Substance Misuse Among Young People

Research Paper 94/104

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The use and abuse of a wide range of substances such as drugs and solvents by young people is causing increasing public concern, reflected widely in the press. This paper examines the evidence for this perceived increase substance misuse, looks at the substances commonly abused and the part schools play in the education of young people about drugs.

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A.Introduction: the extent of the problem.

There has been much written in the press recently about the apparent rise in substance misuse among children and young people[1234] fuelling an increase in both public and parliamentary concern.

However, there is very little hard statistical evidence on the extent of substance misuse in this country. Usually an illegal activity, estimating its extent is very difficult, especially amongst young people.[5] Some indicators which are available to try and attempt to quantify the problem include:

1. The Bulletin of Statistics of Drug Addicts notified to the Home Office.
2. Seizures by HM Customs and prosecutions by the police.
3. Epidemiological studies.

It should be noted here that alcohol and tobacco (both substances commonly abused by young people) are excluded from the following discussion, as most people are already aware of their effects. However, apart from being substances of abuse in their own right (albeit rather more culturally acceptable than smoking pot or sniffing glue) they may function as **pathways** to the abuse of other drugs. A recent report[6] has shown that among the group of 14-15 year olds that it surveyed in Manchester, alcohol was an inportant pathway factor to emerge. Weekly drinkers were far more likely to have been in situations where drugs were on offer and were also more likely to have been offered drugs that month than monthly drinkers. They in turn were more likley to have been offered drugs than occasional drinkers and so on. This pathway trend was found to be carried through into actual drug use. Over 50% of the weekly drinkers had tried a drug in the last year compared to just 1 in 15 non-drinkers: 4 in 10 had used a drug in the last month compared to 1 in 25 non-drinkers. These findings led the report's authors to observe:

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[1]"Abuse by children at record level..."*Independent* 3rd March 1994
[2]"Drug abuse lays waste a generation..." *Independent on Sunday* 8th May 1994
[3]"Scots 'sliding into drug addiction'..." *The Guardian* 9th May 1994
[4]"Slaughter by the needle..." *Independent on Sunday* 8th May 1994
[5]"Drug Abuse in Scotland." Scottish Affairs Committee 1994 para 6
[6] " The post-heroin generation." Measham, Newcombe and Parker. *Druglink* May/June 1993

"Alcohol use, which begins to be a clearly recognisable feature from 12-13 years, is a powerful predictor of drug offers and drug use among adolescents."[7]

Both **1** and **2** are to be dealt with in a forthcoming paper produced jointly by Home Affairs and the Statistics Section and have only limited relevance to the issue as it affects young people, and so are not dealt with here.

3. Epidemiological studies of substance misuse

The pattern of substance misuse especially amongst the young is sometimes a local phenomenon and tends to be heavily influenced by peer group pressure. The extent and nature of substances abused and the manner of abusing them (i.e. whether injected or snorted) can vary between cities, parts of cities and even between neighbourhoods depending on local habits, the amount of money available for buying drugs, the population characteristics and the availability of the substances themselves.

There is only limited statistical and research information available on the health-related behaviour of young people, and from the above it can be appreciated that on the whole the studies which have been carried out in a particular area are only locally valid: different surveys will produce different results depending on the way the survey is carried out, the geographical area, the size of the sample, the age range, the school, and so on. Thus it follows that using these studies to extrapolate the proportion of schoolchildren who are using or who have experimented with drugs across the UK, can yield only very approximate figures. However, there have been several studies published in the past few years, the findings of which are summarised here.

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[7] ibid

a) Preliminary findings from the first stage of a survey of 776 14-15-year-old schoolchildren in Mersey and Greater Manchester[8] showed that nearly 60% had been offered drugs and 36% had tried a drug: 32% cannabis, 14% "poppers"(alkyl nitrites), 13% LSD, 12% solvents, 10% "magic mushrooms" (psilocybin), 10% amphetamines and 6% Ecstasy. 20% had tried a drug in the past month.

b) A study carried out by the Health Promotion Authority for Wales in 1990[9] surveyed 2,239 15-year-olds. Over 20% had tried drugs at least once and roughly 10% had used one of the drugs listed in the survey in the previous month. The substances most commonly cited were cannabis and solvents. It is interesting to note that a survey carried out in Mid-Glamorgan,[10] an economically-deprived corner of Wales, reported rather higher levels of drug misuse. Of a sample of children aged between 13 and 18, 10% had used drugs in the past week, of which roughly half were illegal drugs (usually cannabis), the other half being divided between volatile substances and "over-the-counter" medications.

c) A survey carried out by Strathclyde University between 1987 and 1989 studied the extent of drug misuse among a group of 1000 pupils between the ages of 12 and 16. Over 20% claimed to have tried illegal drugs at least once but as in other studies reported regular use was very low, at just over 2% for cannabis and even less for the other drugs. An interesting feature of this study was that it also recorded teachers' views who cited alcohol and tobacco as the biggest problems in the community, the misuse of volatile substances third, and illegal drugs misuse fourth.[11]

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[8]"*Drinking, Drug Taking and Deviance among Young People"*: paper presented at the Health in Europe Conference, University of Edinburgh, 1992: Newcombe, R, Measham, F and Parker,H

[9]"*Adolexcent Drug use in Wales*": Smith C and nutbeam D: *British Journal of Addiction* 1992: 87; 227-233

[10]"*Crime, Alcohol, Drugs and Leisure*" Mid-Glamorgan Social Crime Prevention Unit 1991

[11]"*National Evaluation of Drug Education in Scotland*:" Coggans N et al, Centre of Occupational Health and Psychology, University of Strathclyde, 1989

The most recent national survey comes from the Schools Health Education Unit at the University of Exeter, published in 1993. These studies,[12] published yearly, take the opportunity to question schoolchildren aged 11-15 about a wide variety of health-related behaviours, including exercise, alcohol and drug use. It should be made clear that the pupils are not selected randomly or to represent a balanced cross-section of schools and communities; their inclusion in the survey depends largely on district health authorities

deciding to use the unit' s questionnaire to survey the health behaviour of local school pupils (i.e. the schools are self-selecting). Nevertheless, the large sample size (20,218 pupils in 1992) and the comparable annual methodology, makes them useful trend indicators. Comparing the figures for 1987 and 1992, there is a clear upward trend in the use of all types of substances including amphetamines, cocaine, Ecstasy, hallucinogens, solvents and tranquillisers. The increase is the most dramatic for cannabis leaf: the proportion of respondents that admitted to having used it increased from under 3% of boys and girls aged 14-15 in 1987 to almost 14% in 1992.

The Home Office has also begun to conduct its own research into patterns of drug misuse. The self-report component of the 1992 British Crime Survey[13] sampled a total of 7,000 people across England and Wales including children as young as 12 years asking them whether they had ever heard of any of a list of 12 drugs,[14] whether they had ever taken any, whether they had been offered any in the last 12 months and whether they had taken any in the last 12 months.

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[12]"*Young People in 1992*": Exeter University Schools Health Education Unit

[13]"*Self-reported drug misuse in England and Wales: main findings from the 1992 British Crime Survey."* Home Office Research and Statistics Department. Research Findings no.7 December 1993. Joy Mott and Catriona Mirrlees-Black.

[14]The drugs listed were amphetamines, cannabis, cocaine, crack, Ecstasy, heroin, LSD, methadone, temazepam, semeron (a fictitious drug) 'magin mushrooms' (containing psilocybin) and 'glue'. Ibid p2

With respect to the school-age children, 3% of the 12-13 year-olds and 14% of the 14-15 year-olds said they had ever taken a drug. People aged between 16 and 29 were most likely to say they had (28%). Most of this drug use is accounted for by the use of cannabis.
Again the authors point out that due to the unwillingness of young people to admit to what is, after all an illegal activity, these figures probably provide a conservative estimate of the extent of drug misuse amongst this age group but act as a useful benchmark against which future surveys may be measured.

B.Substances most commonly abused by young people

Substances commonly misused by young people include drugs such as cannabis leaf, amphetamines ("speed"), ecstasy (MDMA) and LSD mainly due to their availability and affordability. Drugs such as heroin are very unlikely to be available to children, and it is interesting that one unpublished report indicates that 14-15 year-olds are actually not interested in heroin, referring to its users as"junkies." [15]

1.Cannabis (alternative names: marijuana, grass, weed, pot, ganja, skunk, hash, dope).

Derived from *Cannabis silva*, a bushy plant found in most parts of the world and easily cultivated in the UK, cannabis is the most widely used recreational drug in this country and the one to which young people would be most likely to have had access. The psychoactive ingredients are chemicals called tetrahydrocannabinoids (THCs) which are concentrated at the tops of the plants.

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[15]*Druglink* May/June 1993

Cannabis comes in four forms

1. *marijuana* or "grass": the dried vegetative parts of the plant
2. *resin* ("hash"): a compressed brown or black powder which has to be heated or crumbled before use, and secreted by the flowering tops of the female plant
3. cannabis oil
4. "*skunk*"-this is a relatively new form of the drug, first grown in the US but now produced in Holland to such an extent that its production rivals that of the tulip. It is more potent than the normal plant with a higher concentration of THCs.[16]

Used globally, in North Africa and Asia cannabis products are consumed by some social classes in a manner somewhat akin to alcohol in Western society. Most consumption in the Western world is intermittent and recreational; the vast majority of such users take no other drug, although alcohol consumption may be higher than among non-users of cannabis.[17]

All forms are usually smoked though they can be eaten. The effects on consciousness for which cannabis is mainly consumed are very variable and depend on the dose, the setting, the person's state of mind and his expectations. They include a sense of calm elation, a heightened enjoyment of music and an increased appetite for food (the "munchies"). Cannabis may also exaggerate existing moods, increasing hilarity in a humorous situation or accentuating depression or anxiety. Perceptual disturbances may occur and as with many drugs there may be a sense of intense creative thinking or of universal awareness, though the ideas usually seem obvious to the unintoxicated and may even appear so to the person himself afterwards.[18] An intense feeling of anxiety, amounting to terror may follow occasionally from cannabis usage especially if the user is taking a stronger preparation than usual. This usually settles down with time.[19]

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[16]"Illicit pot plants flower into new DIY industry..." *Observer* 3rd July 1994
[17]*Oxford Textbook of Medicine* 1991 p25.29
[18]"*Psychological Medicine*" Peter Storey p343
[19]ibid

It is accepted by the medical profession that cannabis, although it may induce an emotional dependence on the part of the user, is not truly physiologically addictive, i.e. it can be given up without physical symptoms. [20]

The debate as to whether cannabis is safe or unsafe has been raging for many years. The Institute for the Study of Drug Dependence has written in a previous report:

> "There is no conclusive evidence that long-term cannabis use causes lasting damage to physical or mental health." [21]

Although the same report also recognises that the sorts of studies which would have to be carried out to detect medical complications have not yet been done.

A psychiatrist has written:

> "Cannabis...probably has no more serious side effects than alcohol, which has plenty.[22]

No serious side-effects have yet been proven amongst intermittent users though its inhaled smoke irritates the respiratory tract and is potentially carcinogenic (cancer-causing).[23] It is also known that heavy intake, especially of the "Ganja" type may be associated with acute florid psychoses, brief, but almost indistinguishable from acute schizophrenia.[24] It has also not been proven safe in the first three months of pregnancy.[25]

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[20]"*psychologicqal Medicine.*" Peter Storey p338
[21]*Drug Abuse Briefing.* Institute for the Study of Drug Dependence 4th Edition 1991
[22]"*Psychological Medicine*" Peter Storey p343
[23]*Oxford Textbook of Medicine* 1991 p25.29
[24]"*Psychological Medicine*" Peter Storey p343
[25]*Oxford Textbook of Medicine* 1991 25.29

Dependency: psychological dependence.

Legal status: herbal cannabis (everything except the seeds,and the stalks) is controlled under the class B schedule of the *Misuse of Drugs Act 1971*, while the isolated active chemicals (THCs) isolated from the plant count as class A drugs[26]. There is increasing debate over its decriminalisation.

Medical uses: There has been much interest in the possible use of cannabis for medical reasons such as its putative ability to relieve the painful muscle spasms of multiple sclerosis. It is also reported to help in the condition glaucoma, a state in which a high pressure in the

fluids inside the eye may lead to blindness.[27] Although it is now legal to use marihuana for medical purposes in 35 states of the US,[28] the Government's view is that in neither case is it "as effective as other drugs."[29] An independent report into the use of *nabilon*, a semisynthetic cannabis-like drug developed for the treatment of the nausea and vomiting induced by chemotherapy concluded that is was no more effective that standard treatments and had a higher degree of toxicity.[30]

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[26] "Drug Abuse Briefing: 4th edition". Institute for the Study of Drug Dependence 1991
[27]"Inside Story". *The Guardian* 18th September 1993
[28]ibid
[29]HC Deb 31st January 1994 c536w
[30]HC Deb 7th February 1994 c52w

2.Ecstasy (Other names: methylene-dioxy methamphetamine {MDMA} "E,...)

MDMA is a type of hallucinogenic amphetamine, derived from natural oils present in nutmeg. First synthesised in 1914, no use was found for it until therapists in the US "discovered its potential for encouraging empathy between clients and diffusing anger and hostility" (Drug Abuse Briefing: 4th edn. ISDD). As with LSD, the use of Ecstasy eventually filtered through to the general population; discovery of its adverse effects led to it being banned in the US in 1985. Available in this country since the mid-eighties, the drug has since become closely associated with Acid house music and the gatherings, called "raves" at which the music was played. Use of the drug has now become widespread among young people with a figure of over 20% of adults in one survey in Scotland having taken it frequently cited in evidence to the Scottish Affairs Committee in their recent report .[31]

[31] "Drug Abuse in Scotland". Scottish Affairs Committee 1994 para 19

The effects of ecstasy in moderate doses include a mild transient sensation of euphoria followed by a feeling of calmness and the dissipation of anger and hostility. It also seems to stimulate the feeling of empathy between users, and enhances the sensual experience of sex (rather than increasing sexual appetite). It leads to a perception of increased energy usually expended on further dancing, and this, combined with its tendency to decrease appetite, may lead to long-term users appearing thin and gaunt. Controversy has surrounded how "safe" or unsafe ecstasy is, considering the enormous numbers of young people who are taking it. There have been several deaths in young people who have taken Ecstasy; one girl died of liver failure, and other deaths seem to have been caused by exhaustion and dehydration. Its use has been linked with cerebral haemorrhage in some subjects, and with overt paranoia in others.[32]

Research published in the US in 1988 showed that brain damage occurred in monkeys which were injected with MDMA twice a day for two weeks, though the clinical significance of this for humans is unclear

Often described as the "drug that non-drug-users take",[33] Ecstasy was singled out in the recent report by the Scottish Affairs Committee into drug taking in Scotland for special mention as a cause for concern. Anxiety about Ecstasy is focused on a few specific issues:

a) its widespread use (over 20% of a survey of Scottish youngsters claim to use it),
b) the relatively young age of the population who are using it,
c) its poor street quality. Ecstasy is often cut with other substances such as LSD, amphetamines and even heroin, thus making the consequences of taking a drug perceived as "safe" by young people highly dangerous.

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[32]"Ravers play 'russian roulette' with Ecstasy..." *The Independent* 28th January 1991
[33]"Drug Abuse in Scotland". Scottish Affairs Committee 1994 para 141

Concern was also expressed in the report about the use of the prescription sleeping pill temazepam being used to "chill-out" from the adverse effects of Ecstasy, and that use of the benzodiazepine could form a

"...bridge between recreational use and a "hard" or opiate drug problem"[34]

Legal status: Class A drug.[35]

3.Amphetamines (also known as "speed", "Whizz", "ice")

These are synthetic substances which are usually snorted through a tube or injected. Amphetamines were originally marketed as nasal decongestants in the 1920s, and since then have been used to treat a wide variety of conditions including obesity as a result of their ability to suppress appetite. Recreational use has been prevalent since the 1960s. Their prescription by doctors has fallen back, and amphetamines on the streets are now rarely pharmaceutical, but are manufactured in hidden chemical "factories".

In the short-term the effects of amphetamine use include elevation of mood and the strengthening of endurance (including sexual stamina). Adversely, the effects of amphetamines are rather like those of adrenaline, increasing the pulse rate and the blood pressure which may cause crushing chest pain and heart failure or lead to extreme anxiety, irritability, restlessness, panic and feelings of paranoia and persecution which may progress to frank paranoia and psychosis ("amphetamine psychosis").

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[34]ibid para 20
[35] "Drug Abuse Briefing" p 35

Legal status: Prescription-only medicine under the *Medicines Act 1968* but also controlled drugs under the *Misuse of Drugs Act 1971*. Doctors can prescribe them and patients can possess them if they have been prescribed. Some amphetamines are in class B for the purposes of the 1971 act but if they are in their injectable form the class "A" penalties apply (a few milder amphetamine -related stimulants are put in class "C")[36].

Dependency: usually emotional dependence only.

Medical Uses: (now rarely used) narcolepsy, hyperkinesia, short term management of gross obesity.

4. Volatile Substances i.e. solvents.

Another significant group of substances of misuse are volatile substances such as solvents and solvent-based products. The overwhelming problem with this group of substances is their *availability*: each household is supposed on average to contain at least thirty potentially abusable substances ranging from butane gas in cigarette lighters and aerosols to solvent based glues and some types of correcting fluids.[37] Such substances are on sale in a wide variety of retail outlets and usually can be obtained quite easily and cheaply. The number of deaths from solvent abuse has risen steadily from only two notifications in 1971 to 150 in 1991.[38] After road accidents, solvent abuse is the highest unnatural cause of death in young people between the ages of ten to sixteen. Of the deaths in 1991, almost 40% had died after using it for apparently the first time.

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[36]"Drug Abuse Briefing." p 14
[37]"Solvents: a parents guide". Department of Health 1992
[38]Figures from St. George's Hospital Medical School quoted in the *Re-Solv* Annual Review 1992-93, 1993

The problem is not confined to the UK but is a global one: among the countries of western Europe, a WHO school survey (1990) among 15-16 year old pupils showed that 10% admitted to having had misused solvents. In Japan, over 40,000 people, most of them under the age of twenty, were arrested in 1986 under the solvent abuse control law. The problem is endemic among the street children of many Latin American countries, such as Guatemala, Colombia and in Brazil, where roughly 90% of the street children in the city of Belo Horizante, many of whom are as young as six, are addicted to glue.[39]

Roughly 10% of secondary school children will try sniffing: most of these will experiment and the problem is a short-term one, but a few will become heavy or long-term users. Substances are not really sniffed but inhaled usually from plastic bags held over the nose and mouth: thinners may be sniffed from a cloth or coat sleeve.

The effects of substance inhalation are experienced very rapidly as the solvents enter the blood-stream very quickly through the lungs, rather than the rather more lengthy process of being absorbed from the stomach. The effects of inhaled solvents are said to be very similar to being intoxicated with alcohol: dizziness, feelings of unreality, and euphoria, lowering of inhibitions, and "pseudohallucinations", which the individual *knows to be unreal*. The effects are of rapid onset, and wear off with similar speed.

The dangers of solvent abuse are legion and may cause death or long- term damage to health. Sensitisation of the heart to exercise or excitement may occur, and can lead to heart failure or even to a heart attack which may prove fatal. Butane gas sprayed directly into the mouth may cause suffocation. Suffocation from the use of plastic bags may also occur and accidents while intoxicated are also common, e.g. choking to death on one's own vomit while sniffing to the point of near-unconsciousness. Sniffers often congregate in groups in dangerous out-of-the-way environments such as derelict buildings and railway embankments, and accidents such as falls may occur .

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[39]ibid

Long term use of solvents might result in moderate lasting impairment of brain function, and kidney and liver damage. However this is rare: temporary impairment is much more common. A young person sniffing repeatedly will suffer "hangover" effects of pallor, tiredness, forgetfulness, poor concentration, weight loss, depression and tremor, although these effects tend to disappear once sniffing is discontinued. Another danger in volatile substance abuse (VSA) is the development of *tolerance,* the user having to inhale increasing quantities of solvent to ~get high, thus increasing the risk of adverse effects.

Legal Status:

In an attempt to combat the problem of solvent misuse, the *Intoxicating Substances Supply Act* was passed in 1985, making it an offence to supply to any one under 18, a substance which the supplier knows or has reason to believe, will be used to "achieve intoxication." Primarily directed at shopkeepers, the Act could also result in the prosecution of anyindividual who knowingly supplies a young person with a sniffable product[40]. There have been a few prosecutions under the Act, but enforcing the Act is difficult and there is evidence that it may be shifting young people from using solvents and glues to the much more dangerous practice of sniffing gasses such as butane, aerosols and lighter fuel.[41]

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[40] "Drug Abuse Briefing." p 46

[41]Controlling deaths from volatile substances in the under 18s: the effects of legislation" *British Medical Journal* 19th September 1992 p692

Risks of substance misuse

l.contraction of blood-borne infections such as HIV and hepatitis B, bacterial endocarditis, through injecting.

2.disruption of education and risk to future livelihood and well-being.

3.physical consequences of addiction and long~term ill-health, which may lead to premature death (there were 51 deaths associated with the use of controlled drugs in young people under the age of 20 in 1992[42])

4.acquisition of a criminal record by possessing illegal drugs or by turning to crime to finance the habit .In a recent study looking at the attitudes to drugs of adolescents no-one involved in the study knew that Ecstasy was classified as one of the most dangerous drugs (class A) together with the opiates and that the penalties for its possession are up to seven years imprisonment plus an unlimited fine.[43]

5. adverse effect on the family.

6. adverse effect on society: this is almost impossible to calculate and would need to include the cost to the NHS, the cost of law enforcement, prevention, treatment and rehabilitation, and the cost of drug-related crime.

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[42]HC Deb 24th February 1992 c114-115

[43]"Drugs and Young People". Coffield and Gofton. Institute for Public Policy Research 1994 p27

D.Drug Education and Prevention

Concern about the apparently deteriorating drug situation among young people in this country prompted the Advisory Council on the Misuse of Drugs (ACMD) to set up a Prevention Working Group which last year published a report examining prevention issues as they concern young people, focusing specifically on the part schools have to play in educating children about drug use. [44]

Drug education and prevention is a complex issue and there are two main strategies involved. One is to deter young people from ever using drugs or from experimenting further, so-called "primary prevention" while the other is known as "harm reduction", where drug usage is recognised as being a part of contemporary society, but the damage that it may cause is hoped to be minimised by educating young people about how to safely use drugs and warning them of the potential side-effects.

1. Prevention

The Government's Role.

In its widest sense, prevention encompasses all the elements designed to combat drug misuse; international cooperation between the UK and other countries to reduce the supply of illicit drugs smuggled in from abroad, enforcement by police and customs, and measures aimed at deterring individuals and groups from trafficking in, and misusing drugs. Action taken by the Government in respect of each of the above areas is summarised in " *UK Action on Drug Misuse The Government's Strategy* "published by the Home Office in 1990. This document also states that:

> ".....a specific part of this (i.e. prevention) strategy is concerned with action to discourage people, particularly young people who are not misusing drugs, from ever doing so. Such preventive measures are hard to achieve and many will have long-term aims which make it difficult to assess success."

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[44]"Drug Education in Schools: The Need for New Impetus" Home Office 1993 1.5

Prevention Publicity

Following the ACMD's 1984 report on prevention[45], there have been several Governmentsponsored publicity campaigns to discourage illegal drug misuse amongst young people. The first two campaigns dealt with the dangers of heroin, including that of possible HIV and hepatitis B infection. In response to the rising number of deaths of children from solvent abuse (145 in 1990), the Drug Misuse Campaign of 1992 focused specifically on that problem. Costing £1.4 million, the programme aimed to increase parental awareness, promote access to information about substances of abuse and relevant organisations. It was followed shortly after by a £600,000 press-only drugs campaign, again aimed primarily at parents.

In January of this year, a £2.5 million three-month campaign was launched by the Government, addressed once more to parents, encouraging them to talk to their children about drug and solvent abuse, telling them that " if you don't talk to your child about drugs then someone else will."

Accurately evaluating the effectiveness of these costly campaigns has proved very difficult. Where evaluation has taken place, it reveals a high level of public awareness of the publicity, but little as to their effectiveness. When asked about the effect of these campaigns recently, the Scottish office was "less than fulsome in their praise."[46] A recent study in Manchester looking at the attitudes of young drug users heard from one girl who rather admired the main character in the "Heroin screws you up" campaign and had the poster of him on her bedroom wall.[47]

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[45] "*Prevention Report of the Advisory Council on the Misuse of Drugs.*" HMSO 1984
[46]"Drug Abuse in Scotland". para 130
[47]"*Drugs and Young People*" Frank Coffield and Les Gofton. Institute for Public and Policy Research 1994

Prevention in Schools

The importance of preventive health was outlined in the Government white paper "*The Health of The Nation. A strategy for health in England*[48] which in a section entitled "healthy schools" expresses the Government's commitment to a healthy schools initiative being developed jointly by WHO, the European Community and the Council of Europe, which, with the help of the Health Education Authority will look to establish:

> "a pilot network of health promoting schools. This will develop, and assess the effectiveness of, strategies for changing and shaping pupils' patterns of behaviour, with the aim of safeguarding their long term good health."[49]

The Government implemented its prevention strategy for school-age children in two ways:

a) the funding of a network of education co-ordinators in schools
b) the inclusion of drug and substance misuse education in the National Curriculum.

The GEST scheme.

To encourage the development of drugs education in schools and colleges, local education authorities (LEA's) in England and Wales between 1986 and 1990 were able to use Education Support Grants (ESGs) from the then Department of Education and Science (DES, now the Department for Education: DFE) and the Welsh Office, to help to employ Drug Education Co-ordinators (DECs) to develop drug education in schools, colleges and the youth services. In 1990, the system was changed to widen the scope of preventive health education and the DECs were replaced with Health Education Co-ordinators (HECs). This GEST (Grant for Education, Support and Training) scheme was ended in March 1993, although the programme does continue in Wales in a slightly different form.[50] The Government saw the scheme as a

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[48]Department of Health 1992
[49]The Health of the Nation p27
[50]"Drug Education in Schools" Home Office 5.5.1

pump-priming exercise, to help get drug education off the ground, and insisted that responsibility to continue the work rested with the local authorities if they found it valuable. A report by Her Majesty's Inspectorate concluded that GEST funding had played a valuable role in raising levels of health awareness, allowing staff to be equipped with the knowledge and skills to develop and implement programmes of education in health matters.[51] The same report also found the end of funding to have generated "a sense of insecurity which affected long-term planning strategies for further development of health education in many authorities" and called for authorities to examine ways in which the provision for health education could be maintained and even enhanced in the post-GEST period.[52] A survey by the Local Government Drugs Forum (LGDF) in January 1993 showed that only 13 out of 73 local authorities planned to continue present levels of funding for health education coordinator posts after the 1st of April 1993 when the grant ran out.[53]

Drug Prevention in the National Curriculum.

It is generally found that the crucial period at which young people commonly experiment with substance misuse is between the ages of ten to fourteen.[54] In the case of solvent abuse, however, there have been fatalities in children as young as nine. This is reflected in the requirements of the National Curriculum Science for England and Wales in which drug education forms part of the statutory order for National Curriculum Science, and all maintained schools are required to teach it, beginning with children of primary school age.

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[51]"*Monitoring the Grant for Education, Support and Training for Preventive Health Education: Summer and Autumn 1991*". Department for Education 1991
[52]"Drug Education in Schools". 5.5.7
[53]LGDF Circular 1/93 14 January 1993, quoted in *Druglink* March/April 1993.
[54]"Drug Education in Schools" 5.6.3

The aim is:

> "The acquisition of knowledge, understanding and skills which enable pupils to consider the effect of substances such as tobacco, alcohol and other drugs on themselves and others and to make informed and healthy decisions about the use of such substances."[55]

The information on substance use and misuse is staged according to the age range (or "keystage") of the child. Children at key-stage one (aged 5-7) will be introduced to ideas about how to keep healthy and about the role of drugs as medicines, while young people at keystage 4 (aged 14-16) will explore much more complex ideas about substance use, e.g. the historical, cultural and economic background to drug use and production world-wide, the role of the media in influencing attitudes towards drugs and the concept of personal choice and personal responsibility in drug use.[56]

Northern Ireland

The situation here is similar to that prevailing in England and Wales, where though not taught as a distinct subject in itself, health education is identifed as a cross-curricular theme which aims, among other things:

> "...to develop in children a critical awareness of the use, misuse, risks and effects of drugs and other potentially harmful substances; their catastrophic effects on health; and their personal, social and economic implications."[57]

Since September 1992, this inclusion of health education as a cross-curricular theme has been mandatory in law[58].

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[55]"*Curriculum Guidance:* 5. *Health education* "National Curriculum Council, 1990.
[56]"*Drug Education in Schools*" 5.2.1.
[57] "*Drug Education in Schools*." 5.3.1
[58]ibid 5.3.2

Scotland

The situation is rather different in Scotland as there is no compulsory national curriculum. The Scottish Office Education Department (SOED) has the responsibility of co-ordinating guidance on drug education in schools. All education authorities have drug education programmes and each school has a designated teacher with responsibilty for health education. SOED ahs also funded the production of the "Drugwise" education packages which have been made available for distribution to all primary, secondary and special schools.[59] The Scottish Consultative Council on the Curriculum (SCCC) and the Health Education Board for Scotland (HEBS) have also produced a report called "Promoting Good Health" aimed to help plan programmes of health education including drug abuse in the 10-14 age group. This has been made available to all primary and secondary schools in Scotland[60].

Independent schools.

Private or independent schools which receive no funding from the state do not have to comply with the National Curriculum, and hence have no statutory obligation to provide any form of drug education, although they receive information and guidance from the Department of Education and the Welsh Office. The Advisory Council on the Misuse of Drugs points out that independent schools face certain problems with respect to drug education. As they rely on 'market forces' for their intake, publicity about drugs problems may be feared thus leading to a problem not being tackled until it has become a significant one. Also, pupils may be from wealthy families and thus have more opportunity to purchase illicit substances, or they may be at boarding school and away from parental influence, where peer pressure may have much greater force.[61]

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[59]ibid 5.4.1
[60]ibid 5.4.3
[61]"Drug Education in Schools" 6.20

Recent cases of young people being expelled for possessing and supplying drugs (usually cannabis) to their schoolmates both in the private and the public sectors,[62] even to the point where some independent schools are thinking of introducing drug testing,[63] have raised the question as to the best way of dealing with this problem within schools where any form of drugs "scandal" is bad for the school's image. The potential danger to other pupils and also the consequences to the individual child of the complete severance of his or her education have to be balanced. Whether this is really tackling the problem in a fair sensible and practical way is a matter for debate.

Children in care

Similar concerns are voiced by the same report for children in care, whose education, unless in mainstream schools, is not required to follow the National Curriculum:

> "There is consequently no assurance that the component of health and drugs education which is covered in the National Curriculum subjects will be provided for these children."[64]

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[62]*Evening Standard* 16th December 1993, *The Guardian* 28th June 1993, *The Guardian* 2nd September 1994
[63]*Today* 19th October 1993
[64]ibid 8.4.

E.Why are young people attracted to substance misuse?

A significant problem with prevention which has hitherto largely been ignored in the debate on drugs is the lack of data on why young people misuse drugs and volatile substances in the first place.

The recent Scottish Office report on drug abuse in Scotland recently concluded that there was clearly a correlation if not a causal relation between drug misuse and deprivation e.g. in the peripheral housing estates of Scotland's major urban areas.[65] The report further commented:

> "Deprivation may not lead inexorably to drugs but drug misuse is an enormous problem in many areas of multiple deprivation."[66]

Some commentators see it as a corollary to the decline in post-industrial society where:

> "It is impossible to avoid the connection between the escalation of illegal drug use among the younger generation and the strains between those young people and the forces of law and order, strains created by a massive increase in unemployment and little sign of any end to the dismantling of the economic and social fabric of old industrial regions such as the North East. Calculations about the rationality of drug use involve some estimation of what the individual has to lose, and in a situation where the present offers little comfort and where the future looks bleak, negative long-term consequences tend to be discounted....."[67]

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[65]"*Drug abuse in Scotland*." para 30
[66]"*Drug Abuse in Scotland*" para 30
[67]"*Drugs and Young People*". Frank Coffield and Les Gofton Institute for Public and Policy Research 1994 pl5

Even so there remains little information on why some young people never try drugs at all, some try drugs for a short period only and then abandon the practice, and why some youngsters go on to develop a persistent drugs problem.

In their evidence to the Scottish Affairs Select Committee, both Professor Plant and Professor Davies argued against substance misuse being an expression of personal inadequacy and low self-esteem.[68] Young people may be attracted to drugs for a number of reasons. Of these, peer group pressure and influence is one of the strongest.

In a sample of 380 schoolchildren between the ages of 14 and 15, surveying the knowledge and experience of young people regarding drug abuse, the most common reasons cited for use were "to feel big, show off, look grown up" (49% of the respondents) and because friends do, trendy" (34%).[69] Another factor may be the thrill of doing something illegal or of which they know their parents would disapprove. It also must be remembered that for most young people, especially at the outset of their relationship with substance misuse, *the sensations may be intensely pleasurable and exciting*, and they will actually enjoy taking drugs. These first hand accounts describe two children's experiences with solvents, the first from a child called Carl, the second from Steven.

> "..it's something I enjoyed and I wanted to do more. When I first started to smoke a cigarette, I felt ill but I kept on because everyone was doing it, but with sniffing glue when I first tried it I enjoyed it, it's something I did enjoy, that's the reason I started anyway."
>
> "We used to have these games, like we used to have this big trunk, and we used to call that "the dream machine" and we used to get all things like Snow White and the Seven Dwarfs coming down the conveyor belt, lasers, spaceships, everything."[70]

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[68]"*Drug Abuse in Scotland*" para 132
[69]"*Knowledge and experience of young people regarding drug abuse, 1969-1989*" British Medical Journal: 300; pp99-103
[70]"*Solvents: a parents guide*". 1992

As the Scottish Affairs Committee pointed out in their recent report, the anti-drugs message has to be credible. Many youngsters will know people who use drugs, especially cannabis and for these people drug taking is associated with having a good time:

> ".....a message which overstates the dangers, which tells them that drug taking leads to inevitable addiction and death, simply will not work." [71]

Indeed, there was much evidence presented to the Committee that health programmes which focus on health risks could arouse curiosity and even suggest that fears about drugs may be exaggerated.[72]

There is also evidence young people make a very clear distinction between "soft" and "hard" drugs. In the first group comes cannabis, acid (LSD), "poppers" and Ecstasy, the second being reserved for substances such as cocaine, crack and heroin. Users of the first group of drugs feel themselves to be separated by a wide gulf from the users of the second group of drugs. Indeed the authors of the report showing this data found that they:

> "...held the common stereotype of the addicted junkies, the "nutters" or "wierdos" who were thought to be driven by a craving for death-dealing drugs..."

and that they:

> " . . .exhibited real hostility to those who injected or who took cocaine or crack - 'they're the real drug addicts who should be severely punished'.."[73]

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[71]"Drug Abuse in Scotland"
[72]ibid para 136
[73]"*Drugs and Young People*" pp21-22

The approach to be taken when attempting to deter young people from misusing drugs is also a contentious one. There is a split in the field itself as to whether education should aim at "primary prevention" (i.e. total abstinence) or "harm reduction." The latter implies some usage but looks to minimise risk, e.g. by teaching of safe injecting behaviour or by advocating the use of "chill-out" rooms at raves, and is mainly targeted at those for whom drug misuse appears to be a persistent problem. Other approaches cited in the Scottish Office report include attempting to create new youth cultures which do not involve the taking of drugs, or by encouraging young people to make their own, individual decisions. The latter "peer resistance strategies" have been shown in some cases to delay the first use of drugs.[74]

The report also points out that the sort of education that parents might wish for may be inappropriate, and have relatively little effect on the children at whom it is targeted; advice and guidance from adults being in general less effective than allowing young people to develop their own programmes.[75] Some drug prevention programmes may even be counterproductive. The Scottish Affairs Committee was told of Dutch research which demonstrated that the "shock-horror" and the more neutral information-giving approaches, both methods commonly used, led to an *increase* in drug-taking.[76] The only approach which was preferable to doing nothing incorporated the use of a "lifeskills" element aimed at increasing social maturity and the young people's ability to assert their own preferences over those of their peer group.[77] However, some evaluations of the lifeskills approach demonstrate improvements in decision making and self esteem but without any noticeable effect on drug use.

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[74]ibid para 131
[75]DAIS para 133
[76]ibid
[77]ibid para 134

The maelstrom of confusion which surrounds this issue may be related to lack of consistent and effective evaluation of drugs education programmes. Both the ACMD and the Scottish Off1ce reports note this deficiency and make recommendations that in future drug education evaluation should be made an inte~ral part of the programme itself.

> "We therefore recommend that when budgets are drawn up for drug prevention activities, they should include an element for monitoring the implementation of the programme and evaluating the outcome. Evaluation must be seen as a part of drug education policy, not as something to consider only if time and money permit...."[78]

The Government has responded to these issues by asking a Cabinet sub-committee, chaired by Tony Newton, Lord President of the Council, to launch another initiative aimed at young people again warning them of the dangers of drug abuse, which will report to the Prime Minister later in the summer. The package which is expected to be published as a green paper in October is planned to include a:

> "...more liberal approach to teaching children about drugs in primary and secondary school...It is expected to argue that "shock-horror" warning tactics employed by police officers visiting schools have little value when many children know more about drugs than the lecturer..."[79]

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[78]ibid para 136

[79]"*Teachers get key role in combating drugs.*" *The Guardian* 10th September 1994

Selected Reading.

Drug Education in Schools: the need for new impetus. A report by the advisory council on the misuse of drugs. HMSO 1993.

Drug Abuse in Scotland. Scottish Affairs Committee 1994.

Drug Usage and Drugs Prevention. The views and habits of the general public. Home Office 1993.

Drugs and Young People. Coffield and Gofton. Institiute for Public and Policy Research 1994