

# **Final Report of The School Drug Safety Team**

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# CONTENTS

	PAGE NUMBER
<b>BACKGROUND</b>	<b>2</b>
<b>GUIDELINES FOR THE MANAGEMENT OF INCIDENTS OF DRUG MISUSE IN SCHOOLS</b>	<b>4</b>
<b>EFFECTIVE DRUG EDUCATION IN SCHOOLS</b>	<b>6</b>
<b>The Role of Schools</b>	<b>6</b>
<b>The History of Drug Education in Schools</b>	<b>7</b>
<b>The Curriculum</b>	<b>8</b>
<b>Principles of Drug Education</b>	<b>10</b>
<b>Barriers to Effective Drug Education in Schools</b>	<b>14</b>
<b>TEACHER EDUCATION AND MULTI-AGENCY TRAINING</b>	<b>17</b>
<b>Initial Teacher Education</b>	<b>17</b>
<b>Continuing Professional Development</b>	<b>17</b>
<b>Multi-Agency Training</b>	<b>19</b>
<b>EXCHANGE OF BEST PRACTICE</b>	<b>20</b>
<b>CONCLUSIONS AND RECOMMENDATIONS</b>	<b>22</b>
<b>APPENDIX 1</b>	<b>Membership of School Drug Safety Team 26</b>
<b>APPENDIX 2</b>	<b>Respondents to the Consultative Document 27</b>
<b>APPENDIX 3</b>	<b>Guidelines on the Involvement of External Agencies 28</b>

## BACKGROUND

1. Scotland, like other countries round the world faces a serious drug problem. The Scottish Executive is determined to produce a co-ordinated response to the problem. While it is important to acknowledge that the majority of our young people will go through their lives without misusing drugs or becoming involved with the drug scene we know that drug misuse is a feature in the lives of many young people.

2. The importance of drug education is fully recognised in Scotland's drug strategy set out in *Tackling Drugs in Scotland: Action in Partnership*. The Strategy has a number of objectives and action priorities relevant to schools and other agencies with whom they work, aligned under the key aims of:

- helping young people resist drug misuse in order to achieve their full potential in society;
- protecting communities from drug-related anti-social and criminal behaviour;
- enabling people with drug problems to overcome them and live healthy and crime free lives; and
- stifling the availability of illegal drugs on our streets.

3. Drug Action Teams (DATs) have a key role in addressing the objectives and action priorities outlined in the drug strategy. They are required to prepare Annual Corporate Action Plans, which form the main reporting mechanisms between the Executive and the DATs in assessing progress in implementing the strategy. The work of the School Drug Safety Team is seen as a key contribution to helping DATs and partner agencies take forward their work in relation to the school sector.

4. In the school setting, Scotland's action priorities state that every school should provide appropriate drug education for all pupils, in line with national and education authority advice, and that every school and community education provider should have an effective welfare policy on the management of incidents of drug misuse. Research shows the increasing importance of effective education about drug misuse starting in the primary school.

5. The 1998 Research Unit in Health and Behavioural Change survey of health behaviours in Scottish schoolchildren identified that, of those surveyed, 43% of fourth year pupils reported 'ever' having used drugs. Of those reporting 'ever' having used drugs, the peak age of first use was 14 years. Comparison with the previous survey, carried out in 1994, reveals that while the peak age remains 14 years there has been a shift towards the younger ages of first use (see table one).

**Table One: Age at which drugs were first used as reported by pupils in fourth year of secondary school.**

Age of First Use	1994	1998
Up to 12 years	15%	21%
13 years	24%	30%
14 years	39%	34%
15 years	23%	15%

6. To help monitor the situation, the Executive has introduced an annual survey on drug education in schools. In January 2000, local authorities in Scotland were asked to collect information on the drug education provided by all their schools. Each school was asked to give details of whether they provided drug education, what type of drug education they provided and also to describe their procedures for managing incidents of drug misuse. All other schools in Scotland (e.g. independent and grant-aided schools) were also asked to provide similar details of their drug education policies and procedures. The survey showed that 95% of schools in Scotland provided drug education; 89% claimed their drug education was in line with national advice; 56% of local authority schools had written procedures for managing incidents of drug misuse while a further 14% had such procedures in preparation. In responding to this survey the Minister for Children and Education said:

*"This puts us well on course for reaching our target. However there can never be room for complacency and we will continue to monitor schools' performance and provide tools to assist with drug education and misuse of drugs."*

7. Drug education is considered an integral part of health education and personal and social education. In addition, considerable emphasis is placed on health education in the curriculum being seen in the context of the health promoting school. This includes the curriculum, school ethos, health services and other support agencies, and partnerships with parents and the wider community. Health promoting schools recognise that the health and wellbeing of young people are influenced by the total experience provided by schools.

8. The health of all those learning and working in schools is an important aspect of effective education for all. The health and wellbeing of children and young people affect their ability to achieve and their confidence to learn. Research highlights clear links between good health and higher attainment as well as the converse that educational attainment is a factor in influencing the health of individuals and communities.

9. The then Minister for Education set up the School Drug Safety Team in 1999 following a number of drug misuse incidents in primary schools and a report from HM Inspectors of Schools (HMI) indicating that almost 40% of primary schools sampled over 1996-98 did not provide drug education. The Team comprised representatives from a wide range of sectors and agencies including education, health, social work services and police (see Appendix 1). It was set up with the following remit:

*"In the first place the group will concentrate on ensuring that appropriate guidance on handling drug incidents is available to teachers and thereafter advise on the effectiveness of drug education in schools, consider teacher training needs on drug matters and promote the exchange of best practice."*

10. The School Drug Safety Team met on 10 occasions between March 1999 and October 2000 with a sub-group meeting on 2 occasions to consider the draft guidelines for the management of incidents of drug misuse in schools. The Team took account of the recent review of drug education in Scotland undertaken by the Scottish Council for Research in Education (SCRE) and the SCRE interim evaluation of the Scotland Against Drugs Primary School Initiative. In addition, a number of papers were commissioned and a number of organisations and individuals were invited to make presentations.

## **GUIDELINES FOR THE MANAGEMENT OF INCIDENTS OF DRUG MISUSE IN SCHOOLS**

11. The School Drug Safety Team's first priority was to ensure that effective national guidance on handling drug misuse incidents in schools was made available to teachers. The Team produced a consultative document *Guidelines for the Management of Incidents of Drug Misuse in Schools* in October 1999. Key stakeholders were invited to comment on the consultation document which was made available through the Scottish Executive website. A range of responses was received. See Appendix 2 for a list of respondents.

12. For the most part, the consultative document was warmly welcomed and endorsed. A number of recurring themes occurred within the responses, which were taken into account in the revised document. For example, a number of respondents sought further clarification about when, and in what circumstances, a school should involve the police. In addition, stronger links with the role of the DATs and with the concept of the health promoting school were suggested. These points were accepted and the guidelines were launched by the Minister for Children and Education at Hyndland Secondary School, Glasgow on 28 June 2000.

13. The guidelines are designed to support a number of uses. In the first place they provide schools with the necessary background and information to help them develop their policies in advance of any drug-related incident. They also enable schools to identify what school staff need to know about the management of drug incidents in schools and provide easily accessible advice on the handling of such incidents. Copies of the guidelines have been made available to all schools and other relevant agencies.

14. In developing these national guidelines for schools the School Drug Safety Team made the following recommendations:

**The Scottish Executive Minister for Children and Education should ask local inter-agency Drug Action Teams to consider these guidelines, and Teams should seek to ensure that every school, including independent schools, in their area, have written procedures for managing incidents of drug misuse in line with these guidelines. This task should be included in the Corporate Action Plans of the DATs.**

**The Scottish Executive Education Department should address the updating of the guidelines on a regular basis, in consultation with the Scottish Advisory Committee on Drug Misuse.**

**All local authorities and all schools should ensure that there are updated policies in place that are available to all staff. Local authorities should encourage headteachers to use these guidelines to prepare their policy for handling incidents of drug misuse in advance of need.**

**These guidelines should be used as a template against which existing local authority and individual school policies should be measured.**

**SOEID Circular 5/90 identified the need for a senior co-ordinator in the school and education authority as well as nominated contacts with services such as social work, police and health. The School Drug Safety Team recommends that these professionals should include within their remit managing risk from drug-related incidents in schools.**

**Local authorities should ensure that they have a named person, either in the education department or another local authority department such as the social work service, for schools to contact for information and advice about dealing with drug-related incidents, resources and training. This named person should be informed of all drug-related incidents in schools to enable an overview of local circumstances.**

**Each school should ensure that a member of staff has basic training in recognising signs of drug misuse, potential effects of ingestion of controlled and other drugs, and how to respond to drug-related emergencies, such as intoxication or overdose.**

**Every school should develop the concept of the health promoting school, ensuring not only that health education is integral to the curriculum but also that school ethos, policies, services and extra-curricular activities foster mental, physical and social well being and healthy development.**

**Every school should have an effective programme of drug education in place.**

## **EFFECTIVE DRUG EDUCATION IN SCHOOLS**

### **The Role of Schools**

15. Drug education is more likely to be effective if it is set within the context of the personal and social development of young people. Equity and democracy are central to the modern concept of the health promoting school. If young people feel they have an involvement in the life of the school and a sense of ownership in it, it is more likely that they will generate a positive ethos in relation to physical, emotional and social health.

16. There is evidence emerging that the rate of smoking and illegal drug use among young people in secondary schools varies significantly even when socio-economic factors are taken into account. This suggests that schools, in partnership with the home and community, can make a difference to the health behaviours of young people.

17. However, schools cannot achieve all of the changes needed on their own. A collaborative approach which makes efficient use of parents, the wider community, health and social service, the police and other specialist agencies is likely to be the most effective. DATs have an important role in co-ordinating and monitoring this collaborative approach.

18. Schools can play a number of key roles:

- assisting young people at levels appropriate to their understanding, to look critically at a range of drug use and to explore what are, or may be, the implications for themselves and for people who use drugs;
- using participative and inclusive teaching and learning methods to develop individual awareness and understanding of the possible consequences of drug misuse for one's self and others;
- helping young people to identify and consider influences and pressures, which they may experience at different stages of their lives, to misuse drugs; and
- widening the opportunities for young people to develop their self-confidence and to take part in stimulating, health promoting experiences.

19. Schools, especially at secondary level, can also help by basing curriculum planning on the needs of the individual pupil so as to ensure that those vulnerable pupils, for whom a standard curriculum may be unsuitable, are able to participate in education and training suitable to their needs delivered both in school and for some in alternative provision, perhaps with a strongly vocational element. If such vulnerable young people are able to experience a meaningful education experience, leading to some success and perhaps to subsequent employment, they may be less prone to indulge in drug-taking. Local Drug Action Teams (DATs) have a key role to play in encouraging multi-agency working to meet the needs of vulnerable young people.

20. The Scottish Executive, local authorities, health boards and trusts, the police, specialist agencies and communities give a high priority to tackling the misuse of drugs in society. The mass media often accord a high profile to drug misuse issues. However, the stances taken by official organisations can be in conflict with the views of some young people who do not perceive the 'recreational' use of substances as necessarily constituting a problem. Effective drug education should take full account of the range of issues and viewpoints in modern society and the realities of

drug use as viewed by young people themselves. This approach should not be misconstrued as accepting the misuse of drugs as inevitable. However, to be effective, drug education should take account of the young people's knowledge, beliefs and attitudes relating to drug use.

### **The History of Drug Education in Schools**

21. There were no significant initiatives on drug education in Scottish schools until the 1980s. Educational initiatives in relation to alcohol and smoking have a longer history because health and social concerns relating to alcohol and tobacco are themselves more longstanding. A school health education report in 1939 had one reference to smoking, which stated:

*'Opportunities should be taken by teachers of emphasising the physical and mental disadvantages of the cigarette habit, sometimes contracted by young boys.'*

The full health effects of smoking were only to become apparent a generation later, but the same report gave considerable weight to the problems associated with the use of alcohol by young people.

22. In Curriculum Paper 14 in 1974, health education was given a higher profile and aspects such as smoking were featured both in curriculum terms and in the wider life of the school.

*'Possibly nothing does more to obscure the clarity of the anti-smoking message than the blue haze which emanates from the staffroom.'*

23. In the 1980s drug education began to develop in response to a realisation that the use of illegal substances was increasing in society. There was a concerted attempt to provide drug education training for key groups of teachers and community educators across Scotland. The government provided additional funding for drug education co-ordinators in England and Wales. This was not thought necessary in Scotland where funding was made available for a series of regional training events mainly for teachers and community educators. A 'template' course structure of two sets of three days was developed with support from the Scottish Health Education Group and in most areas the courses were delivered separately to teachers and community educators. For the latter group, the Scottish Community Education Council (now Community Learning Scotland) played a key role. In a minority of cases there were multi-disciplinary groups, a model perhaps closer to present day thinking. The voluntary sector's involvement was limited to input from specialist agencies, although there were fewer of these at that time.

24. As a result of these events, most secondary schools and community education centres had at least one member of staff who had experienced basic drug education training. The Scottish Office made funding for drug education training programmes available to councils over a ten-year period. Training for teachers since then arose from initiatives undertaken by councils and/or health promotion departments of health boards but they have not been universal across the country. In some cases there has been generic training in social education/health education, which is valuable for understanding many of the skills and process issues in drug education.

25. In 1998, Scotland Against Drugs (SAD) embarked on a new initiative to support primary teachers in their approach to drug education. The initiative was designed to:

- develop and enhance the impact of drug education in primary schools;
- enable staff to deliver and manage drug education within the concept of life skills training and the health promoting primary school;

- assist in the effective use of existing resources within the primary school; and
- develop a flexible approach that incorporates a partnership of public and private agencies which pool their experience, drive, and financial support.

26. The training, which is due to continue to March 2001, provides support for two members of staff from each primary school in Scotland to attend two days of training which enables them to initiate or progress developments in drug education in their school. The precise form of the training is negotiated by each education authority and SAD. The Scottish Council for Research in Education (SCRE) was commissioned to undertake an evaluation of the training programme. An interim report of this evaluation indicates that teachers find the training valuable.

27. In the higher education sector, there have been a number of developments in recent years. The University of Paisley has developed a post graduate diploma in alcohol and drug studies over the last twenty years which has played a significant role in developing expertise in a range of relevant agencies in Scotland. Another important example of the contribution of higher education is the University of Stirling's drug training project for a wide range of professionals.

28. In the late 1980s and early 1990s there were several examples of projects producing classroom resources to support teachers with the implementation of drug education. These included the *Drugwise* series developed jointly by the former Strathclyde Regional Council and the Scottish Office, *Police Box* from Grampian Police in conjunction with other authorities and with sponsorship from Shell, the TACADE series focusing on a skills-based approach and a video-based resource from the Health Education Board for Scotland (HEBS) entitled *It's My Life*. In addition the HEBS resource *The Facts of Drugs: A Parent's Guide* has run to several editions in the last five years.

29. There have been several helpful research and evaluation projects in recent years, but there is a need for rigorous research to be carried out into short and long term outcomes of drug education as well as into the processes involved. Where research has been done it has often focused on the processes rather than the outcomes of the interventions.

30. The drug strategy for Scotland, *Tackling Drugs in Scotland: Action in Partnership*, has set up a national committee to develop strategy for research into drug-related matters.

**The Team recommends that research should be commissioned into the outcomes as well as the process of educating young people on drug-related issues.**

## **The Curriculum**

31. In Scotland, the curriculum is not prescribed by statute but it is set out in national guidelines developed through wide consultation. The responsibility for organising and delivering the curriculum rests with education authorities and school managers. National advice is provided by the Scottish Executive and this advice seeks to ensure that health education has a secure place within the curriculum and is provided by all schools. Authorities are encouraged to address health education, including drug education within a comprehensive programme of personal and social education.

32. To be fully effective, the curriculum generally must be less rigid, especially at secondary level. There needs to be a greater recognition of needs of the individual students leading to greater flexibility in the curriculum. There should be a relaxation where necessary of the current "age/stage" conditions and, for certain teenage boys in particular, there needs to be an attempt to

input a stronger vocational element into the curriculum. Such steps may make the curriculum in schools more meaningful and relevant for those young people most at risk and may create a climate of acceptance in which programmes of personal and social education, including health education, may be successful. The DATs have a key role to play in supporting schools and other agencies to ensure that the particular needs of vulnerable young people are fully addressed.

33. There are several ongoing developments in the national 5-14 guidelines that will effect the delivery of health education as follows.

- Health Education 5-14, which was formerly located within Environmental Studies, will have its own guidelines alongside related areas of the curriculum such as Personal and Social Development (PSD) 5-14 and Religious and Moral Education (RME) 5-14. The guidelines entitled *The Structure and Balance of the Curriculum 5–14* will be revised to outline the effects of these changes on the curriculum and give guidance on time allocations.
- The new 5-14 Health Education Guidelines are based on three interconnected themes of *physical health, emotional health and social health*. *Physical health* explores physical factors in relation to our health and looking after ourselves. *Emotional health* explores emotions, feelings and mental health and how these affect us and our relationships. *Social health* explores the interactions of the individual, the community and the environment in relation to health and safety.
- While there are currently no plans to review the 5-14 guidelines for PSD or RME, Learning and Teaching Scotland (LTScotland) is undertaking a review of PSD 5-18 and associated support for teachers. The development of a programme relating to the theme of citizenship is also planned. More detailed national advice and exemplification on PSD 5-18 is currently being considered and these will be produced in 2001.

34. When the new guidelines and advice are in place, schools will be expected to take account of them in designing and delivering programmes for PSD, health education and RME. Schools may choose to deliver these as separate programmes or may develop courses, which link 2 or more programmes together. Whatever structure is used, teachers will be expected to help pupils understand the close links between aspects of learning within these areas.

35. There are currently no plans to review health education within current Standard Grade and Higher Still arrangements. From S3 onwards, schools are expected to design and offer a curriculum to pupils which covers personal and social education (PSE) and health education and which takes appropriate account of national advice and of the structure of the S3-S6 curriculum.

36. The Health Education for Living Project (HELP), a curriculum framework for health education jointly developed by the Scottish Office and Strathclyde Region in 1995 (updated in 1998), covers the span from pre-5 to S5/S6 and gives a particular focus to drug education. HELP has been made available to all Scottish schools, free of charge.

37. While drug education is clearly integrated within the 5-14 framework, there is not a consistent provision of drug education from S3 to S6 in all Scottish schools. Even within a school, the nature of the curriculum choices made by young people, can affect the drug education/health education provision available to them.

**The Team recommends that the Executive consider how to strengthen the curriculum position of health education, including drug education, beyond 5-14.**

**The Team recommends that all young people should receive a core curriculum provision of health education, including drug education, post S2.**

**The Team recommends that there should be greater flexibility generally within the curriculum, especially at secondary level, so that the needs of individual young people are fully recognised and more adequately met.**

## **Principles of Drug Education**

### Introduction

38. To be credible and effective, drug education has to be both up-to-date and relate to pupils' actual needs. This requires systematic assessment of pupils' prior knowledge, experience and attitudes and, subsequently, of the learning gains made as a result of the drug education programme. *Draw and Write Approaches*, for use with younger pupils as described in *Confidence to Learn* (HEBS 1998), and entry and exit tests for older pupils can help schools identify pupils' learning needs for use in planning and adapting programmes.

39. Local health board life-style surveys and drug education research disseminated through the SEED Research Unit's *Interchange* series provide schools with good information to use in targeting their drug education at appropriate age-groups, local drug issues and patterns of drug misuse. There is a particular need for schools to establish effective liaison with local agencies to ensure that they keep up to date with local drug issues.

40. Drug education will be most effective when:

- it takes place within a school community which is active in developing a positive ethos and understands the potential influence on young people of a health-promoting environment;
- the school establishes effective partnerships with its local community and community organisations;
- drug education is planned for the whole school and reflects accepted good practice in health education and PSD;
- drug education takes account of the experiences, prior knowledge, beliefs and attitudes of the young people; and
- the school policy on drug education reflects national and local authority guidelines and is reviewed regularly.

### Aims

41. Drug education in primary and secondary schools should aim to:

- enable pupils to develop knowledge and understanding about drugs, their effects, and implications of misuse;
- provide opportunities for pupils to explore beliefs, attitudes and values about drugs;
- develop skills which enable pupils to make healthy choices and decisions about drugs; and

- link with other components of personal social and health education to develop life skills and promote health.

### Management and Co-ordination

42. School management should:

- accord drug education a high priority and have a strategy for delivery which includes recognition of the importance of deploying staff effectively and staff development;
- ensure that a coherent drug education programme, which is properly planned and evaluated, is provided at all stages of the curriculum;
- provide a coherent, whole-school approach to drug-related issues which gives consideration to young people who are already alienated from school and who may be very vulnerable to a range of health compromising behaviours; and
- recognise the critical influence of the young person's experience in the home and the community and the supportive role that parents and outside agencies can have in the provision of effective drug education.

**The Team recommends that each school, or cluster of schools, have a designated health education co-ordinator at an appropriate level of seniority.**

### Involvement of External Agencies

43. Teachers will always be the main source of expertise for delivering any programme of health education. However, the school may wish to invite another person or agency to visit the school to assist them in the delivery of a particular aspect of the programme. The experiences of such groups and individuals may contribute to a broader understanding of drug use but their contribution should:

- be given by individuals who are prepared to prove they are drug free;
- be evaluated in the light of references furnished by credible sources;
- be an integral part of the programme already planned by the school;
- allow teachers to build upon the learning experience in a planned way;
- satisfy child protection requirements; and
- satisfy recommendations made under the Rehabilitation of Offenders legislation.

44. Schools should ensure that they have a clear policy on the use of external agencies within programmes which ensures that visitors to schools are not allowed free access to children and are supervised at all times.

**The team recommends that the Executive issue national guidelines on the involvement of external agencies in the delivery of health education programmes. (See Appendix 3 for a possible outline)**

### Content and Delivery

45. The drug education programme should:

- provide teachers with clear, realistic aims and objectives which are regularly monitored and evaluated;
- incorporate appropriate resources and teaching processes and consider the use of peer education and other innovative approaches;
- address a range of perspectives appropriate to the age and stage of pupils; and
- provide opportunities to:
  - consider and discuss concepts and opinions;
  - explore perceptions and attitudes;
  - consider and develop personal attitudes and values in a range of circumstances;
  - assess elements of various types of risk; and
  - practise skills such as problem-solving, decision-making and assertiveness.

**The Team recommends that the Executive commission work which establishes key targets for drug education at the various ages and stages in schools in line with recently revised national advice on the curriculum.**

### Effective Learning and Teaching

46. The way in which teachers work with young people is as crucial as the content of any programme. To be effective, there are five elements which should be integral to learning and teaching. These are:

- *a supportive climate for learning*: the relationships established between the teacher and the young people themselves are very important, they should promote a sense of well-being and a disposition to learn and foster mutual respect, empathy and genuineness;
- *making learning clear for the learner*: the purpose of any activity should be relevant and meaningful to the young people's previous experiences;
- *using a variety of approaches*: the use of active learning, where young people are engaged in structured activities or tasks that encourage interaction, should provide opportunities to generate and share ideas and to challenge views in a supportive climate;
- *giving and receiving regular feedback*: young people are more likely to progress and succeed when they are clear about their objectives and when they engage in activities that have meaning and relevance for them; and
- *monitoring attainment and progress in learning*: teachers should employ strategies for monitoring that guide, encourage and recognise achievement. As well as the teacher's role

in this, young people themselves can be involved through the use of self and peer assessment.

(Source: Learning and Teaching Scotland)

### Quality Assurance

47. To be effective, drug education programmes should be subject to regular monitoring and evaluation. The national approach to self evaluation is set out in *How Good is Our School?: Self-evaluation using performance indicators* (HMI: Audit Unit 1996), a tool to assist schools in carrying out an audit of their practice. It provides a coherent and consistent, yet flexible, approach to evaluating performance in schools. The same performance indicators are used within external evaluation by HMI and within education authority procedures for quality assurance. The approach is based on three questions:

- how are we doing?
- how do we know? and
- what are we going to do now?

48. Health education provision is subject to inspection by HM Inspectors of Schools and in recent years HMI have published a number of reports on health education including drug education which offer evaluations and advice to local authorities and schools as they develop their policies and practice.

**The Team recommends that the Executive assist schools with self-evaluation in drug education by commissioning the production of a "*Taking a Closer Look at Drug Education*" self-evaluation document based on "*How Good is Our School?: Self-evaluation using performance indicators*"**

**The Team recommends that HM Inspectors of Schools continue to evaluate health education, including drug education, in the general inspection programme and in addition, undertake a follow-up aspect inspection of primary and secondary schools focusing on the quality of drug education within the next two years.**

49. DATs have a key role in addressing the objectives and action priorities outlined in Scotland's drug strategy. There is also a key strategic role for them in establishing and co-ordinating an evidence-based approach to drug education and prevention in their areas which ensures the consistency of the core messages being delivered to young people whatever the agency involved. For this to be effective in the school setting it is imperative that education authorities are active participants in the DAT at an appropriate level of seniority.

**The Team recommends that DATs take on a strategic role in establishing and co-ordinating an evidence-based approach to drug education and prevention in their area which ensures a coherent and consistent approach whatever the agency involved.**

**The Team recommends that education authorities participate actively in DATs at an appropriate level of seniority.**

## Social and Educational Inclusion

50. For drug education to be effective, schools and support agencies have to acknowledge the diverse nature of pupil populations within schools, and where possible, respond to the individual circumstances of pupils. There are a number of pupil groups which require particular consideration. These include young people:

- with special educational needs;
- who are already alienated from school;
- who are looked after by local authorities; and
- who come from a family where the parents misuse drugs.

51. As we made clear in paragraphs 19 and 32, DATs have a key role to play in supporting schools and other agencies in ensuring that the particular needs of these young people are met.

## **Barriers to Effective Drug Education In Schools**

52. Having considered what constitutes effective drug education, the Team examined the factors which can impede the delivery of effective drug education in schools.

53. The Team concluded that the factors which affect the implementation of effective drug education could not easily be extricated from those which affect delivery of the curriculum more generally. There is an expectation that teachers will be able to deliver a wide range of provision aimed at the personal and social development of pupils. This expectation has expanded dramatically in the last decade. Many teachers feel it has done so without the necessary development of support in schools to deliver it effectively.

54. Developments in personal and social education, health education, education for work, enterprise education and the imminent introduction of education for citizenship all pose challenges for school managers and teachers. These challenges will be directly influenced by two key issues:

- the current status of PSE/health education within the curriculum structure; and
- the availability and effectiveness of current models of teacher education.

55. These two issues cannot be settled by providing the right 'teaching package' or ensuring the appropriate contribution of external agencies. A strategy which begins to tackle these two issues has the potential to deliver a sustainable, long term improvement in drug education and related areas of the curriculum. Outlined below is a brief analysis of how the current status of PSE/health education within the curriculum structure impacts on the teaching of drug education in secondary schools. The effect of current approaches to teacher education is examined in paragraphs 64 - 74.

## The Current Status of PSE/Health Education Within the Curriculum Structure Of Schools

### The Primary School

56. Although most primary schools do attempt to provide drug education, there is a number of

current difficulties which must be addressed:-

- Staff Development:
  - need for all staff to be trained
  - time for training
  - implication for school development budget
  - need for continuous professional development
  - consistency with the school development plan which must deal with many other developmental needs also
- Co-ordination
  - Ideally there must be a co-ordinator of health, (including drug), education, but there must be time for the co-ordinator to fulfil the remit and to help train/update staff.
  - The co-ordinator must have time to study resources, to research and to produce up to date guidelines. In many primary schools, especially the smaller ones, only the headteacher will be free of full class commitment and this may make the position of a co-ordinator of health/drug education difficult to fulfil meaningfully.
- Time within the curriculum
  - There needs to be greater flexibility within the primary school curriculum if proper regard is to be given to health/drug education. Current time allocations are too short to be fully meaningful and there must be a deeper realism of what can be achieved by schools.
  - Time must also be found to monitor the provision made so as to strive for continuous improvement towards greater effectiveness.
- Resources
  - A realistic allocation of resources should be made available so that schools have the most recent/up to date materials available.

### The Secondary School

57. PSE, including drug education, is generally delivered by subject specialists in secondary schools, often on a period-a-week basis. Not all are necessarily very interested in this area of the curriculum, and may lack training in appropriate approaches and methods.

58. There is no defined career progression within schools for teachers of PSE and health education. The teaching of issues such as drug education may therefore seem less important to teachers than subject and guidance responsibilities. As a consequence of this, and the fact that health education has to compete with other areas, staff development has been limited in this area.

59. Good teachers at departmental level are already heavily engaged in the development of raising standards within their subject(s). Thus the selection of staff for PSE and drug education can often be governed by the constraints of the timetable. Consequently, PSE may at times be delivered by teachers who feel they have been conscripted and who may feel ill-prepared for the challenge.

60. An associated factor aligned to the lack of status for PSE is the limited allocation of time for the co-ordinator of drug education to discharge the remit effectively. Currently, co-ordination of drug education tends to be allocated in one of the following ways:

- one of a wide range of responsibilities within the remit of an Assistant Head Teacher, who may also have a 50% teaching commitment;

- an additional 'whole-school' remit for a PT Guidance Teacher who has a teaching commitment and also pastoral responsibility for up to 150-200 pupils; or
- one of several aspects of a Senior Teacher's remit, all of which have to be discharged within an extra allocation of one or two periods per week.

Such practice creates significant difficulties for effective co-ordination of drug education.

61. If the teaching of PSE/health education, including drug education, is a key element within a national strategy to improve the health and well-being of young people, consideration should be given to raising the status of this area of the curriculum. Such action would serve to give substance to statements about the importance of PSE which are to be found within national and local policy authority documents but which are not fully matched with the actual provision.

62. One approach for the secondary sector might be to introduce experienced specialist PSE teaching staff within a PSE or wider Support for Learning Department, as a route to the provision of more effective delivery.

63. There is a need to improve the climate within which drug education and PSE is delivered in schools and radically improve the effectiveness and consistency of delivery.

**The Team recommends a review of the place of PSE within the school curriculum/structure which considers giving formal recognition to the status of PSE teaching.**

**The Team recommends that the Executive commission the development of an additional teacher qualification in PSE.**

## TEACHER EDUCATION AND MULTI-AGENCY TRAINING

### Initial Teacher Education

64. The Scottish Executive Education Department's competences for initial teacher education (ITE) published in 1998 illustrate ways in which teachers and schools can contribute to the personal and social development of all young people. It is anticipated that teachers will develop these competences as a result of undertaking initial teacher education and subsequently throughout their career.

65. Teachers are expected to *“demonstrate an awareness of his or her responsibilities for contributing to the ethos of the school, for example by promoting positive relationships between staff, pupils and parents.”*

66. Other competences remind us that schools and teachers can make a difference to the young person's total school experience. More specifically, teachers are expected to *“demonstrate a knowledge of, and the ability to play a part in, personal and social education, health education, education for sustainable development, enterprise and, when appropriate, vocational education”*. The recent consultation paper on benchmark information for the Standard for Initial Teacher Education contained similar statements.

67. A review of current policies and practice within the ITE sector revealed that, while health education and drug education were present in programmes, pressure on the programmes often meant that the drug education element was not extensive enough to prepare teachers for their task fully. The Team therefore concluded that the key to effective staff development lies in the development of an effective on-going training programme building on the foundations laid within ITE, developing within the probationary period prior to final registration and then extending through programmes of continuous professional development.

### Continuing Professional Development

68. The SCRE research project *Providing drug education to meet young people's needs* indicated that while most primary and secondary teachers valued drug education training, the majority had not received such training in the last two years (as at June 1999). However, it was recognised that this may be changing as current initiatives such as the SAD Primary Schools Initiative gather pace. Teachers viewed on-going staff development as necessary to keep pace with developments in the drug culture and advances in drug education. The research also found that schools which possessed well-considered, agreed written policies on drug education were more likely than those without such policies to conduct active evaluation of drug education and provide appropriate training for teachers.

69. The research also indicated that, in considering the development of teacher education programmes the following issues should be taken into account:

- there is a need to be realistic about what teachers can, and should be expected to, deliver in schools. While the prime aim should be to focus on the curriculum and what can be delivered in schools there was a need to strengthen links between schools and the wider community;
- concerns were raised regarding the lack of credibility some teachers might have in drug education. The knowledge levels of teachers needed to be raised to allow them to become

comfortable and confident with the delivery of drug education and to maintain credibility with pupils. This was largely a confidence issue. In particular, teachers often feel uncomfortable about providing drug education to children at stages below P6/P7;

- teachers need to be given the opportunity to reflect on the issues around drug misuse if they are to become truly effective in the delivery of drug education;
- the SAD Primary School Initiative emphasised that schools and teachers cannot “do” drug education on their own and encouraged them to make links with key agencies and communities, particularly in relation to vulnerable young people;
- many teachers feel they have a lack of knowledge and experience in the area of illegal drugs and underestimate their ability to provide drug education. The anxieties which teachers express about lack of knowledge may conceal stress about the teacher's educational role in view of their limited understanding of the legal background to drug misuse; and
- since drug education is often delivered on a multi-agency basis, consideration needs to be given to maximising the opportunities to develop multi-agency professional training.

70. Continuing Professional Development (CPD) is seen as a key element in improving teachers' performance and, consequently, raising standards in schools and pre-school centres. In July 1998, the Scottish Office published a consultation document which contained proposals for developing a framework for CPD for the teaching profession in Scotland. It was envisaged that the framework would be based on statements of the competences and the standards of performance required for various aspects of teachers' jobs at various stages in their careers, with qualifications related to these where appropriate. The consultation document outlined the Government's belief that a strategic national framework for CPD was required in order to raise standards of teaching and, consequently, pupils' attainment. It was also felt that the framework could act as a planning tool - providing a better focus for the allocation and use of resources and enabling teachers to plan their career development. A Ministerial Strategy Committee for CPD under the Chairmanship of the Deputy Minister for Children and Education, has been established to take matters forward.

71. In the health education context CPD should provide teachers with the confidence that they have the necessary skills and support to deliver drug education programmes.

72. In a secondary school of around 800 pupils up to 30 staff may be required to teach PSE, including drug education. All subject teachers are in theory potential PSE teachers. The traditional, occasional one day or even three-day centralised in-service training model of drug education is no longer wholly appropriate. It has proved to have short term effects, does not reflect either the need for frequent updating nor the large numbers of staff in a school who are currently teaching drug education and who require training, and it fails to take account of the increasing mobility of teaching staff.

73. The Team considered a number of options for the delivery of CPD:

- while mass training off the school premises in school hours is not usually a realistic option, in-service days may provide such opportunities;
- the secondary sector might be able to introduce a core of trained, up-to-date and experienced staff who are peripatetic within a local authority. Such staff might be 'booked' by schools to co-operate with teachers in the classroom and prepare and support the delivery of drug education or other sensitive issues. Within such a model, teachers could learn from each

other in the class while at the same time retaining control of the lesson to use their unique knowledge of the pupils and of the local community to respond sensitively to issues which arise; and

- a teacher, or teachers, with specialist expertise or training could be employed in each primary/secondary cluster to deliver lessons and to work with and train other teachers.

**The Team recommends that the ITE sector continue to develop health education and drug education programmes to maximise the opportunities for student teachers to develop core competences in these areas.**

**The Team recommends that the Executive include a core competence in drug education for all teachers in the Standard for Full Registration and establish further more demanding optional competences in the Expert Teacher Standard within the emerging national framework for continuing professional development.**

**The Team recommends that the Executive and education authorities pay due regard to the on-going training needs in the primary school sector once the SAD Primary School Initiative has completed its initial round of training in March 2001.**

**The Team recommends that the Executive and education authorities develop or commission a staff training model similar to the SAD Primary School Initiative for drug education which takes account of the range of needs in secondary schools.**

### **Multi-Agency Training**

74. Effective multi-agency working is based on a sound understanding of the contribution of respective agencies and their representatives and commitment to get involved. In supporting schools in their drug education role the opportunity to participate in training which brings together school staff covering all facets of school life with representatives of other key agencies in the community requires high priority. DAT's can take a lead role in developing a locally responsive training strategy which ensures that not only joint planning and presentation occurs but that ways are found to release teachers to participate in such training.

75. The perspectives and experience of support agencies working in the drugs field are of great benefit to teachers tackling the issue of drugs in the classroom. Equally important is the need for agencies to appreciate and understand the schools contribution and role. This is best achieved through planned, multi-agency training which adapts styles of learning and teaching consistent with interactive classroom approaches. Such training may be required on a regular and up-date basis to ensure effective approaches are implemented which target the context of current drug use in the community.

**The Team recommends that consideration be given to the role of a national staff development agency to support multi-agency training at national and local level in which the DAT would have a leading role in developing the local multi-agency training strategy.**

**The Team recommends that in all aspects of training there should be an opportunity for multi-agency participation/presentation.**

## EXCHANGE OF BEST PRACTICE

76. The Team recognises that much good practice in health education/health promotion with regard to drugs exists throughout schools in Scotland. Effective arrangements for the dissemination of information and the exchange of best practice would be a key element to the successful ongoing development of effective drug education.

77. A proactive approach to the identification and promotion of good practice is deemed to be essential. Current methods of communication which prove to be effective and which are easily accessed by school staff e.g. employee newsletters etc as well as regular updates and training are just as important as innovative communication means. Ease of access and presentation of the information in an immediately usable form is crucial. The newly formed “Effective Intervention Unit” established to support the Scottish Drugs Strategy can play a key part but the Team suggests that there is merit in developing the role of the proposed Health Promoting School Unit to incorporate this activity. This will strengthen consideration of the drugs issue in the overall context of personal and social development and the Health Promoting School.

78. The Team saw many benefits to be derived from the development of an ICT based system. Representatives from the then Scottish Council for Education and Training were invited to give a presentation about the opportunities offered by the developing *National Grid for Learning, the Scottish Virtual Teachers Centre (SVTC)* and representatives from the Common Services Agency Information Services Directorate (ISD) were invited to explain their role in collecting information for the Scottish Drug Strategy as described in *Tackling Drugs in Scotland: Action in Partnership*.

79. The Team concluded that the development of a dedicated website to support drug education in schools would offer a central resource, which would be a reliable vehicle for the rapid dissemination of up-to-date information. The focus could be set at many levels. e.g. sample lessons, current developments, recent research dissemination, teacher training needs (INSET/CPD), news and views, shared experiences, case studies, policies and procedures. Developing a website which had a core of sound advice on drug education, possibly with case studies and which directed the user to other useful websites, could be a powerful tool in raising and maintaining teachers' competence.

80. Drugscope is one of the UK's leading centres of expertise on drugs providing quality drug information, promoting effective responses to drug taking, undertaking and disseminating research etc. Drugscope website is <http://www.drugscope.org.uk>

81. In considering the development of a website the following issues should be taken into account:

- there is a need to be clear about the potential role of the site and the need to distinguish the target audience (i.e. teachers, young people and/or parents);
- whether the website facilities were developed by ISD or the SVTC, clear links between the information held by each is vital;
- there would also be a need to provide effective links to other related websites containing information of high value such as HEBSWEB; HERO; and Drugscope.
- there is a need to consider the potential role in ITE for any site that might be developed; and

- there is a need to provide dedicated resources to ensure that the site is maintained and kept up to date.

**The Team recommends that the Executive commission the development of a website to support the exchanges of best practice in drug education and to make links with other relevant health education sites.** While the Team did not have a firm view about the 'home' of such a site it was recognised that the Scottish Virtual Teachers Centre (SVTC) may be the most appropriate location for such a site.

**The Team recommend that local authorities use the website as a means of sharing and promoting good practice in drug and health education both within and between authorities.**

**The Team recommends that the Executive arrange regular seminars for senior staff in education authorities for the dissemination of good practice in drug education.**

## **CONCLUSIONS AND RECOMMENDATIONS**

82. Scotland, like other countries round the world faces a serious drug problem. The importance of drug education is fully recognised in Scotland's drug strategy set out in *Tackling Drugs in Scotland: Action in Partnership* and the work of the School Drug Safety Team is seen as a key step in helping the agencies involved in taking forward the drug strategy in relation to the school sector.

83. In many primary and secondary schools throughout Scotland, there is a great deal of good practice evident both in relation to the curriculum aspects of drug education as part of the health education programme and in whole-school approaches which encompass the wider role of the school and the community in addressing a range of issues relating to drug misuse. The Team wishes to acknowledge that good practice and to provide the opportunity for all schools to consolidate and develop their drug education in all its aspects.

84. In support of schools and the task they face in addressing drug misuse realistically and to encourage DATs to take a strategic and co-ordinating role, the Team offers a number of recommendations to the Scottish Executive.

### **General**

- 1. This report to Scottish Executive Ministers, together with an early indication of Ministers' response to the recommendations, should be made publicly available, to the key stakeholders, e.g. education authorities, DATs, police, health promotion departments, social work departments and relevant voluntary organisations.**
- 2. The Team recognises that this is one of a number of initiatives involving developments in health education in Scottish schools and recommends that the Executive arranges regional seminars for key personnel to help them prepare for the further development of their policies and procedures in health education including drug education.**
- 3. The Executive should provide financial support to assist authorities and schools in taking forward these recommendations.**
- 4. The Executive should undertake a further review drug education in schools in 2003/4.**

### **Guidelines for the Management of Incidents of Drug Misuse in Schools**

- 5. The Scottish Executive Minister for Children and Education should ask local inter-agency Drug Action Teams to consider these guidelines, and Teams should seek to ensure that every school, including independent schools, in their area, have written procedures for managing incidents of drug misuse in line with these guidelines. This task should be included in the Corporate Action Plans of the DATs. (page 4)**
- 6. The Scottish Executive Education Department should address the updating of the guidelines on a regular basis, in consultation with the Scottish Advisory Committee on Drug Misuse. (page 4)**
- 7. All local authorities and all schools should ensure that there are updated policies in place that are available to all staff. Local authorities should encourage headteachers to use these guidelines to prepare their policy for handling incidents of drug misuse in advance of need. (page 4)**

8. **These guidelines should be used as a template against which existing local authority and individual school policies should be measured. (page 4)**
9. **SOEID Circular 5/90 identified the need for a senior co-ordinator in the school and education authority as well as nominated contacts with services such as social work, police and health. The School Drug Safety Team recommends that these professionals should include within their remit managing risk from drug-related incidents in schools. (page 4)**
10. **Local authorities should ensure that they have a named person, either in the education department or another local authority department such as the social work service, for schools to contact for information and advice about dealing with drug-related incidents, resources and training. This named person should be informed of all drug-related incidents in schools to enable an overview of local circumstances. (page 5)**
11. **Each school should ensure that a member of staff has basic training in recognising signs of drug misuse, potential effects of ingestion of controlled and other drugs, and how to respond to drug-related emergencies, such as intoxication or overdose. (page 5)**
12. **Every school should develop the concept of the health promoting school, ensuring not only that health education is integral to the curriculum but also that school ethos, policies, services and extra-curricular activities foster mental, physical and social well being and healthy development. (page 5)**
13. **Every school should have an effective programme of drug education in place. (page 5)**

#### **Research**

14. **Research should be commissioned into the outcomes as well as the process of educating young people on drug-related issues. (page 8)**

#### **The Curriculum**

15. **The Executive should consider how to strengthen the curriculum position of health education, including drug education, beyond 5-14. (page 9)**
16. **All young people should receive a core curriculum provision of health education, including drug education, post S2. (page 10)**
17. **There should be greater flexibility generally within the curriculum, especially at secondary level, so that the needs, of individual young people are fully recognised and more adequately met. (page 10)**

#### **Key Principles**

##### Management and Co-ordination

18. **Each school, or cluster of schools, should have a designated health education co-ordinator at an appropriate level of seniority. (page 11)**

### Involvement of External Agencies

- 19. The Executive should issue national guidelines on the involvement of external agencies in the delivery of health education programmes. (See Appendix 3 for a possible outline) (page 12)**

### Content and Delivery

- 20. The Executive should commission work which establishes key targets for drug education at the various ages and stages in schools in line with recently revised national advice on the curriculum. (page 12)**

### Quality Assurance

- 21. The Executive should assist schools with self-evaluation in drug education by commissioning the production of a *Taking a Closer Look at Drug Education* self-evaluation document based on *How Good is Our School?: Self-evaluation using performance indicators*. (page 13)**
- 22. HM Inspectors of Schools should continue to evaluate health education, including drug education, in the general inspection programme and in addition, undertake, within the next two years, a follow-up aspect inspection of primary and secondary schools focusing on the quality of drug education. (page 13)**
- 23. DATs should take on a strategic role in establishing and co-ordinating an evidence based approach to drug education and prevention in their area which ensures a coherent and consistent approach whatever the agency involved. (page 13)**
- 24. Education authorities should participate actively in DATs at an appropriate level of seniority. (page 13)**

### **Barriers to Effective Drug Education in Schools**

- 25. A review of the place of PSE within the school curriculum/structure which considers giving formal recognition to the status of PSE teaching should be undertaken. (page 16)**
- 26. The Executive should commission the development of an additional teacher qualification in PSE. (page 16)**

### **Teacher Education**

- 27. The ITE sector should continue to develop health education and drug education programmes to maximise the opportunities for student teachers to develop core competences in this area. (page 19)**
- 28. The Executive should include a core competence in drug education for all teachers in the Standard for Full Registration and establish further more demanding optional competences in the Expert Teacher Standard within the emerging national framework for continuing professional development. (page 19)**

**29. The Executive and education authorities should pay due regard to the on-going training needs in the primary school sector once the SAD Primary School Initiative has completed its initial round of training in March 2001. (page 19)**

**30. The Executive and education authorities should develop or commission a staff training model similar to the SAD Primary School Initiative for drug education which takes account of the range of needs in secondary schools. (page 19)**

#### **Multi-Agency Training**

**31. Consideration be given to the role of a national staff development agency to support multi-agency training at national and local level in which the DAT would have a leading role in developing the local multi-agency training strategy. (page 19)**

**32. In all aspects of training there should be an opportunity for multi agency participation/presentation. (page 19)**

#### **Exchange of Best Practice**

**33. The Executive should commission the development of a website to support the exchanges of best practice in drug education and to make links with other relevant health education sites. (page 21)**

**34. Local authorities should use the website as a means of sharing and promoting good practice in drug and health education both within and between authorities. (page 21)**

**35. The Executive should arrange regular seminars for senior staff in education authorities for the dissemination of good practice in drug education. (page 21)**

**Ken Corsar  
Chairman  
School Drug Safety Team  
October 2000**

**MEMBERSHIP OF THE SCHOOL DRUG SAFETY TEAM**

The Members of the School Drug Safety Team were:

<b>Ken Corsar (Chair)</b>	Director of Education, City of Glasgow
<b>Harry Black</b>	Fife Primary Care NHS Trust
<b>Christine Compton</b>	Aberdeen City Council
<b>William Crosbie</b>	Castlebrae Community High School, Edinburgh
<b>Barry Dougall</b>	Strathclyde Police
<b>Joan Forrest</b>	University of Strathclyde
<b>Beth McIntyre</b>	Kirkland High School and Community College, Fife
<b>Alistair Ramsay</b>	Scotland Against Drugs
<b>Raymond de Souza</b>	City of Edinburgh Council
<b>Harvey Stalker</b>	HM Chief Inspector of Schools
<b>Justine Walker</b>	COSLA
<b>Ian Young</b>	Health Education Board for Scotland

## **GUIDELINES FOR THE MANAGEMENT OF INCIDENTS OF DRUG MISUSE IN SCHOOLS**

### **RESPONDENTS TO THE CONSULTATIVE DOCUMENT**

400 copies of the draft document were issued and the document was made available through the Scottish Executive website. In all, 39 responses were received from:

Aberdeen City Council - Social Work Department  
Aberdeenshire Council - Education & Research Department  
Association of Chief Police Officers in Scotland  
Association of Directors of Education in Scotland  
The Association of Scottish Police Superintendents  
Ayrshire and Arran Primary Care NHS Trust  
Clackmannanshire Council - Education & Community Services  
Dumfries & Galloway Council - Department for Education  
Dundee City Council - Education  
East Lothian Council - Education & Community Services  
East Renfrewshire Council - Education  
Edinburgh The City Of Edinburgh Council - Social Work  
The Educational Institute of Scotland  
Falkirk Council - Education Services  
Fife Health Board  
Fife Council - Social Work Service  
Forth Valley Primary Care NHS Trust  
Glasgow City Council - Social Work Services  
Headteachers Association of Scotland  
Highland Primary Care NHS Trust  
Lanarkshire Drug Action Team  
Lomond & Argyll Primary Care NHS Trust  
Lothian Health Board - Health Promotion  
Midlothian Children's Panel Advisory Committee  
The Moray Council - Moray Children's Panel  
The Moray Council - Department of Education  
North Ayrshire Council - Educational Services  
North Lanarkshire Council - Department of Administration  
North Lanarkshire Council - Department of Education  
Renfrewshire Council - Education and Leisure Services  
The Scottish Association of Children's Panels  
Scottish Borders Council - Department of Education  
Scottish Children's Reporter Administration  
Scottish Drugs Forum  
South Lanarkshire Council - Social Work Resources  
The University of Edinburgh - Faculty of Education  
West Lothian Council - Education Services  
West Dunbartonshire Council - Education Services  
Yorkhill NHS Trust

## GUIDELINES ON THE INVOLVEMENT OF EXTERNAL AGENCIES

### GUIDANCE TO HEAD TEACHERS ON USE OF OTHER AGENCIES IN SCHOOL HEALTH EDUCATION PROGRAMMES

Teachers will always be the main source of expertise for delivering any programme of health education. All of the initial teacher education programmes contain significant input on health education and most authorities also offer substantial opportunities for in-service training in health education materials and techniques.

It is possible that in health education, as in other aspects of education, teachers may find it valuable to invite another person or agency to contribute to particular aspects of course work with the teacher and the pupils.

The expertise which such groups provide can prove invaluable in complementing the efforts of the school. Carefully chosen individuals or agencies are able to provide additional knowledge and the benefit of experience which might prove difficult for many teachers to provide without extensive research and training. With careful planning these groups can be utilised by schools to benefit the health education experience of pupils in a meaningful way. On some occasions, external agencies can also be used as a means of staff development for teachers who themselves will implement the full health education programme.

In order to maximise the effectiveness of contributions made, the following guidelines have been prepared to give advice and assistance on the criteria to be met in the choice and use of visiting individuals or agencies by schools. These guidelines are not meant to be restrictive or to impede local decision-making or flexibility. They are designed to offer advice on preparation, curriculum continuity, parental guidance and school security. They are also meant to be used in conjunction with the school/authority policies on Child Protection Procedures.

1. Visitors should be viewed as complementing the curriculum already in place. They should not be seen as a substitute for the school's mainline provision as outlined in the school plan.

*“Where there is collaboration with an agency to develop a particular programme in which an outsider can participate, this is probably most educationally acceptable. Where a one-off visit is arranged with no preparation and no follow-up, then the impact and benefits are limited.”* Source Health Education in Scottish Schools — SCORE

2. The class teacher should be present throughout the presentation for a variety of reasons:
  - the teacher has planned this aspect of the curriculum for the year;
  - the teacher is legally responsible for class;
  - the teacher cannot ensure continuity of programme if absent;
  - additional information gained by the teacher may enhance the programme further; and
  - the teacher should be present to ensure proper conduct of presentation.
3. External speakers should be from credible, acceptable and, where possible, local organisations. Individuals should be agreeable to vetting or checking by the head teacher. Good indicators of such organisations are:

- staff who are subject to SCRO checking before being employed by agency; and.
  - good links with statutory bodies, such as the local health board, the local Council Social Work Services, or with the Health Education Board for Scotland (HEBS). A major organisation like the police may also be useful in complementing specific programmes on road safety or drug education, especially when the visiting officers are being asked to speak about or demonstrate their own particular expertise in a particular area of activity.
4. The presentation should be appropriate to the ages and stages of the pupils concerned. It would not be appropriate for the same presentation to be delivered regardless of age and stage. The school should ensure that the presentation is pitched at the appropriate level as well as being interesting and stimulating for the pupils concerned.
  5. The school should hold a preliminary meeting with the external agency to plan the event so as to incorporate the contribution as fully as possible into the ongoing curriculum and policy of the school.
  6. Criticism implied or direct, of other unconnected organisations should not be permitted during the presentation whether the agency or individual believes it appropriate or not. The contribution of the agency or individual to the health education programme should provide the limit of input and should be based on the previous experience and expertise of the individual or agency involved.
  7. Paper or other materials to be used during presentations should be submitted to the Head Teacher in advance of the presentation to ensure their suitability for use in the school. A sensible approach will be required, for example, with drama presentations for older pupils where difficult or sensitive issues are explored.
  8. External agencies should not be permitted to sell publications to pupils or ask for donations from them. Any fee for the presentation should be agreed with the head teacher beforehand.
  9. Parents should be informed and involved as appropriate. School Boards should be consulted before any new initiatives are undertaken which may involve sensitive areas of health education. In the denominational school sector, prior discussion will be necessary with the appropriate Church authorities.
  10. If any difficulties or doubts remain unresolved by these guidelines, the head teacher should consult the Director of Education.