



## A hard habit to break? A role for substance use education in the new millenium

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## GUEST EDITORIAL

Guest editorial

# A hard habit to break? A role for substance use education in the new millennium

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Judith Aldridge  
*University of Manchester, Manchester, UK*

### Abstract

**Purpose** – The purpose of this paper is to introduce the five papers comprising this special issue on post-millennium trends in young people's substance use in the UK. The positions taken by the authors of each of the papers in the issue are compared with respect to their conclusions on how best to reduce harmful outcomes for young people in relation to their substance use, and what role exists for health education in this process.

**Design/methodology/approach** – The approach takes the form of a narrative review of the papers in the issue.

**Findings** – Across substances (alcohol, tobacco and illicit drugs), the authors identify slight downward trends in population prevalence of use by adolescents and young adults since 2000. This downward trend follows some fairly steep rises during the 1990s, resulting in levels of use remaining historically relatively high. The importance of global and demographic changes is identified as being important in understanding the (arguably somewhat limited) scope for changing youthful behaviour. The different recommendations for how to reduce harmful outcomes for young people are discussed: modifying the context/environment of use (for alcohol and tobacco), drugs treatment (for drug-using offenders), tackling inequality and disadvantage (for heroin and crack cocaine).

**Practical implications** – Two key roles for health educators are identified: first, supporting mechanisms already known to be effective in reducing use/harmful use such as smoke-free environments; second, providing an "expert" source of information used by the vast majority of young people who both want and require this on their lifelong health and drug "journeys". Health education should have a harm reduction role; measuring success in terms of reducing population prevalence of substance use may be inappropriate and unrealistic.

**Originality/value** – Important insights are gained into substance use trends by young people when UK trends are set alongside international trends, and when all the psychoactive substances consumed are considered together.

**Keywords** Health education, Tobacco, Alcoholic drinks, Drugs

**Paper type** Research paper

Can information-based drugs education reduce the prevalence of tobacco, alcohol and illicit drug use amongst young people? The international evidence suggests that most programmes fail to change behaviour, and that even programmes demonstrating some success regularly show effects that are small, uneven, and not sustained over the longer term. Despite recent promising developments in our understanding of how education can influence substance use behaviour (Coggans, 2006), the challenges facing those who seek to prevent substance use in young people, and measure success in terms of changes in behaviour itself, are manifold. Programmes are often based on poorly conceived or outdated conceptual models. Many evaluations have



methodological weaknesses, making it difficult to be certain of programme effects. “Universal” style interventions aimed at the general population of young people are less likely to be able to address more problematic substance use amongst vulnerable groups. On the other hand, selective targeting of “at risk” young people provides no easy solution, owing to the lack of a clear understanding of risk factors that are causally associated with harmful substance use outcomes. This makes probable that “at risk” individuals will be over-identified on the basis of known risk factors. This is particularly problematic given that interventions sometimes have the unintended consequence of increasing rather than decreasing substance use. Given all these negatives, should health educators even be trying to change substance use behaviour in young people?

This special issue aimed to provide an opportunity for those with a focus in their work on young people’s substance use to describe recent trends, and to reflect on the implications of their findings for health educators. Although all the papers in the issue describe trends and patterns in substance use amongst young people in the UK, there is evidence of considerable overlap in substance use trends across many developed countries, and the observations made should have implications for health educators in other countries. The papers in the issue cover a range of substances: illicit drugs (Judith Aldridge), alcohol (Fiona Measham), tobacco (Amanda Sandford), and heroin and crack cocaine (Toby Seddon). The fifth article by Trevor Bennett and Katy Holloway examines specific health problems faced by drug using young offenders. Taken together, the papers synthesise results from an impressive array of good quality data sources. The authors of each paper offer answers to the question of what role exists for those who provide substance use education, particularly given the fairly gloomy assessment amongst the contributors of broadly-based education programmes to deal with the substance use.

There is considerable similarity in post-2000 trends for the psychoactive substances commonly consumed by most “ordinary” young people. The papers by Sandford, Measham, along with my own, all describe slight downward trends since 2000 in the prevalence of tobacco, alcohol and illegal/illicit drug use in the UK. The value of taking a longer view in interpreting recent trends, however, is clear, as without this kind of context, inappropriate conclusions are easy to draw. For example, it may be tempting to conclude that “binge” drinking amongst young people is falling, or that the “drug problem” amongst teenagers is getting better. A more accurate conclusion becomes apparent when these recent trends are placed into a longer-term context: both binge drinking and drug taking have stabilised amongst young people at fairly high levels. As regards illicit drug use, there is much continuity between young people now, and young people of a decade ago, a peak period for youthful drug taking in the UK. For example, acknowledging these modest downward trends in the use of illicit drugs, I point in my own paper to research showing that the percentage of young adults taking “Class A” drugs in Britain in the past year (around 8 per cent) remained unchanged between 1997 and 2006/2007. The post-2000 downward trend in drug taking overall might be mistaken for “big change” when it is actually mostly just continuity.

Nevertheless, the fact that these sustained (if moderate) reductions since 2000 are observed across substances (alcohol, tobacco, and the most commonly taken illegal/illicit drugs) suggests that processes may be underway that are effecting change in psychoactive consumption across the range of substances. I suggest in my own

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paper that a cohort effect may in part account for the reductions in drug taking amongst young adults, with the last of the (relatively) highly drug-involved teenagers of the 1990s now moving into their thirties, and no longer therefore captured in current prevalence statistics for young adults. This suggests that drug taking prevalence reductions could conceivably just be a feature of population shifts, rather than actual behaviour change. The possibility of “bigger forces” like this being at work in affecting levels of substance use is also apparent when the UK trends identified in this issue are compared with those in other countries. Bauman and Phongsavan (1999) found that for tobacco, hazardous use of alcohol, and most types of illicit drug use, the consistent and quite sharp increases in prevalence of use in the UK since 1990 were also identified in most developed countries including those in Europe, North America, and in Asia and the South Pacific. It is clear that macro and global economic and social trends, and population demographic shifts, exert an important global influence on substance use. This suggests that local efforts to buck global trends are likely to be met with limited success (though of course viewed in another way, local change must be an ingredient in global change). Again, these kinds of observations might be heard to sound a rather pessimistic note for the possibilities of health education to effect behaviour change.

Indeed, all the papers in this issue conclude that school-based health education programmes have limited success when judged particularly in terms of capacity to change behaviour. All recommend approaches for effecting change that vary considerably, and all see the role of health education differently. Both Sandford (in relation to smoking) and Measham (in relation to drinking) advocate changes to the context/environment of consumption, and to changes in policy that limit availability. Measham advocates environment-based harm minimisation strategies and fiscal initiatives. She recognises that a key ingredient for minimising alcohol-related harm could be the provision of “safe social spaces” for young people. Sandford argues that population-wide measures to influence smoking (e.g. the creation of smoke-free spaces) are likely to have a substantial impact on young people, and supporting these should be an important role for health educators.

Bennett and Holloway recommend drugs treatment as the best way forward for their arguably “vulnerable” group of drug-using offenders, and identify a range of treatment modalities with demonstrated success. Seddon too recognises vulnerability as an important characteristic of his heroin/crack cocaine using young people, but in contrast to Bennett and Holloway, and perhaps surprisingly given his focus on drugs typically used by those seeking treatment, finds little utility in an approach emphasising “health” or “treatment”. For Seddon, the solution requires nothing less than tackling the inequality and disadvantage at the root of the multiple problems experienced by heroin and crack cocaine-using young people. He advocates integrated and community-based approaches to tackle the effects of these often profound inequalities. In my own paper, the focus is instead on the majority of young people who do not experience seriously problematic drug use. I draw on the notions of drugs and health “journeys” to encourage a recognition that drugs “status” is constantly negotiated and subject to change; “normalisation” to encourage a harm reduction approach to education; and reject the idea that if some drug taking is fairly heavily problematic, the rest is not problematic at all.

Just as young people seek out information from friends in making drugs decisions, they seek out expert sources too, thus confirming an important role for health

educators. Even if broadly based health education has not yet been shown to reduce drug taking prevalence, it does not mean that it is not considered and used by young people in their ongoing drug decision making. Perhaps the question should not address whether there should be a role for health education in influencing the substance use decisions of young people, but instead: is the only way to measure that successful influence in primary prevention terms?

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#### Corresponding author

Judith Aldridge can be contacted at: [judith.aldridge@manchester.ac.uk](mailto:judith.aldridge@manchester.ac.uk)