

**Delivering Drug Education in the
Classroom – Lessons from the
Blueprint Programme
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The views expressed in this report are those of the authors, not necessarily those of the Home Office (nor do they represent government policy).

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Introduction

Blueprint is a multi-component drug use prevention programme targeted primarily on young people aged 11 to 13. The overall aim of the programme is to slow the normal rate of increase in the prevalence rates for the use of these substances in early adolescence and to reduce the harm to self and others arising from the use of these drugs. It includes:

- a curriculum component based on evidence of effective practice;
- a training programme for the teachers delivering Blueprint;
- structured support from local School Drug Advisers (SDAs);
- a parental component designed to raise awareness and encourage parents to deliver consistent drug prevention messages at home;

• Blueprint is designed not only to provide effective drug education in schools but also to influence public attitudes towards drugs and create a normative climate that reinforces the drug education messages that children are receiving at school.

The evaluation of the Blueprint Programme h

- a media component designed to raise awareness of Blueprint, deliver its key messages and encourage active participation in drug prevention; and, finally,

a health policy component aimed at ensuring greater compliance with legislation on the sale of alcohol, tobacco and volatile substances to under-age young people. as been structured around these different components. A consortium of universities and research agencies, led by the Institute of Social Marketing at the University of Stirling, has drawn together a number of specialist research teams who have focused on different components or on different elements within these components. For example, regarding the school component of Blueprint, one research team concentrated on observing the delivery of Blueprint lessons in a sample of pilot school classrooms. Another team conducted surveys of the prevalence of drug use amongst the young people before, during and after they had experienced the programme. There have also been surveys of the impact Blueprint has had on the young participants' knowledge, attitudes and skills, and qualitative research with samples of teachers delivering Blueprint lessons, their pupils and the SDAs who provided support for these teachers.

Overall the programme evaluation focused on the processes of drug prevention, their impact and outcomes, and the costs of delivering it. Reports on different aspects of the evaluation will be published in due course. Two key reports, one on the processes of delivering the Blueprint Programme and the other on its impact, will draw together findings from the different research studies.

This particular report presents findings from just one element of the Evaluation of the Blueprint Drug Use Prevention Programme, namely the systematic observations of the delivery of Blueprint lessons in the schools which piloted the programme in 2004-2005¹. The main purpose of this report is to highlight some of the findings which are particularly relevant to teachers engaged in drug education.

Background

In 1998 the Government launched its National Drug Strategy². The overall aim was to reduce the harm caused by illegal drugs. The strategy started from the premise that the use of illegal drugs does not occur in isolation but relates to the wider context of the misuse of other substances, such as alcohol and tobacco, drug-related crime, youth crime, truancy and school exclusion, social deprivation, family problems and the environment in which many young people grow up. Drug education and drug use prevention in schools was seen as a priority. Substance misuse education was included in the National Curriculum and schools were encouraged to develop drug policies. The Drug Strategy was updated in 2002 through a range of policies and interventions which concentrated on the most dangerous drugs and the most vulnerable communities and groups. Drug education in schools continued to be a central part of the Drug Strategy, with a particular emphasis on expanding provision and improving its quality.

Underpinning this policy was the assumption that there is a direct association between effective drug education in schools and a reduction in drug use prevalence amongst young people. This assumption was based mainly on evidence from evaluations of drug education in other countries, particularly in the United States³. While a number of research studies had identified drug education programmes in other countries which had had a positive impact, it was felt that any one programme would require extensive adaptation if it were to reflect the English social and cultural context and, at the same time, fit into the prevailing mode of delivering drug education in England, namely through Personal, Social and Health Education (PSHE). It was recognised, however, that it was possible to distil some key principles of effective drug education from this evidence base which could be used to develop a pilot programme that could be trialled in English schools and evaluated as systematically as these other programmes.

¹ This report draws only on some aspects of the observation data since one function of this part of the evaluation was to observe fidelity to the programme in order to ensure that the outcomes, in terms of impact on pupils' knowledge, attitudes and skills and their use of drugs, could be directly related to their experience of the programme. This part of the evaluation will not be reported here because the analysis of pupil data is still ongoing.

² Cabinet Office (1998) *Tackling Drugs to Build a Better Britain*, cm 3945, Stationery Office, London.

³ Reviews of the evidence base in other countries that were particularly influential at this time included: Cuijpers, P. (2002) 'Effective ingredients of school-based drug prevention programs. A systematic review', *Addictive Behaviors*, 27, pp.1009-1023; Dusenbury, L. & Falco, M. (1995) Eleven components of effective drug abuse prevention curricula, *Journal of School Health*, 65 (10) pp. 420-425; Midford, R. et al. (2002) Principles that underpin effective school-based drug education, *Journal of Drug Education*, 32(4) pp. 363-386; Tobler, N. (1992) Drug prevention programs can work: Research Findings, *Journal of Addictive Diseases*, 11(3) pp.1-25; Tobler N. & Stratton H. (1997) Effectiveness of School-Based Drug Prevention Programs: A Meta-Analysis of the Literature, *The Journal of Primary Prevention*, Vol. 18 No. 1, pp. 71-128; White, D. & Pitts, M. (1998) Educating young people about drugs: a systematic review, *Addiction*, 93 (10) pp.1475-1487.

In September 2003, the Home Office, in partnership with the then Department for Education and Skills and the Department of Health, launched the Blueprint Programme after nearly three years of planning, research and development. As noted in the introduction to this report, it is a multi-component programme incorporating the curriculum, teacher training, SDA support, parental involvement, the media and health policy. This reflected research evidence that multi-component interventions tended to be more effective⁴. It also built on the Home Office's experience of delivering three other demonstration projects: Project Charlie⁵, NE Choices⁶ and the Integrated Programme⁷. Finally, Blueprint was based on the key principles of effective drug education that had been distilled from various recent systematic reviews of the research literature. The review by Dusenbury and Falco (1995) was particularly influential in this respect.

Box 1: Points highlighted in Dusenbury and Falco's review of the research literature as supporting effectiveness

- The information and materials used are designed for the skills and knowledge levels of the target group of young people.
- The approaches are based on research evidence of what has proved to be effective.
- The young people develop the life skills necessary for better-informed decisions, assessing risks, resisting unwanted pressure from peers and other social influences.
- They demonstrate that drug use is not as widespread as the young people might think (i.e. normative education).
- They use interactive teaching and learning styles.
- They include teacher training and support.
- They allow sufficient classroom time to cover the relevant topics and follow them up.

⁴ See, e.g., Flynn, B. S. et al. (1992) Prevention of cigarette smoking through mass media intervention and school programs, *American Journal of Public Health*, 82 (6), pp. 827-834; Pentz, M. A. (1993) Integrated school and community programs, in H. M. Wallace et al. (eds), *Principles and practices of student health*, Oakland, CA.; Pentz, M. A. & Valente, W. (1993) Project STAR: a substance abuse prevention campaign in Kansas City, in Backer, T. E. & Rogers, E. M. (eds) *Organizational aspects of health communication campaigns: what works?* Newbury Park, CA; Perry, C. D. et al. (1989) WHO collaborative study on alcohol education and young people: outcomes of a four-country programme study, *The International Journal of Addictions*, 24, pp. 1145-1171.

⁵ McGurk, H. & Hurry, J. (1995) Project Charlie: an evaluation of a life skills drug education programme for primary schools, *Drugs Prevention Initiative Paper No. 1*, London, Home Office; Hurry, J. & Lloyd, C. (1997) A follow-up evaluation of Project Charlie: a life skills drug education programme for primary schools, *Drugs Prevention Initiative Paper No. 16*, London, Home Office.

⁶ Stead, M. et al. (2000) NE Choices: the development of a multi-component drug prevention programme for adolescents, *Home Office Drugs Prevention Advisory Service Paper 4*; MacKintosh, A. M. et al. (2001) NE Choices: the results of a multi-component drug prevention programme for adolescents, *Drugs Prevention Advisory Service Paper 14*, London, Home Office.

⁷ Morris, J. et al. (2002) The Integrated Programme: an evaluation of a multi-component drugs prevention programme in northern England (1996-1999), *Drugs: Education, Prevention and Policy*, Vol. 9 (2) pp. 153-168.

- They are culturally sensitive to the diverse backgrounds of the target group.
- They are multi-component programmes.
- They are rigorously evaluated to identify evidence that they work as intended.

Source: Dusenbury, L. & Falco, M. (1995) Eleven components of effective drug abuse prevention curricula, *Journal of School Health*, 65 (10)

The curriculum component of Blueprint

The curriculum component comprised two teacher manuals, one for Year 7 and one for Year 8, which included:

- 15 lesson plans based on the approaches identified as effective in the research literature (ten in Year 7 and five in Year 8);
- background information for the teachers about the thinking behind the Blueprint approach;
- information about drugs and drug use statistics;
- guidance on how the lessons fit into the National Curriculum framework for PSHE at Key Stage 3; and
- guidance on classroom management, interactive learning and handling confidentiality issues during lessons.

A brief summary of the lesson plans is included in Appendix 1. Teachers were also given a pack of support materials, including quizzes, games, card sort activities and a booklet for pupils. Booklets were also provided for the parents so that they not only knew about the Blueprint approach but could also support their children's learning.

In addition, every teacher received six days training; three for Year 7 lessons and three for Year 8. Two of these training days were provided before the delivery of Year 7 lessons and there was an additional review day after these lessons had been delivered. For Year 8 the same approach to training was adopted. The training was delivered by the team who had developed the curriculum component. It was highly interactive, with a strong emphasis on modelling the Blueprint lesson activities. School Drug Advisers were also funded to support the participating schools during the pilot phase and they too received training in the Blueprint approach.

These various elements, which together constituted the Blueprint school component, were designed to support the overall aims of the multi-component drug prevention programme— that is, to:

- reduce the number of young people using drugs;
- delay the onset of drug use;

- minimise the harm caused by drugs; and
- enable those who have concerns about drug use to seek help.

Within this school component of Blueprint the specific curriculum objectives were to provide opportunities for pupils in Years 7 and 8 to develop their knowledge, understanding, skills and attitudes about drugs and to relate this to their own and other young people's choices and behaviour.

The Blueprint Programme adopted a wide definition of a drug as "a substance people take to change the way they feel, think or behave". This is the definition used by the United Nations Drug Control Programme and includes not only illegal drugs but also medicines, volatile substances, alcohol, tobacco and caffeine⁸. It is also the definition used by the then Department for Education and Skills in its guidance for schools on drugs and drug education⁹. The rationale for using such a wide definition is that it includes not only illegal drugs but all other substances which, when used without care or supervision, have the potential to cause harm and to be addictive.

Each lesson lasted 50 minutes. All 15 lessons tended to follow a similar structure, with a short introduction explaining the aims and objectives of the lesson and making links with previous lessons where relevant, followed by three to four learning activities, ranging in duration from 10 to 20 minutes, and ending with a five-minute review and reflection session to reinforce the learning.

Early drafts of the lesson plans and support materials were tested by a small sample of teachers in local authorities which did not participate in the pilot programme. Their feedback led to revisions to some of the lesson plans. In addition a group of curriculum experts also reviewed the final drafts before they were distributed to pilot schools.

The lessons were implemented in 23 pilot secondary schools located in local authorities in the north-west of England and the East Midlands.¹⁰ A further six schools in the same local authorities also took part in the project but did not use the Blueprint lesson plans and materials. These schools were asked to continue delivering their usual drug education programmes within PSHE lessons and the evaluators collected data on the delivery of these lessons and their impact on Year 7 and Year 8 pupils to provide a basis for comparison with the Blueprint pilot schools.

The Year 7 Blueprint lessons were delivered and evaluated in the spring term of 2004 and the Year 8 lessons were delivered and evaluated in the same term in 2005.

The evaluation of the curriculum component

Since Blueprint was a multi-component programme it was necessary to employ a wide range of different evaluation methods tailored to the specific characteristics of

⁸ UNDCP (2002) A participatory youth handbook for drug abuse prevention programmes, United Nations, New York.

⁹ DfES (2004) Drugs: Guidance for Schools, DfES Publications, Nottingham.

¹⁰ Initially there were 24 pilot schools but one withdrew from the Blueprint Programme after being placed under special measures by OfSTED.

each component. Some components were evaluated using several different methods; equally, some evaluation methods examined several different components.

Several research exercises contributed to the evaluation of the Blueprint curriculum component and these are briefly described in Appendix 2¹¹. One of the two final reports of the Blueprint evaluation (dated 2007) will bring together evidence from each of these research exercises in order to evaluate the delivery of the Blueprint Programme. The second report will draw on these and other research exercises to evaluate the impact of Blueprint in preventing the use of drugs. In this respect, drug use prevention is defined as delaying the onset of drug use, slowing the normal rate of increase in the prevalence rates for using tobacco, alcohol, volatile substances and illegal drugs during early adolescence and reducing the harm to self and others arising from the use of these substances. A third report will examine the methodologies used to evaluate the programme.

This report focuses primarily on the findings from the observations of the delivery of Blueprint in the pilot schools' classrooms. Where appropriate, it also draws on evidence from interviews with teachers in 12 of the pilot schools and 44 young people drawn from 11 pilot schools who were interviewed at the end of the Year 7 lessons and again after the Year 8 lessons.

The classroom observations were also undertaken to collect data at class-level exposure to Blueprint that could be tested for relationship with the class-level aggregated data to emerge from the later impact studies on young people's knowledge, attitudes and behaviour regarding the use of alcohol, tobacco, controlled drugs and other potentially harmful substances. However, it has been decided to release some of the findings in advance of the main evaluation reports because it was felt that they were of particular interest to practitioners working in the field of drug education and drug prevention in schools.

The methodology employed in classroom observation

The classroom observation element of the evaluation focused mainly on how teachers delivered the Blueprint lessons and used the accompanying learning materials. There were four primary objectives, three of which are considered in this report:

1. The first was to gauge the extent to which the teachers in the pilot schools actually followed the Blueprint lesson plans and used the teaching and learning approaches and support materials as intended. Knowing how faithfully an initiative has been implemented is critically important in gauging its impact¹². If there appears to be a significant change in the attitudes and behaviour of the young people and drug use is either delayed or prevented but the drug use prevention programme was not faithfully implemented then how can the positive outcomes be attributed to it? Likewise, as Yeaton and Sechrest point out, data suggesting that an

¹¹ For a more detailed account see the forthcoming report on the methodologies employed in the evaluation of Blueprint.

¹² Dusenbury, L. et al. (2003) A review of research on fidelity of implementation: implications for drug prevention in school settings, *Health Education Research* 18 (2) pp. 237-56.

¹³ Yeaton, W. H. & Sechrest, L. (1981) Critical dimensions in the choice and maintenance of successful treatments: strength, integrity and effectiveness', *Journal of Consulting and Clinical Psychology*, 49, 156-167.

intervention had failed becomes “uninteresting” if it can also be shown that it was not faithfully implemented.¹³

2. The second main objective was to identify any factors within the classrooms or within the pilot schools in general which may have supported the delivery of Blueprint lessons or acted as barriers to faithful implementation.
3. The third objective was to provide systematic evidence that might inform decisions about the possible roll-out of the Blueprint approach to drug education, including evidence of the need for any changes or improvements in the lesson plans and materials to ensure that they work as intended.
4. There was a fourth objective – to compare the approaches to drug education employed in the Blueprint pilot schools with those employed in the comparison schools – but the results from this part of the research are not reported here because the comparative analysis needs to be understood in relation to the outcome findings derived from the prevalence surveys and the surveys measuring the impact of Blueprint on the pupils.

The research was carried out by a team from the University of Edinburgh who observed classroom practice in all 23 Blueprint pilot schools and in the six comparison schools. The observation schedules developed for evaluating the delivery of Blueprint lessons included items designed to measure the following:

- the extent to which teachers kept to the pre-specified timings for each task or learning activity in each lesson;
- the extent to which the teacher and class had covered the pre-specified content;
- the proportion of pupils who appeared to understand what was required of them in each task and learning activity;
- the proportion of pupils who appeared to be actively participating in each lesson;
- the extent to which key Blueprint procedures for classroom management were followed; and
- the extent to which Blueprint teaching materials were used.

A total of 320 lessons was observed, 266 of which were in the pilot schools (comprising 177 Year 7 lessons and 89 Year 8 lessons) while the remaining 54 were in the comparison schools (comprising 36 Year 7 lessons and 18 Year 8 lessons). Further details on the classroom observation methodology are included in Appendix 3.¹⁴

¹⁴ For a more detailed account, see the forthcoming report on the methodologies employed in the evaluation of Blueprint.

Findings

Fidelity to the programme

Implementation fidelity, also sometimes referred to as programme integrity, is concerned with determining how well a programme is being implemented in comparison with the original programme design. A growing body of empirical evidence from a variety of different prevention programmes shows that the closer an intervention adheres to the original design, the greater the degree of behaviour change amongst the participants.¹⁵ Indeed, some research even suggests that a high level of implementation fidelity for a poor programme may be more effective in changing behaviour than a best practice programme where fidelity is low.¹⁶ In the context of Blueprint, the main purpose of measuring implementation fidelity was to check whether or not any changes in pupils' behaviour, attitudes or understanding of drugs and the risks involved in using them could be directly attributed to exposure to the curriculum component of Blueprint. In this respect, it was also important within the evaluation to identify factors which might enhance or reduce fidelity. This relationship between implementation fidelity and impact on the learners will be examined in a later report.

For the purposes of the evaluation, implementation fidelity was defined as *teaching and learning which is faithful to the pre-specified content, objectives and methodology of Blueprint, the timings allotted to each segment of each lesson and the values and spirit of the Blueprint approach.*

A variety of measures of fidelity were used in the evaluation. There were some general indicators, such as whether each pilot school delivered all 15 lessons to the appropriate age groups; whether the staff who delivered these lessons had participated in the training programme; and whether or not any teachers made use of additional resources or activities that were not specified in the Blueprint Programme. However, a variety of measures were also used which focused specifically on the classroom processes which are central to the Blueprint approach. These measures indicated the extent to which the teachers adhered to the lesson plans in terms of the specific content, teaching and learning approaches, activities and tasks, the scheduled timings for each activity, and the use of support materials. Delivering a programme as intended not only involves teaching the lessons as they were designed, it also involves being prepared, enthusiastic and deploying the requisite approaches and methods with skill and confidence. Observation data were also collected to judge the quality of programme delivery in this way. Finally, the observers also collected data to permit judgements about the young people's responsiveness to the lesson content and activities.

As already noted, much of the evidence on fidelity, both in terms of delivery and impact on learners, will be discussed in subsequent reports. It is sufficient at this point to note that around one-third of the observed lessons exhibited a very high degree of fidelity to the content and approaches that were central to the Blueprint Programme, and most of the other lessons that were observed scored around 70–75 per cent for content fidelity. In most instances the main reason for any reduction in

¹⁵ Mihalic, S. (2002) The Importance of Implementation Fidelity, Center for the Study and Prevention of Violence, Colorado University, Boulder, Colorado, USA.

¹⁶ Gottfredson, G. D., Gottfredson, D. C. and Czeh, E. R. (2000) National Study of Delinquency Prevention in Schools, Gottfredson Associates, Maryland, USA.

fidelity to content and approaches was that the teachers ran out of time before they had completed all of the activities in the lesson plan. In some cases this was because the scheduled timings for specific activities seemed to be unrealistic; in other instances it was due to poor preparation by the teacher or disruptive behaviour by some of the pupils. However, only 42 of the 266 observed Blueprint lessons were assigned particularly low scores for content fidelity (i.e. under 60 per cent) and only two of the 84 teachers who were observed regularly scored low for content fidelity.

Some of the evidence which emerged when analysing the data for fidelity to Blueprint is not only relevant to the evaluation of Blueprint, it also has immediate relevance to all practitioners involved in delivering drug education and drug prevention programmes within schools and is therefore discussed below.

Messages emerging from the Blueprint lessons

Pupils responded positively to active and interactive learning in drug education. There was a strong emphasis in Blueprint on active learning and interactivity, i.e. pupils learning together and from each other as well as engaging with the teacher. Most pupils enjoyed this approach and responded positively by being on task and actively participating with each other most of the time. Pupil participation ratings and on-task ratings were highest in those learning activities which involved brainstorming, problem solving, sorting sets of information cards, taking part in quizzes, playing games and discussing possible solutions to scenarios involving social influences. The pupils' rating scores for being on-task and actively participating tended to drop when the teacher was doing most of the talking or asking questions directed at the whole class.

An emphasis on active and interactive learning had important implications for lesson planning and classroom organisation. Most of the Year 7 lessons were tightly packed with information and learning activities and some teachers found it difficult to complete everything within the allotted 50-minute period. A typical Year 7 Blueprint lesson had five elements: an introduction, three main learning activities and a short review and reflection session at the end. Many teachers felt that the timings for some of the main activities were unrealistic, mainly because it usually took longer than the lesson plans allowed for teachers to get the pupils into groups and then settled down again after completing a group activity. This created a knock-on effect. When teachers realised that an activity was taking longer than was intended they would usually either cut it or rush through one of the subsequent activities. In either case this tended to reduce fidelity to content. The review and reflection sessions were the activities most likely to be cut, despite the Blueprint Teacher Manual emphasising how important these were in helping to reinforce the key messages of the lesson. As the teachers became more familiar with the Teacher Manual some of them began to recognise that certain kinds of activities usually took longer than the time allotted for them and planned accordingly.

Following feedback from the evaluators and some of the teachers, the development team reduced the number of learning activities in the Year 8 lesson plans. While retaining the introductory and review sessions, they usually included only one or two main learning activities, particularly where these involved a considerable amount of participatory and interactive learning. Even so, it was still found that the timings for some of these activities were unrealistic, even when they were scheduled to last between 30 and 45 minutes. The reduction in numbers of activities was not necessarily balanced by a reduction in the amount of content to be covered in each lesson.

Many pupils had a narrow concept of drugs and drug education which influenced their response to some lessons. Although Blueprint adopted a wide definition of drugs, as any substance which people take to change the way they feel, think or behave, most pupils appeared to associate the term primarily with illegal drugs unless a particular learning activity specifically required them to focus on cigarettes, alcohol, volatile substances, medicines or caffeine. Substances which were not illegal did not seem to fit with their concept of what drug education was all about. Similarly, although observers' judgements about pupils' understanding of what was being asked of them showed that the majority of pupils understood the tasks they were required to do in over 80 per cent of the learning activities that were observed, the rating scores for understanding what was required tended to drop when the learning activity was not clearly related to drugs and drug use.

Perhaps the clearest example of this was a lesson on advertising. Its main objective was to show how people's lifestyle choices are influenced by the media. After some whole-class discussion on the techniques which advertisers use to sell a particular product or brand to a specific target group, the teacher distributed a handout which explained these techniques in more detail. The class then divided into groups with each group given an A4-sized advertisement to analyse with the help of the guidance in the handout. Only one of these adverts related to any of the substances covered in their work on drugs (a bottle of beer). Most pupils were able to identify the product, the advertising technique being used and the overt message in the advert. But in almost every observed class there were some pupils who seemed to find it difficult to de-code the hidden messages about the kind of consumer who was being targeted by each advert and the kind of lifestyle that was being promoted. The more able pupils tended to make the links for themselves and sometimes talked about the promotion of certain products by celebrities who were associated with using drugs. But for the others, teachers needed to help them make such links in a more structured and systematic way. And yet, only one of the 17 teachers observed delivering this lesson made an explicit link between advertising, drug use, lifestyle choices and people's attitudes towards drugs.

In post-observation interviews some teachers were critical of the range of advertisements that were provided because only one of them focused on substances included in the Blueprint list of nine drugs. Indeed, one head of PSHE indicated that in future she and her colleagues would use this lesson but would download examples of advertisements from an American drug education site which were more explicitly focused on various drugs. Another head of PSHE indicated that in future his colleagues would probably use video clips from some of the television drug prevention campaigns instead. It was felt that these would offer useful stimulus for discussion because they were designed to highlight the negative social consequences of using various substances. In the authors' view the content of the advertisements used in a lesson like this is a secondary issue. What is important is that the young people understand how the mass media – and the celebrities who feature in the media – could influence not just their choice of specific products but also their self image, their aspirations and their idea of a desirable lifestyle. For some pupils this will happen as a result of analysing specific media examples. Others will need some structured discussion or brainstorming to help them make that leap from the specific item to the underlying drug education message.

The integration of evidence-based drug education with best practice in PSHE could be problematic. The evidence base for effective drug education programmes is rooted in the learning approaches which have been demonstrated, when used in combination, to bring about changes in young people's awareness, attitudes and behaviour. However, Blueprint also drew on best practice in Personal, Social and

Health Education. For example, in the first Year 7 lesson plan, the teacher was asked to involve the pupils in developing a Group Agreement on how Blueprint lessons would proceed. If the school (or class) already used Group Agreements then they were asked to review them and discuss any changes that might be needed specifically for drug education lessons. Each class also produced a new or amended Group Agreement at the beginning of the Year 8 Blueprint lessons. The Teacher Manuals for both years specified that these Group Agreements should be prominently displayed in the classroom in all subsequent lessons and that teachers and pupils should refer to them when any part of the Agreement was infringed by either a pupil or the teacher.

Blueprint also provided a Question Box for each pilot school class to enable pupils to ask questions anonymously. These would then be answered by the teacher in a subsequent lesson. In Year 8, the development team also introduced Graffiti Sheets (large sheets of blank paper displayed around the classroom walls) to complement the review and reflection sessions and to provide feedback to teachers about what the pupils were learning, what they liked and disliked, and what they would like more information about.

In practice using these features of the PSHE approach proved variable, mainly because they were not perceived by all of the teachers to be central to the Blueprint approach to drug education. This reflected a tendency for some of the teachers to interpret implementation fidelity narrowly as fidelity to the content and learning activities. As a result the Group Agreement was only prominently displayed in around half of the observed lessons and became less visible in the lessons delivered later in the programme. Furthermore, the likelihood of it being displayed and regularly referred to depended to a large degree on whether or not the Blueprint lessons were held in the designated PSHE room or in the teacher's own classroom. The Agreement was less likely to be visible if the teacher had to carry it around from lesson to lesson. Over one-third of the observed teachers did not display the Question Box and the majority of those who did display it did not explain its purpose. Very few teachers provided opportunities during lessons to respond to any questions that might have been left in the box. The Graffiti Sheets were only displayed in 25 per cent of the Year 8 lessons observed. However, where they were displayed they became increasingly popular with the pupils.

Variable use was made of the support materials produced for Blueprint. These resources included booklets for each pupil in Years 7 and 8, an information resource called Street Fax, a Blueprint poster, a board game on the legal status and the health risks of different drugs, and a strip of printed card, called a Z-Card, which was pocket-sized and contained addresses and contact numbers where young people could go for help or further information.

The board game was used by all of the teachers because it was an integral part of one of the lesson plans for Year 8. However, it was difficult to complete the game in the time allotted if the teacher was unable to get into the classroom a few minutes before the lesson to set it up. Most of the other resources were only used in a minority of the lessons observed, even though teachers and pupils alike were impressed by their quality. Again, it appeared that most of the teachers felt that implementation fidelity required them to deliver the lesson plans as intended and designed but they regarded most of the support resources as optional unless they were specifically integrated into lesson plans. If there were constraints on their use (time or movement from class to class) then teachers often opted not to use them.

Box 2: Key points for practitioners emerging from the Blueprint lessons

- **A high level of active and interactive learning encouraged pupil engagement and understanding.**
 - o Most pupils also responded positively to the enhanced opportunities for active and interactive learning in pairs and small groups. In most of the observed lessons pupil participation was high and most remained on task.
 - o The impact of interactive learning in drug education may be lessened if pupils are not using similar approaches elsewhere in PSHE and in other areas of the curriculum.
 - o Pupils also welcomed opportunities to draw on their own knowledge and experience.
 - o A broad definition of drugs needs regular reiteration in drug education lessons. Most pupils associate the term with illegal drugs. If a wide definition is to be adopted, it may be necessary for teachers to regularly remind pupils of this and/or have a poster or wall chart containing the broad definition and the kinds of substances that can change the way people think, feel and act.
- **Lessons should not be overambitious in terms of content and timing.**
 - o When teachers were under time pressures they often cut or omitted those elements of the lesson plan which were designed specifically either to help pupils make connections with earlier drug education lessons or to help them to reflect on what they had learned and to reinforce the key drug prevention messages. A balance needs to be struck between the need to provide pupils with essential information, which may often be highly specific about particular drugs and the risks associated with them, and the need to ensure that the fundamental messages behind an approach to drug prevention which emphasises reduction of risk and harm are understood and reinforced.
- **Well-produced, high-quality materials encouraged a high level of teacher and pupil engagement in PSHE lessons.**
 - o In the schools participating in the evaluation PSHE often tended to be seen as the 'Cinderella' of the curriculum with limited access to well-produced and up-to-date commercial resources, particularly for drug education. The introduction of the materials produced for Blueprint changed this perception for most of the teachers and pupils. Board games, well-produced pupil booklets, and card sort sets raised the status of PSHE lessons and many of the pupils responded by engaging positively with the learning activities.
- **The use of appropriate support materials needs to be fully integrated into lesson planning** with clear links made between the materials, the learning objectives and the learning activities where they will be employed.
 - o This is particularly important where the same lesson plans will be shared by a team of teachers

Factors impeding and facilitating the delivery of Blueprint lessons

Previous research into health education has highlighted that fidelity to curriculum programmes and packages can be enhanced by factors such as intensive teacher training, compatibility with approaches already being used in PSHE and support from senior management. Fidelity can be hindered by teachers not being comfortable with the emphasis on interactive learning, staff absences and lack of understanding of the theoretical approach which underpins the programme and timetabling issues.¹⁷

As noted earlier, the impact of these factors on implementation fidelity will be reported elsewhere. However, some of these factors have a more general relevance to practitioners.

Previous experience of delivering drug education or PSHE was not essential but it was certainly the case that some (but by no means all) of the form tutors delivering Blueprint were more anxious about active and interactive learning than those who were members of specialist PSHE teams. They were particularly concerned about the unpredictable outcomes and the potential scope for disruptive behaviour and loss of classroom control. In practice it was found that most form tutors gained confidence in their ability to facilitate interactive learning through the training, the detailed lesson plans, the guidance provided and their experience of delivering Blueprint in the first year of the pilot.

Before they began teaching Blueprint some of the teachers also expressed concern about responding to pupils' questions about drugs. They felt that they had neither the street knowledge nor the relevant life experiences to be able to have any credibility with the more street-wise youngsters in their classes. Every teacher who attended the Blueprint training was given a guide to drugs but the training also emphasised that if pupils asked specific questions which the teacher could not answer they should admit this and say that they would find out by the next lesson.

Some of the teachers probably had good reason to feel concerned about this kind of questioning. The interviews with young people from the pilot schools clearly showed that teachers' street credibility was important. In order to be considered credible the teachers needed to demonstrate a good knowledge of drugs, including their street names. It was apparent that the younger teachers tended to have an advantage here and their street knowledge was rated more highly by the pupils. In practice, however, most pupils felt that their teachers were reliable sources and only a small number of observed teachers seemed to experience a credibility gap. In most cases this appeared to be because they were inadequately prepared for specific lessons and had to keep referring to the Teacher Manual. In the few instances where pupils perceived that their teachers did not know very much about drugs this did seem to damage the overall credibility of the programme.

It was important that teachers understood the thinking behind the Blueprint approach. While the emphasis in the training programme on experiential learning and modelling helped some teachers to make the transition to a more facilitative style of teaching, this left little time during the training days for discussion of the drug

¹⁷ See, e.g., Buston, K., Wight, D., Hart, G. and Scott, S. (2002) Implementation of a teacher-delivered sex education programme: obstacles and facilitating factors, *Health Education Research*, 17, pp. 59-72.

education messages underpinning the Blueprint programme. The teachers completed evaluation questionnaires after each training session and at that stage most felt that they understood the thinking behind the Blueprint programme. However, the classroom observations indicated some variability here. In particular, a minority of teachers appeared to misunderstand the purpose behind some of the learning activities designed around the social influences and risk and harm reduction approaches. In the case of the former, they emphasised direct social pressure and persuasion but tended to overlook the ways in which these influences also create expectations and attitudes towards lifestyle, self image and behaviour within social groups. In the case of the latter, a small minority of teachers expressed disappointment that Blueprint did not provide pupils with more hard hitting information, particularly about the effects and consequences of using different drugs. They tended to emphasise the risks involved in drug use but overlooked the importance of developing social strategies for reducing risks. This would seem to indicate that they were either unclear about the harm minimisation approach or disagreed with it.

Shifting the timetabling arrangements for Blueprint lessons did not appear to be problematic. When the lesson plans were originally devised it was assumed that the pilot schools would deliver the Year 7 lessons over a period of ten weeks and the Year 8 lessons over a period of five weeks. Most of the pilot schools followed this pattern. However, a small number of schools opted instead for a collapsed timetable approach, where a block of three to five Blueprint lessons would be delivered in a single day. The observations indicated that there was a trade-off between these two modes of implementation. Pupils often enjoyed the block of drug education lessons over a day because it turned the lessons into more of an event. It also enhanced continuity and progression of learning. The key drug prevention messages were often reinforced more effectively. On the other hand, teachers and pupils alike tended to get rather tired by the end of the day, particularly because of the extensive interactive learning that was taking place, and this had a negative impact. Also teachers delivering Blueprint in blocks tended to think they had more flexibility. In some instances the lessons delivered earlier in the day overran and then content and even specific activities were cut in the later lessons in order to catch up.

Although there was no clear evidence that support from senior management was essential for the successful delivery of Blueprint, it did appear to have an indirect impact. It was clear, for example, that where there was strong support it reinforced existing positive feelings about Blueprint amongst the staff delivering it and where there was not much senior management support this tended to reinforce any existing negativity amongst the staff.

In practice, teachers worked round their classroom environments and settings. It was anticipated that small classrooms, purpose-built classrooms (laboratories and computer rooms) and traditional classroom settings (rows of desks or fixed tables) could prove a difficult obstacle for some of the more interactive learning activities, particularly those which required the whole class to move around the classroom, position themselves along a physical continuum, form teams to participate in a quiz, take part in role plays, or comment on each other's work. In practice classroom setting rarely had an adverse effect on the pupils' participation in those activities and did not reduce fidelity to the content. There was also no evidence to suggest that classroom setting had any major impact on the timings of learning activities. Instead teachers often proved to be creative in their use of limited space and adjusted the learning activities to the circumstances with which they had to work without reducing the scope for active and interactive learning.

The content of the Blueprint lessons was appropriate for most pupils in Years 7 and 8. Generally, most of the young people who were interviewed after completing the Year 7 Blueprint lessons thought that the lesson content was pitched at the right level for their age group. Some reported that it was difficult to remember and recall some of the information about controlled drugs, particularly regarding their effects, but others said that the content, though more detailed and wide ranging, was similar to the content covered in their last year at primary school.

Some of the teachers felt that their pupils, particularly in Year 7, were too naïve to understand and respond to some of the content on controlled drugs. Their view was that this material was better suited to drug education in Years 9 and 10. It was certainly the case that pupils tended to engage most actively with content which resonated with their own experiences, particularly on alcohol, tobacco and volatile substances. However, it was also the case that there were some pupils in almost every class who had older family members with experience of controlled drugs. Generally, knowledge and experience of drugs varied widely in almost every class from those young people with very little knowledge of the local drug scene to those who were street wise, knew the colloquial names of drugs and even the prices on the street. The latter often made a positive contribution to drug education lessons.

Blueprint lessons were delivered for the most part to mixed-ability classes and classes which included pupils with a range of special needs. This reflected how PSHE was delivered in most of the pilot schools. In some instances schools also decided to include in these classes those young people who were usually taught in separate units because of their behavioural problems. This reflected their concern that these young people might be particularly vulnerable in situations where drugs were on offer. Some pupils with low literacy levels or short attention spans tended to struggle with some of the learning activities, particularly enquiry-based learning, quizzes and decision-making activities. A few teachers expressed concern that the language level was too demanding for this particular group of pupils and called for more differentiated learning activities and materials. The teachers most likely to express this view were those with a high proportion of less able children and children with learning difficulties in their classes. Nevertheless, other teachers with similar classes tended to report that they used a number of strategies to get round these problems. For example, they increased the print size for some materials or they ensured that there were always one or two pupils in each mixed-ability group who could act as scribes and keep their group on-task.

Before the materials for Year 8 were finalised, they were checked for language level and some differentiated activities were introduced into each lesson plan which teachers could use at their own discretion. This was generally welcomed by the teachers although most either did not use them or used them in an undifferentiated way with the whole class. This may be because these materials tended to be designed as extension activities for those pupils who completed their activities more quickly than the rest rather than as activities tailored to those with learning difficulties.

Some of the teachers whose classes included pupils with severe communication problems and multiple and complex learning difficulties reported that these young people experienced problems with some of the drug education materials and with the activities that emphasised active and interactive learning. There is already some concern about the need for sex education materials specifically designed for young people with complex learning needs and difficulties. In the authors' view, further research and development work may be needed to develop a drug education pack for them. This should take into account their need for visual rather than written stimuli and be tailored to their circumstances, given that they are probably on medication for

their condition and may also find themselves in a variety of settings where prescription drugs as well as illegal drugs might be accessed or offered.

Box 3: Key points for practitioners on factors impeding and facilitating delivery

- **Implementation fidelity is important.** For drug education lessons to have an impact on young people's current and future attitudes and behaviour towards drugs, it is essential that all teachers involved in the delivery of lessons adhere to the whole programme using the recommended teaching and learning approaches rather than cherry-pick those elements with which they feel most comfortable.
- **A support package is needed for teachers who are inexperienced in PSHE and specifically in drug education.** It is essential that the teachers who have not previously been involved in delivering much drug education or PSHE, receive support in terms of detailed lessons plans, including realistic timings for each activity, guidance on the rationale behind the different approaches being used, and opportunities to discuss regularly with the other members of the team any difficulties they may be having with specific activities.
- **Preparation work is essential** if teachers are going to be able to manage the extensive use of active and interactive learning in drug education. It is also necessary to do some preparation work on types of drugs and their effects if they are going to retain credibility with the more street-wise pupils.
- **The use of smaller and more traditional classrooms, or science and computer labs, is not necessarily a barrier to effective drug education** if teachers use the space creatively and find alternative ways of engaging pupils interactively.
- **Collapsing the school timetable for two to three days over the course of a term and delivering drug education in intensive blocks of lessons can be as effective as delivering it through a series of weekly PSHE lessons.** This may in fact enhance continuity and progression of learning but the issues relating to the pacing of the lessons and providing opportunities to reflect on learning are different from those associated with delivering drug education through a series of weekly 50-minute lessons.
- **Pupils in the 11–13 age range are not too young to cope with a drug education programme** which is based on a wide range of drugs and substances and is designed around a social-influences approach with a particular emphasis on normative education, reduction of risk and harm and resistance and decision-making skills. However, it may be advisable to employ extension activities and differentiated teaching with some mixed-ability and lower-ability classes.
- **Pupils with profound and complex learning needs are just as vulnerable as their peers but may need a specially designed curriculum and support materials tailored to their circumstances.**

The Blueprint approach in action

As noted in the Background section of this report, the approach adopted by the development team who produced the curriculum component for Blueprint in 2003 (Dixon-Collier Consultancies Limited) built on a substantial body of research evidence and expert guidance. Their work also reflected the principles set out in draft DfES Guidance (published in 2004), the QCA Guidance on Drug, Alcohol and Tobacco Education (2002) and *The Right Choice: Guidance on Selecting Drug Education Materials for Schools*, produced by DrugScope in 1999.

However, the design of a new curriculum resource is not an exact science. The underpinning approaches may be evidence-based in terms of the emphasis both on active and interactive learning as the main means of delivery, and on reducing harm, addressing misconceptions about the prevalence and acceptability of drugs, providing the skills and knowledge to enable young people to make informed choices, and giving them the means to recognise, resist and counteract social pressures to use drugs. The ways in which these approaches were translated into specific learning activities, however, were relatively untested. This included decisions about the structure of the lessons, the timings assigned to different tasks and activities, the decisions made about the sequence of activities and lessons, the language used in the support materials, and so forth. It was important therefore to evaluate not only whether or not the teachers were delivering Blueprint as intended but also to establish whether the specific lessons and learning activities were also working as intended.

Active and interactive learning

Drug education is likely to be most effective when pupils are actively engaged in their learning: seeking out relevant information for themselves, developing and practising their communication, negotiation and decision-making skills and learning how to resist social pressure and influences. The learning also needs to be interactive – not just teachers and pupils interacting but also pupils interacting with each other, learning together and learning from each other¹⁸.

Blueprint used a wide range of learning activities designed to maximise participation by pupils. These included:

- warm-up activities designed to energise and engage them;
- brainstorming to encourage them to contribute their own ideas and draw on their own experience and knowledge;
- small group investigations to find factual information about drugs or to assess the risks involved in using different kinds of drugs;

¹⁸ See, e.g. Tobler, N. S. and Stratton, H. (1997) Effectiveness of school-based drug prevention programmes: a meta-analysis of the research, *Journal of Primary Prevention*, 18(1) pp. 71-128. Tobler and colleagues have produced two subsequent reviews that also highlight the effectiveness of interactivity: Tobler et al. (1999) Effectiveness of school-based drug prevention programs for marijuana use, *School Psychology International*, 20(1) pp. 105-137; and Tobler et al. (2000) School-based adolescent drug prevention programs: 1998 meta-analysis, *Journal of Primary Prevention*, 20(4) pp. 275-336.

- quizzes not only to check and reinforce learning but also as a means of introducing some normative education (see below);
- games where pupils competed with each other in teams, usually as a means of utilising and demonstrating the knowledge they had acquired about specific drugs and their effects and risks;
- continuums (exercises where pupils present their opinions along a physical continuum) to enable the class to explore different points of view about issues relating to the use of drugs;
- prioritising and decision-making activities, such as a Diamond Nine activity (where pupils sort a set of priority cards on a specific issue into a diamond shape with their highest priorities at the apex). These are designed to structure group discussion and explore the factors that the pupils usually take into account when making choices and those which they usually ignore or regard as less relevant;
- scenarios based on the choices that young people often have to make to encourage pupils to put themselves in another's shoes and find a solution that reduces the potential risks involved;
- role plays to rehearse strategies for coping with specific social situations, particularly those where persuasion or pressure is being used by peers to influence a young person to experiment with substances; and
- planning and giving presentations on what they have learned from their drug education lessons.

Pupils clearly enjoyed these activities; participation was high and this often had a positive effect on their engagement in subsequent learning tasks and activities. This tended to be the case irrespective of whether or not they were familiar with warm-up and icebreaker activities, role plays, quizzes, brainstorming and values continuums in their other PSHE lessons or elsewhere in the curriculum.

Active and interactive learning also tended to raise the pupils' expectations of their PSHE in general and their drug education in particular, although it was also apparent that some of them became restless and inattentive when they had to listen to the teacher or work independently. At the same time, while the emphasis on active and interactive learning enhanced levels of pupil participation in every observed class, the quality of the learning outcomes appeared to vary and this depended to some degree on the purpose of the activity. Many of the interactive activities employed in Blueprint had a clear structure, e.g. games, quizzes or values continuums. If the pupils participated and stayed on task, it was likely that most of them would achieve the kinds of learning outcomes determined for these activities. However, in some of the more open-ended interactive activities, e.g. brainstorming and paired or small group discussions, it was sometimes difficult for observers to establish what some of the pupils were learning and in some cases the learning outcomes achieved by some of the pupils seemed rather superficial¹⁹.

¹⁹ It should be noted that these findings are based on observations of lessons and, in particular, how the pupils articulated and summarised their learning. It may be that the impact surveys undertaken with the pupils after completing the Blueprint Programme will reflect broader and deeper outcomes, not just in terms of knowledge and understanding but also in attitudes and behaviour.

Two examples illustrate this. First, in Lesson 3 (a Year 7 Blueprint lesson) the pupils, in mixed-ability groups, were given sheets of paper, each with the name of a drug on it, and were asked to write down everything they knew about that drug. Having done this they were then asked to use various information resources to identify three key facts which they thought their friends should know about the drug they had been researching. This lesson was observed in 13 different pilot schools. The responses of over one hundred pupil groups were then analysed in terms of the breadth of the information they had collected and presented. The sources they used would have enabled them to identify the street names of various drugs, their legal status and classification (if controlled drugs), the different ways in which people might take these drugs, the effects each drug can have and the potential health, social and legal consequences of using them or being caught supplying them. Just over half of the observed pupil groups collected and presented fairly wide-ranging information about their chosen drug, usually identifying one or more street names for the drug, its classification, how most users took it and some of its effects. The remaining groups came up with far more limited information, in some cases only providing two or three street names for their chosen drug.

The second example relates to Blueprint Lessons 9 and 10 (also in Year 7) where pupils in small groups were asked to prepare and then give presentations (to the whole class or year group) on what they had learned from Blueprint. Again, there was a clear emphasis on interactive working. In all, 159 presentations in 18 pilot schools were observed. In 29 of the presentations (18 per cent) the pupil groups opted for a simplistic message that was not consistent with the overall Blueprint approach. In most instances the message was some variant on: "Take Drug X and you will die".

The pupil surveys indicated that most pupils had better recall of their lessons than this example would seem to suggest, although it should also be noted that the questionnaire presented them with prompts about the content of the lessons.

Since the authors were observing lessons rather than interviewing pupils about what they had learned in specific activities, they can only speculate about what was happening here. There seemed to be two related factors which may help to explain the findings. First, a number of teachers said that their Year 7 pupils were not used to brainstorming activities or presentations. In their schools, neither approach was used in PSHE or in other curriculum areas. Second, these particular active and interactive approaches were open-ended and relatively unstructured. When delivering Lesson 3 some of the observed teachers went round from group to group to encourage them to collect a wider range of information about their chosen drugs. In both instances some pupils could have benefited from a framework of questions to guide their thinking or their search for information.

In other words, it is important when developing a drug education programme where the main mode of delivery is active and interactive learning, to find ways of structuring pupils' experiential learning so that:

- the key drug education messages underpinning the programme emerge through their experiential activity;
- learning is focused and purposeful;
- pupils can effectively organise the information they are acquiring; and
- they can relate this information to their own and others' experiences and make connections to and build upon their previous learning.

Most of the Blueprint activities, particularly the quizzes and the board game, did just this and, as a result, proved to be effective means of reinforcing learning by encouraging pupils to use their knowledge in a purposeful way. The more open-ended forms of experiential learning also needed to be structured to ensure that the desired learning outcomes were achievable and achieved.

The impact of the more structured active and interactive approaches, such as the quizzes and the board game, depended on careful preparation by teachers. Teachers needed to familiarise themselves with the content of the quiz or game and its rules beforehand; they also needed to have a clear sense of how long it took to set it up, get the pupils to listen to the instructions, play the quiz or game and then settle them down at the end of it to review what had been learned. The impact of these activities was noticeably reduced when it was clear to pupils that the teacher was not familiar with the content of the quiz or game and its rules. Where teachers found it necessary to cut elements of the game or quiz the pupils became frustrated and the learning value of the activity was diminished. For the lessons devised for Year 8 pupils, the development team decided that there should only be one major activity of this kind per lesson (for a 50-minute lesson) to reduce the likelihood of these problems arising.

Box 4: Key points for practitioners on active and interactive learning

- **Pupils' lack of familiarity with active and interactive learning in PSHE was not an obstacle to their participation** in activities based on them during their drug education lessons. Participation in the interactive activities also had a positive effect on their engagement in subsequent learning activities in those lessons.
- **Active and interactive learning enhanced pupil engagement with their drug education.** For many of the pupils, active and interactive learning proved to be an important element in ensuring that they engaged with and took ownership of their drug education in a way that is often missing in more directive approaches which rely heavily on inputs from visiting speakers, videos and worksheets.
- **The impact of active and interactive learning can be further enhanced by helping pupils to structure what they are learning.** Active listening strategies, selective use of worksheets and other structuring devices can reinforce learning and help pupils to make connections with their earlier learning.
- **Pupils need to be clear about the reasons underpinning the use of active and interactive learning.** For some pupils, active and interactive learning can become an end in itself (i.e. an enjoyable lesson) rather than a vehicle for experiential learning (i.e. learning by doing). Again, structuring and reflection activities can help to clarify the purpose behind the activities.
- **Preparation is important.** The impact of active and interactive learning could be reduced where teachers are not well prepared.

Normative education

Normative education seeks to address any misconceptions that learners might have about the prevalence of drug use and misuse (or any other risk-taking behaviour)

amongst their age group or within their community. There are three related assumptions which underpin this approach. First, that many young people over-estimate the extent of risk-taking behaviours amongst their peers. Second, that they wrongly believe that these behaviours are the norm. Third, that because of these misconceptions they are vulnerable to social pressure to conform to this norm. The approach, often drawing on survey data collected from young people, seeks to undermine these misconceptions and thereby reduce the number of young people who feel that they should experiment with drugs because they believe that everyone else is.

A normative education approach was a central part of the Blueprint curriculum. This was based on the research evidence summarised in a number of the systematic reviews of the research literature undertaken between the mid-1990s and 2004²⁰.

The development team had access to data from prevalence surveys of pupils in the schools used to test the Blueprint materials. (These were schools not in the local authorities used for piloting the Blueprint Programme.) This was incorporated into specific learning activities to address potential misconceptions about drug use prevalence. In a Year 7 lesson teachers were asked to form their classes into six teams and distribute a quiz sheet. This sheet contained nine questions, most of which asked the pupils to guess how many young people in a Year 8 class of 30 had, over a given period of time, smoked a cigarette, drunk any alcohol, tried an illegal drug or talked to parents about drugs. When everyone had completed the quiz sheet, each team discussed the answers to each question to try and get a consensus. Then the teams competed in a quiz. The teacher's role was to keep the score, announce the winners and also encourage the pupils to consider any discrepancies between their answers and the correct ones.

A similar kind of activity was included in a Year 8 lesson. Here too the pupils were divided into teams and read a series of statements using data from the Blueprint drug use prevalence survey. In this case the data came from a survey which the pupils themselves had completed when they were in Year 7. Again the questions focused on the proportion of young people who had experimented with specific substances. In each case the pupils were given a figure and asked if they thought the equivalent proportion from the Blueprint prevalence survey emerging from a real life context would be higher, lower or about the same.

In the classes that were observed in both Year 7 and Year 8 a relatively high proportion of the pupils did not accurately estimate the relationship of the survey figures to their perceptions of prevalence. Furthermore, they tended to assume that the numbers taking the specified substances were higher than the surveys indicated. Because of this, the scope for normative education was high.

However, two problems emerged in the observed lessons. First, teachers did not always take the time to explore discrepancies between pupils' answers and the data from the surveys. Consequently, an important dimension of normative education was left out in those particular lessons.

Second, in most of the observed lessons at least some pupils questioned the validity of the answers and, in some cases, these doubts were raised by the majority of the class. They were most likely to challenge the survey findings on the prevalence of

²⁰ For a recent overview see Stead, M. & Angus, K. (2004) Literature Review on the Effectiveness of School Drug Education, Scottish Executive Education Department, Edinburgh.

alcohol consumption, smoking and sniffing volatile substances. The Year 7 pupils who had doubts tended to argue that the respondents were lying about their use of drugs or that the survey did not include young people from their area and therefore did not reflect their local situation. The older Year 8 pupils who had doubts tended to argue that they or others of their acquaintance had lied when completing the Blueprint questionnaire in case someone who knew them would read their answers.

The Teacher Manuals for Years 7 and 8 recommended that where pupils challenged the validity of the survey data, teachers should explain the procedures used to ensure the anonymity of the respondents and reduce the likelihood of bias and also explain that the survey findings were similar to those from surveys carried out on a national basis. This was not always done and when it was, it did not always allay pupils' doubts.

Box 5: Key points for practitioners on normative education

- **The impact of normative education depends on the pupils being convinced of the validity and reliability of drug use prevalence data** And taking on board that drug use is not as widespread as they think. Teachers need to be prepared for the kinds of doubts that are most likely to be expressed by pupils and to discuss the steps that are taken when conducting surveys (a) to ensure anonymity and confidentiality and (b) to design questions that will encourage respondents to give honest answers.
- **The impact of normative education also depends on teachers finding the time to discuss any clear discrepancies** between pupils' estimates of drug use prevalence and survey data or government statistics.
- **The normative education approach needs preparation time.** It may be rather ambitious to assume that it can be covered through activities in just two drug education lessons, as was the case with Blueprint. Since it has potential relevance for all areas of PSHE, but particularly bullying, sex education, healthy eating, exercise and use of leisure time, there is a strong argument for incorporating the approach into all PSHE teaching. Pupils would then have more opportunities to think about the prevalence of different kinds of behaviour in a wider range of contexts.
- **Pupils' confidence in the validity and reliability of survey data could be enhanced by direct experience of planning and conducting prevalence and life style surveys.** This need not necessarily be a survey about drugs. It could focus on any other potentially sensitive issue being covered in PSHE or be a general lifestyle survey.

Reducing risk and the potential for harm

This approach seeks to raise awareness about the risks involved in the use of drugs and to develop social strategies for reducing those risks and for supporting others who may be at risk.

As with the normative education approach, systematic surveys of the research evidence have highlighted reduction of harm and risk as an important element of

effective drug education. Blueprint incorporated this approach into the lesson plans in a variety of ways. In Year 7 the pupils used card-sort activities and mini-enquiries to find out about the possible effects and risks associated with specific substances. They also discussed scenarios in order to work out ways of dealing with situations where there was a heightened risk of peer pressure to experiment with drugs. In Year 8 the main theme was risk, risk assessment and strategies for minimising risks. First, the pupils played a board game involving question and answer cards about different drugs. There were three categories: red cards to cover drugs and risks; blue cards covering drugs and the law; and yellow cards providing factual information about drugs. The aim of the game was to reinforce accurate information about drugs by collecting pairs of correct question and answer cards.

The subsequent two lessons were structured around a social scenario, The Party. The pupils, working in groups, were asked to answer ten questions about the possible risks which the party could present to each character. These included: being offered alcohol and illegal drugs; being given a spiked drink which was supposed to be non-alcoholic; an attempt to persuade one of the characters to go upstairs to one of the bedrooms and the offer of a lift home from a stranger and his mates. At various points in the story the teacher pauses to ask questions about what the various characters should do in such situations and then makes a list on a flipchart of the risks identified by the pupils for subsequent review and reflection.

Risks to relationships and risks to health constituted around two-thirds of all of the risks raised by pupils. Health risks tended to be physical and immediate and most pupil groups spent much of their time talking about how to strike a balance between not losing face with friends and yet not doing things which would anger their parents. There was very little discussion about the law and the legal consequences of any of the actions undertaken by the characters in the story.

The observations indicated that some of the pupils had clearly grasped the thinking behind an approach to reducing harm and risks and were applying it to the various social situations described in the story. This included advice on how to manage social situations where there was a potential for substance misuse or other risky behaviours. The advice to others took the form of planning ahead, e.g. checking out the situation, arranging in advance to be picked up or nursing a drink.

On the other hand many of the pupils in observed lessons opted for scare tactics and uncompromising messages such as *You can get cancer if you smoke; If you try this you could die* and so forth. Others offered advice and admonitions which they themselves would probably reject in similar circumstances such as *Don't do it; Drugs can kill; Stick to fruit juice* and so on. Indeed, in one class the teacher said to the pupils, *"Do you think that talking to someone your own age and saying 'Don't do this' would be a good way of advising them?"* and most of the pupils agreed that it probably would not work. However, in spite of their training and the guidance in the Teacher Manual, a number of observed teachers seemed to share this preference for tough messages and admonitions and introduced prompts into the discussions which seemed to be guaranteed to reinforce the scare tactics approach. One teacher, for example interjected the same question at various points, *"What's the worst thing that could happen here?"* Very few teachers asked the pupils what they could do if things did go wrong.

Box 6: Key points for practitioners on reducing risk and harm

- **The impact of an approach to reducing risk and harm depends on pupils having an appropriate concept of what is meant by risk.** In practice, many of the pupils in the observed classes, when asked what they associated with the word risk, talked about accidents and life-threatening behaviours and immediate rather than long-term risks. Very few mentioned risks associated with drug use. Before pupils can effectively understand the thinking behind a harm minimisation approach they need to understand:
 - the difference between short-term and longer-term risks
 - that risk is not simply the same thing as immediate physical danger; and
 - that risk is related to chance or probability, e.g. that the chance (or risk) of Z happening is increased or reduced by Behaviour Y (or even by Behaviours W, X and Y).
- **Social scenarios have the potential to engage pupils in considering strategies for minimising the risks** and keeping themselves and others safe in typical social situations where peer pressure can operate. But to be effective it is crucial that the pupils have already done some work on the effects and risks associated with specific substances and can therefore understand the risks which the characters face in the scenarios presented.
- **The Blueprint approach goes beyond identifying risks to considering social strategies for reducing them.** Asking pupils what each character should do to reduce the specific kinds of risk in each social situation focuses their thinking on the strategies which individuals might employ to effectively manage situations where substance misuse might arise.

Skills and knowledge to help pupils make informed choices

There was a strong emphasis in Blueprint not simply on providing young people with useful information about drugs and other potentially harmful substances and where they could obtain help, but also on providing them with the skills to seek out that information for themselves, assess its validity and relevance to them and then use it constructively to make informed decisions and choices.

The Blueprint lessons emphasised enquiry-based learning, usually in small groups. The favoured approach was to start with the pupils' existing knowledge about particular drugs and when they had written down on a large sheet of paper everything they knew about this drug they were asked to use fact cards and other sources to check and supplement their knowledge.

As noted earlier, there were wide variations in the breadth and depth of information which pupils collected on specific drugs and substances. Some of the teachers interviewed after these lessons indicated that this may have been because their pupils were not used to enquiry-based work in their PSHE lessons and may have needed a more structured learning experience. It was also noticeable that pupils tended to collect and present more wide-ranging information on some controlled drugs such as heroin than they did on those substances that were more widely used

in their presence, such as tobacco. It is possible that this also reflected curiosity about those drugs with which they were least familiar and which they associated with high-risk behaviours.

Some pupils also experienced difficulties with the range of substances covered by Blueprint and the definition used of what constituted a drug. The lessons and the support materials focused on nine substances: alcohol, caffeine, cannabis, cocaine, ecstasy, heroin, medicines, tobacco and volatile substances.

Two general points emerged from the observations regarding this list and the definition itself. First, when brainstorming about the names of drugs they had heard about, many of them referred to hallucinogens such as Magic Mushrooms and LSD, amphetamines, nitrites or poppers, anabolic steroids (because of sport) and the so-called date-rape drugs, Rohypnol and GHB. They were particularly surprised that Magic Mushrooms, poppers and steroids were not included in Blueprint lessons.

Second, some of the pupils seemed to find the broad definition of a drug counter-intuitive. Their inclination was to reserve the term drugs for illegal substances. They were prepared to include tobacco and alcohol within the definition when it was explained that these are also substances that can change the way people think, feel and behave. But it was clear that a sizeable minority found it difficult to think of substances containing caffeine, such as tea, coffee, chocolate or cola, as drugs. This tension between legal and illegal substances, as well as related tensions between high-risk and comparatively low-risk substances and short-term and long-term risks, remained a cause of confusion for some pupils throughout the Year 7 and Year 8 lessons.

Blueprint lessons also included several opportunities for pupils to develop and practise decision-making skills. They were introduced to what was referred to as the *Four Cs* approach to decision making (i.e. **Clarifying** the problem, **Considering** the options, thinking about the **Consequences** of each and **Choosing** the best option). They were then given scenarios involving peer-group pressure where young people might be called upon to make a choice and asked to apply the *Four Cs* approach. One scenario involved peer pressure to smoke a cigarette and the other involved peer pressure to buy lighter fuel for friends who had been experimenting with sniffing solvents.

In practice most of the observed pupil groups did not apply the *Four Cs* approach in full. They tended to focus on one or two options and, to a lesser degree, the possible consequences of these options. They worked hard at trying to find compromises that would get the individual off the hook with friends and parents. They were less likely to clarify the actual problem. Some teachers intervened to spell out what the problem was in each scenario and tried to get the pupils to consider whether their options were the most appropriate or most effective for dealing with this problem.

Pupils seemed to find the second scenario more difficult than the first. The problem in the first scenario was straightforward. The individual was faced with a situation where friends were passing round a packet of cigarettes and he or she had never smoked and knew that parents would be angry if (s)he did. Pupils mostly saw this as a dilemma about how to avoid losing face with friends while avoiding parental wrath. The second scenario was more multi-layered. In this the individual had friends who were experimenting with sniffing volatile substances. (S)he was asked by one of them to buy some lighter fuel refills from a local newsagent. They knew that (s)he was often sent to this shop by her/his father to buy refills for him. This scenario called for judgements at different levels with the possibility of various personal, social and

legal consequences in addition to the need to decide between losing face with friends or colluding in an activity which put them at risk. Some pupils found it harder to reach a solution here given the various potential consequences associated with any decision.

Some pupils questioned how realistic the *Four Cs* approach might be, arguing that in real-life situations it would not always be possible to have the time to analyse the problem, think through all the possible options and weigh up the potential consequences. They argued that in such situations they would rely on their feelings or instincts.

Box 7: Key points for practitioners

- **The choice of drugs to be covered in a drug education programme needs to reflect the range of learning objectives underpinning that programme.** The nine drugs covered in Blueprint lessons and resources were selected to serve different learning purposes. Volatile substances, alcohol, tobacco and cannabis were included because they are the ones that 11-13 year-olds are most likely to be experimenting with. Some other drugs – cocaine, ecstasy and heroin – were included because many of the youngsters are likely to encounter situations in later adolescence where these drugs are available and on offer. The other substances – caffeine and medicines – were included to raise awareness that we live in a drug-using society, that we all use drugs in some form and that even legal drugs need to be used with care and can be harmful if misused.
- **Pupils need to be clear as to why certain drugs are covered and others are not.** In practice, most of the lessons focused on alcohol, tobacco and illegal drugs and the risks involved in using them. Few activities actually focused on those drugs included for other purposes. Pupils often seemed confused about why substances which they did not think were harmful or illegal were included in drug education lessons.
- **Pupils expect that the drugs which are covered will resonate with their experiences and the experiences of their peer group.** In Blueprint many pupils expected a wider range of the drugs with which their peers were experimenting. These included Magic Mushrooms and nitrites/poppers. They were also surprised that performance-enhancing drugs, such as anabolic steroids, and the so-called date-rape drugs, such as GHB and Rohypnol, were not included in spite of their high profile in the mass media.
- **The skills to be learned in drug education lessons also need to be practised elsewhere in the PSHE curriculum.** In circumstances where pupils seldom engage in enquiry-based learning for PSHE lessons (or other areas of the curriculum) it may be necessary to provide them with more opportunities to practise these skills. This is particularly so for other topics where a knowledge base is necessary if pupils are to be encouraged to adopt strategies for reducing risk. Only having one or two lessons where social scenarios are discussed and analysed may not be sufficient to develop the appropriate decision-making and problem-solving skills. It may be necessary to explore how such social scenarios can also be introduced into more areas of PSHE. Since so many pupils indicated that in these kinds of social situations they would usually rely on their feelings and instinctive reactions, this would provide opportunities beforehand where they could test the reliability of their instincts before going on to practise a more systematic approach to making choices and decisions.
- **Where an enquiry-based approach is integrated with active and interactive learning it may be necessary to help pupils to structure their learning.** Where pupils did use an enquiry-based approach many would have benefited from some kind of framework such as a short questionnaire or worksheet to structure their search for factual information and then help them to prioritise it.

Recognising, resisting and counteracting social pressures to use drugs

Blueprint included activities designed to raise pupils' awareness about how various social influences operate, particularly the mass media, advertising and peer group pressure, and activities designed to help them to practise strategies for asserting themselves and resisting any social pressure to experiment with cigarettes, alcohol, volatile substances or illegal drugs. Some of the teaching and learning approaches already discussed above, such as normative education and the reduction of harm and risk, are also key elements in this broad social influences approach to preventing and reducing drug use.

When pupils brainstormed the different influences that might either persuade them into, or dissuade them from, experimenting with drugs they tended to identify two broad types of influence:

Social influences, such as family, friends, peers at school, teachers, the public lifestyles of celebrities, television, teen magazines and advertising. These were perceived as operating as both positive or negative influences. It was generally recognised that their families would be worried about any experimentation with drugs and would seek to dissuade them but some pupils – a minority – also pointed out that some parents smoked and drank alcohol and that some older siblings were already using drugs of various kinds. Similarly, while many pupils thought that peer pressure was likely to be a major influence in persuading young people to try cigarettes, alcohol and controlled drugs, others felt that they were more likely to listen to a friend who was trying to dissuade them from experimenting with drugs than to a parent or teacher.

Personal reasons most frequently mentioned by pupils for experimenting with drugs were curiosity; a desire to do what they think lots of other young people are doing; fear of losing face with their friends; wanting to look cool and cultivate a certain kind of self image; and looking for ways of helping them to cope with stress and depression. Some pupils highlighted that people already using drugs or already addicted to drugs would also be influenced by their pattern of usage and may also want to experiment with harder drugs. The personal reasons for not experimenting with drugs most frequently mentioned were the consequences of being caught, the risk to health and the financial cost of a lifestyle that involved taking drugs.

Although the discussion that took place after these brainstorming sessions usually led to pupils identifying those social pressures and personal reasons that were most influential on young people, the discussion did not usually extend to any analysis of how these different influences actually worked. As a result, opportunities for making a direct link between influences and misconceptions about drug use prevalence (i.e. normative education) were not always established.

As noted earlier, the Blueprint lesson which focused on advertisements was less successful than it might have been, partly because many pupils were able to identify the overt but not the hidden messages in the examples they were given and partly because, for legal reasons, hardly any of the advertisements were concerned with trying to persuade people to purchase cigarettes, alcohol or other drugs. Very few examples were observed of teachers helping the pupils establish a connection between the power of the media to influence people's images of themselves and the

use and misuse of drugs in society. It was assumed that the link would emerge because the lesson was included within a drug education programme but many of the pupils did not appear to make this connection.

To help pupils learn how to resist effectively any peer pressure to try drugs, one of the Year 7 lessons was designed around a scenario in which a Year 7 pupil, Sam, encountered another pupil in the school toilets who tried to pressure Sam into buying some cigarettes. After talking the pupils through the scenario there was a whole-class brainstorming activity on what Sam could do in this situation. At this point the Teacher Manual advised that teachers should remind their pupils of the *Four Cs* approach to decision making which they had practised in the previous lesson and use this approach to devise an effective strategy for Sam or any other young person in this kind of situation. The teacher then modelled one possible strategy for Sam to employ which, in the Teacher Manual and lesson plans, is referred to as *The Five Refusal Skills*. Here the young person who is subjected to pressure is recommended to adopt a progressively assertive approach to refusing the offer of any drugs. Having seen the strategy modelled by the teacher, the class was then divided into pairs and each pair was given a card describing various situations in which they might use resistance or refusal skills. The pupils had to use the cards to help them devise and enact role plays around the use of the *Five Refusal Skills*.

The role plays proved very popular with most of the classes that were observed but a sizeable minority of pupils seemed to have difficulty in differentiating between assertiveness and aggression and this was particularly apparent in their role plays. The Teacher Manual stressed the importance of teachers not only modelling verbal responses but also showing how tone of voice, gestures and general body language could be interpreted either as confidently assertive or aggressive in specific situations. However, in a packed lesson some teachers did not do this and in those instances pupils were much more likely to adopt aggressive stances in their role plays.

It was clear that some kind of story-based scenario was a useful way into thinking about how to refuse an offer of any kind of drug, but it was equally clear that most pupils and teachers saw the Blueprint scenario as concerned with bullying rather than a situation where peer pressure to experiment with cigarettes or any other drug was likely to happen. In most of the observed lessons some of the pupils suggested that peer pressure to try a cigarette or another kind of drug usually came from friends and that the pressure was more insidious than the overt bullying which occurred in the scenario involving Sam.

However, by changing a bullying scenario to a social influences scenario involving the use of a variety of different persuasive techniques by a friend or acquaintance, it might be that the *Five Refusal Skills* approach (sometimes described by Blueprint teachers as the cracked record technique of five different ways of saying 'No') would not necessarily be the most effective response in every social situation. Pupils would need a repertoire of different strategies for responding to different persuasive techniques. This was recognised by the development team in the social scenarios which they devised for Year 8 lessons.

Box 8: Key points for practitioners on helping pupils counteract social pressure to use drugs

- **Pupils' concern with the consequences of drug-related behaviours supports a social influences approach.** Most of the young people paid little attention to the personal consequences of drug misuse, particularly the longer-term implications for their health, or the consequences of their actions for others. They tended to focus more on the immediate consequences for themselves, particularly loss of face with their friends and peers or a negative self image. This would seem to support a social influences approach to drug education.
- **Structured support is needed to help young people understand the connections between the influence of the media on self image and lifestyle and their choices and actions.** Young people need to understand how advertising and the mass media's interest in celebrities can influence the image people may have of themselves and a desirable lifestyle. They also need to understand that this, in turn, may indirectly influence their attitudes and behaviour towards drugs and drug use. However, to attain this level of understanding, more needs to be done to structure the learning process so that they can make connections between the image and lifestyle to which they aspire, the choices they make and the actions they take.
- **Young people may need help with exploring assumptions and expectations about drug use prevalence amongst their peers.** As part of the normative education approach young people need to be encouraged to think about whether these various social influences pressure people into exaggerating the extent of their experience of trying different drugs.
- **Skill in resisting social pressure needs to be practised** and the exercises for practising these skills need to be reviewed and reflected upon. Again this is an approach that needs to be built into all PSHE to optimise opportunities for reinforcement.
- **It is likely that no single approach to resisting social pressure could be universally applied.** A repertoire of strategies is needed that could be called upon in different social situations where pressure to behave in certain ways takes different forms. However, that means that young people not only need to learn how to resist social pressure effectively, they also need to make informed judgements about which strategy would be most appropriate in any given situation they might encounter.

Conclusions

This report has presented some of the emergent findings from a multi-component evaluation of the Blueprint Drug Use Prevention Programme. It has focused specifically on those findings which are likely to have wider implications and relevance for practitioners involved in the provision of school-based drug education.

The Blueprint approach, with its emphasis on active and interactive learning and the development of skills to help young people assess the risks associated with drug use, develop strategies for minimising those risks, make informed choices and be able to effectively resist social pressure to experiment with drugs, proved very popular with the large majority of pupils and teachers who participated in the pilot programme.

The evaluation has highlighted a number of developmental points and issues which may need to be taken into consideration if practitioners seek to develop their own drug education programmes along similar lines and these are outlined below.

Delivering drug education

- Pupils in the 11–13 age range are not too young for the kind of content and drug education messages which underpinned the Blueprint approach.
- Pupils in this age range are not blank slates with regard to drug education. Many of them have knowledge and experience which needs to be integrated into the learning process. They respond positively when this is done.
- Although it is tempting to pack the lessons with content, this can be counter-productive when the learning approach is predominantly active and interactive. Time needs to be allowed for the transition from one interactive activity to another and for reflection on what has been learned. Generally, it was found that lessons worked best with two to three main learning activities where these were active and interactive.
- The broad definition of drugs is important since it draws attention to the possible risks and harm associated with the inappropriate use of medicines and substances that can be found in most homes and shops. Nevertheless, there was a tendency for some pupils to assume that drug education would focus on illegal drugs. It is important, therefore, to find ways in drug education lessons to reinforce this broader definition and to reiterate why pupils should also be concerned about the uses of other substances which can change the way people think, feel and act.

Factors which can enhance delivery

- Effective drug education lessons can be delivered by teachers who are not specialists in PSHE but in-service training in drug education can be valuable in explaining the principles behind the lessons and helping to give them the confidence to use active and interactive learning strategies.

- Preparation by teachers is essential if there is to be extensive use of active and interactive learning in drug education.
- Teachers need access to information about drugs. This enhances their credibility with pupils and their confidence in dealing with pupils' questions. This does not mean that they have to be experts. The Blueprint Teacher Manual suggests that they should admit when they did not know something and say that they would find out and bring the information to the next lesson. However, it was important that they did actually follow through and do this.
- It does not seem to matter greatly whether drug education is delivered through weekly lessons or by collapsing the timetable for a day or two and delivering it in blocks of lessons. Both strategies have their advantages and disadvantages. Collapsing the timetable seemed to enhance continuity and progression of learning and sometimes reinforced the key messages more effectively but some teachers and pupils also seemed to run out of steam where they were doing a whole day of lessons on drug education.
- Where there was a strong emphasis on active and interactive learning, particularly in pairs and small groups, the more able pupils tended to consistently finish their work more quickly than the others. As a result, it is useful to have some extension activities that can be introduced to maintain the momentum.

Drug education in action

- Active and interactive learning contributed to ensuring that pupils engaged with and took ownership of their drug education. However, for some of the pupils the more open-ended forms of active and interactive learning, such as brainstorming, enquiry-based work and small group discussion, did not always produce the desired learning outcomes. Active listening strategies and the use of structuring devices might help these pupils to think more deeply about the content and the purposes behind these activities.
- Normative education can encourage pupils to challenge some of the misconceptions and taken-for-granted assumptions about drug use amongst their peers but for this to happen it is essential that pupils are convinced of the validity and reliability of the data being used to challenge their perceptions. Teachers need to be prepared for the kinds of doubts which some pupils will express. It may also be necessary to find additional ways of familiarising pupils with the normative education approach, e.g. by designing and carrying out lifestyle surveys in their PSHE lessons and by applying this approach to other PSHE topics, including sex education, healthy eating and diet and self image.
- Raising awareness about the risks involved in the use of drugs and developing social strategies for reducing those risks and for supporting others who may be at risk are also important evidence-based elements of an effective drug education programme. However, two points need to be kept in mind when planning lessons around this theme:
 - Many pupils seem to have a limited concept of risk. They do not always take sufficient account of the longer-term risks, particularly to health, and do not always understand that the chance of something happening that is potentially harmful can be reduced by taking specific actions. It may, therefore, be necessary to build into the learning process some discussion of types of risk in both short-term and long-

term contexts and encompassing a range of health, legal, social and personal contexts.

- They may require a repertoire of different strategies for reducing risks and the potential for harm that can be applied in different social situations. They also need opportunities to analyse a range of scenarios to decide what kind of strategy would work in each.
- Scenarios are also a useful means of helping pupils to seek out information, assess it and then use it constructively to practise making informed decisions and choices. However, the evaluation showed that while many pupils could apply these learned decision-making skills in a systematic way to such scenarios, they believed that in the real life context, they would trust their feelings and instinctive reactions rather than apply these skills. It may be necessary, therefore, to provide pupils with opportunities to test the reliability of their instincts in a variety of situations.
- The evidence base also indicates that effective drug education needs:
 - to raise pupils' awareness about how various social influences seek to persuade them directly or indirectly to experiment with various substances or create a climate in which drug use appears to be normal or acceptable; and
 - to provide them with the information and the skills to resist those influences.

Many PSHE programmes now include lessons that are designed to help pupils learn and practise what are variously referred to as resistance skills, assertiveness skills or refusal skills. However, the kinds of social pressures this is designed to address take a variety of forms and pupils need a repertoire of strategies that they can apply to counter these different kinds of pressure and sufficient opportunities to practise these skills and strategies so that they can become more adept at thinking on their feet in different kinds of social situation.

Finally, it should be reiterated here that Blueprint is a multi-component drug use prevention programme. The school component, comprising mainly the drug education lessons, support materials and teacher training, was also accompanied by work with parents, the local community, the local media and trading standards officers who were targeting local retailers to ensure greater compliance with legislation on the sale of various substances. This report has focused solely on the delivery of the classroom component. Ultimately, the effectiveness of Blueprint will need to be measured in terms of the combined impact of all of these components on the behaviour and attitudes of the young people who participated in the programme.

Appendix 1: Brief summaries of the 15 Blueprint lessons

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 looking at questions on prevalence and sharing their answers; whole class reflecting on discrepancies between belief and reality when the teacher reveals actual prevalence rates.
5. Thinking about drugs	Recognising and understanding a range of values and attitudes towards drug use; understanding the need for rules and laws governing drug-related behaviours, including school drug policy.
6. Advertising and the media	Considering advertising techniques and their influences on lifestyle choices, including norms.
7. Decisions, decisions	Exploring different – and effective – ways of making decisions and recognising the range of factors that influence decision making.
8. Seeing it through	Analysing how assertive behaviour works including 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	Delivering a presentation with audience feedback and positive closure of the Year 7 lessons.
11. Thinking back, looking forward	Recalling, revisiting and reinforcing key learning points and group agreements from Year 7; introducing Year 8 sequence of lessons and the concept of risk.
12. Your street, your story – the game	Playing the board game 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?	Comparing beliefs about drug use with data from the Blueprint baseline survey.
14. Party time	Highlighting the risks and effects of drug use, particularly alcohol and the consequences for self and others; working through a party scenario which requires the pupils to identify with the characters and discuss the risks associated with their behaviour.
15. Bringing it together	Considering strategies to reduce risk and keep self and others safe; looking at sources of help and information about drugs and drug use; identifying learning from all aspects of the programme.

Appendix 2: The approaches employed for evaluating the curriculum component of Blueprint

Several research exercises contributed to the evaluation of this component:

Prevalence surveys of the pupils in the participating schools were conducted at critical points to assess levels of smoking, drinking alcohol and drug use. These were conducted before the Blueprint lessons started (to provide a baseline); and then repeated in the autumn terms of 2005 and 2006.

Impact surveys with samples of pupils were also conducted to gauge reactions to the Blueprint programme. These were conducted in April 2004 and again in April 2005.

In-depth interviews were conducted in the summer terms of 2004 and 2005 with a sub-sample of pupils to explore their reactions to Blueprint in more detail.

Observations of the delivery of drug education lessons in both the pilot and comparison schools were undertaken primarily during the spring terms of 2004 and 2005 (although the observations in the comparison schools tended to be spread over a longer period to accommodate their timetables). Wherever possible teachers were also interviewed about the lessons that had been observed to gauge their reactions and their views on what worked and what might need to be improved.

A detailed analysis of costs was also carried out to ascertain the real costs of delivering the Blueprint curriculum component. This covered development and production costs, evaluation costs, the time required for preparing and training the teachers and the costs of covering teachers while they were participating in the training.

Appendix 3: The strategy adopted for observing the delivery of Blueprint lessons in the pilot schools

Although the observation schedules contained certain generic or common categories which did not relate specifically to Blueprint but were designed to record the normal practices and procedures of classroom management, it proved necessary to devise a separate schedule for each of the 15 Blueprint lessons in order to measure fidelity to lesson content and timings.

This raised a particular problem for the evaluators. Because the pilot schools were all delivering the Blueprint Programme at roughly the same time, it was not possible to trial each of these 15 observation schedules beforehand. Instead steps were taken to trial the principles behind the design of these schedules, i.e. structuring the observation schedule around a detailed drug education lesson plan (including its objectives, the curriculum content to be covered, the learning activities and specified timings) and developing a scoring system to be used to measure fidelity to those lesson plans. A number of schools in Scotland were identified which were using a locally-produced drug education programme which shared a number of core features with Blueprint. Detailed lesson plans for pupils aged between 11 and 13 were obtained from these schools and appropriate observation schedules were then developed. These were then tested in the Scottish trial schools in September, 2003. These trials proved successful and the design principles were then applied to the development of observation schedules for Blueprint. The new version of the schedules was then subjected to a second trialling process in schools in a local authority in the north of England where some of the Blueprint lesson plans were being pilot tested for the development team. After this second phase of trialling the schedules were again revised and the final versions were then developed.

The observations were carried out by a team of 16 researchers who were trained in the use of the observation schedules. This involved an introduction to the Blueprint Programme and an opportunity to go through the observation schedules in detail in order to identify and discuss any likely issues and concerns. However, the main focus of the training was in the actual application of the schedule to evaluate lessons. To do this the research team were asked to observe videos of drug education lessons delivered in the trial schools and to use the appropriate schedule to record what they saw. This provided an opportunity for checking inter-observer reliability. The level of agreement between the observers was measured on a number of criteria, including timings of learning activities, confirmation of content covered and judgements of pupils' engagement in tasks. The team leaders were looking for an average inter-observer correlation of at least 0.6. Had the results been lower than that it would have been necessary to provide additional training for the team and possibly introduce revisions to the design of the observation schedule. In practice, the resulting average inter-observer correlations ranged from 0.71 to 0.92 depending on what was being observed.

The observations of the Blueprint Programme took place between January 2004 and June 2005. Eight classes in seven of the 23 pilot schools were observed participating in all ten Year 7 lessons in 2004 and then in all five Year 8 lessons in 2005. This provided an opportunity to assess how pupils in these years responded to the whole Blueprint curriculum. In the other 16 pilot schools the researchers observed an average of ten of the 15 lessons, with a minimum of six lessons from Year 7 and a minimum of three from Year 8. The observations were selected to ensure that every lesson was observed in a wide cross-section of pilot schools (averaging 17 observations per lesson in both years).