Blueprint 'not following a flawed evidence base'

Contrary to the title of your article in FINDINGS issue 8, STAR is not coming to England, but now is a good time to update readers on Blueprint, the national evaluation of drug education in England. While your article was being developed, we continued to explore the evidence base for drug education to see which approaches have been shown, through rigorous evaluation, to be effective or ineffective. We are interested in the structure and processes for the mobilisation of drug prevention provided by STAR – which remains one of the most rigorously evaluated initiatives – and by other promising approaches. However, the language and cultural relevance of specific programmes require adaptation to the UK context. Therefore, Blueprint is based on a distillation of the key principles of effective drug education and not on the direct implantation of materials from one country to another.

Blueprint is Britain's first major evaluation of drug education based on systematic reviews and analyses of materials for their degree of fit with the UK context. We have looked at the relative weighting of normative education, decision-making, and social interaction skills found in effective programmes, and adapted PSHE lesson plans accordingly. Blueprint is in fact a pilot study designed to test the adoption and sustainability of an evidence-based approach to drug education. This includes an assessment of: the knowledge, attitudes and behaviour of young people; the quantity and quality of communication between parents and young people; cost; the reactions of teachers, pupils and parents; and the ease of adoption by community education and prevention practitioners.

We would challenge a view that poor behavioural outcomes could undermine support for drug education in Britain. Young people have the right to accurate information about tobacco, alcohol and drugs and should expect to have the opportunity to develop their values and opinions regarding substance use. The national drug strategy requires, through Blueprint, an assessment of the potential role of drug education in reducing the prevalence of drug use. We also aim to develop curricular materials which are an asset to teachers and maximise the credibility and utility of drug education for young people.

Blueprint will run in four LEA areas (Cheshire, Derby, Derbyshire and Lancashire) and will involve 30 (not 50) secondary schools at level two or three of the National Healthy School Standard. This autumn the programme features teacher training and the baseline pupil survey, before implementation in 2004 and 2005 and post-implementation surveys in 2005 and 2006.

The revised drug strategy is underpinned by the available evidence base, and development of the Blueprint programme has responded to reviews of evidence, including your own article and others. In relation to the closing remarks of your article, the role of drug education in an overarching strategy and the ease of transfer of evidence are not well established. We confidently expect Blueprint to make a valuable contribution to the debate.

Paul Baker
Blueprint Research Manager

We are pleased to have been able to contribute to Blueprint's change of direction and agree that it promises to provide valuable lessons. References to Blueprint in our article (including that it was to be based on STAR and Life Skills Training and would involve 50 schools) were correct as far as we knew, included in an early draft sent to the Blueprint team, confirmed in a response from Blueprint, and not subsequently corrected. Editor

OFFCUTS

Evaluations of substance misuse treatment rarely forefront what probably matters most to the patient – their **quality of life**, a yardstick often applied to other patients. Especially for illegal drug users, the focus instead is on the outcomes that matter most to the wider society.

Recently a few studies have started to redress this balance. What they find is that the patient's own assessment of their well-being is often poorly related (and sometimes not at all) to conventional outcome measures such as substance use, abstinence and severity of drug problems. Using quality of life as a yardstick would often give a very different impression of how well a client has progressed, how well a service is performing, and whether one treatment is better than another. For example, in one US study, at the end of treatment a third to a half of the clients who had sustained abstinence nevertheless had a poor quality of life, while around half who had 'lapsed' felt they had a good quality of life. In another, clients were more often abstinent after 12-step based group therapy, but also experienced reverses on dimensions reflecting quality of life. In contrast, more or less the opposite was the case for a therapy focused less on abstinence than on changing irrational beliefs thought to underlie dependence. Satisfaction with treatment, another measure taken from the client's point of view, is also inconsistently related to substance use outcomes but may (there is very little evidence) be more closely related to quality of life.

In methadone and other substitution treatments too, conventional indicators of success (such as reaching the point where a patient no longer tops up their prescription with heroin) are not necessarily related to the patient's own assessment of their well-being and functioning. The likely explanation is that some addicts do not enter treatment to abandon a heroin-based lifestyle but in order to manage it better by gaining 'time out' before returning to the street and reducing hassle and expenditure, or to have a taster of what life without heroin might be like. They may see the treatment episode as a success even though they continue to use heroin and dip in and out treatment in ways which make the service's retention and urine test records look poor. The same kind of motivation provides an alternative explanation for what is often criticised as the under-dosing of methadone patients: for many this is precisely what they want – to restrain their methadone dose so they can continue to 'enjoy' heroin.

References and fuller text available on request from da.findings@blueyonder.co.uk – ask for the quality of life dossier.

Annual Conference 2003
5 November 2003 at The Law Society, London, WC2A 1PL

Alcohol Concern

This year's conference and AGM will look at key priorities coming out of the National Alcohol Harm Reduction strategy as well as providing a chance to discuss and learn more on how to deliver these effectively at a local level. It will also celebrate 20 year of Alcohol Concern's work in the field. The conference is the main national event for anyone working in the range of fields on which alcohol impacts including voluntary or statutory alcohol services, community safety, probation, police, drug action teams and health.

For more information visit www.alcoholconcern.org.uk and click on WHAT'S NEW, contact Ewa Cwirko-Godycka on 020 7928 7377, or e-mail ecwirko-godyck@alcoholconcern.org.uk.

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