised cigarette brands, which is connected with an increased risk of taking up smoking.

Anderson refers to the World Health Organisation 2001 Declaration on alcohol which pointed out that:

> *'Alcohol policies directed at young people should be part of a broader societal response, since drinking among young people to a large extent reflects the attitudes and practices of the wider adult society.'*[122]

Environmental strategies such as price, availability, and enforced drinking-driving counter-measures all have an important place. Thus, education is only one part of strategies to improve health. (For example, the Government's Alcohol Strategy (published in 2004) sees the role of alcohol education in the broader context of social and legislative changes.[123])

Nevertheless, Government policies alone can only achieve so much: Kurtz[124] looked at the impact of government policies on children's health and well-being and found that although there is some evidence for improvement in areas such as in reducing suicides and teenage pregnancy rates, other areas such as obesity, diabetes, smoking, alcohol and drug use have showed deterioration in recent years.

The Wanless (2003) report commissioned by the Government, systematically sets out the areas of health concerns in terms of the health and economic costs to the nation, of unhealthy lifestyles, including obesity. However, the solutions are not readily identifiable, as they may involve a conflict of ideologies, in which personal lifestyle choices conflicts with the need for a healthy (and cost effective) nation (see again, health education models – Section 1).

Thus, some commentators have pointed up the apparent contradictions in Government policy, which appear to send conflicting messages around individual responsibility and the role of Government in exerting influences on the health of children. For example, the recently published House of Commons Select Committee on Health (2004) Third Report[125] is critical of Government inaction (as the report sees it) to tackle the growing problem of obesity, through controls on the food industry. Another example is the criticism of the relaxation of licensing laws, which the ACPO has correlated with increased drunken disorder and violence in inner cities[126].

Evaluation Issues

In terms of accumulating a credible evidence base on which to formulate public health policy and education interventions, the research literature shows that properly implemented and followed-through programmes are very rare, and long term follow-up (longitudinal) studies are rarer still (see again Sherman *et al*, Section 4). Whilst accepting there are methodological and practical difficulties with such research, the lack of empirical studies which can stand up to expert external scrutiny, is a problem for policy makers and practitioners in forming clear conclusions around resource allocation to public health policies and prevention activities.

Nevertheless, the literature reviewed here has allowed the presentation of Figure 1 overleaf which summarises the influences on positive health-promoting decisions and behaviour of young people. The Figure is presented as a basis for discussion, and for consideration by those in the public, private and voluntary sectors engaged in health promotion and education activities.

Fig. 1: CHILDREN, YOUNG PEOPLE AN

Positive influences on health-promo

Family and Parenting

- Good parenting skills including setting clear boundaries for behaviour
- Secure and stable family environment
- Good models of constructive social and educational values including high aspirations for personal fulfilment and good citizenship
- Intellectual stimulation
- Loving and supportive relationships
- Good communication between parents and children
- Parental involvement throughout pre-school and school experience
- Responsible Parental modelling around alcohol, smoking and illicit drug use

School

General

- Positive attitudes towards school
- Academic achievement
- Regular attendance
- School effective at supporting academic, social and emotional development, including those pupils with special needs
- School engages parents in children's progress
- Schools provide a safe and orderly environment for children to engage in learning
- Safer School Partnerships (SSP) and/or similar initiatives to promote school safety

School-specifi

School health programmes which effectiveness namely:

- are evidence based, effectively te supported by coherent policies (H Anti-bullying, Behaviour manage
- are developed through pupil invo incorporating both primary and s the case of drugs and sex educati
- use well trained, credible and co pupils, and send coherent messag
- use life skills approaches based o
- start before experimentation with provide sustained, developmenta school career
- use interactive teaching approach of drug and sexual behaviour
- are culturally sensitive, for exam analysis/consultations with BME
- provide targeted interventions fo
- engage parents in school and hea
- have effective partnerships with community, to support positive v
- use Media interventions to suppo around young people's health
- include evaluations which inform

ND HEALTH-RELATED DECISIONS

oting decisions of young people

c Health Education

n incorporate research findings on

eacher managed and co-ordinated,
Healthy Schools, Drugs, Citizenship,
ement

olvement and needs-analysis,
econdary prevention as appropriate in
on

mpetent educators, who empathise with
ges aligned to pupil needs

on the effectiveness literature

n drugs and sexual behaviour, and
lly appropriate provision throughout

nes which address normative perceptions

ple, incorporating needs
f pupils

r at risk pupils appropriate to their needs

alth education initiatives

parents, agencies and individuals in the
values around health

ort school and community messages

n on-going programme provision

Communities

- Strong social cohesion
- Clear behaviour expectations of young people within neighbourhood communities
- Buoyant local economy
- Few (and controlled) alcohol outlets
- Low levels of crime in local area
- Illegal drugs not easily available
- Good housing
- Low tolerance of anti-social behaviour, street drinking, graffiti, criminal damage, intimidating (bullying) behaviour
- Majority of peer and friendship groups engaged in legitimate recreational activities as opposed to - legal/illegal drug use, vandalism, neighbourhood disturbance, gang memberships
- Positive engagement by police with young people and communities through Safer School Partnerships and Public Reassurance schemes in addition to other social controls exerted

Conclusions and Implications for Health Educators:

In summary, this literature review has demonstrated that impacting on children and young people's health behaviours is most likely to happen through a coherent and planned approach which engages significant components known to have an influence in the process. Figure 1 presented above, puts the school at the centre of such endeavours, acknowledging current national and local policy imperatives which see schools as crucial for co-ordinated provision. Further research to test whether the multi-faceted approach illustrated here, and recommended from the literature, has the greatest impact on young people's health related decisions (in contrast to single faceted approaches) would add to the evidence base.

In conclusion, the implications of the Literature Review (see Figure 1) for the Health Education policy and practice of organisations and individuals are as follows:

- Health education programmes should take account of the context in which they operate – ensuring consistency and coherence with organisational values, management structures and educational provision. School health education programmes are delivered within complex environments, which need to be connected at all levels to health education messages delivered in the classroom. The research suggests that schools which are effective in supporting pupils' academic, social and emotional development, will also positively influence their health related decisions.
- The above point suggests that the overall expertise base in schools to support health education is critical to effectiveness. This means that investment in effective teaching and learning approaches, and measures to support pupils at risk of school exclusion (Behaviour and Education Support Teams (BEST) and Safer School Partnerships (SSP) may all prove effective. The National Healthy Schools Standard and DfES support of accredited Teacher In-Service Training in PSHCE are also moves in the right direction. However, not all schools are yet committed to becoming Healthy Schools, or investing in the appropriate training for teachers. Training key teachers in all schools to a nationally agreed standard could move good practice into the mainstream.
- Integration of external and internal health educators with overall school efforts to address health issues for children and young people is crucial, but partnerships and collaborations with parents and other key community agencies across the broad areas of child welfare and health will maximise impact.
- Monitoring and evaluation of single-faceted programmes have proved problematic, applying monitoring and evaluation procedures and related Quality Control measures to multifaceted interventions suggested by the review, would provide further challenges to those working within partnerships and collaborations. Nevertheless, the accumulation of such evidence could support investment in the best strategies and approaches. The BLUEPRINT evaluation should help in this regard.

- The elements of the review pertaining to effective health/drug education programmes (Figure 1: School-specific Health Education) suggest that there are core principles and factors which relate to effective programmes. It follows that health educators providing health and drug related programmes should endeavour to incorporate best practice principles derived from them. External funders, making decisions on supporting a range of programmes provided for children and young people, might usefully take into account whether such programmes incorporate evidenced best practice, and the comparative costs of programmes which do so.
- Overall, the review suggests that there are some key research findings which can inform principles for health education policy and practice. It is important that realistic expectations are set for education programmes in schools, which the research indicates will have modest effects at best. However, if these are strengthened by the multi-faceted components presented in Figure 1, the potential for positive impact is significantly increased.

Finally, the importance of parental influences on children's and young people's health related decisions and overall life choices, is identified strongly across all aspects of the literature. Therefore all those concerned with the healthy development of children and young people, would wish to consider how parent involvement, education and support might be integrated as a core component of their work.

GLOSSARY

At-risk groups: These are groups of people especially 'at risk' of certain behaviours or consequences.

Authorised drugs: As used by the DfES, this means, 'principally, medicines and any other drugs sanctioned for legitimate use (such as alcohol stored for a raffle, safe storage and use of hazardous chemicals).' For the DfES, drugs, whether legal or not, are unauthorised in all other circumstances.

Blueprint: Blueprint is a Home Office-funded, research-based, drug education project designed to examine the effectiveness of a multi-component approach to drug education. It is intended to provide evidence of 'what works' in educating 11- to 13-year-olds about the risks of drug use and, in the longer term, it should provide research-based information on reducing the number of young people who become involved in using all kinds of drugs.

Controlled drugs: Those drugs controlled under the Misuse of Drugs Act 1971 (also known as illegal drugs).

Drug Action Teams: Drug Action Teams (DATs) are multi-agency teams, within every English Local Authority, with responsibility for the local delivery of the drugs strategy. They involve education, health, police, social services, youth service and the voluntary sector. In some areas they are called Drug and Alcohol Action Teams (DAATs).

Evaluate: DfES definition: 'To evaluate drug education is to determine the extent to which the aims of the programme and pupils' needs have been met.'

Health Development Agency (HDA): The HDA is the national authority on what works to improve people's health and reduce health inequalities. It gathers evidence and produces advice for policy makers, professionals and practitioners, aiming to get evidence into practice.

Key Stages: Key Stages (KS) represent a child's progression through school. Key Stage 1 covers pupils from age 5 to age 7, Key stage 2 from 7 to 11, Key Stage 3 from 11 to 14 and Key Stage 4 from 14 to 16.

NHSS (National Healthy School Standard): The National Healthy School Standard is an established national programme delivered by local education and health partnerships through local Healthy Schools Programmes. It aims to support schools to promote physical and emotional health and to provide a physical and social environment that is conducive to learning.

Ofsted is the Government's Office for Standards in Education.

PSHE: Personal, social and health education.

PSHE framework: The PSHE framework sets out, through all the 4 Key Stages (ages 5-16), a structured programme of learning opportunities through which pupils can be taught the knowledge, skills and understanding to take responsibility for themselves, show respect for others and develop the self-awareness and confidence needed for life.

Risk factors: DfES definition: 'There are a range of risk factors, which, particularly, in combination, may make children and young people more vulnerable to drug misuse and/or play a role in the later development of drug problems. These include chaotic home environments, lack of nurturing by parents/carers, parent/carer drug misuse, being in Local Authority care, truanting and school exclusion, school failure, association with drug using peers, early age of first drug use, neighbourhood deprivation or low socio-economic status, physical or sexual abuse, physical disabilities, mental health and behaviour problems, poor coping skills, homelessness, involvement in crime or prostitution and being labelled as a drug misuser.'

Safer School Partnerships: Safer school partnerships involve an operational police officer working in a selected school to reduce crime, make the school a safer place for learning, keep young people in education and re-engage youngsters with their community.

RCT (randomised control trials): A rigorous research method that uses control groups to enable appropriate comparisons to be made between the intervention being tested and other interventions, or no intervention. Widely used in medical research, it is seldom used in social research because of methodological and ethical difficulties.

Targeting: 'Targeting' means aiming prevention programmes at particular (often vulnerable) groups

Vulnerable groups: DfES definition: 'Vulnerable groups are those at increased risk of the misuse of drugs. Pupils found to be more vulnerable may include those who are in Local Authority care, truants and pupils excluded from school, those who have been physically or sexually abused, homeless young people, those in contact with mental health services or the criminal justice system and those involved in prostitution.'

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The *educari* consultancy focuses on children and young people. Our work includes: research, evaluation and policy analysis; website development; consultancy and training; publications; and international work. We have a special interest and track record in work concerned with young people and drug misuse. Our publications include an educational CD-ROM on drugs, *Xoteric*, for KS3-4, and we are currently completing *Boozeville*, a CD-ROM on alcohol. For more information, see www.educari.com.

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