Informing consent: should ‘providers’ inform ‘purchasers’ about the risks of drug education?

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SUMMARY
This paper argues that most drug education is problematic as an ‘evidence-based’ intervention, as it either lacks sufficient empirical support for its implementation, or it continues in the face of negative results. It is argued that drug education is a good example of an entrenched but risky public health intervention which is unimpeded by any burden of evidence, but this fact is not well known in the purchasing communities which often mandate such preventive programs universally. A morally informed public health policy would suggest that such quality assurance data is mandatory for the continuation or maintenance of any preventative drug education.

Key words: drug education; informed consent; quality assurance

It is fairly evident, especially when one examines dominant discourses of public health, that classical disease theory underlies many modern responses to public health problems. Drug abuse prevention is one good example which derives its meanings and methodologies from modern immunology (McGuire and Papageorgis, 1961; Webb et al., 1978; Duryea, 1983; Wallace, 1983, 1996). One of the significant achievements of the modern world is the naturalisation of health interventions, and their subsequent rendering as not only harmless but ‘obligatory points of passage’ to problem resolution (Latour, 1987). It is the purpose of this paper to reveal some of the hidden dimensions of prevention practice, through a particular examination of drug educational interventions within the primary and secondary school systems.

The educational arm of drug abuse prevention generally embodies linear and mechanistic interventions which privilege the cognitive capacities of individuals, yet remains silent both about more distal antecedents to drug use and other forms of intervention, such as a public health approach might countenance (Room, 1985; Nikelly, 1994; Royal College of Physicians, 1995). In other words, the primary focus of drug education at the school level is on the individual. The main aim of these programs is to educate children on the harmful effects and consequences of drug use. Some programs also focus on children learning to develop some cognitive skills to cope with peer and other related pressures associated with potential and current drug use.

In the modern world view it is unproblematic for most parents to assume that exposure to information about the dangers of various drugs is effective in preventing, if not diminishing, drug use in their children. They might further assume, as in vaccination, that all children can be protected in a fairly standard way and that full protection is available through these methods. They would at least be confident that no harm could come to their children as a result of exposure to drug prevention programs. Although there is a range of popular approaches to drug usage inoculation, ranging from strong challenges to passive exposure, it is generally assumed that all these approaches confer some immunity on recipients, and that this fact has been conclusively demonstrated through properly conducted scientific studies. If questions about these fundamental beliefs were to be raised, it might even be assumed that evaluations of such programs...
would, at the very least, be able to show some empirical evidence of programmatic efficacy in eliminating or suppressing the usage of drugs in children.

Governments have supported the use of drug education with considerable vigour and resourcing. For example, in the United States, Congress mandated drug education through the 1986 Drug Free Communities and Schools Act, despite the fact that most programs supported through this initiative have never been evaluated to determine either benefit or burden (Ellickson, 1995). Various governments in Australia have engaged in similar universal schemes of prevention, and most acquiesce to the nostrum of education as the most politically palatable alternative. It is not coincidental that conservative governments have usually favoured interventions founded upon the individualist project, which favours education as a first line strategy.

Most recently we have seen the drug problem revisited in the State of Victoria by a committee of experts (known as the Penington Committee) who have made findings and recommendations on the prevention of drug problems. The Penington Committee was appointed by, and reported directly to the State Premier. The committee endorsed the ‘development of school-based education programs about the misuse of licit and illicit drugs’ (Premier’s Drug Advisory Council, 1996, p. vii) which will be implemented in the next school year. Although there was nothing especially new arising out of the work of this committee, what is interesting is the cyclic remaking of education as innovation; a favoured political lever which has historically been re-invented almost every half decade in this country’s preventive history.

What might surprise parents of children exposed to preventive drug education is the dearth of impact studies of these programs, and a marked lack of drug-usage outcome measures in such studies, despite increasing interest in program evaluation in other arenas. The rhetoric of many program-providers speaks of ‘drug free schools’, abstinence, ‘saying no’ and drug-use prevention. Given the enormous support given to such programs by parents generally, one would expect some encouraging results from any evaluations, and fairly swift and decisive government action taken if programs were not fulfilling the reasonable expectations of the community. Notwithstanding the critiques made of some of the programs’ goals, it is the contention of this paper that parents might not unreasonably expect that any drug education program would not of itself accelerate drug use. Indeed it is one of the primary principles of drug education that the effect of a drug education program ‘should ultimately be measured by the extent to which the behaviour of people is changed’ (Commonwealth Department of Health, 1985, p. 3). As the principal funding body for drug education programs in Australia, the Commonwealth Department of Health argued that ‘program evaluation’ was an essential program component.

OUTCOMES OF DRUG EDUCATION

So what do we know about the outcomes of drug education programs? How well are they preventing drug use in children and how confident can we be in the evaluations? Given that some comprehensive attempts to review outcomes of drug education programs are now somewhat dated (Randall and Wong, 1976; Kinder et al., 1980; Schaps et al., 1981; Wallace, 1983), it is perhaps pertinent to review some recent outcome evaluation literature at this point, focusing only on interventions which were aimed at school-aged recipients of drug education.

The objectives of these programs have ranged from the somewhat obvious to the more indirect. A number of American programs simply aim to train students to resist peer pressure to conform to normative behaviour, which is sometimes called refusal skills training (Aniskiewicz and Wysong, 1990; Rosenbaum et al., 1994; Clayton et al., 1996). Other programs aim to help students make wise choices, informed decisions, or even to avoid the use of alcohol altogether (Jackson and Caslyn, 1977; Domino, 1982; Young and Rausch, 1991; Kooler and Bruvold, 1992; Kim et al., 1993; Hawthorne et al., 1995).

One of the most popular programs used in North America—the Drug Abuse Resistance Education program, better known as DARE—has been the subject of the greatest number of evaluative studies. DARE has been shown to provide high client satisfaction through positive evaluations by parents, teachers and school administrations, and to be ‘popular’ with recipients and successful and cost effective in putting drug education into schools through a number of unpublished (or ‘house’ studies), which show universally positive results from this program. There are few published studies which show
significant impacts on drug usage in the desired direction, and most of these report only evidence of positive attitudes in its recipients (Harmon, 1993), higher coping skills and drug knowledge (Aniskiewicz and Wysong, 1990). These findings contrast with other studies which could detect no program impact on drug use attitudes (Wysong et al., 1994; Rosenbaum et al., 1994). While some studies of the DARE program did report lower alcohol (Harmon, 1993) and other drug use (Hecht et al., 1993), especially among boys (De Jong, 1987), other outcome studies found the program had no measurable impact on student drug use (Wysong et al., 1994; Rosenbaum et al., 1994; Clayton et al., 1996).

Some of the measured positive gains arising from other drug education programs have been: increased drug knowledge (Casswell et al., 1982; Zoller and Weiss, 1982; Ambtman et al., 1990); positive attitudes (Chen et al., 1982; Greenberg and Pollack, 1982; Young and Rausch, 1991); greater decision-making skills (Young and Rausch, 1991); and less risky behaviour and lower recidivism (Kooler and Bruvold, 1992). A few studies have found lower drug use following exposure to prevention programs (e.g. Swisher et al., 1985; Nelson and Erickson, 1995).

Yet these results contrast with a number of outcome studies which showed that drug education programs had no impact on the drug use of the recipients (e.g. Swisher and Crawford, 1971; Korn and Goldstein, 1973; Barresi and Gigliotti, 1975; Jackson and Caslyn, 1977; Domino, 1982; Barnes, 1984; Kim et al., 1993). Of even more concern are the findings that certain drug education programs seem to increase rather than reduce the legal (Casswell, 1982; Stephenson et al., 1988; Hawthorne et al., 1995) and illegal drug use of young children (Serdahely and Behunin, 1977).

Consequently, a number of serious questions arise from this analysis. One might ask why drug education retains its primacy in the prevention portfolio despite its record of inefficacy. A critical analysis of the Australian experience of a popular drug education package may provide some illuminating answers. Life Education is a privately run organisation involving a number of caravans which visit schools once a year to deliver the annual dose of drug education. This approach took some time to establish its place as a popular paradigm across the nation, despite receiving a high level of political patronage and a broad range of community support. The resistance to Life Education may have been partly due to professional opposition based upon the National Drug Education Program (NDEP) guidelines which conflicted heavily with Life Education’s design and execution of drug education programs (see Commonwealth Department of Health; 1985, 1987; Wallace and Rolley, 1988). However, ultimately the government-sponsored guidelines were largely ignored (before being shelved), and Life Education was fully supported by state and federal governments. This situation prevailed over 10 years of substantive government funding and considerable community support until an independent outcome study was publicly funded (Hawthorne et al., 1995), and the results were disappointing to all concerned.

Nobody could have wished for the disastrous results of the first large scale outcome study of the Life Education program (Hawthorne et al., 1995) which were consistent with earlier evaluations (Stephenson et al., 1988; Wallace and Rolley, 1988). Although design considerations would suggest that a one-shot, other-delivered, standard package would fail to reduce drug use, nobody wanted to believe this about Life Education. In the wake of this evaluation, a number of Life Education’s allies were drawn together to attempt to dismantle the credibility of the study on methodological grounds. Irrespective of the validity of these grounds, such appeals after the fact show remarkably bad faith, especially considering that Life Education officials were continuously involved in the design and execution of the Hawthorne study, and no methodological problems were raised until after the data was analysed. None the less, the principal author, has recently reviewed outcome data on Life Education and concluded that ‘there was no preventative effect associated with the program’ and that a considerable proportion of the statewide drug use of year six schoolchildren ‘was attributable to participation in Life Education’ (Hawthorne, 1996, p. 1151).

Yet, after evaluations of the Life Education program showed that it appeared to produce rather than reduce drug use in children, the political responses were interesting. Rather than withdrawing government funding or halting the program until further research had clarified the Hawthorne study, the Victorian government provided more funding to the program within 2 months of the report’s completion. Furthermore, it embedded Life Education
in its statewide prevention strategy, ‘Turning the Tide’. Government support for this version of drug abuse prevention has in no way been diluted by any reference to these outcome studies. In fact, Life Education was the sole recipient of funding to prevent drug use under a recent ‘evidence-based’ public health initiative arising out of the Federal Budget. Almost one million dollars was allocated to this organisation to develop a national secretariat and expand their programs into the secondary school.

INFORMING THE PURCHASERS OF THE OUTCOMES

So it appears that some popular drug education programs, which are sold on the promise of immunity, at best fail their primary warrant, while others show equivocal results. In the light of these findings, it is not unreasonable that the purchasers of such services need at least to be alerted to the promissory nature of this risky enterprise. Rather it could be argued, on ethical grounds, that providers should seek informed consent from purchasers (including schools, parents and funding bodies). This paper argues that informed consent is a necessary professional responsibility. This needs to be particularly heeded in the context of drug education programs, where inconsistent findings, methodological and theoretical concerns, and possible negative outcomes have all been diligently documented in the professional literature. Hence, rather than confronting the epistemic gap between research and action (Crosswaite and Curtice, 1994), we are left with the most profound and disconcerting paradoxes.

Leaving aside the duty of care of governments, it might be argued that providers should endorse only those programs meeting the minimal standards of non-iatrogenesis. Whilst political expediency and institutional loyalty might impede critical discourse in some quarters, it is pertinent to ask why critique of drug education programs published in scholarly journals and publications has had such little impact in government circles. This paper is an attempt to revitalise discussion of the ethical duty of professionals by explicitly recognising a duty of disclosure to the downstream ‘purchasers’ of drug education programs (Catford, 1995). Whether arguing from a blatantly ethical perspective, or from a comparable professional code of health practice, it seems unarguable that educational enterprise should not neglect to inform its consumers/purchasers of the risk/benefit ratio of the interventions to which they are exposed. In this golden age of user-pays, it behoves the provider to provide quality assurance data, such as it exists. Notwithstanding programs which totally lack any empirical base, programs which have been the subject of empirical study should presumably include efficacy data and some indices of adverse events for their purchasers. One group to whom it presumably should be offered is the parents of the children who are to be exposed to these interventions.

How much unlearning about drug education is now required? It seems that what is commonly accepted as fact about drug education is challengeable and may require drastic revision. But where is this work going on, and where are the resources to teach the parents about drug education and its vicissitudes? It is clear that governments have such data about drug education; it is their reluctance to allow such data to impede populist practice that is ethically troubling. In the meantime, we may ask why some ‘purchasers’ are not being informed of the possible risks, costs and consequences of their children being administered a dose of drug education.

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REFERENCES


