

# Interview with SHELAGH HETREED

Avon Education Authority

## Drugs and the curriculum: an Advisory Teacher's view

In this interview, Shelagh Hetreed recalls two years' experience of trying to give teachers the confidence to tackle drug-related education in secondary schools, and to help schools explain to parents what they are doing in this area. She is frank about the difficulties involved, but offers a plan for a successful parents' evening that could be used by any school.

*I believe that one of your strategies was to carry out an Avon survey of pupils' health-related behaviour.*

That's right. As Advisory Teacher for drug-related education, I am always looking for ways of getting schools and teachers to acknowledge the fact that the children they are dealing with are involved in drugs. These drugs might be cigarettes, solvents, or alcohol rather than the hard drugs that are always highlighted as the ones to be addressed. So when I came across the Health Related Behaviour Questionnaire, it seemed a good way of facing the schools with reality by being able to say: "Look, this isn't what is happening throughout the British Isles or even the county, but what is happening among your group of pupils".

It was the officers with responsibility for alcohol education in the four Health Education Districts who suggested funding to offer to every secondary school in the county a chance to survey a hundred 4th-year pupils, to get an idea of the alcohol intake and smoking levels in this year group. The money was made available by the Understanding Alcohol

project, and the majority of schools were surveyed between January and July 1987.

*What were your responses to the results?*

I was fascinated by the things that were coming out — for example, the girls in the most deprived area of the city (an estate area with all sorts of problems) are all drinking cider in vast quantities, but in the middle-class area the girls are drinking wine with their meals; in the inner-city schools the girls are drinking spirits in pubs, which is almost what you would have expected, so that the initial stereotyping was confirmed by the statistics: patterns of drinking are affected by the environment.

The self-esteem figures were staggering to me — right across the board, the girls had conspicuously lower self-esteem scores than the boys. It could be said that the questions were of the sort that would give a lower response, since girls are always making less of themselves than boys are — but isn't that what self-esteem is about? It is too universal, as far as our results are concerned, to ignore. I find it very disturbing, and I want to go on to find out ways of doing something about

it, possibly by facing 14-year-olds with the questions and asking them why they should have answered them the way they did.

*I understand you included a follow-up workshop as part of the package.*

Yes — but the response, even though there was funding available to cover the teachers' time, was not as good as we had hoped, since many schools did not feel that the subject — which was not curriculum-based — had a sufficiently high priority to justify the time spent out of school. However, enough were there to carry out a successful active workshop, taking them through different strategies which were at first aimed at themselves, and then asking if these strategies could be used for the children instead. They were all anxious to see where the children in the other schools were at in their levels of behaviour.

The major result of the workshop was what I had hoped it would be — teachers were recognising the need to understand the children's behaviour before planning curriculum development, and to start from where the children were. They came to this conclusion by saying, for example — "Look, there aren't as many children smoking as we'd thought: perhaps some of the messages have got across. Perhaps we should be looking at the pressures which cause people to smoke rather than the damage it may do."

*Can you yet say what positive results have emerged with respect to promoting drugs education in these schools?*

As to the effect that the questionnaire survey itself has had upon what schools are offering, it is still early days, and the feedback has been very small. But I should like to make some comments upon the effect of the various workshops I have been running on drug education. It's very sad to consider that during the past two years I have probably had a minimum of one person from all the 63 secondary schools and 33 special schools in the county at one or other of these events, but when they go back they are just one among eighty or a hundred staff who

have that understanding, so the dilution factor almost makes one despair.

I think that the active strategies and new ways of working with people developed during the courses have been really beneficial, but their potential for facilitating actual drugs education is extremely limited. If teachers could go back fresh from a course and immediately do something in an after-school meeting for an hour, something might result — but working with your own staff seems to be ten times more terrifying than working with any other group. I really do think that the cascade model has proved a failure.

*So what's to be done?*

Well, I wish that initial teacher education would give support to this type of work, because having asked the four teacher education institutions in Avon how much they do, they have all been positive about having someone to come and talk to them about it. It concerns me that young people, coming out of teacher education colleges are saying "My subject is geography — what has this to do with me?" It's common enough, and understandable enough, when someone has been teaching for twenty or thirty years, although I'm not saying I defend it even then. So I think that teacher education is one answer, and I am glad to do my bit, but is one morning in a 3-year course enough?

*You imply that it isn't.*

You see, there's a major worry which concerns me about teachers' attitudes towards drug education — this blind, pre-conceived notion that if you tell people the facts they will change their behaviour, or it is their fault if they don't. Even if PSE methods are instilled and found to work in 'safe' areas, it is usually found that as soon as teachers are faced with something new (such as drugs or AIDS) they revert to the knowledge angle, and cannot easily turn the skills of interpersonal relationships into this new channel: they don't know where to look, since it's not in the Active Tutorial Workbook, so they go back to chalk and talk.

Sex education, possibly for different reasons, is the same thing — they don't want to be sat among the children talking about something as sensitive as that, and to get behind a desk and impart the facts is easier. This is not meant as a criticism of teachers, who simply haven't got the time to turn round and think out something that's new, so they go back to what they are sure of in an unsure situation. That's normal human behaviour.

*You have also been trying to help schools promote links with parents over drug education.*

I feel this is most important, but schools initially shied away from the prospect on the grounds that if they held a 'drugs awareness' evening, people would think that they had a drug problem. But before the survey was carried out, one brave school took the plunge and did an absolutely superb parents' evening with 150 parents attending. We worked out a model for the evening using five different active strategies in 20-minute slots, and it worked so well that I wrote it up and now offer it to any other school that is doing a parents' evening, and I can think of about ten that have used it successfully.

*Please describe this superb evening.*

The evening starts off with whatever the school wants in the way of introduction. The questionnaire from the *Drugwise* (14-18 year old) pack is then used as a 'starter' for everyone — a copy is lying on each chair together with a coloured programme, and since the colours define the groups which move through the activities they are mixed up so that couples are split up. *Drugwise*, by the way, was produced by TACADE, the HEA, and the Institute for the Study of Drug Dependence (ISDD).

The questionnaire examines knowledge of different drugs, and the answers are then given quite quickly before the groups move off to the activities. The four (plus a cocktail break) which have been found to work well are as follows:

1. The card game from *Drugwise*, where they sit in pairs and try to match up 12

pairs of cards — one set has drug names, and the other has different effects, risks, and so on, so it's like Happy Families. Any remaining time is spent talking about what they have realised.

2. The 'Happy Birthday' video, which is an extra resource for TACADE's *Alcohol Syllabus* materials. It lasts for nine minutes, leaving time for discussion. It is very interesting to listen in on the discussions, in particular hearing how the Dads consider that the Mums have got it all wrong, putting the blame on to somebody else instead of looking at what's been going on overall.

3. An 'attitude continuum' activity. The schools often make up their own statements, such as *cannabis should be legalised*, and one agrees or disagrees on a scale of 1-5. Although we have tried to persuade schools to make parents actually move around and stand by the number of their choice, so far they have fought shy of this — but it still works pretty well with parents sitting in a circle and getting a discussion going with prompts from the leader.

4. Why do young people take drugs? This is from the *Drugwise* pack, and it is a 'diamond 9' exercise, where they choose the two extreme statements and arrange the rest in a 2-3-2 order between them.

5. The non-alcoholic cocktails can be prepared in Home Economics lessons. They make an exciting change from the usual coffee break, and a choice of about four varieties can be made up from a variety of fruit juices and blended fresh fruit.

*Is there a final session together?*

It's optional. At the end of the evening the parents are told that they are free to leave if they wish, but that the HEO, the schools liaison police, the school nurse, and possibly the drug education co-ordinator are available to be met. The Health Education Unit may also put up a display. The response to me may be summarised as "I wish more parents' evenings could be like that", and how they have learned an awful lot. So I think that if schools can just be convinced that

it is worthwhile as a public-relations exercise to get the parents in (which for a lot of schools is a major problem), then it will be a real success. I have written out a complete 'idiot's guide' to running the evening.

*Presumably the Health Related Behaviour Questionnaire results could form a stimulus for the evening.*

This is another model I am working on. The first thing would be to translate the tables into large, easy-to-read, and possibly colour-coded graphs. One of the group activities could then be to focus on how they feel about the apparent level of involvement with alcohol or other drugs. For example, the question concerning where alcohol was consumed during the past week might show the pub to be a favourite place, and it could be that parents would express alarm and disapproval.

This would be the point at which to introduce an exercise studying the costs and benefits of drinking in a pub as opposed to elsewhere. Depending on the area and the alternative facilities available for young people at night, some parents may come to the conclusion that drinking in a pub (though illegal) may not be a bad option. Arising out of this, some attitude continuum statements could be offered, such as:

1. Adolescents should be introduced to limited, sensible drinking patterns at home with their families.

2. Pubs should be more strict about serving under-age drinkers.

3. Parents have a duty to ensure that off-licences, supermarkets, and other retailers do not break the law with respect to alcohol and cigarette sales.

4. The only way to learn about the effects of drinking too much is to try it.

5. It is better for young people to start drinking alcohol than to be experimenting with other drugs.

*You seem to have developed some most productive models for schools wishing to reach parents.*

I hope so. Any discussion which enables parents to discover other parents' problems and pressures with their offspring, perhaps finding that their children are not so different in their demands and behaviour, can only be beneficial. The Health Related Behaviour Questionnaire results provide a concrete reason for raising all these issues, knowing that they relate specifically to the children concerned. It would, of course, be of equal benefit to go through the same process with the pupils themselves, altering the presentation of the issues to suit their level.

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*John Balding writes:* We have supported many such surveys involving groups of

Region:	BOYS			GIRLS		
	Inner city	Outer city	Rural	Inner city	Outer city	Rural
Never smoked . . . . .	46	49	52	35	48	41
Smoked once or twice . . . . .	26	29	25	24	27	24
Given up smoking . . . . .	11	14	13	17	12	18
Would like to stop . . . . .	12	6	7	15	11	6
Doesn't want to stop . . . . .	4	2	3	8	2	10
Total 'smokers' . . . . .	16	8	10	23	13	16

*Table 1. Home location and smoking in 14-15 year olds. The results are based on a sample of 770 boys and 695 girls in one District Health Authority completing the Health Related Behaviour Questionnaire in 1987. Figures in percentages of pupils in each region.*

schools served by individual District Health Authorities, and have made available to them combined results so that individual schools can compare their results with the total picture for the district. Recently, in one district including a large city and involving nearly 30 schools – not the Avon study described above – the Health Authority and the LEA personnel responsible for coordinating and funding the enterprise divided the schools, for analysis purposes, into inner city, outer city, and rural groups. Table 1 reveals differences in smoking behaviour for 4th year boys and girls in this particular study.

Perhaps the results are predictable:

higher levels of smoking prevail (1) for girls and (2) for the inner city neighbourhoods. Shelagh Hetreed commented on similarly 'predictable' results for consumption of alcoholic drink. However, the term 'inner urban' or 'inner city' to describe an area of poor housing and attendant social problems is not necessarily accurate geographically, since we know of at least one city where the 'problem' areas are in ill-planned suburban housing estates.

The presentation of such tables for all the 240 behaviours recorded provides a feast for the epidemiologist in the Health Authority and a resource for the LEA advisory staff.

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