Drugs Education and Prevention for School-aged Young People

Patrick McCrystal & Kerry Winning

Drug misuse in Northern Ireland, like many parts of the world, is becoming one of the major issues facing society today. A first stage to addressing this problem is effective drugs education and prevention strategies to school-aged young people. A survey of a range of education providers including mainstream and special needs schools, and school exclusion projects, suggests that all education providers aim to provide drugs education. Within mainstream schools, drugs education and prevention for young people with special education needs is provided within an existing framework developed for all school children. In contrast, special education providers deliver this facility through an approach developed to meet the specific requirements of their client group. The findings suggest that whilst expertise in the delivery of drugs education and prevention strategies exist for young people with special education needs, it may not be specifically targeted at all of them whilst attending school.

Introduction

Increasing drug use and misuse by young people is one of the major problems to be confronted by society in the twenty-first century (Weinberg, Harper, & Brumback, 2002). Despite the volume of evidence on drug use behaviour of young people generally (for example, Flood-Page, Campbell, Harrington, & Miller, 2000; Miller & Plant, 2001), the empirical evidence base on the drug-using behaviours of young people with special education needs remains limited (McCrystal & McKiernan, 2003). Existing evidence shows clear trends of rising levels of substance abuse amongst these young people, suggesting they may be more “vulnerable” or at a higher level of “risk” to drug misuse (McCrystal, Percy, & Higgins, 2007b). Some commentators have further noted that young people with special education needs were being deprived of drug-prevention education programmes (Carlton, 1991), a standard instrument to combat this behaviour. Drug education is now part of the curriculum delivered in
Drug Use amongst Young People in Northern Ireland

Studies of drug use did not occur in Northern Ireland until 1992 (McEvoy, McElrath, & Higgins, 1998). From these, it has been suggested that Northern Ireland may not have experienced the same level of drug use and misuse as other areas in the United Kingdom (Higgins & McElrath, 2000). This has, in part, been attributed to the period of conflict known collectively as “The Troubles”. During this period of political conflict, Northern Ireland was regarded as an area with relatively low levels of drug use compared with other European countries (Brewer et al., 1997; Mayhew & Dijk, 1997). This was explained to some extent by the high levels of policing and military surveillance. Following the 1998 Belfast Act, which was the result of discussion known as the Good Friday Agreement, several hundred paramilitary prisoners were released back into Northern Ireland society. For some the drug trade offered the opportunity for a lucrative income. Whilst offering some insights, however, this does not provide a full explanation for the perceived increase in drug use and distribution in Northern Ireland from the mid-1990s.

Some indicators have shown that the level of drug use appears to be increasing in Northern Ireland, although some have also shown little change (McCrystal, Percy, & Higgins, 2007a), and there are signs it is occurring at an earlier age (McCrystal, 2003). Conclusions from the 1998 Northern Ireland self-reported Crime Survey, which surveyed 2277 respondents aged between 16 and 59 years old, showed that lifetime prevalence of illicit drug use in Northern Ireland was 24% and that 9% had taken an illegal drug within the past year (Northern Ireland Statistics and Research Agency, 1998). By 2005, the Northern Ireland Crime Survey indicated that lifetime prevalence stood at 26% and that 8% had taken an illegal drug within the past year (McCrystal et al., 2007a). Preliminary findings from the Belfast Youth Development Study showed that the most common drug of choice at age 11/12 was alcohol, followed by tobacco. Eight per cent of young people aged 11/12 admitted to having “ever used” cannabis. Lifetime cannabis use increased rapidly over the years (over five-fold) to 43% at age 14/15. A more modest increase was noted at age 15/16 to 47%, perhaps suggesting that cannabis use could be starting to stabilise for this group (McCrystal, Higgins, & Percy, 2006; McCrystal et al., 2007b). This may match the trends observed from the British Crime Study 2007/2008.

Drugs Education Prevention

The treatment of drug misuse begins with prevention (Brook, Balka, & Whitemen, 1999). The earlier prevention strategies are implemented, the more likely they are to be effective, for this reason schools are frequently the setting for such interventions.
Targeting specific needs and experiences of recipients has become a key principle for effective drug-prevention initiatives including age and appropriateness (White & Pitts, 1998) with a focus on vulnerable groups (Drugs Prevention Advisory Service, 2002). Such an approach is also considered highly cost-effective (Smyth & Saulnier, 1996).

All schools in the United Kingdom are expected to provide a drugs education programme (Ofsted, 2005) with the provision of appropriate information about the risks linked to drug use key to the effectiveness of these programmes (Advisory Council on the Misuse of Drugs, 2006). These programmes should address issues specific to their general lifestyle and should be regularly updated to reflect any changes to the local drug scene (EMCDDA, 2007). However, the contemporary information base on illicit drug use amongst young people in secondary education is almost non-existent (McCrystal, 2008). This means that our knowledge base upon which the most appropriate interventions are based remains incomplete (McCrystal, 2009). Historically, young people with special education needs have been excluded from these programmes because of their long-standing emotional and intellectual programmes (Dockreall, Peacey, & Lunt, 2002).

A major focus of the UK Government’s Drug Strategy is to reduce drug use amongst young people (Home Office, 1998). Following the updating of the strategy in 2002, the reduction of drug use amongst the most vulnerable groups of young people was highlighted through targeting preventive interventions at those most in need (Home Office, 2002). Such targeted interventions are now seen as particularly beneficial for several reasons. Firstly, because universal programmes may be inefficient in terms of addressing the needs of some young people who are not at risk they may not be concentrating sufficiently on those in need (Roe & Becker, 2005). Secondly, targeting interventions on young people vulnerable to drug use promises not only a more efficient use of resources but also a greater chance of achieving results where they are most required (Eggert, Thompson, Herting, Nicholas, & Dicker, 1994; Crome & McArdle, 2004).

Lerner and Galambos (1998) in their review of prevention strategies argued that the most effective strategies for drug education were designed at the developmental level of the target audience as they claim that successful prevention programmes emphasise the capacities of the young people for positive development. Based on the evaluation of 100 drugs education programmes, Dryfoos (1990) noted the value of a focus on the young people’s “characteristics of individuality”. In essence Dryfoos (1990) argues that there are multiple features of person and context that should be combined to design and deliver a successful programme preventing the actualisation of risk in adolescence. To succeed, targeting preventive interventions rely on the accurate identification of those groups susceptible to drug use. Despite the extensive range of information on risk and protective factors for drug use (for example, Hawkins, Catalano, & Miller, 1992), there is relatively little known about what works to prevent drug use amongst high-risk groups (Roe & Becker, 2005). One exception reported by Smyth and Saulnier (1996) found that interventions with high-risk young people could be effective when programmes were culturally relevant, included
outreach and incentives and involved peers or families. Catalano, Haggerty, Gainey, Hoppe, and Brewer (1998) defined high-risk groups as those either exposed to multiple risk factors or to an elevated level on one particular risk factor. They describe the term “at risk” in relation to children and young people as referring to:

children and youth who are in danger of failing at school, in their social life, or in making a successful transition to work. Educational, social and vocational failure are predictable to some extent by a range of factors, including, ethnic status, family circumstances, language, type of school, geography and community. (Day, van Veen, & Walraven, 1997)

The role of school and/or education in the lives of young people is key here. Existing research findings suggest that children and young people often survive exposure to a single risk factor, but that exposure to multiple risks significantly increases the risk of maladaptive outcomes (Rutter, 1979).

Drug Use Prevention within the Context of Special Education Needs

Being educated in a special school is highly correlated with attaining few, if any, qualifications at 16 years, with school league tables indicating that very few special schools have any pupils attaining A–C grades at GCSE (Cole, 2000). School under-achievement is one of the risk factors to illicit drug use in adolescence (Gottfredson & Gottfredson, 2002). In general, education professionals believe that pupils with special education needs should be educated in the same institutions as all other children and young people (Howlin, 2002). However, Hornby, Atkinson, and Howard (1997) claim that the aim of the Education Reform Act 1981 and subsequent initiatives (that is, Department of Education and Employment, 1997) should be to ensure that all children with special education needs are provided with an education that enables them to make optimum academic, social and emotional progress to offer them the best chance of effective integration to adulthood, an acknowledged protective factor to drug use. In contrast, others argue that the aim of education should be to successfully meet individual needs and to help all children to have an active role in society (Burach, Root, & Zigler, 1997). Howlin (2002) believes that, in order to achieve this aim, education in a special setting will be a necessary requirement for some children.

The importance of this issue is further highlighted by Weinberg et al. (2002), who states the importance of identifying factors that may be contributing to school failure and social exclusion for young people with special education needs, which are also high-risk variables for substance misuse (Suissa, 2001). The literature on substance misuse and learning disabilities is limited compared with those in mainstream settings (Snow, Wallace, & Munro, 2001). Existing evidence suggests that licit and illicit substance use is lower (Annand & Rus, 1998; Emmerson & Turnbull, 2005; McCrystal et al., 2007b; Stavrakaki, 2002), with few including staff reports on these populations (Addictions Resource Agency for Commissioners, 2002; Wandsworth Drug and Action Team, 2003), but there appears to be a lack of consensus regarding
prevalence estimates amongst these young people (Sturmey, Reyer, Lee, & Robek, 2003). This has lead to difficulties in recognising the range of substance misuse amongst these populations (Taggart, McLaughlin, Quinn, and McFarlane, 2007). This may explain to some extent the comparatively limited attention paid to their specific needs in relation to drugs education. However, what is clear is the significant health and social consequences of substance misuse for young people with special education needs. This includes cardiovascular respiratory trait and gastrointestinal problems; increased epileptic activity; increased risk of a co-morbid mental health problem; and an increased likelihood of admission to a specialist hospital (Clarke & Wilson, 1999; Doody, Thompson, Miller, & Johnstone, 2000; Mayer, 2001; McGillivray & Moore, 2001).

Overall, support for young people with special education needs remaining in mainstream school is high, even if this means providing them with specialised support to meet their specific needs (Weinberg & McLean, 1986; Weinberg, Penick, Hammerman, & Jackoway, 1971; Weinberg, Harper, & Brumback, 1998). For Weinberg et al. (2002) this may be a limiting variable in schools (i.e. not recognising or meeting the specific needs of young people with special education needs), which in contemporary education includes providing a strategy for drugs education and prevention (Department of Education for Northern Ireland, 2001). The aim of the present study was to assess the level of drug education provision in secondary schools generally, but particularly in relation to the needs of young people with special education needs.

A range of educational settings participated in this research. This included teaching staff in mainstream schools, alternative education provision (AEP) and Emotional and Behavioural Difficulty (EBD) units. AEP consists of local community-based projects for young people who have become disaffected with school. Their aim is to re-engage these young people into education in a respectful learning environment through delivery of the Common Curriculum as feasible. These projects have considerable status within their local community with parents, young people and wider groups (Clarke, 2002). In many cases these young people have been isolated for a substantial part of their adolescence and require additional support to assist them in the reintegration process post 16 years. EBD units are relatively small educational settings that deliver a curriculum designed for the specific needs of children and young people with social, emotional and behavioural problems that makes it impossible to attend mainstream school.

The Study

Research Design

A cross-sectional quantitative research approach was utilised for the present study. This involved a questionnaire survey of 42 post-primary schools, two EBD units, one educational resource centre attended by young people with moderate learning difficulties and two AEPs in the Greater Belfast area.
Sample

All of these educational facilities are participating in the Belfast Youth Development Study, a longitudinal study of the onset and development of adolescent drug use (McCrystal, Higgins, Percy, & Thornton, 2003). This included post-primary schools, EBD units and AEPs in Belfast, Ballymena and Downpatrick.

The Measuring Instrument

The questionnaire used in the study was developed to obtain data on drug-prevention strategies in schools and special education needs facilities, particularly in relation to the requirements of young people with special education needs. The questionnaire was developed with reference to information obtained from a number of sources. These included school drug policies, the drug education strategy of the Department of Education for Northern Ireland, existing literature on drug use behaviours in adolescence and young people with special educational needs and the experiences of researchers in other jurisdictions (for example, O’Dea, 2005). The specific focus of the questionnaire was to obtain data on the facilitation of drugs education to young people in all these educational settings.

Data Collection

The questionnaire was administered by researchers to all schools and non-school education settings within the Belfast Youth Development Study. Each questionnaire was completed by a senior teacher/ member of staff in each setting and returned to the researchers on the day we visited the school. The data were obtained from experienced teachers, usually a vice-principal, senior teacher or member of staff. Two-thirds of schools reported that a senior teacher had responsibility as a drugs education coordinator.

Data Analysis

The completed questionnaires were coded and input onto the SPSS software system for analysis. Descriptive and bivariate analysis was undertaken on the data obtained to explore the range of drug-prevention initiatives within each education setting.

Limitations of the Study

This research method has several potential limitations that may raise questions about its value beyond this study. The data collection instrument was very focused on the specific school policy of each participating school, with the information obtained from a senior member of staff with responsibility for drugs education and prevention. Furthermore the study did not collect detailed information on existing drugs education policies and programmes or their effectiveness. These limitations should
not undermine the value of the findings to our general understanding of the place of drugs education within the range of educational settings participating in the research.

Results

Two-thirds of schools in the survey were non-grammar schools, the others were grammar schools. One-quarter of participating schools had a male-only register, a further one-quarter were female-only and the others were co-educational; the EBD units, AEPs and educational resource centre were co-educational.

All but one school reported they had a written drugs education policy that was agreed mainly by senior members of staff. This was based upon guidelines issued by the Department of Education for Northern Ireland. School management was most influential when deciding upon the content of school drugs policy. In grammar schools, school governors, parents and pupils were more likely to be involved in this process than in secondary schools. Only one-third of schools, one AEP and the educational resource centre noted input from parents, and one-quarter from pupils when developing this policy. Each EBD unit, AEP and the educational resource centre reported the existence of a written drugs education policy. Each EBD unit and one AEP had a written drugs policy agreed by teaching staff only.

Only one school did not have a drugs education programme. Both EBD units and AEPs and the education resource centre had a drugs education programme. Only nine schools delivered a specific drug education programme for pupils with special education needs. Eight of these were non-grammar schools. Both EBD units, AEPs and the education resource centre delivered drugs education for young people with special education needs.

A standard drugs education programme was used for all pupils in 20 of the 42 schools regardless of the specific education needs of pupils attending the schools. This was more likely to be the case in grammar schools. In EBD units and the education resource centre, drugs education programmes were designed specifically to meet the requirements of young people with special education needs. The AEP projects delivered drugs education to young people with special education needs and to young people without a statement of special education needs. As the research did not obtain copies of the drug policy documents from each setting, this study did not set out to comment on these specific details.

A range of sources was indicated as providers of drugs education within each education facility. Teachers were the main providers, with guest speakers noted by most schools as playing an important role. Teachers with responsibility for special education needs were unlikely to be involved in this task in schools. Only six schools noted the role of a school counsellor, with five of these counsellors placed in secondary schools. Six schools noted the role of a school nurse or health visitor, five of these being in secondary schools. In EBD units and AEPs, drugs education is provided by teachers in the facility and outside specialists only. In the educational resource centre for young people with moderate learning difficulty, only teachers deliver drugs education to young people.
Discussion

The findings from this survey demonstrate that post-primary schools are addressing the issue of drugs education in a serious manner through the development of drugs education policies and the role of senior members of teaching staff in its development and delivery. However, as many schools rely on guest speakers, mainly from agencies who specialise in drugs prevention for young people, schools may not possess the full spectrum of expertise required to deliver drugs education and prevention. Most schools deliver drugs education through a standard drug-prevention education approach that also forms the basis of drugs education to young people with special education needs. However, only one-fifth of the schools report amending this strategy to meet the particular requirements of young people with special education needs, with only three schools reporting a role for the Special Education Needs Coordinator in the delivery of drugs education. As EBD units, AEPs and the educational resource centre for young people with moderate learning difficulties provide drugs education designed for young people with special education needs, they may provide examples of good practice for mainstream schools aiming to target drugs education to the specific needs of those with special education needs in mainstream schools. However, the existence of this provision within EBD units and the education resource centre demonstrate that expertise does exist in this area within the education sector.

These findings appear to support commentators who argue that, despite the policy of maintaining young people with special education needs in mainstream schools, drugs education delivered in schools does not appear to address their specific needs (Botvin, 1999). If this is the case then school-based drugs education prevention strategies may not be meeting the needs of all school-aged young people. With one exception, only non-grammar schools provide drugs education programmes for young people with special education needs. As these schools are more likely to include young people with special education needs, this may reflect an “informed” approach to meet the specific needs of all young people in these schools. However, whilst the findings in this study may support such an assumption, this is not proven conclusively.

In contrast, EBD units, AEPs and the education resource centre deliver drugs education specifically targeted at those with special education needs, demonstrating that experience of such targeted intervention does exist. The findings of this study may also contribute to the relatively limited research base on drugs education and prevention targeted at high-risk groups. However, the structured and quantitative nature of the study perhaps limits the potential scope to more fully explore these findings. Nonetheless, as a tried and tested data collection approach, the findings presented from the survey approach of this study do provide information on the current strategy in schools and other education facilities offering some insights into the delivery of drugs education to young people with special education needs and in specialist education facilities, which is an area demanding attention from practitioners, policy-makers and researchers in the field. More generally, within all participating education providers, drugs education is coordinated by senior staff.
Whilst this highlights to some extent the seriousness with which the issue is being addressed, it may also limit the potential impact of this provision as these staff tend to have a range of competing demands and responsibilities on their time. Furthermore if these staff are not trained to deliver drugs education, this may further undermine the effectiveness of this provision due to the central role of the individual responsible for drug education.

This study supports recent findings that current service provision may not be meeting the needs of young people in special education who are at an increased risk to substance misuse (Taggart et al., 2007). Staff within these educational settings need to be fully aware of existing relevant supports and resources to maintain cognisance with contemporary developments. These developments should be based upon sound empirical evidence, which is extremely limited but requires attention from the drugs research community. Whilst presenting specific challenges, this study and others (McCrystal, 2009; McCrystal, Percy, & Higgins, 2008; Taggart et al., 2007) have shown such empirical evidence can be obtained. This can help us re-examine the validity of existing provision for those in special education who for too long have been known as a “hidden” population.

In summation, the study provides further evidence to demonstrate that the field of drugs education in special education needs remains primarily, but not exclusively, the domain of special education providers. Whilst many mainstream schools have attempted to address this matter (i.e. mainly non-grammar schools), this has been done within the existing framework of drugs education for all school children. Whilst this could be interpreted as addressing the needs of special education needs within mainstream education, alternatively it may not be achieving this to its full potential.

References


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