# Star turns: Blueprint comes to Britain

Over-priced, over-hyped and over here? The government is about to spend £11m over the next five years on another US drug education and prevention package. In the second of a two-part article **Blaine Stothard** asks if we really need this

THE US model for Blueprint is Project STAR which aims to prevent substance use and violence. It is a combination of curriculum input and work with parents and through the community. School inputs start with an intense programme of drug education lessons, including refusal skills, in the first year at secondary school, with booster sessions the year after.

## EVIDENCE INCONCLUSIVE

Does it work? The findings of Project STAR evaluation studies have been inconclusive. The impact shown by studies in Indianapolis has not been confirmed by studies in Kansas, except to show that the greatest impact of Project STAR appears to be in reducing tobacco use. There is no evidence to demonstrate that Project STAR universally prevents, reduces or delays substance use in all settings. Some of the studies can be interpreted as showing that it is the enthusiasm of the school, its ethos of pastoral support and encouragement of pupils rather than the content of the programme itself which makes the most impact on adolescent substance using behaviour.

The original Home Office proposal for the Blueprint programme aimed to start in the final year of primary school. This has now been amended to secondary age. While logistically this is understandable – the dispersal of primary school children to different secondary schools – this change runs counter to established knowledge about the importance of whole-school career (i.e. ages 5 to 16) input on substance use if attitude and behaviour changes are to result.

On the plus side, other shifts in Home Office thinking suggest an approach more responsive to established UK knowledge and practice. Blueprint will

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## PROGRAMME AIMS

1. To reduce the proportion of young people using drugs, including alcohol, tobacco and solvents
2. To delay the age of onset of drug use
3. To reduce the capacity for harm

not slavishly follow the STAR model. Of most significance is the recognition of the role of harm reduction in health education – the third of the three programme objectives which are in line with experience gained from evaluations of school-based sex education programmes. These emphasise the importance of long-term effort, not one or two year inputs at adolescence.

### NOT JUST THE CURRICULUM

The inclusion in the Blueprint programme of parents, families and communities is in line with recent research findings, including those from Project STAR. This can be seen as an acknowledgement of the influence on young people of their elders and the communities in which they are growing up. This in turn questions 'peer pressure' as sufficient explanation for adolescent substance use. However, is it helpful to encourage those parents, whose communications and relationships with their children are already poor, to re-start the process by talking to their children about drugs, especially as it assumes that 'parents' (i.e. adults) don't do drugs – only 'children' do?

This community and family dimension can be seen as a tacit acknowledgement that relying solely on curriculum-based school drug education programmes is insufficient. The UK debate about risk and protection factors and young people's health-related and social behaviours suggests that the 'head-on' approach of curriculum-based programmes may be ineffective, or even counter-productive, in preventing or reducing substance use. The introduction of a rigid curriculum-based drug education programme into English schools will make considerable time and practice demands and implies a political and centralised approach to drug education and prevention. It remains unclear whether decision makers accept or understand practitioners' findings and knowledge, which challenge the notion that simply providing the facts about the dangers of drugs will change behaviour.

### VISIONARY CIRCULAR

A recognition and use of interactive teaching seems essential if behaviour is to be influenced. This term 'interactive' refers to classroom practice where discussion, dialogue and challenge are an established part of lessons, and where teachers do not feel that they are the only source of valid and relevant information or opinion. The impact of interactive teaching and learning is being increasingly established and recognized in the UK and elsewhere. This links in closely with the changing demands by government on the teaching profession. The roles and skills of schools and teachers are focussed on imparting knowledge while the demands made of schools by UK governments are increasingly to equip young people with a wider range of social and personal coping skills – a skill set for teachers which is absent from initial professional training. Yet for drug education, it was all there in the old Department for Education Circular 4/95: *Drug Prevention in Schools*. This recommended that drug education skills, including pastoral skills, be included in initial teacher training programmes — a glimpse of genuine vision not usually associated with government circulars.

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### IS IT RESEARCH?

Given that Blueprint has been modified from an off the shelf package suggesting a largely predetermined result – is Blueprint really a research project?

Notwithstanding the ideological shifts made by the Home Office, this indicates an 'English' approach to drug education and prevention programmes which compares unfavourably with the approach adopted in Scotland, especially when the rhetoric emphases 'evidence based' practice. The English approach can be caricatured as: 'Here's the answer – studies x y and z in the US show that it works – now make it work here'. How else do you define a blueprint except as something which is set in stone? In Scotland, the response (for example to Life Skills Training) has been: 'Here's a promising idea – let's have a closer look to see if it really does work – and if it does, whether it might work here'.

The reliance and trust placed by many UK politicians in programmes and initiatives originating in the USA may not be appropriate to UK settings, where there are major cultural, social and demographic differences to the USA. It would be reassuring to know that UK decision makers are also looking at experience and studies from, for example, Germany, France, Italy, and The Netherlands. Favouring US programmes and responses to social issues does suggest that political (not to mention linguistic) rather than practitioner and – yes, let's say it – evidence based considerations hold sway. Champions of Project STAR are also eager to point out the copyright and training conditions attached to use of the programme, less so to engage in discussion of outcomes and evaluation studies. So are commercial interests compromising objectivity and evidence?

There is much knowledge and experience already available to those in government willing to listen which could enable us to make more effective contributions through school programmes. The obsession with the curriculum and the perfect programme diverts attention from the social, affective and environmental contributions schools can make to substance use. We are aware of and responsive to the influence of 'setting' on substance use. Why do decision makers seem so resistant to the similar influence that 'setting' could have on prevention? ■

**A more detailed discussion of the evaluation and other studies of Project STAR has been written by Mike Ashton and published in Issue 8 (the current issue) of Drug and Alcohol Findings. To subscribe to Findings go to www.drugandalcoholfindings.org**

**In the next issue of Druglink the Blueprint team replies.**


References

1 Cf. Baldo, Aggleton and Slutkin: 1993: Does sex education lead to earlier or increased sexual activity in youth?: WHO Global Programme on AIDS.