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Drugs and Drugs Education in the Inner City: the views of 12-year-olds and their parents

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Introduction

Young people in England have increasing access to illegal drugs. One recent study found that the proportion of young people who reported knowing someone taking drugs quadrupled and the number being offered drugs increased nine-fold between 1969 and 1994 (Wright & Pearl, 1995). The Health Education Authority reports on young people and health behaviour indicate that the number of young people being offered drugs increased from 55% in 1990 to 77% in 1995 (HEA, 1992; Turtle *et al.*, 1997). The national drug strategy 'Tackling Drugs Together' seeks to make drugs less available and less acceptable to young people (DOH & DFE, 1995) through education, information and partnership between public and voluntary agencies. The Department for Education has acknowledged that 'schools alone cannot "solve" the problem of drug use in society' but recommends that 'an effective programme of drug education in schools can be an important step in tackling it' (DFE, 1995, p. 3).

To support integrated local policies towards drug misuse, the Government has established local 'Drug Action Teams'—co-ordinating bodies representing the main local public agencies and the voluntary sector. Camden and Islington are two inner London boroughs forming a single National Health Service (NHS) district, covered by a single Drug Action Team. The district has a population of 370,000. There is considerable economic and social depravation, and about 20% of the population are from ethnic minority groups (McCarthy, 1997). The district also has one of the highest rates of drug misusers in the country. Kings Cross, on the boundary between the two boroughs, is a major location for the sale of illegal 'hard' drugs, while fashionable clubs and pubs in the two boroughs provide many outlets for the sale of 'recreational' drugs.

'Tackling Drugs Together' gives priority to the education of young people as a means of limiting harmful drugs use. Throughout the early 1990s there had been concern among members of both the local Health and Education Authorities about the health and health-compromising behaviours of young people in the two boroughs. As a result an interview-based survey of young people age 12/13 years (Year 8 of education) and their parents was undertaken in 1995. Year

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Table 1. Sample characteristics

	Young people		Parents	
	Female	Male	Female	Male
Bangladeshi	20 (25%)	21 (27%)	14 (29%)	10 (20%)
Black African	20 (25%)	20 (25%)	9 (17%)	10 (20%)
Black Caribbean	14 (18%)	13 (16%)	6 (12%)	9 (18%)
White	25 (32%)	25 (32%)	20 (42%)	20 (41%)

8 students were chosen as a local advisory group and fellow academics thought this would be the age at which health education initiatives would have the most impact but were seldom pursued. The survey sample was especially chosen to provide information on contrasting ethnic groups in the boroughs. This paper describes the ideas and attitudes these young people have about their own and other people's drug use, the drugs education provided at school, the strategies parents use to discourage drug use and parental expectations of school-based drugs education.

Methods

All of the 20 state secondary and grant-maintained schools in Camden and Islington were asked to take part in the study, 18 agreed to do so. An individual was eligible for inclusion in the study if they were aged 12 (reaching their 13th birthday during the school year), and had been resident in the borough for at least a year. More than 30% of the children in the borough are from ethnic minority groups, and the study reflected this by sampling equally from the four largest ethnic groups for this age band—Bangladeshi, Black African, Black Caribbean and White (English, Scottish, Welsh)—using school registers (where ethnicity is recorded) as the sampling frame. Young people and their parents were invited to take part in the study and active consent was sought from both parties. Appropriate translations of letters and consent forms were provided. At least two reminder letters were sent and those families that did not reply were telephoned or visited to confirm that they did not wish to take part in the interviews.

A target of 50 (25 girls and 25 boys) young people for each ethnic group was set and a stratified sample of 371 young people was drawn. Of these, 158 young people and 97 of their parents agreed to be interviewed (Table 1). Further details of the design and sampling methodology for this study have been published elsewhere (Rogers *et al.*, 1997). The interviews were semi-structured and included both open and closed questions. All the interviews were undertaken by the same interviewer, the young people were interviewed at school, in a private room and the parents were interviewed at home. The young people were assured of the confidentiality of the interview and encouraged to answer the questions honestly, being told it would be better and acceptable to say 'I don't want to answer that' than to tell a lie.

The interviews were tape recorded and the coding checked and relevant sections were transcribed. Data from the closed questions were entered on a

Table 2. What drugs do you know and how are they taken (excluding alcohol and tobacco)?

	Named drug		Correct use	
	Young people	Parents	Young people	Parents
Amphetamines	16 (10%)	21 (22%)	5 (3%)	15 (15%)
Cannabis	68 (43%)	53 (55%)	59 (37%)	46 (47%)
Cocaine	98 (62%)	69 (71%)	45 (28%)	47 (48%)
Crack cocaine	30 (19%)	41 (42%)	5 (3%)	9 (9%)
Ecstasy	37 (23%)	31 (32%)	23 (15%)	28 (29%)
Glue solvents	101 (64%)	53 (55%)	97 (61%)	53 (55%)
Heroin	57 (36%)	55 (57%)	27 (17%)	36 (37%)
LSD	21 (13%)	19 (20%)	8 (5%)	15 (15%)
Magic mushrooms	6 (4%)	2 (2%)	1 (1%)	—

database and analysed using Statistical Package for Social Science (6.0). Data from the open questions were subject to content analysis, which involves organizing the data into common themes, categories and basic descriptive units (Mays & Pope, 1996; Strauss, 1987). Factual responses on how a particular drug may be used were confirmed using standard information provided by the Institute for the Study of Drug Dependence (ISDD, 1988).

Results

A number of schools involved in the study were anxious that the research interview would not provide their students with any new knowledge, particularly relating to illegal drugs. So the open questions, 'what drugs do you know the names of?', supplemented with the probe 'can you tell me how that is used?' were employed to assess the level of knowledge the young people had about illicit drugs. In contrast, the desire of schools to know about the inappropriate use of glues and solvents allowed us to ask the direct question 'What can you tell me about glues and solvents'. The young people were encouraged to use slang and local names for drugs and their method of use, these were later 'decoded' sometimes with the help of local drug agencies.

Thirty-one (20%) young people were unable or preferred not to name any drug. Excluding tobacco and alcohol (which some respondents included in their replies), 79% of young people could name a drug and 70% could say how at least one drug was used. Glues and solvents, asked about directly, were the most frequently mentioned 'drug', 101 (64%) young people could name one that could be abused and 97 (61%) could say how this is done. Cocaine (62%), cannabis (43%), heroin (36%), ecstasy (23%) and crack (19%) were the most frequently remembered drugs. Young people were most knowledgeable about the use of cocaine 45 (28%), cannabis 39 (37%), heroin 27 (17%), ecstasy 23 (15%) and LSD 8 (5%) (Table 2).

Personal and Other People's Drug Use

The young people were asked if they knew anyone and if they knew anyone of

their own age who used drugs. Sixty (45%) young people reported knowing anyone who used drugs and 48 (36%) knew some one of their own age who did so.

When asked if they had ever used any of the drugs nine young people, three girls and six boys, eight White and one Bangladeshi reported ever having done so. All had either experimented with or were still using cannabis and all had been given it by friends with whom they had used it. Two young people reported continued and regular use of cannabis.

Reasons for Using and Not Using Drugs

Current Users and Experimenters. For seven young people experimenting with cannabis had not been an enjoyable experience, ending in feelings of nausea or vomiting, or it had been a disappointing experience, with the young people having few or none of the expected effects of taking the drug.

Commonly cannabis experimenters and current users went to great lengths to explain why cannabis was different to other drugs. They would claim that it was not addictive, some thought it ought to be legalized and others believed that it was beneficial to certain people. The following quote includes all these elements:

> (White male who currently used cannabis)
> I mean cannabis is different because ... I think it should be legalized, I don't know. I think its different. (How) It's not like it's addictive, I don't know. It can be good for people who are sick and things. I've never really taken (other) drugs because it's basically illegal. It takes your mind off—it's a different world and cannabis didn't do that.

Moreover cannabis was given special status and to some extent normalized as some young people knew that their parents had used or continue to use it. As one of the interviewees reported:

> (White female who had experimented with cannabis)
> My mum said when she was young she used to have it, never did anything for her either, all her friends would be giggling and she would just sit there doing nothing 'cos it didn't affect her.

Non-users. When asked why they did not use or no longer used drugs the most common answer was that they are 'bad for you', often reinforced with statements like 'they kill you' or 'you might die'. Worries about addiction, 'changing as a person', 'going mad' or 'off your head' and 'losing control', all featured as reasons for not using, as did concern about getting into trouble with parents, at school or with the police. The quotes below are illustrative of these themes:

> (White male who had experimented with cannabis and who had friends who used drugs)
> Interviewer: what discouraged you from using puff?
> Interviewee: I suppose I'm afraid of being caught, that was half the fun of it being afraid of to get caught, with cigarettes you know they're legal but puff is illegal. So I didn't want to end up a junkie and be messed up when I'm older.
> (Black African male who had not used drugs)
> It's bad for you, just that it's bad for you, it mucks up your life. Like

> if you get addicted then you won't—you'll always be wanting it, it'll kill you in the end.

The cost of buying drugs was also a deterrent. Illegal drugs were perceived as being expensive and addiction to them would lead to a life of crime in order to finance the habit. Four young people stated that HIV/AIDS discouraged them from using drugs. Ten young people reported not using drugs because they had not had the opportunity.

A small group of young people gave very positive reasons for not using drugs. This group thought that drugs would not add anything to their lives, believing they had better things to do with their time and money. Some but not all of this group were heavily involved in sporting or keep fit activities, believed they had invested in their health and did not want to put their efforts to waste. Others had better things to do with their money.

> (Black African female)
> Well the first thing I think about, I know people that are older than me that do it (take illegal drugs), 'cos they get a lot of money from their parents, like, say they stole it, or are going away from the weekend, might give them 50 pounds, and they go and spend 20 pounds on drugs. But me I could never get that sort of money to go spending, if I did have that money I'd go and buy myself some new clothes and make up and go out and enjoy myself rather than spend it on drugs.

Health Education

When asked what they had been taught about in Personal and Social Education lessons, 38 (24%) of young people, at least one from each school involved in the study could remember being taught about drugs at school, 25 of whom thought they had 'learnt something new about drugs'. When asked who or what most influenced their ideas about health 92 (58%) young people reported being influenced by their parents, 81 (51%) by what they had learnt at school and 48 (30%) thought they were influenced by 'the media' be it television, radio, magazines or health information advertisements or leaflets. In all, 104 (66%) young people thought that school was the best place to learn about health.

Parents

Knowledge of Drugs. Parents were able to spontaneously name specific drugs rather more frequently than the young people (Table 2) and they were also more likely to be able to say how a particular drug is used. Despite some debate about the status of cannabis and the pros and cons of its use, not least because some parents had used the drug themselves, 36% of parents were concerned about their child's health and well-being because of drugs or the 'drug-using culture' that parents thought existed near their homes. As one Black African mother put it 'it's (drug use) not some thing you can hide and pretend it's not there'. When asked 'Do you ever worry that your child might do things that are bad for their health?', 35 (56%) parents included future drug use in their replies.

Parents' Attitudes Towards Drugs Education. Whatever their level of knowledge

about drugs parents felt that they did not know enough about drugs to educate their child, as reflected by these two parents:

> (Black African mother)
> I have concerns around drugs and I think that's because my knowledge around it is not good.
> (White mother)
> I think the drug issue is quite interesting because I think it's—you know we all think we know about drugs as parents but actually we have gaps, and I'm aware as a counsellor working with that age group that I have gaps, and that's something I would quite appreciate the school doing.

Parents were asked in what ways they tried to influence their child's attitude towards illegal drugs and coping with their potential use. Parents reported three basic strategies. The first strategy can be summed up as 'bribes, coercion and threats'. Parents would offer money or material goods if their child could reach a certain age without using illegal drugs. Coercion was mostly emotional, e.g. parental disappointment or feelings of failure that they would experience if the child were to use drugs. Threats were mostly concerned with restrictions to social activities and very rarely included threats of physical violence.

The second strategy was to talk to their children, especially in relation to television programmes or newspaper reports. There were many references to the programme 'Casualty' and pictures of people suffering symptoms of withdrawal from drugs and things that were 'scary' about drugs and the drug-using subculture.

The third strategy was one of resignation. These parents felt their was little they could do to stop their child becoming involved in drug use and frequently stated 'I can't protect them from everything'.

Parents were asked 'What would you like your child to be taught about health at school?', just over half the parents 56 (58%) included drugs education in their answer. Many parents had definite views about its content and format, indicating that their child would be more responsive to informal rather than didactic methods. Commonly parents thought that young people should be actively involved in the lesson either through role play, visiting theatre groups or structured group discussions. Parents also thought there was a place for lessons based on informative television programmes that emphasize the negative consequences of drug use.

Forty-seven (49%) reported knowing what their child had learnt about health in school, of these 16 (25%) thought their child had had some drugs education. Eighty (83%) parents thought that school is the best place to learn about health; 77 (79%) stated that they would like to know more about what is taught in school. Parents often qualified their answers regarding the 'best place for health education' with statements about the importance of both home and family in health education. As one Black Caribbean mother replied:

> Difficult. I think it should come from home and the school. Because school takes up a big part of kids' life, they are there an awfully long time. Ideally both should be actively involved in teaching about health often with parents supporting school-based lessons ... need to know when and what is taught.

Discussion

Our findings on young people's own knowledge of drugs and others they know who use drugs, are comparable with reports from other recent surveys (Balding, 1995; HEA, 1997; Wright and Pearl, 1995). While the number of young people being offered, experimenting with and/or regularly using drugs is increasing and the level of exposure to illicit drug use increases with age (HEA, 1996), it is important to emphasize that the majority of young teenagers do not experiment with or regularly use illegal drugs. The Health Education Authority survey of drug use among young people revealed that prior to age 16 less than 30% of young people had ever used a drug despite over 60% having been offered them (HEA, 1996).

The research evidence shows that much of the reported exposure to drugs and personal drug use relates to cannabis (Balding, 1995; HEA, 1997; Miller and Plant, 1996), and this was confirmed by our sample of 12/13-year-olds in inner London. Yet even this comparatively young group of young people had very complex and sophisticated views on the use of cannabis. They were able to articulate current popular debates about its legalization and possible medicinal benefits of its use, and if necessary use these as justification for their own use. As Hendry stated 'Young people's own culture ... denies that cannabis is harmful—often it is seen as less dangerous than alcohol ...' (Hendry *et al.*, 1995, p. 45). For some young people in this study cannabis was also legitimized by knowledge of their parents' current or previous use of it. Thus the official status of cannabis as an illegal drug is questioned, and the drugs education that groups it together with so-called 'hard drugs' may lack both relevance and authority.

Parental anxieties about lack of appropriate knowledge of drugs and drug use have been reported elsewhere (Blackman, 1996) and were evident among this group of parents. However, many appeared to lack basic facts about drug use. Most parents actively discouraged drug use and even those that felt resigned to the prospect of their child using drugs voiced their disapproval of them in general. Parental strategies such as coercion, bribes or threats, or relying on scare stories from the media or popular drama, are likely to be ineffective in terms of health promotion/education in general (Coggans, *et al.*, 1991). They also differ from the 'Health Skills' (Anderson, 1986) approach of much school-based drugs education which aims to provide young people with the knowledge and social skills needed to assess the risks associated with drug use and to be able to refuse drugs offered to them.

As was expected, given that the schools involved in this study provide none or very little drugs education in or before Year 8 of schooling, less than a quarter of these young people could remember being taught about drugs at school, however nearly three out of four of these said they had 'learnt something new about drugs at school'. Given that over half the sampled young people stressed the importance of both home and school in shaping their ideas about health, it was disappointing to note that just under half of all parents reported knowing what their child had learnt about health at school and over three-quarters would have liked more information about what was being taught. The difficulties in involving parents in the health education curriculum have been noted elsewhere (Blackman, 1996; Hendry, *et al.*, 1995): problems of poor attendance at parents' evenings and/or parents' drug education sessions were reported anecdotally within both the boroughs involved in the study. However, there may be marked

reluctance on the part of both young people and their parents to discuss potentially embarrassing or controversial subjects such as drugs and young people may act as gatekeepers to knowledge of what is taught or proposed at school.

Parents made frequent request for less formal, more interactive lessons about drugs, but there is no evidence to suggest that these methods are more successful than more didactic approaches in deterring or postponing drug use. Despite an increase in the number of evaluated health education programmes and projects in general (Nutbeam *et al.*, 1990), many school-based education programmes are either untested or fail to meet their stated objectives (Coggans *et al.*, 1991; Swadi, 1987). The National Evaluation of Drug Education in Scotland (Coggans, *et al.*, 1991) found that school-based drug education was most successful in raising levels of knowledge about drugs and does not appear to effect either illegal or legal drug use. While Hansen's review of school-based substance abuse prevention initiatives in the USA concluded that some programmes appeared to deter substance misuse, 'Numerous intervening characteristics ..., including training and background of teachers, fidelity of presentation and target population affect the success of even the best educational programmes' (Hansen, 1992).

The gap between knowledge, intended behaviour and actual behaviour is widely acknowledged (Gatherer *et al.*, 1979). However in the case of drugs, where experimentation is likely to be covert and always potentially dangerous, there is a strong case in favour of sound knowledge, especially in terms of harm reduction. If an increase in knowledge is at present the most achievable outcome of drugs education, such initiatives should both acknowledge the current debates about cannabis and work actively to involve parents.

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