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BLUEPRINT DRUGS EDUCATION:
THE RESPONSE OF PUPILS AND PARENTS TO THE PROGRAMME

EXECUTIVE SUMMARY
Autumn 2009

blueprint

The Blueprint Programme

The Blueprint drug education programme was an evidence-based, multi-component programme that was piloted in 23 schools in England during the spring terms of 2004 and 2005. It was developed to support the Government target to 'reduce the use of Class A drugs and the frequent use of any illicit drugs among all young people under the age of 25, especially by the most vulnerable young people'.

Funded by the Home Office, the focus of the programme was the provision of drug education lessons to secondary school children in Year 7 (when pupils are age 11) and Year 8 (when pupils are age 12), complemented by four further components: parent, media, health policy and community.

The programme aimed to equip pupils with the knowledge and experiences necessary to make informed choices about drug use, incorporating the support of parents and the wider community in its multi-component approach – an approach that previous initiatives have shown to be effective in education.

The implementation of the programme was assessed during the first stage of the evaluation and is reported separately (Stead 2007). This report focuses on the second stage of the evaluation which set out to assess:

- **how pupils and parents responded to the programme;**
- **pupils' awareness and knowledge of drug use;**
- **pupils' perception of drug use prevalence among same-age peers;**
- **perceived acceptability of drug use and**
- **the quality and frequency of parent-child communication.**

This report also outlines key learning points for future education programmes and the implications this has for policy development in this area.

The Evaluation

An evaluation of the programme was undertaken by a consortium of researchers led by the Institute for Social Marketing (ISM) at the University of Stirling and The Open University.

Pupils were asked to complete a Prevalence Survey, which measured pupils' attitudes, norms and behaviours in relation to drug use, and an Impact Survey, which measured pupils' reaction to Blueprint. Their parents or carers were also asked to complete the Parents Survey, which examined awareness and opinions of Blueprint. Cross sectional, longitudinal and multivariate analysis was used to analyse the data. A smaller sample of pupils from local schools, who received drugs education through their Personal, Social, Health and Economic (PSHE) education classes, were also asked to complete some of the same measures used to assess Blueprint pupils.

It was originally intended that the local school sample would act as a comparison group so that the efficacy of the Blueprint programme could be tested. However, analysis during the development of the evaluation concluded that to be able to detect differences between the two samples would require a sample of at least 50 schools. This was considered beyond the scope of the evaluation, both in terms of the resources it would require and what was appropriate for the evaluation of an untested approach.

Instead, it was decided that the implementation of the programme would be the main focus of the evaluation, and that the ratio of 23 Blueprint schools and six local schools would be kept so that large-scale implementation could be assessed.

While it was still planned that the local school data would be presented alongside the Blueprint school data, to enable some comparisons to be drawn between the two samples, recent academic and statistical reviews concluded that to present the data in this way would be misleading, given that the sample sizes are not sufficient to detect real differences between the two groups. Instead, findings from the local school data are presented separately in the report to provide some context to this work but do not act as a comparison group.

While this has limited the scope of the findings, this report adds to the evidence base on drug use among young people, providing valuable data on how pupils and parents who took part in Blueprint responded to the programme, as well as prevalence rates, attitudes towards drug use and drug use norms. It also reinforces many of the findings from the implementation report (Stead 2007).

Key findings

Pupils' and parents' response to the programme

Pupils were positive about the programme, demonstrating good recall of drugs knowledge and gaining experience of how to deal with situations in which they could be offered drugs. Parents also benefited from the support that the programme provided, helping them to communicate with their children about drugs.

- **The vast majority of Blueprint pupils reported that the lessons they received were an important source of information about drugs.**
- **Pupils enjoyed the format of the lessons, in particular the active teaching methods, e.g. role play.**
- **Taking part in Blueprint gave pupils the opportunity to learn some of the skills needed to deal with situations in which they might be offered drugs.**
- **Pupils demonstrated good recall of drug knowledge, which research suggests will help them to make informed choices about drugs in the future.**
- **Parents approved of their children being taught about drugs at school.**
- **The Blueprint materials format was effective in engaging parents in drug education; parents felt they benefited from the drug education material and that it increased their knowledge and helped them to talk to their children about drugs.**

Prevalence, attitudes towards drug use and drug use norms

- **Among Blueprint pupils, prevalence of smoking, drinking and drug use increased between Y7 and Y10.**
- **Multi-level modelling found that higher likelihood of drug taking was associated with previous use, truancy and exclusion.**
- **Many pupils overestimated the number of their peers who smoked and drank alcohol. Fewer pupils overestimated drug use among their peers.**
- **Statistical modelling indicated that higher perceptions of prevalence of drug use were associated with truancy, exclusion, being older and being a girl. These factors were also associated with higher perceived prevalence of smoking and drinking.**
- **Perceived acceptability of smoking, drinking and drug use increased between Y7 and Y10. Drinking was considered more acceptable than smoking or drug use.**

Local school data

- **Pupils from the local school sample were also positive about the drug education they received as part of their PSHE lessons.**
- **Almost half of pupils cited these lessons as an important source of information and the format, content and delivery of the lessons themselves was rated highly.**

- **Pupils also demonstrated high recall of drugs knowledge and, again, their parents approved of their children receiving drugs education at school.**

- **In local schools, prevalence of smoking, drinking and drug use increased between Y7 and Y10.**

Key learning points

There are a number of key learning points in relation to large scale implementation of a multi-component programme as well as in trying to demonstrate the impact of the programme on pupils' behaviour.

- **While the majority of the components were implemented successfully, getting parents to participate in the programme through workshops proved difficult. Given that parental influence may be the single most important factor when educating children, identifying more effective ways of engaging parents is essential. Parents did report that the drug education materials they received were helpful in enabling them to talk to their children about drugs. Future programmes could focus more on the pupil and parent components, co-ordinating pupils' education with parental support, and less on the community, health policy and media components.**

- **The original design of the Blueprint evaluation was not sufficiently robust to allow an evaluation of impact and outcomes, and consequently the report cannot draw any conclusions on the efficacy of Blueprint in comparison to existing drug education programmes. However, evaluating programmes on this scale is not straightforward. The multi-component approach and the large sample sizes make this type of work costly and time consuming. Future initiatives should look again at the viability of using matched samples for comparison purposes and ways of scaling down the overall breadth of the project to focus on pupils and their parents. If pupils were followed up over a longer period, it would also be possible to monitor drug use behaviour as pupils got older and were increasingly exposed to drug offers.**

- **This type of initiative could benefit from being implemented earlier; research suggests that most children who take drugs start to experiment from the age of 11, and the introduction of drug education programmes in primary school could pre-empt this stage in their development.**

Policy development

The findings from the Blueprint Delivery and Practitioner Reports published in November 2007 (Stead 2007) provided a valuable source of evidence in the Substance Misuse Education Review in 2008. One of the key commitments from the review was that PSHE education should be made a statutory part of the school curriculum. The key learning from all the Blueprint reports will also be considered as part of the review and revision of drug guidance for schools being undertaken by the Department for Children, Schools and Families.

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Further relevant sources of information

Blueprint programme

This report should be read in conjunction with the previous Blueprint reports released in November 2007.

The delivery report assesses the extent to which the programme was delivered as intended and identifies factors which either facilitated or hindered delivery.

The practitioner report highlights findings particularly relevant to teachers delivering drug education.

Website:
http://drugs.homeoffice.gov.uk/publication-search/blueprint/dpreports/

Drugs: Protecting Families and Communities

The drug strategy aims to reduce the harm that drugs cause to society, to communities, individuals and families.

The 2008-2018 drug strategy comprises four strands of work:

- **protecting communities through tackling drug supply, drug-related crime and anti-social behaviour**
- **preventing harm to children, young people and families affected by drug misuse**
- **delivering new approaches to drug treatment and social re-integration**
- **public information campaigns, communications and community engagement**

Website:
http://drugs.homeoffice.gov.uk/publication-search/drug-strategy/drug-strategy-2008

TeacherNet

TeacherNet is the Government site for teachers. It provides access to resources, training, professional development and support, and to information on drug education within the PSHE Framework.

Website: www.teachernet.gov.uk/pshe

Teachers may also wish to refer parents/carers to the parents portal.

Website: www.parentscentre.gov.uk

FRANK

FRANK is the joint Department for Children, Schools and Families, Department of Health and Home Office drugs advice and information campaign for young people. The aim of the FRANK campaign is to prevent drug use amongst young people (11-18) by changing their attitudes and perceptions towards drugs and drug users.

Website: www.talktofrank.com

National Healthy Schools Programme

The National Healthy Schools Programme has produced the following guidance resources for schools:
"PSHE education Guidance for Schools"
http://www.healthyschools.gov.uk/Uploads/Resources/2e5f8827-9b0a-4915-9e5c-59a98d59e94a/PSHE%20Guidance.pdf

"Engaging Parents and Carers Guidance for Schools":
http://www.healthyschools.gov.uk/Uploads/Resources/5756263e-8dee-45ff-9d4b-ffd624ab6f09/Engaging%20Parents%20and%20Carers%20-%20Guidance%20for%20Schools.pdf

Drug Education Forum

The Drug Education Forum is the umbrella body for national organisations that deliver or support the delivery of drug education in England:
http://www.drugeducationforum.org.uk/