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Developing a Blueprint for evidence-based drug prevention in England

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Abstract
Blueprint is a universal multi-component prevention programme involving young people aged 11 to 13. In 2005 Blueprint completed delivery of drug prevention through work with schools, parents and the media in communities in England, reinforced by increased action to restrict the availability of tobacco, alcohol and volatile substances to under-age youth. The programme evaluation includes process, impact, outcome and cost measures. This article describes the formative research and process of planning that formed the development of the Blueprint programme and the evidence base underpinning the approach. The process has established for the first time the systematic integration of research with the framework of the national school curriculum and Drug Strategy delivery partnerships. The completed evaluation in 2007 will be a major opportunity to reassess the role of drug education and prevention in meeting educational needs and as part of national drug and alcohol strategies.

Keywords: *Blue print, multi-component, drug, prevention, education, evidence base, evaluation*

Introduction

Reviews of drug education have established an evidence base for reducing the prevalence of alcohol, tobacco and cannabis consumption (Cuijpers, 2002a, b; Dusenbury & Falco, 1995; Midford, Munro, McBride, Snow, & Ladzinski, 2002; Tobler, 1986, 1992; Tobler, Lessard, Marshall, Ochshorn, & Roona, 1999; Tobler, Roona, Ochshorn, Marshall, Streke, & Stackpole, 2000; Tobler & Stratton, 1997; White & Pitts, 1998) and limiting the harm from using alcohol (McBride, Midford, Farringdon, & Phillips, 2000; McBride, Farringdon, Midford, Meuleners, & Phillips, 2004). For this evidence base to inform the

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National Drug Strategy and influence future practice, learning from evaluated programmes needs to be distilled and integrated with the national curriculum for schools and the processes of strategic partnerships. This learning must also acknowledge the limitations of earlier research as identified by recent reviews (e.g. Coggans, Cheyne, & McKellar, 2002).

The Blueprint programme was set up to address these issues. Blueprint is a partnership of three Government departments: the Home Office, the Department for Education and Skills (DfES), and the Department of Health (DH). It builds on the experience of the Home Office delivering three demonstration projects: Project Charlie (Hurry & Lloyd, 1997; McGurk & Hurry, 1995); NE Choices (MacKintosh, Stead, Eadie, & Hastings, 2001; Stead, MacKintosh, Eadie, & Hastings, 2000; Stead, MacKintosh, Eadie, & Hastings, 2001) and the Integrated Programme (Morris, Parker, & Aldridge, 2002).

Since the National Drug Strategy began (President of the Council, 1998) it has been assumed, on the basis of mainly overseas evidence, that drug education can impact upon the drug use of young people. The UK Anti-Drugs Co-ordinator's National Plan 2000–2001 (Cabinet Office, 2000) features the policy of enhancing the effectiveness of drug education in schools under the target of reducing the proportion of young people using illegal drugs. However, the UK evidence base has been lacking in terms of linking the ends (reduction in drug use prevalence) with the means (implementing drug education). In order to address this challenge, Blueprint took a more systematic approach to integrating research and programme development than had previously been attempted in England.

Development of Blueprint started in 2000, and the programme launched in September 2003 to implement six connected strategies for drug prevention focused on changes in practice and capacity across the domains of: curriculum; teacher training; School Drug Adviser (SDA) support; parental support; media and health policy. This makes Blueprint a 'multi-component programme'. It is generally recognized that multi-component interventions can be more effective than single-channel interventions (Flynn et al., 1992; Johnson et al., 1990; Pentz et al., 1989; Pentz & Valente, 1993; Perry, Kelder, Murray, & Klepp, 1992). Pupils aged 11 to 13 are the primary target group. Secondary target groups are parents, teachers and drug-prevention professionals. Therefore, Blueprint is also a 'universal' intervention in that it is designed for the general school population.

Schools in the programme (23 secondary schools in the North-West and East Midlands) have delivered a drug-education curriculum for two academic years designed to build on and enhance Personal, Social and Health Education (PSHE) provision. Children joining secondary school at age 11 (Year 7) in Autumn 2003 were taught Blueprint as a cohort through Year 7 (10 lessons) and Year 8 (five lessons) up to mid-2005. The teachers involved in delivering the 15 Blueprint lessons received six days of training: two training days prior to delivery in each academic year and an additional day to reflect on experience of the programme. Teachers had the support of SDAs in the preparation and delivery of the Blueprint curriculum. Complementing the work in schools, parents received

a drug information pack containing learning activities for them and their children. Parents were also invited to attend workshops, a presentation on what their children had learned, and an opportunity to contribute to development of their school's drug policy. Partnerships with journalists and other promotional activity generated coverage of the programme in regional newspapers and on local radio. In 2004 the programme introduced an enhancement of efforts to restrict the sales of alcohol, tobacco and volatile substances to under-age youth.

This article explains how schools were recruited to the programme, describes the evidence base for Blueprint, and the formative research, development and design that helped to build the programme.

Aims

Blueprint aims to design, deliver and evaluate an evidence-based drug prevention programme. Prevention is operationally defined as slowing the normal rate of increase in population-based use prevalence rates of tobacco, alcohol, volatile substances and cannabis during early adolescence, and reducing the harm to self and others arising from the use of these substances. The programme adopts a wide definition of a drug as 'a substance people take to change the way they feel, think or behave' (United Nations Drug Control Programme, 2002). This includes medicines, volatile substances, alcohol, tobacco, caffeine and illegal drugs.

The evaluation plan for Blueprint was devised as an exploration of trial conditions rather than a definitive trial. This is because the sample size of a trial was estimated as being around 50 schools (Raab, Storkey, & Bird, 2002)—a very large step for an improvement in the limited UK evidence base. Furthermore, the Medical Research Council has issued guidance on the development of evaluations of complex interventions that advises a cumulative approach to understanding how outcomes are achieved, moving from theory, to modelling, to an exploratory trial to a definitive trial (Medical Research Council, 2000).

Sample

The sampling strategy aimed to recruit 30 schools, with a ratio of 24 programme schools to six comparison schools. This target was determined by: (a) the need to test implementation on a wide scale; (b) the need to assess the added value of the Blueprint programme in comparison to standard PSHE provision; and (c) the need to test how evaluation methods are applied to, and impact on, comparison schools.

The basis of the sampling frame was secondary schools in 154 Local Education Authority (LEA) areas of England. The sampling procedure required that LEAs were eligible for the programme if they contained a minimum of five eligible schools under the assumption that only 15% of schools in each LEA would take part in the programme. This assumption was made to ensure that the geographic

areas involved in the study were of manageable size. The procedure selected adjacent areas. The inclusion and exclusion criteria for LEAs and schools are shown in Table I.

Eight adjacent areas were identified that met LEA criteria: Birmingham, Cheshire, Derby, Derbyshire, Lancashire, Leeds, Staffordshire and Stoke. In February 2002 all eligible schools ($n = 122$) across the eight areas were invited by letter to take part in the programme, with an offer of the incentive of two annual cash sums of £3750 to be spent on any aspect of the health curriculum other than drug education. The information leaflet set out the inclusion criteria, including being part of the National Healthy School Standard (NHSS), as NHSS schools have a degree of readiness to adopt a specialized drug education programme through accreditation against key criteria (National Healthy School Standard, 2003).

There were 46 positive responses, including 30 schools in Derby, Derbyshire, Cheshire and Lancashire. These 30 schools were allocated to programme or comparison school status using a systematic method. Because Derbyshire encloses Derby City, these two LEAs were merged into a single geographical area, giving 30 schools in three county-sized areas. Within each area, two comparison group schools were selected, one with a relatively low and one with a relatively high score for the Index of Multiple Deprivation (IMD), giving six comparison schools in total. The remaining 24 schools were selected as programme schools. Subsequently, one programme school (in Derby) withdrew from the programme after being placed under special measures by the Office of Standards in Education (OfSTED). This left 23 programme schools and six comparison schools.

After schools had been allocated to the programme, Blueprint team members met Chief Education Officers, Drug Action Teams, SDAs and Healthy School Co-ordinators to describe Blueprint to them, and to negotiate the enhancement

Table I. Blueprint sample.

Inclusion criteria
Type of school
Mixed sex
Comprehensive secondary schools providing education to 11–16/11–18-year-olds
School capacity and context for drug prevention
A named Personal, Social and Health Education and/or drug education co-ordinator in post
An established drug policy and drug education programme implemented within the school
Engagement in the National Healthy School Standard programme at level 2 or level 3
Location restrictions
Within an LEA containing at least 5 schools satisfying the eligibility criteria listed above
Exclusion criteria on type of school
Pupil Referral Units
Schools for pupils with special needs
Independent schools
Middle schools

of the SDA role to provide support to the programme schools. Comparison schools continued to deliver their normal drug education programmes.

Development of the Blueprint curriculum

Three stages of formative research and development were needed to fit the evidence base with the way that drug education is delivered in England—mainly through Personal, Social and Health Education (PSHE) as part of schools' planned provision to promote personal and social development, including health and wellbeing.

Identifying promising programmes from systematic review

White and Pitts (1998) identified 11 sound studies of programmes with a positive effect size. Adapting any one programme to fit with English drug education would require extensive work to reflect the PSHE strategy and English language, culture and diversity with no guarantee of transferring outcomes. Therefore, Blueprint is based on the distillation of key principles of effective drug education rather than relying on any one programme model; recent research has identified the features that appear consistently in the more effective programmes (Cuijpers, 2002a; Dusenbury & Falco, 1995; Midford et al., 2002).

Mapping of research against practice guidance

The design of a new evidence-based curriculum resource was experienced as being an inexact science because the focus on abstinence in most of the literature means that tailor-made solutions are needed to accommodate recent findings on harm minimization interventions (McBride et al., 2000, 2004) seamlessly with other elements of effective drug education. Also, reviews of research (e.g. Dusenbury & Falco, 1995) may not identify the target time to devote to specific learning objectives or the actual timings from implementation assessment. Therefore, one can say that the evidence base has provided recipes for success (outcomes) but with the relative balance of critical ingredients (inputs) missing. The balance of school programme elements is particularly important in relation to normative education, a key driver of behaviour change in prevention programmes (e.g. Hansen & Graham, 1991).

Normative education demonstrates to young people that both actual rates of drug use, and approval of drug use, are lower than they think they are and examines social influence factors within peer networks and through the media (Stead & Angus, 2002). Lesson plan materials need to reflect the evidence that normative education is more important than resistance skills in reducing social motivation to use drugs (Donaldson, Graham, & Hansen, 1994; Donaldson, Graham, Piccinin, & Hansen,1995; Hansen & Graham, 1991, 1998; MacKinnon et al., 1991). Furthermore, McIntosh, MacDonald, and McKeganey (2003) found that while peer pressure and a desire to conform to the group are involved in some experiences of peer interaction involving first drug use, the dominant

factors are personal choice and curiosity. Other authors have identified the need to make a distinction between peer pressure, peer influence and peer preference (e.g. Coggans & McKellar, 1994). The 'Right Choice' (SCoDA, 1999) suggests that one of the key factors in effective drug education is starting where children are in terms of their knowledge, experience and perceptions of drugs. A study for Blueprint of the perceptions that pupils have of drugs and drug use also supported a wide definition of drugs, a normative approach and examining risks and peer influence rather than peer pressure (McWhirter, Young, & Wetton, 2002, 2004). Therefore, the Blueprint curriculum focused on normative education and included only one lesson on resistance skills that was framed in terms of making and maintaining a decision using cognitive and interpersonal skills.

Blueprint commissioned an editor of education materials to identify the 'key competencies' targeted by effective programmes identified by White and Pitts (1998), contrasted to competencies in PSHE. Following this, a tabulation of a basic hybrid model of research and practice was performed by merging columns of Key Stage 3 PSHE learning objectives in Qualifications and Curriculum Authority guidance (Qualifications and Curriculum Authority, 2003) versus science-based programme content (Dusenbury & Falco, 1995; McBride et al., 2000, 2004; Midford et al., 2002). This process generated 15 lesson plans, each of 50-minute duration. Table II provides a summary of these lesson plans.

Developing the Blueprint for delivering the school component

The processes described above led to the writing of a contractual specification for the delivery of the curriculum design, provision of training, and the production of supporting teacher, governor, pupil and parent resources. These areas of work were commissioned to Dixon Collier Consultancies Limited, a provider who worked with a team of drug-education trainers and writers.

Market research with groups of 11- to 13-year-old children and separate groups of parents found an appealing and appropriate illustrative style for the lesson plan materials (Front Line, 2003). Front Line (2004) also tested materials in development for use in Year 8 lessons with year 8 pupils.

Nine teachers across schools in Sheffield, Barnsley and Cumbria tested delivery of Year 7 lesson plans in 2003 and Year 8 lesson plans in 2004. The feedback led to a revised number of learning objectives in some of the lesson plans in order to meet 50 minutes of delivery. In addition, a group of curriculum experts reviewed consultation drafts of each lesson plan in both Year 7 and Year 8 as part of an extended steering group.

The process for the Year 8 materials was enhanced by consultation with teachers who reviewed drafts of lessons plans, and by commissioning a reading specialist to reflect on the reading-age level and comprehension level of the materials. The development process therefore indicated the curriculum's strengths and weaknesses, and a realistic perspective on the logistical challenges involved in teaching the lessons, such as working within the allotted time,

Table II. Summary of Blueprint lesson plans.

Lesson	Content
1. Starting out	Aims, values and content of lessons and materials for pupils and parents; forming a group agreement on voicing and sharing views and listening to each other.
2. What do we know?	Definition of 'drugs' and names for drugs, medicines and products containing drugs; how and why drugs are used in medicinal and non-medicinal situations.
3. Questions about drugs	Facts about drugs and drug use; retrieving reliable factual information from reference material.
4. What do you think?	Small groups look at questions on prevalence and share their answers; the whole class reflects on discrepancies between belief and reality when the teacher reveals actual prevalence rates.
5. Thinking about drugs	Recognize and understand a range of values and attitudes towards drug use; understand the need for rules and laws governing drug-related behaviours, including school drug policy.
6. Advertising and the media	Advertising techniques and their influences on lifestyle choices, including norms.
7. Decisions, decisions	Different—and effective—ways of making decisions and recognizing the range of factors that influence decision making.
8. Seeing it through	Elements of assertive behaviour; maintaining a decision; whole-class discussion on an issue of persuasion, and paired role-play of maintaining a decision.
9. What have we learned?	Preparing a presentation of Blueprint learning to other pupils, staff and/or parents.
10. Presenting what we have learned	Presentation with audience feedback and positive closure of the Year 7 lessons.
11. Thinking back, looking forward	Recall, revisit and reinforce key learning points and group agreement from Year 7; introduce Year 8 sequence of lessons and the concept of risk.
12. Your street, your story—the game	Board game played in groups: collecting matching question and answer pairs of cards on risks, the law and effects of drug use; whole class review and reflection.
13. Is everyone doing it?	Compare beliefs about drug use with data from the Blueprint baseline survey.
14. Party time	Risks and effects of drug use, particularly alcohol; consequences for self and others; a party scenario requires the pupils to identify with the characters and discuss the risks associated with their behaviour.
15. Bringing it together	Strategies to reduce risk and keep self and others safe; sources of help and information about drugs and drug use; identify learning from all aspects of the programme.

maintaining students' interest and focus, and adapting lessons to students' comprehension levels.

Blueprint teacher training

Drug prevention programmes have made considerable efforts to teach curricular materials exactly as they are intended (e.g. Botvin, Baker, Dusenbury, Botvin, & Diaz, 1995; Pentz et al., 1990). The literature on training obtained by Blueprint

was largely restricted to comparisons of standard training versus video resources. For example, Basen-Enquist et al. (1994) found that live teacher training resulted in greater fidelity of implementation and greater use of interactive methods than a video-based approach in a smoking prevention programme. In contrast, Botvin et al. (1995) found that live teacher training and video training resulted in equivalent levels of implementation. However, one can argue that pupil outcomes were not sufficiently linked to the type of teacher training to enable a choice about which approach to use. More recently, Dusenbury, Hansen, and Giles (2003) report that a video-enhanced course (two hours of instruction plus video) increased knowledge of norm-setting more than standard training.

In view of the balance of this evidence, Blueprint designed training based on direct trainer and trainee contact in order to observe the demonstration of skills. The teacher training underwent a test-run in both Year 7 and Year 8. In addition, Blueprint featured its approach to drug education within PSHE in a DVD that accompanied a national PSHE resource book (Department for Education and Skills, 2004).

School drug adviser support

Blueprint also considered the value of structured conditions and logistical and professional support for drug prevention. It is known from research on a limited number of community case studies that researcher-initiated coalitions for drug prevention have some advantages over grass-roots methods (Mansergh, Rohrbach, Montgomery, Pentz, & Johnson, 1996). However, Blueprint has made no assumptions about the degree of 'community readiness' as drug prevention in England is embedded in community partnerships through regional and local delivery of the Drug Strategy. For example, School Drug Advisers (SDAs) are employed by LEAs to support schools in drug educational policy and practice. The Blueprint programme provided funding to extend this support role. Thirteen staff delivered the extended SDA support role. Their tasks included:

- supporting classroom delivery, e.g. by working alongside school staff, teaching and advising on effective delivery of the Blueprint lessons;
- acting as a link point for strategic partnerships, including Drug Action Teams responsible for the regional and local delivery of the National Drug Strategy, LEA and NHSS;
- acting as a local media contact between LEA Press Office and the Blueprint public relations partner;
- managing and co-ordinating a series of alliances in drug education designed to promote effective practice across schools with external contributors of drug education; and
- managing a review of school drug policy—Blueprint provided models for the consultation process to involve the whole school community in the review process.

Parental component

Blueprint aims to raise the awareness of parents in support of their children's learning and increase the quantity and quality of communication between children and parents on drug issues. The design of the parental component drew much from the report for the Home Office by Velleman, Mistral, and Sanderling (2000). Their review indicated the importance of involving parents and families in drug prevention work as a way of reinforcing and ensuring consistency with drug prevention messages delivered through other channels.

Programmes seeking to involve parents appear to have problems in achieving participation targets. Participation rates may be as low as 10% and may rarely include parents whose offspring are at the highest risk of drug use (for example, Cohen & Linton, 1995). There is a dilemma for prevention planners and practitioners in that Mallick, Evans, and Stein (1998) conclude that parents rate drug education as important but predominantly want their children to be taught the 'just say no' message. Further, while many young people say their parents openly negotiate boundaries around their drinking alcohol, cannabis use is rarely talked about openly (Highet, 2005).

There is very little literature that reports on the uptake of different approaches with parents. From a 45% survey response rate, Rohrbach et al. (1994) report the following rates of parent participation in Project STAR: homework exercises (66%); parenting skills workshops (23%); community drug prevention meetings (23%); parent programme implementation committee (9%); and community advisory council (7%).

Aware of the challenges in this area of drug prevention work, the Blueprint team set a service specification requiring a systematic approach to opportunities and barriers to recruitment and retention. Blueprint appointed a consortium, comprising ContinYou, Adfam and the Parenting Education and Support Forum, to deliver an initial launch event, followed by a series of six parent skills workshops for each Blueprint school community. In addition, all parents of children in Blueprint schools were provided with information about drugs and activity books for both years of the curriculum programme.

The objectives of the workshops focused on parent–child communication and support skills in three key areas: parenting skills to strengthen family relationships and parents' ability to deal with caring, control and conflict resolution; improved substance-related knowledge and skills; and skills that support self-confidence in the parenting role.

The project plan featured workshops in four discrete phases to allow cumulative learning to support delivery: four launches in March 2004, and a further 9–10 in each of three further phases in June 2004, September/October 2004 and November/December 2004, with workshops completed by February 2005.

The Blueprint team separately commissioned the Centre for Ethnicity and Health, University of Central Lancashire (UCLAN) to devise strategies to assist the Parent Trust in the recruitment of parents from minority ethnic communities

and advise on the cultural sensitivity of Blueprint materials. This work was funded from April 2004 to February 2005.

Media component

The use of media in drug prevention can be effective in raising awareness and providing information (Dorn & Murji, 1992). Behaviour change objectives are generally hardest to meet by media-only campaigns. However, media campaigns combined with school programmes show more positive results when there is sufficient campaign length and intensity, multiple channels and messages from multiple sources (e.g. Flynn et al., 1992).

Porter Novelli, a public relations company, was commissioned to attend to three objectives relating to the evidence base: raising awareness and understanding of Blueprint; delivering Blueprint's key messages on norms and shared action in drug prevention; and to motivate and encourage active participation in the programme. The key activities of Porter Novelli were:

- *media relations*: to bring a selection of key media into the programme as partners by identifying journalists to follow the programme to secure guaranteed coverage;
- *news programme*: announcing programme milestones (e.g. teacher training and the launch of parenting skills workshops); research-based news fed by surveys of parents and children on topics such what parents and children discuss, avoid and worry about;
- *features*: based on key people involved in programme delivery and their experiences, e.g. SDAs; trainers; parenting skills facilitators and teachers; and
- '*roadshows*': where a portable presentation was set up in the foyer of a major supermarket in each Blueprint LEA, to communicate Blueprint to the wider community and to check awareness of the programme and of drugs.

Policy component

The health-policy component introduces supply reduction to Blueprint by aiming to restrict the sale of alcohol and cigarettes to under-age youth. Although existing legislation in the United Kingdom prohibits the sale of tobacco to those under the age of 16 and limits legal purchases of alcohol and volatile substance to those over 18, reports of the widespread commercial availability of tobacco (e.g. Jarvis, 1977) and alcohol (e.g. Willner, Hart, Binmore, Cavendish, & Dunphy, 2000) to minors provides evidence that some retailers are failing to comply with sales laws.

Devlin, McDermott, Stead, and Angus (2002) provided Blueprint with a literature review. Their review concluded that community strategies that combine efforts such as retailer education, enforcement by police and trading standards, and proof-of-age schemes are the most likely to affect youth drinking and smoking

behaviour, although evidence of sustainability is weak. The most radical multi-component programmes (Pentz et al., 1989; Perry et al., 1989, 1992, 1996) facilitate supply-reduction policies aimed at raising the drinking age, limiting access to tobacco and alcohol in public bars, restaurants and stores, increasing taxation on cigarettes and alcohol and restricting the number of retail outlets selling them. Such actions are outside the remit of the Blueprint programme. However, strategies should seek to influence the normative climate and public attitudes to reinforce the educational messages that children are receiving at school (Altman, Wheelis, McFarlane, Hye-Ryeon, & Fortmann, 1999; Hinds, 1992).

The Blueprint team convened a seminar in February 2004 to share examples of existing practice within England and develop local plans in the four Blueprint areas. These local plans were supported by a Home Office grant to each community safety partnership in Blueprint areas, dependent on demonstrating that retailer education, enforcement and proof-of-age approaches would be targeted appropriately, increased significantly from previous years, and publicized in the local media.

Sequential development; overlapping delivery

The Blueprint programme relied upon a partnership of delivery agents commissioned by a small team of five people and supported by three steering groups focused on research, practice and project management. A partnership board co-ordinated the work of the organizations delivering the programme.

Research suggests that the implementation of multi-component programmes and policies should be deployed in sequence to minimize a drain on community resources and to maintain interest (Pentz, 1993) and provides an ordering of approaches (Pentz, Bonnie, & Shopland, 1996). To secure research results by the end of the ten-year Drug Strategy in 2007, Blueprint opted for sequential development of programme components (to fit with available human resources), with overlapping delivery of components within two years. Programme and comparison schools were located in the same geographic areas. Therefore, children in programme schools had exposure to all programme components, whereas children in comparison schools had exposure to the media and health policy components. Table III shows the distribution of components across programme and comparison populations and the duration of component delivery.

Although Blueprint does not feature the community engagement approaches seen in other multi-component programmes (e.g. Pentz et al., 1989), it did make direct contact with the public and with professional stakeholders. For example, the media road shows were as much about taking prevention messages into communities as they were about creating news hooks. Also, UCLAN made connections with local Muslim groups, mosques, Sure Start groups and local adult-education services.

Table III. The timing of Blueprint components and their balance of coverage across programme and comparison sites.

Component	Duration	Coverage
Blueprint Curriculum: 10 lessons in Year 7 and 5 lessons in Year 8	January 2004 to June 2004 and January 2005 to May 2005	Delivery is in Blueprint schools only.
Blueprint teacher training	September/October 2003 and June 2004; September/October 2004 and June 2005	Delivery to Blueprint teachers and Blueprint SDAs.
School Drug Adviser support	September 2003 to May 2005	Additional support funded for SDA input to Blueprint schools only.
Parent component	March 2004 to February 2005	Invitations sent to parents of Blueprint children only.
Media component	September 2003 to March 2005	This component reaches the population of the programme and comparison sites.
Health policy	April 2004 to March 2005	This component reaches the population of the programme and comparison sites.

Conclusion

Blueprint has so far achieved delivery of a drug prevention programme engineered to be close to the evidence base and the context of English schools and drug prevention partnerships. It has delivered a programme to over 3000 pupils, supported by the training of 200 teachers and 13 staff in the SDA role. The programme will be completed when the evaluation team—a consortium led by the Institute for Social Marketing at the University of Stirling and the Open University—provides a report to the Drug Strategy Directorate in December 2007. The evaluation will assess the fidelity of implementation, factors affecting delivery, the reaction of parents, pupils, teachers and other professionals, the cost of the programme, and the impact on norms, communication between parents and pupils, prevalence and harm. A baseline survey deployed in Autumn 2003 and repeated in Autumn 2005 and Autumn 2006 will identify any potential for Blueprint to impact on behaviour change.

The results may trigger a fundamental assessment of the place of drug education within the National Drug and Alcohol Strategies, and debate about the cost-effectiveness of specific programmes against the impact of policy options in prevention, such as tobacco and alcohol tax regulation. Furthermore, although Blueprint is not a definitive trial, it is designed to provide a broad assessment of process, impact and outcome measures, and the cost and time involved in such programmes may also drive decisions about what level of evidence is good enough to change policy and practice. Because of the recording of delivery and issues identified by teachers, parents and pupils, the final evaluation has the potential to be 'formative' in that it may guide changes to programme design and delivery,

including the extent to which the Blueprint lessons can link to and be supported by the broader context of PSHE.

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Note

The contents of this article are the responsibility of the author and do not necessarily represent the policy position of the UK Government.

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