DEPENDENCY :
EDUCATION AND PREVENTION

DAVID A. LANE

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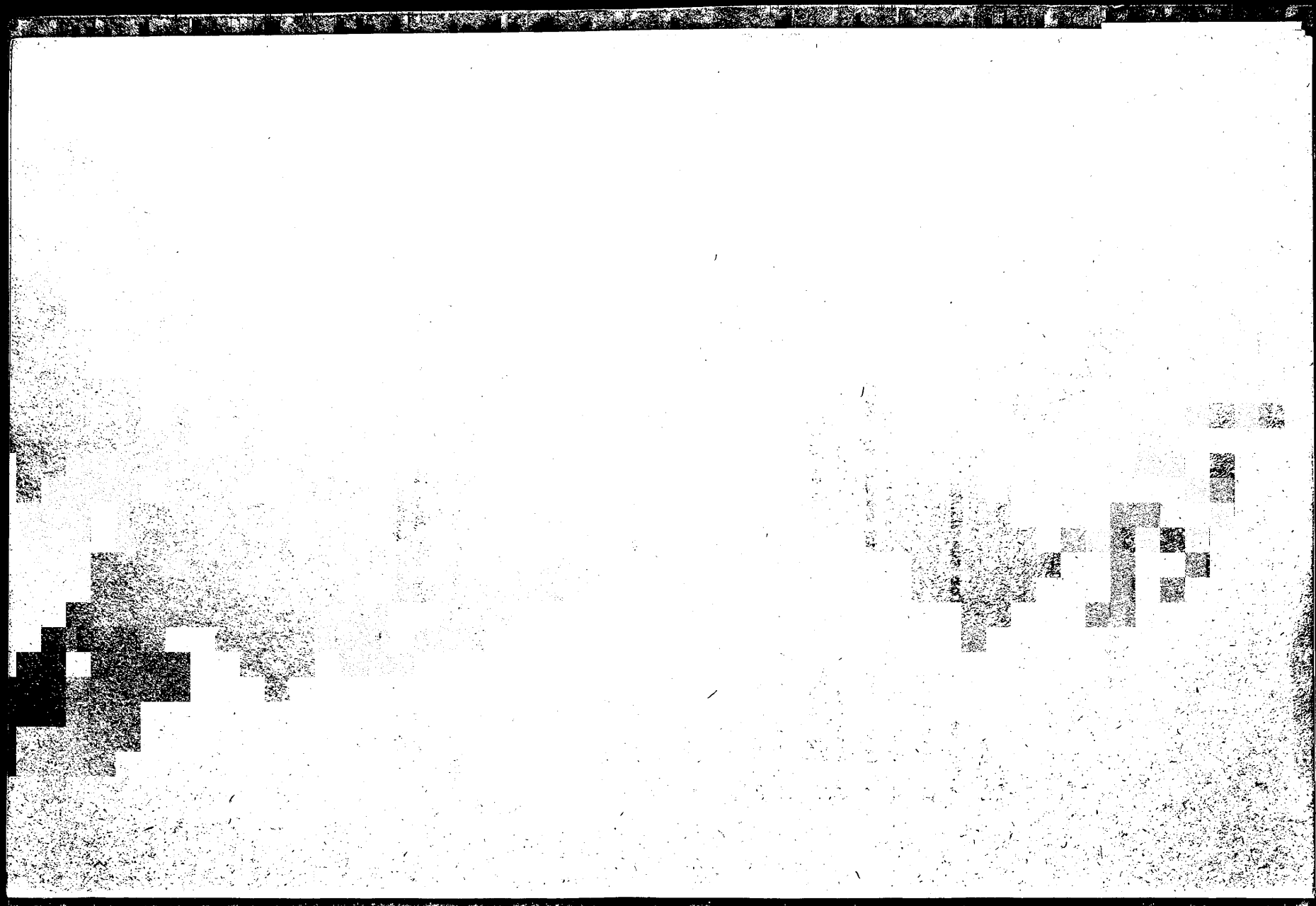
Report prepared for the Drug Dependency Discussion Group,
The Kings Fund Centre, London.



PREFACE

The Drug Dependency Discussion Group was founded in 1968 to provide a forum for the exchange of ideas for those working in the drug dependency treatment clinics.

Its work quickly extended beyond those confines to include social workers in the community, teachers and a variety of other groups.

In 1974 after six years of operation, a review was undertaken by this author of the work of the DDDG, at the request of its management committee. This review resulted in a survey of priorities, and a national conference to plan future development.

One of the outcomes of the conference was to try to achieve a more adequate dissemination of views and research within the membership.

This report represents a part of that process in which the author's papers for the DDDG and other bodies are brought together in a more accessible form.

The original paper, 'survey of priorities' is included, together with a new compilation of the author's reports. A subsequent Kings Fund Centre paper is included, since it reports an approach referred to in the compilation, but not previously described in detail. The references to the original papers are also appended.

KING EDWARD'S HOSPITAL FUND FOR LONDON

KING'S FUND CENTRE

KFC 74/203

Director:
M. C. Hardie, M.A., F.H.A.

Telephone:
01-262 2641

24, NUTFORD PLACE,
LONDON,
W1H 6AN

Drug Dependency Discussion Group

SURVEY OF PRIORITIES FOR THE DDDG

Paper by Mr. David Lane

Introduction ..... The Drug Dependency Discussion Group, 1968 to 1974

The original objective of the DDDG was to enable those working in the, then newly established, treatment clinics to become aware of each others work and to benefit from this communication. This objective was quickly achieved and there is general agreement that the DDDG has performed a useful service. Although this objective was achieved, wider objectives quickly developed through the recognition of the fact that dependency involves broader issues.

The papers that were presented and the discussion that took place at the meetings during this period vary from precise statements of method to confused impressions of need, but they all serve to show the vitality and conflict in the field of dependency over the past six years. A simple examination of the recurring and in some cases, recurring and recurring themes at these meetings indicates the objectives, achievements, and future priorities that have been set by those concerned with the day to day management of clinics and wi th education and prevention.

Each area can with profit be considered separately before general conclusions are drawn.

Education - objectives and achievements.

Education was one of the main preoccupations of the Group. Numerous members appealed for education, often seeing it as a panacea for all the ills of society. TIME AND AGAIN discussion turned to the need to educate the young. However, education was often confused with prevention and the gap between the ideal of a broad-based education, with drugs as just a part, provided by the pupils' own teachers and the reality of outside speakers being used to give one-off talks became increasingly apparent.

Gradually it was recognised that in fact few people were in a position to advise schools, since 'experts' were only just beginning to find their own way and the idea that drugs education might be counter-productive also started to appear. So, specific educational proposals, for the training of nurses, teachers, the police and so on developed. Action on specific proposals usually followed.

Perhaps this preoccupation with education can cease to have pride of place and the Group's resources can be put to better use through influence on the curriculum development of other bodies such as the Media Resources Centre (ILEA), the Schools Council project on health education, SCODA, and of course through other educational work in the liason committees. The Group can, however, play an important role in continuing approrpiate additional training for professional staff.

Since much of the concern over education was in fact a concern over prevention, the influence that the group may be able to bring to areas such as prescribing habits and the realistic development of alternative treatments for stress, inadequate problem-solving, and so forth will, for the future, answer many of the objectives which were unrealistically expected of education.

Since professional education is the only remaining objective, general education of the public and particularly the young should now take a back seat. Such general education as might be useful is best undertaken at a local level through drug liason committees, concentrating on issues such as 'drug collection weeks". In this way the important rule of thumb in health education 'that education works best when it can build upon the existing values of the community' can be applied.

The nature of the problem - objectives and achievements.

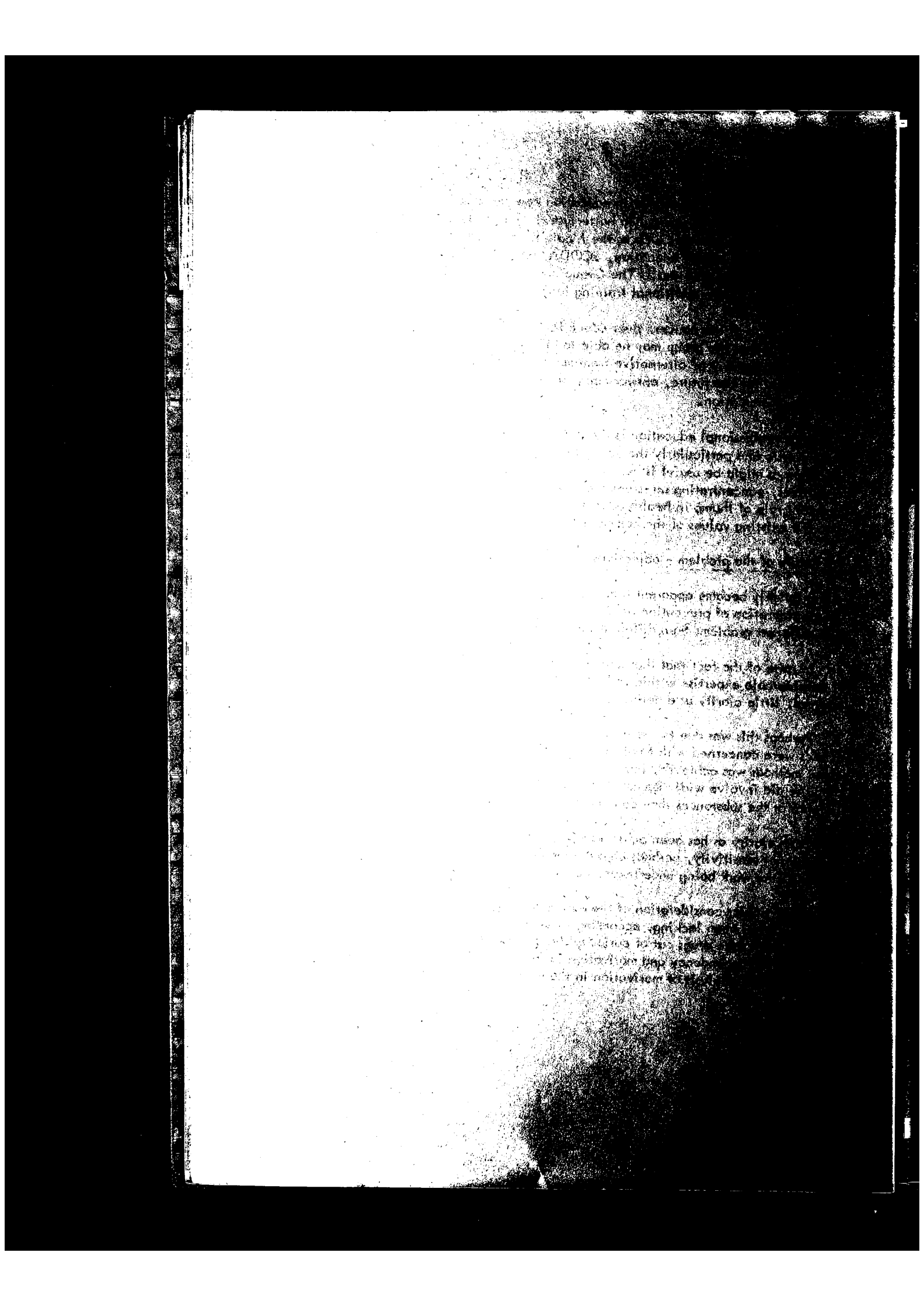
It quickly became apparent that dependency is not one overall phenomenon. Yet the consideration of prevention never really came to grips with this. If we are dealing with different problems then different approaches are needed.

In spite of the fact that the nature of dependency is a major research area and one of considerable expertise within the Group, and also an area to which members often referred, little clarity at a detailed level on the nature of dependency was forthcoming.

Perhaps this was due to the practical nature of the Group, since those working in clinics were concerned with treatment methods and the original objective of communication about methods was achieved, but most people realised that this was not enough and that drug use did involve wider issues which could not be understood simply by defining patients in terms of the substances they consumed.

Such clarity as has been achieved so far, has been implicit rather than explicit and professional sensitivity, perhaps, has prevented too much discussion of the purpose or nature of the work being undertaken, but this remains a central objective.

In particular consideration of the nature of failure and the motivation of dependent individuals has been lacking, according to several members. Although statements such as 'youngsters take drugs out of curiosity' have been common, a thorough consideration of motivation in dependency and motivation in treatment has not taken place and no one has even suggested analysis of motivation in the way that personality analysis has been propagated.



However the basis for such consideration has been firmly laid by descriptive discussion of drug use in various forms, and it may be that the Group has adopted an appropriate research strategy in describing the various facets of usage before attempting the formulation of hypotheses and their investigation within an experimental framework. But, such hypotheses are now possible and the Group's considerable research potential should not be left untapped.

The consideration of such hypotheses might include the differences in the learning of drug dependent behaviour between different users. Various meetings of the DDDG have underlined the fact that we need to understand the nature of these groups and perhaps work in a pre-treatment situation with some of them. Even apparently similar usage in terms of the substance consumed might include such varied reasons as the difference between those who use drugs to deal with a non-severe stress situation, those with grossly disturbed personalities, those who simply use drugs as part of a recreational activity and those whose dependence in induced as part of the normal cultural response of a doctor to his patient. All of these have been mentioned but few of them developed at DDDG meetings.

The consideration of personality characteristics of drug users in which some people see themselves as grossly disturbed, opens up possible hypotheses both in terms of this factor in the motivation for dependency (and the implications of this for educational programmes which stress the inadequacy of drug users) and in consideration of the validity of our present approach to measurement. We have not yet reached the point when we can rely on someone to present a paper on the subject, as we have in the past, but rather might need to make use of workshop sessions in which ideas can be presented and jointly explored. The discussion of individual and social aspects, for example, raises the possibility that a measure based on the individual's perception of his interactions with others and the perception of those others of the dependent individual might provide an objective framework for measurement. The insights and questions provided by members might provide in a structured format a clue to the values which are found in drug use by a particular individual and also a measure of change following therapy.

The possibility of some predictive measure of the likelihood of response to treatment might be explored to ensure more effective use of resources and the provision of pre-treatment orientation and support to deal with factors which might precipitate failure, rather than to treat anyway and thereby further confirm the individual's failure complex.

We are perhaps close to such varied treatment approaches in for example maintainance therapy prior to the start of a treatment programme for withdrawal but the limits of such need to be explored.

There is in the DDDG the potential for advance in such areas providing we can clarify the nature of the problem and treat the conflict of opinion that exists on these questions as potentials for new advance, rather than as barriers to keep professionals apart.

However, we must face the question of the right of individuals to use drugs or even to destroy themselves if they so choose. Occasional voices have been raised on this point, but discussion of it has quickly passed on to some other business. Are we unable to come to terms with 'the true meaning of freedom'?

Legal and preventative aspects - objectives and achievements.

The distrust between workers in the nedical and legal side of drug use was made clear at numerous meetings of the DDDG, yet this is also the area in which the Group has made an important contribution. The involvement of the police in the Group, and the work of the liaison committees, enabled an increasing understanding of the differing roles of the professionals involved in these different aspects to develop. In a real sense the limits of these different roles were actually shaped for the members at DDDG meetings.

The success achieved in some constabularies in increasing communication was slower to develop in the Metropolitain force: This was something that caused concern to many. The different structure of operations in London partly accounted for this, and ignorance on the part of other workers partly accounted for the distrust, but in more recent years a more satisfactory relationship has been achieved, fashioned from experience and discussion.

The police are adapting their role to the realities of drug use and medical and social workers are accepting the value of their role. While contacts with many forces throughout the country remain limited, a start has been made - a start that is being extended to the courts as well, and therefore the priority for the future would appear to be to consolidate and extend that foundation, since it is felt that from such contacts a clearer awareness of the limits and interaction of the medical and legal roles will emerge.

A continuing, unmet priority, remains the provision of appropriate facilities, such as a bail hostel, for those awaiting court proceedings. Perhaps the Group can shame the appropriate department into action or find some benefactors who are not biased against drug users who might put up the money.

The working party on police relations did much to clarify priorities and the report of the working party provides a basis for future action. The real potential for preventive action of the type that can only be undertaken by the police cannot be realised without this cooperation. For unless medical and legal personnel talk to each other, appropriate control is impossible. Perhaps we are beginning to move in this direction, but we have certainly a great deal of thinking to do to ensure that these roles are complementary and not to the detriment of the sufferer and society. The history of control shows how little is achieved by punitive action against the dependent. To avoid the mistakes of the past we must take the trouble to learn from them. Communication between professionals is perhaps the only way this can be achieved.

Treatment - objectives and achievements.

The original objective of the DDDG to exchange information and develop communication between the staff of treatment clinics was achieved. However, most of the communication centered on practical problems of day-to-day administration, one of which, the orientation of staff, continues to receive attention.

There were few attempts to clarify purpose and principles, this in spite of the fact that the importance of wider issues and the need for cooperation between professional groups was recognised.

Rehabilitation formed an important element in treatment ideas yet its development remained neglected. Treatment concepts in practice tended to define and treat patients in terms of the substances they consumed.

The expressed priority of exchange between units has taken place at a factual level, with the exchange of staff, ideas and concern with the implications of the wider issues hardly taking place at all. In particular an inadequately defined approach to re-educating the patient to be able to cope with life has been in evidence. However, this is gradually giving way to detailed therapeutic programmes.

Certain areas of dependency have remained neglected in spite of the efforts of some members of the Group and the Group continues in many respects to function under the restraints and ideologies of heroin addiction, even though it is now a broadly-based association of individuals concerned with dependence in all its forms.

On numerous occasions, the difference between successful and unsuccessful treatment was stated to be the motivation of the addict, yet the nature of this motivation was not considered and little attention was given to the question of how to create appropriate motivation. Treatment responsibility seems to have been passed to the patient, stress being laid on his responsibility rather than on the joint responsibility of patient and staff. Even if this is a reflection of a particular therapy ideology, given that for many patients drugs have become self-motivating, refusal to consider the generation of alternative motivation is a serious omission. The Group must address itself to this, particularly in view of the question of the responsibility of the medical profession for creating drug problems which has been raised at several meetings.

Rehabilitation - objectives and achievements.

This was a preoccupation of the Group from the start and from the start a clear idea of the range of supportive care needed appeared. In practice little advance was made, particularly at the clinical level. In rehabilitation outside the hospital setting rather than within it the greatest strides were made. Work through liaison committees and through the therapeutic communities set the pace. But, as comments at a very recent meeting show enormous areas remain undeveloped.

It was frequently recognised that rehabilitation involves establishment viable alternative life-styles, yet in answer to the complexity of such a task often little more than the 'evening class' mentality was offered. The complexity was recognised but not tackled. Part of this perhaps reflected the Group's tendency to avoid detailed clarification of what was going on and to concentrate on the problem of young addicts to the virtual exclusion of other areas of dependency. While valuable work has certainly been undertaken, it has been rather thinly spread throughout the country.

The priorities for rehabilitation remain largely as they were expressed at the Group's inception:

> 'Rehabiliation has been considered in three stages, before, during, and after treatment. The pre-treatment stage involved a shelter operation at street level .... During treatment continuity of relationships was essential and after treatment the task was to help the addicts to find their role and status in the community.'

The creation of therapeutic communities and recent considerations of the options made available from a wide range of treatment techniques (e.g. behaviour therapy) indicates that the move towards creating viable alternatives is under way but there is still far to go.

An area that perhaps needs to be considered is the patterns of response that are not available to the addict because they were excluded during the patterns of learning of his dependent behaviour. For example, although it is recognised that individuals have often missed much education, and evening classes are provided in English and Maths etc., it is not realised that the addict has missed not simply the factual data necessary to the subjects, but has also missed the opportunity to learn that data can be evaluated in alternative ways. The whole pattern of learning of dependent behaviour, whatever the nature of the dependency, has been based on the restriction of alternative response styles. This applies not simply to feelings, but to ideas, the means by which rewards and punishment are sought, and so forth, covering a wide response area of human behaviour. Dependency enables that area to be narrowed, and rehabilitation must include the opportunity to expand those alternatives. Some therapy programmes of themself further restrict thinking by providing only one acceptable form of response and rely on communication patterns which are just as cult-based as junkie language.

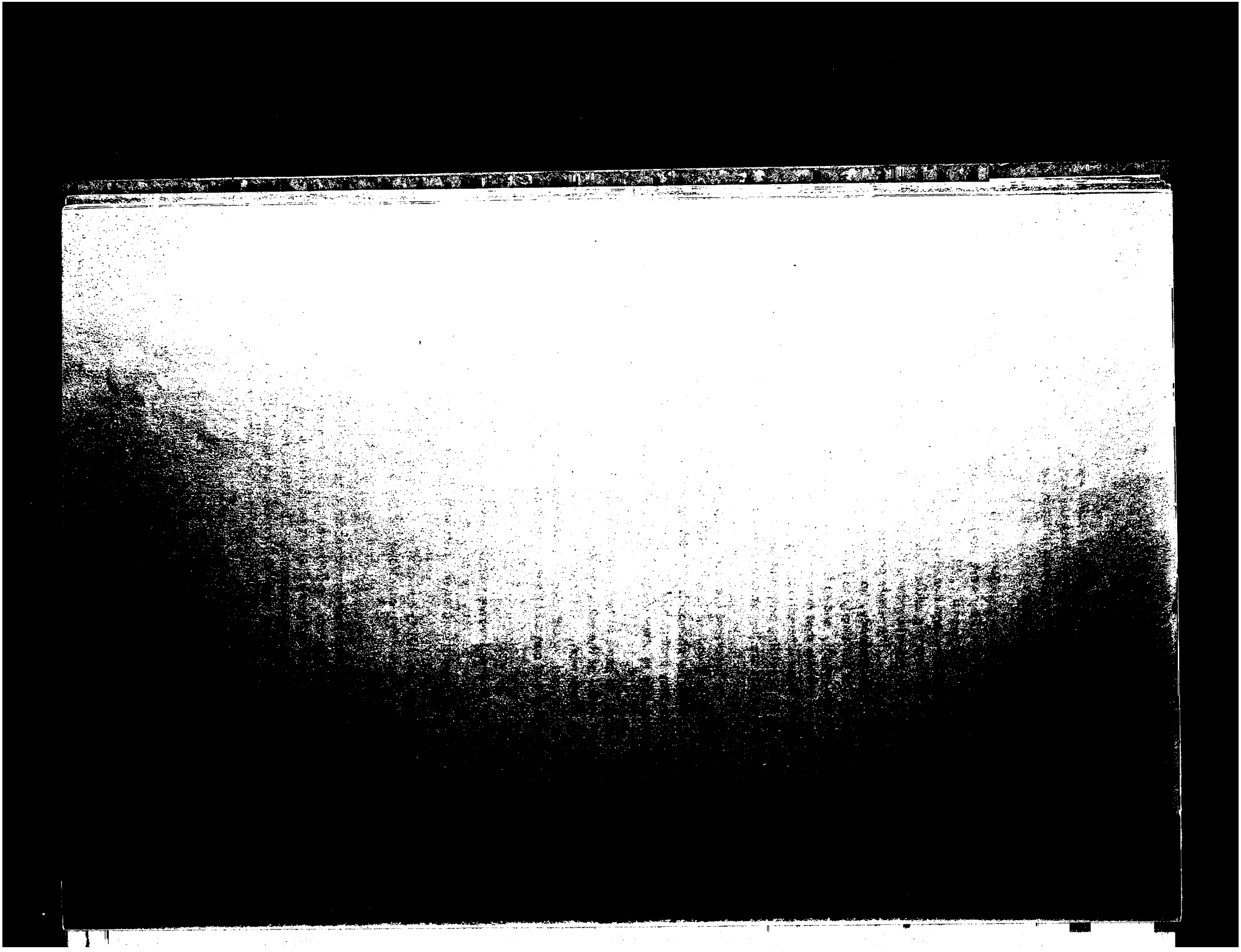
Cognitive rehearsal, an important element in such behaviour, is excluded from some rehabilitation theory in favour of 'dealing with feelings' yet the link between feeling, thinking and action for change is not made so the individual is left with a response repertoire which may enable him to deal with his feelings about drugs, but which may not be appropriate to other areas of human endeavour.

Rehabilitation has got to come to terms with this complexity, perhaps by looking away from the clinical model of the addict to the possible contribution of other professionals to rehabilitation of the whole man. This may also serve to include in our consideration the problems of doctor-induced dependence in middle-age, so that our thinking can encompass the alternatives that can be offered when prescribing habits are criticised, and hopefully change.

Although rehabilitation does involve complex patterns of re-learning these are not beyond our capacity to achieve but they can only be achieved if we are very clear in our assessment of the nature of the difficulties and potentials that we are tackling.

It is to this clarity that the DDDG can perhaps more than any other body direct itself with profit. These complexities, mentioned at the DDDG in the past must now be considered in greater detail.

The priorities for rehabilitation therefore are both practical, in provision of urgently needed facilities of shelter and therapy, and theoretical, in the need for clarity of purpose. The size of effort needed to achieve these priorities for the future should not, however, blind us to the achievement of the past six years. The clinics for the treatment of dependence set up from scratch, and those working in rehabilitation from an equally difficult start, have made important strides from the days when the possibilities of recovery were bleak to the more hopeful present.



Communication and information - objectives and achievements.

The prime objective of the group was better communication and this is also the Group's prime achievement, but it still remains a prime objective.

Information-sharing has received less happy treatment and confusion over the form such sharing should take remains to be clarified.

The working party report indicates the achievements and shortcomings and the views of the management committee of the group showed considerable agreement on objectives in this area. These views clearly reflected the feeling expressed at many meetings over a long period. The objectives in this field can be tabulated as follows:

1. To give members working in the field of dependency an opportunity to know each other and to provide a basis for professional trust.

2. To exchange and develop knowledge and information.

3. To initiate and carry out small-scale research projects in those areas in which the Group works best involving limited aims and time-scales.

4. To influence the creation of policy by other bodies including government departments, law enforcement agencies, and even members of parliament who change laws or create new services on any matter that the Group feels would be beneficial to the sufferer, his relatives, or society in general.

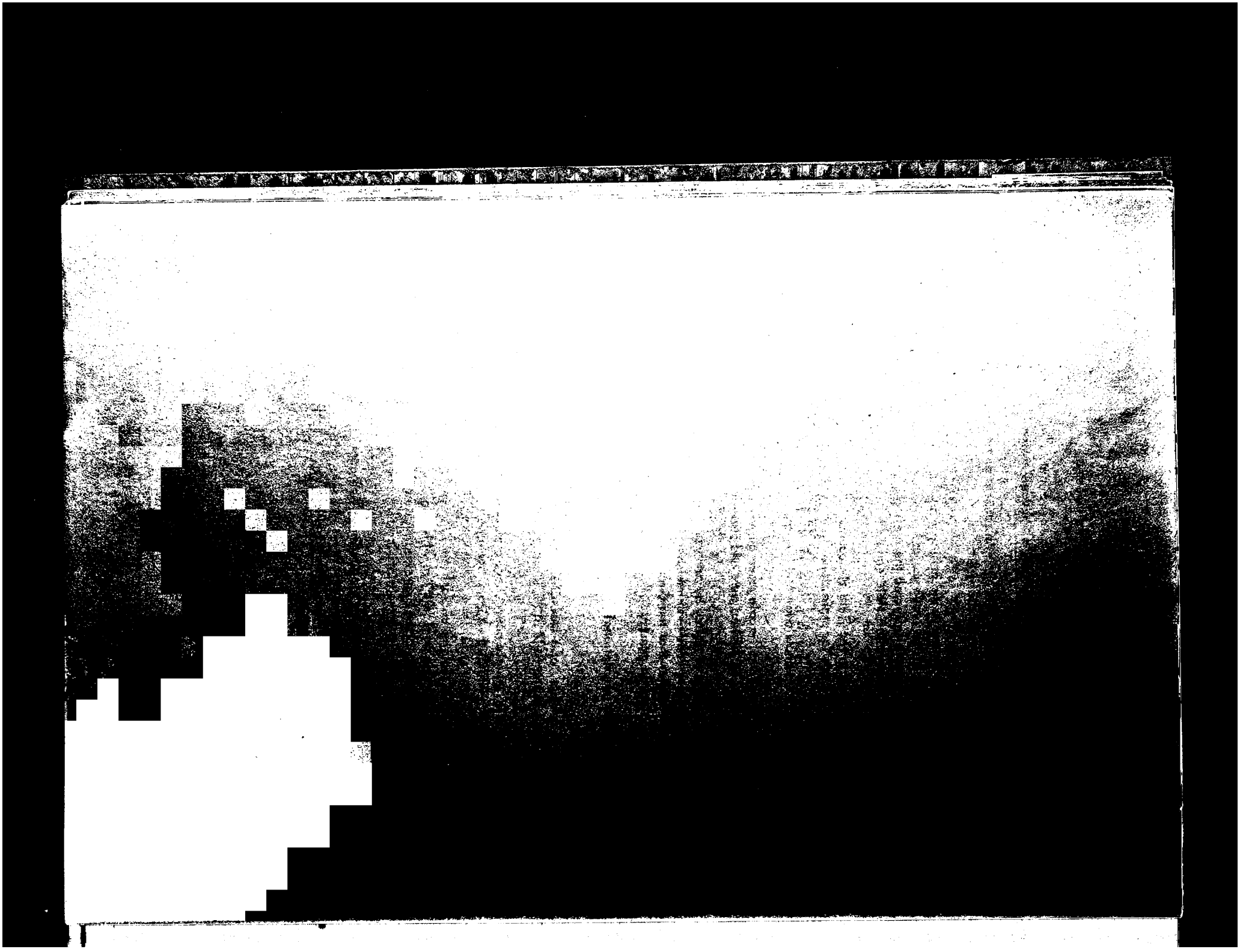
5. To gain national and international recognition for the Group since it represents informed opinion.

6. To establish short courses, at a specialist rather than a general level, for the various disciplines involved in the field of drug use and abuse.

7. To prepare and publish widely papers and research covering those aspects of the field of drug dependency in which the Group has a particular part to play.

However, one objective remains unclarified although it has been raised many times and that is for a drug information pool (DIP) to which individuals could refer quickly for reliable information. This need, often expressed, has not been met and there is little agreement on how it might be met. Some clarification is needed.

Some clarification is also needed on the sharing of information within liaison committees. The establishment of these committees was a significant achievement, yet having established a committee many people seem unclear of their role. Attention will have to be given to this as a matter of urgency.



Conclusion

Certain major themes came to the fore early in the life of the Group and remain to this day, these include:

1. The establishment of appropriate rehabilitation before, during and after treatment.

2. The spread of liaison and coordination of information between professionals.

3. The identification of those at risk from whatever cause.

4. The clarification of the nature of the problem.

5. The development of educational programmes to increase knowledge, understanding sensitivity amounst those professionally involved.

6. The development of specific action on certain drugs.

7. The need for a research orientation in most areas based on limited but clearly defined objectives, studied over a limited time-scale and arising out of actual problems.

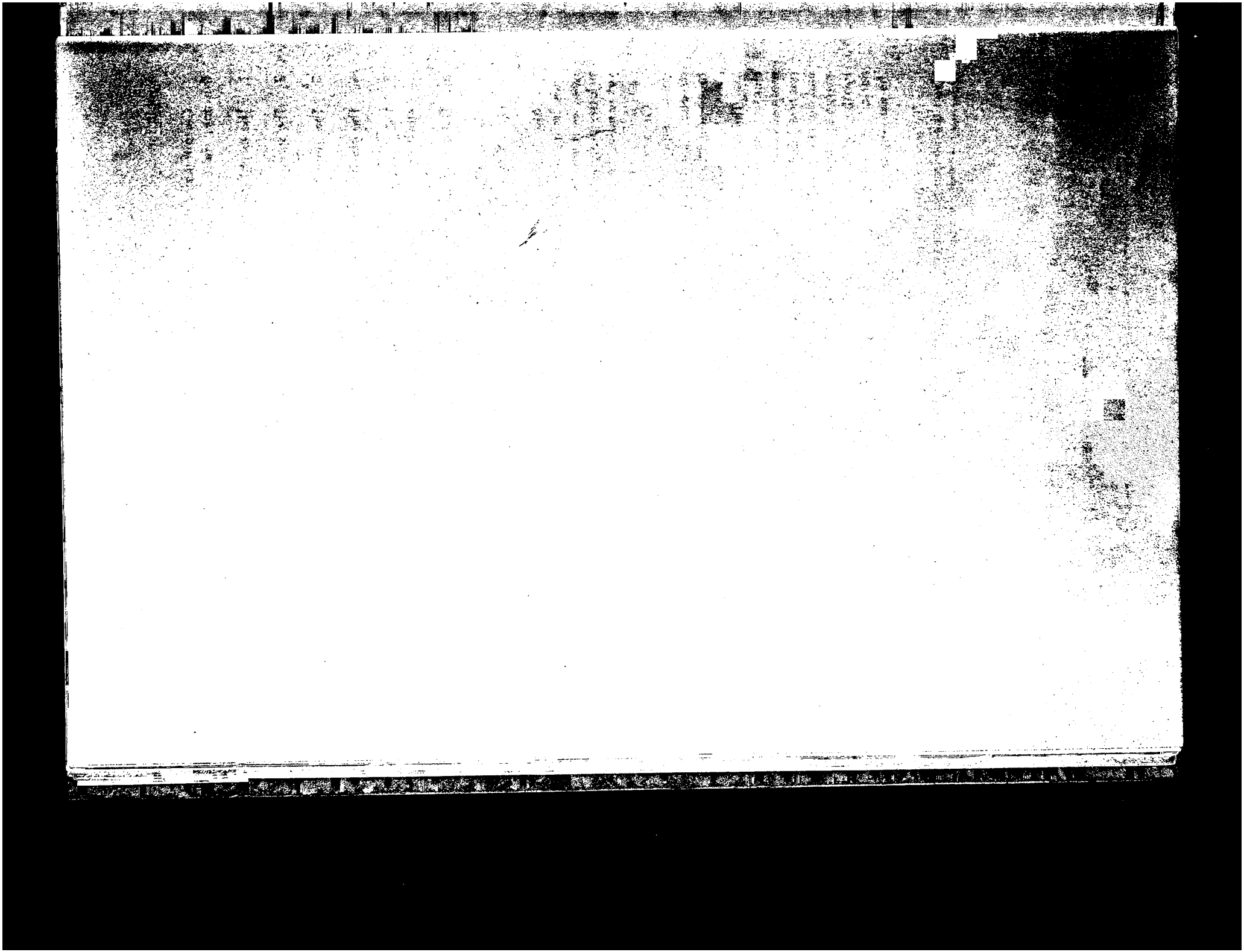
Also the feeling exists that the time is right for a clear look at the purpose of the work being undertaken rather than simply the methods. But, the major priority remains now, as it was in the early meetings of the Group, in action for supportive care. This priority presents itself in numerous forms, as appeals for education, prevention or treatment yet remains the preoccupation.

Other priorities include the further development of the drug liaison committees and consolidation of the improvement in relations with the police and, mentioned but not developed, action in areas of dependence such as dependence in middle-age so far only touched upon.

The achievements of the Group have been considerable, particularly in the development of communication, liaison and the trust brought about through personal contact between professionals. The conflict and distrust that was apparent at many of the earlier meetings has now largely disappeared. There is still, however, much to be achieved and to this end the now formally constituted body should seek to develop its effectiveness in influencing action by other bodies whose work closely affects its own. Since the priorities which exist involve not only areas which can be tackled by the group, but also others wh ich need joint action, this influence through meetings, publications and so forth will become essential to the working of the group.

The membership will need to define clearly those areas which are to be pursued, given the limited resources of the group yet building upon its enormous multi-disciplinary expertise.

April 1974



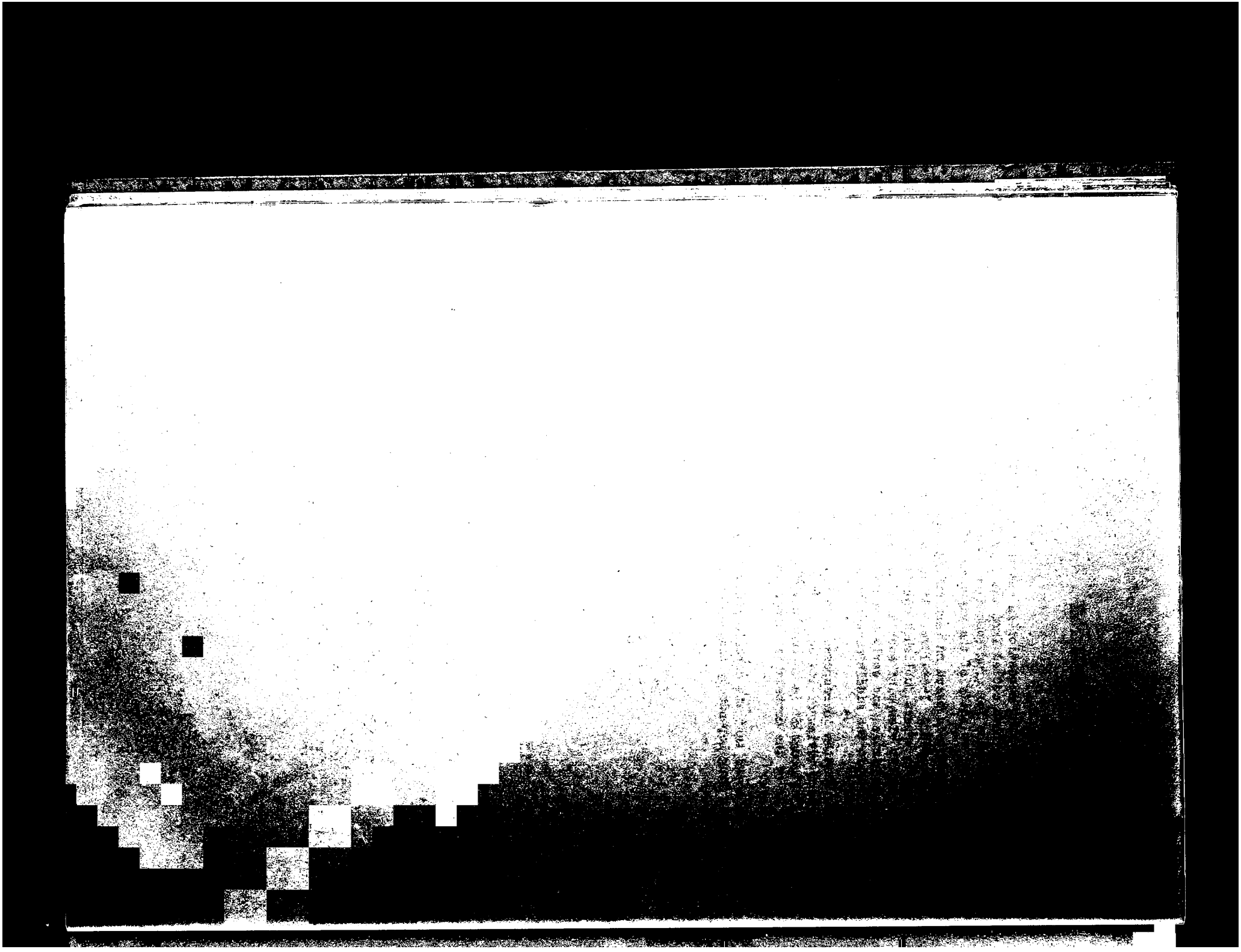
INTRODUCTION

The field of drug education is one that is still filled with emotion, but feelings have cooled from the days in the late sixties when evangelical demands for drug education were made, irrespective of the educational validity of the views expounded.

This document is based on work undertaken and published by the author over eight years, 1968-1976. It is not a review with hindsight, but is based on papers published during the period. Rather, it reflects a particular viewpoint such as it exists, which, when expounded in the late sixties and early seventies, was not the majority view, but which now in the middle seventies has gained wider acceptance.

It was written in response to a request from the DDDG as part of a long-term review of its work. It does not reflect the policy of the DDDG, although it is in some way a reflection of views expressed at, for, or by the membership, since those views influenced this author's own work.

It is hoped that its circulation will be of value to the membership of the Drug Dependency Discussion Group. It is offered with thanks.



2. EDUCATION ABOUT DRUGS

The State of the Art

A fourteen year old girl once said, 'Adults say we're all concerned about drugs and sex but here it's the teachers; they talk about nothing else, we get it in English, Social Studies, P.E., and even Religion.' This statement underlines the confusion in drugs education at the present time. We seem to be educating at the extreme of either nothing but or nothing at all.

This confusion in the minds of schools and education authorities is hardly helped by the experts, some of whom cry out for more drugs education and others who cry 'no'. Such appeals for education as we face are hardly ever preceded by a clear statement of the purpose for which the appeal is being made, and much education seems to be, in reality, a thinly disguised form of therapy aimed at the sort of preventive role for which drugs education is most unsuited.

Telling people about drugs, however well it is done, cannot prevent drugs use and therefore anyone who does appeal for education must be very clear in their mind as to whether it is education or prevention that they are after. Education seems to have become a sort of cry to relieve the personal anxieties of those who worry about drugs use amongst the young. It arose, as Jasper Woodcock, of the Institute for the Study of Drug Dependence, has said as a response by the middle-classes to the fact that their children were being dragged through the courts on drug charges, and education was appealed for to perform the preventive role rather than the court.

Such appeals lack clarity and any thought of purpose as to the aims of education. Drug education has an aim, which is how I will conclude this article, because drug use is a part of society and education in preparing individuals for society needs to take account of this but it cannot serve to right all society's wrongs.

Some clarity of purpose then is the first priority, and consideration of the developments in drugs education over the past few years may help to provide it.

The development in attitudes since 1969

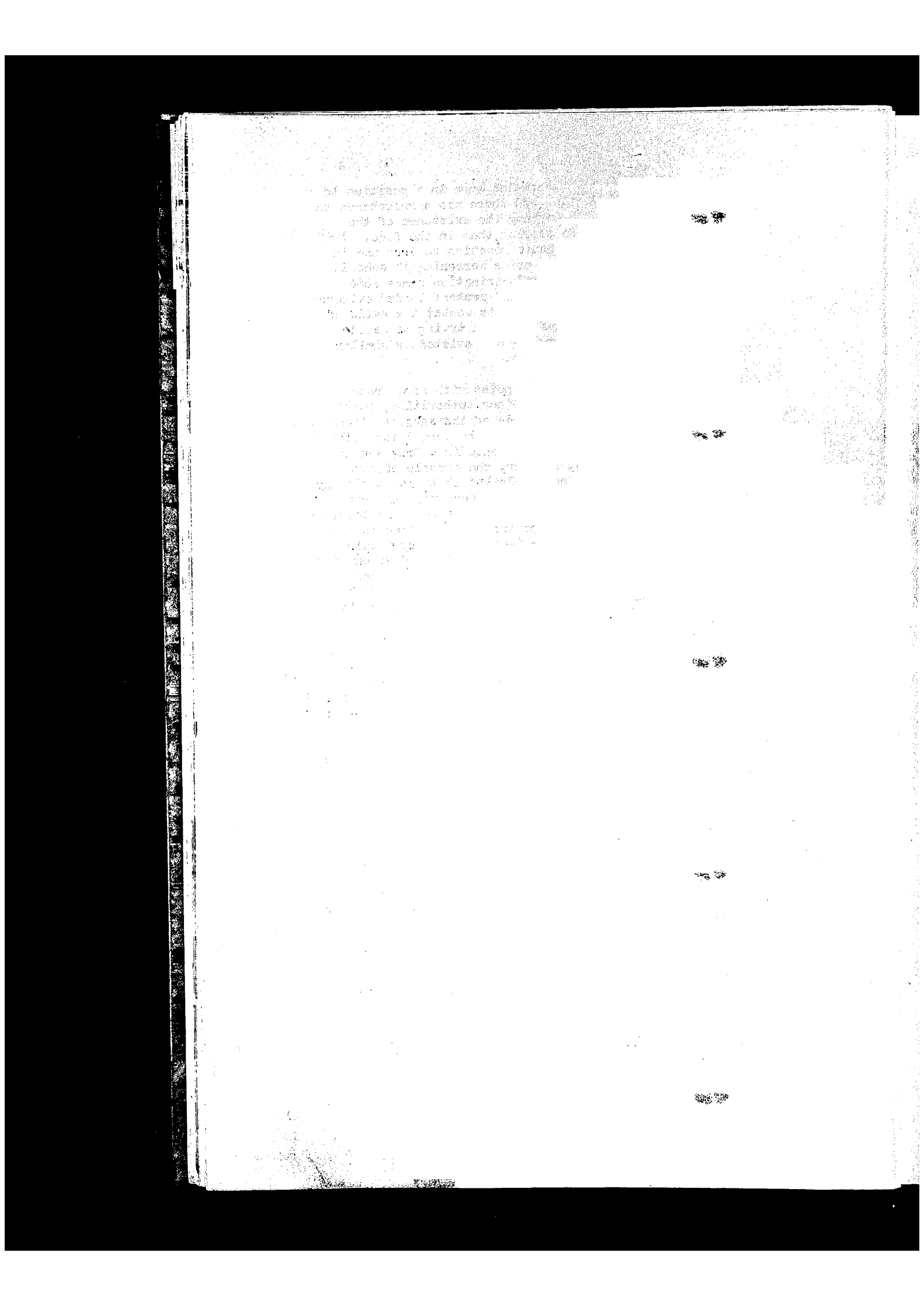
In 1969 it was estimated at a D.D.D.G. meeting that almost half the Medical Officers of Health in England and Wales denied knowledge of addiction or facilities to deal with the problem in

their area. In fact few local authorities were in a position to advise on the problem even if asked and there was a reluctance to ask on the part of schools, many denying the existence of the problem even with evidence of use staring them in the face. 1969 was perhaps also the start of the panic reaction to drug use in schools which reigned briefly. Mass urine screening in schools and widespread indoctrination (yes, indoctrination since some educators readily admitted that they would present loaded evidence to children on this subject) was demanded to combat the evils of drug use. The difficulties teachers faced in trying to decide their own attitudes to drug using pupils was matched by similar confusion within educational authorities.

We had education at the extreme at this point with some areas going overboard on drugs education and other authorities, perhaps as a reaction to this, washing their hands of the subject altogether. Unfortunately, this polarization lead those who were doing nothing to turn their backs on the increasing evidence from drug squads that use was increasing. We had, however, the example of some authorities that took the matter seriously but that also seriously considered how they would approach it. Bradford was the prime example of this in setting up a liaison committee to bring together those professionally involved. This pattern was repeated in other authorities and these more appropriate ideas of working within a broad health framework with teachers, youth leaders and so on spread to such places as Portsmouth, parts of Yorkshire, Croydon and perhaps half a dozen other islands of enlightenment. Although mistakes were made in these areas, they were at least trying to tailor the education to the realities of the local situation.

By 1971 increasing evidence was available on the extent and nature of the problem and on the education being pursued. From those authorities co-operating with the Liaison Committees and from individuals working with such bodies as the Drug Dependency Discussion Group came the increasing realisation that drug education seen in isolation as an attempt to prevent drug misuse was likely to be counter-productive, and so the trend developed for drug use to be placed squarely within the framework of a full programme of health education.

However, while we avoided the worst excesses that took place in the American drug education bonanza, the lack of thought in some areas allowed individual teachers to propogate ill-informed and excessive drug education as a response to their own anxieties rather than as a response to the needs of the pupil or school. Of course it is a tradition in our educational system for the individual teacher to be allowed to teach more or less in his own way but although a teacher could not add up so would not be allowed near a maths class, heads were reluctant to prevent teachers, who



knew less about drugs than their pupils, from giving drug education lessons.

This pattern although becoming less common still continues to this day.

The information available from research and Liaison Committees showed variation in patterns of use from area to area and education to take account of this variability is only possible within an integrated programme. The irrelevance of 'one off' educational attempts, therefore, became clear and some good began to develop out of the confusion through the inclusion of drug use in curriculum planning and the impetus given to liaison work.

To date we are moving towards a concensus view on the importance of education on drug use (and not simply abuse) as part of co-ordinated programmes within schools and the community. The concensus is by no means complete and we still have occasional cries to teach them about drugs in response to the latest upsurge in use in a particular area, but the move towards a reasoned approach is now so strong that hopefully it cannot be stopped.

There are three main areas of concern in drugs education, the education of the young, community education and the education of the professional. Each will be considered below.

Education within the school

There is still much inappropriate drug education in schools but there is now an increasing opportunity which is in part the result of concern over drugs for a broad based framework of health education. Given the spread of drug education what experimental evidence is there to aid in the task.

The experimental study of drugs education, what does it tell us?

A study by the National Association of Youth Clubs indicates that the information given in drugs education lessons incites many people to want to try drugs who might otherwise not have done so. This problem of the arbitrary results of education and the difficulty in predicting its effects, is supported by other work in the mass communications field although the view that individuals are incited is more contentious.

McQuail (1969) has argued that there is overwhelming evidence that the net changes in attitudes or opinions as a result of persuasive material are likely to be small. The more likely effects of direct presentations of subjects such as drugs in which individual's

attitudes, prejudices, and values are involved is their filtration through various other influences. Thus friends, opinion leaders and so on are more likely to influence the interpretation of the material received. Berelson and Steiner (1964) argue that the effects of communication tend to take the form of a reinforcement of existing attitudes and opinions, individuals hearing and seeing that which is favourable to their pre-dispositions. This is particularly important in the drugs field not only in terms of the potential user but also in terms of prejudice towards the user.

This filtration effect lies not only in individual responses to communications but also in the fact that the content of communications are often mediated by the structure of relations amongst the listeners, information flowing from source to opinion leaders and then to less active members of groups. Such evidence as there is suggests that communications are used by individuals to suit their own ends. The communicator is in a largely powerless position. This is particularly important in the area of drug use, since as has been argued in various studies, attitudes and values tend to be developed in intimate personal relationships (Sutherland and Cressey, 1955). Attitudes favourable to drugs use are likely to be learnt in cultures which favour their use (Becker, 1963).

It is not the communication which matters, but what recipients do with the communications they receive. In particular does the individual view himself as someone to whom a message is addressed? Such research as there is does not show that drugs education is or is not harmful but that it is likely to be used selectively by individuals. Thus the drug user may accept pro-drug education while the non-user may accept anti-drug messages. The person who does not care may ignore the message altogether, regarding it as something not addressed to him in spite of its preventive or informative aspects. We must therefore look at the groups to which communications are directed.

In any school class there are likely to be pro- and anti-drugs pupils whose minds are made up and who are unlikely to be influenced by education. These must be approached informally. For other pupils who are ambivalent or not committed, reasonable communication is likely to be most effective particularly when it shows both sides of the argument and does not involve high level threats of the dire consequences of drugs use. It is such two-sided communications which enable individuals to deal with contradictory information at a later date. See for example, a study of health education and of propoganda by Lumsdaine and Janis (1953) and Janis and Feshback (1953).

Unfortunately, many educational attempts in this area are exactly the opposite approach. The Institute for the Study of Drug

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It is not the [illegible] with the [illegible] individual [illegible] Such [illegible] or is not [illegible] individuals. [illegible] while the non-user [illegible] does not [illegible] something [illegible] informative aspects [illegible] communications are directed.

In any school class there [illegible] pupils whose minds [illegible] influenced by [illegible] other pupils who are [illegible] communication is likely [illegible] shows both sides of the argument and [illegible] threats of the dire consequences of [illegible] sided communications which enable individuals to [illegible] contradictory information at a later stage. [illegible] study of health education and [illegible] Janis (1953) and Janis and Feshbach (1953).

Unfortunately, many educational [illegible] the opposite approach. The [illegible]

Dependence (ISDD) has established a review panel for films, and teachers wishing to use films can obtain from the Institute copies of the comments of the panel on individual films. This same body in a recent survey (Dorn, 1972), found that pupils often knew more about the subject than their teachers. Teachers should therefore refer to reliable sources of information, such as the Media Resources Centre of the Inner London Education Authority, but even their film list should be checked against the ISDD review.

It is pointless convincing pupils that cannabis and heroin are both dangerous if when they leave the classroom they are faced with views they can't ignore which show cannabis not to be harmful. It is not important in communications terms whether or not this pupil-based information is correct only that it be believed. The danger is that having discovered that the teacher is 'lying' about cannabis the pupil may feel that perhaps other drugs also are not as harmful as the teacher made out. The status of the teacher, or those in authority generally, as a reliable source of information might be reduced very seriously by such contradictory communications.

The effects of such situations in the long run are difficult to assess but preliminary results from the ISDD study (Dorn, 1972) followed up on a large sample are beginning to be made available. This indicates that short term effects are no guide to long term results.

The very variable results of research reviewed by the ISDD underline these difficulties. The ISDD study indicated that some presentations have some effects. This fact lead to the development of the suggestion that prevention as a concept in drug education should be treated very differently.

Therefore an overall goal of prevention must be split into different parts. That might include the strictly preventive role of helping individuals to cope with stress to to counteract the harm caused by experimentation, etc. More traditionally, education might be concerned with increasing the pupils' decision-making ability, increasing knowledge, etc.

Thus it is particular goals, instead of a global aim of stopping drug use, which need to be explored. If one goal is changing behaviour, then intervention techniques are needed. These are discussed later. If increasing knowledge and other educational goals are the aim, then these can be approached through an integrated programme based on a policy for the school as a whole.

This is what we have not done very successfully in the past.

The most recent developments in this field have come about somewhat indirectly through the new awareness of curriculum planning following in the wake of numerous schools council reports. Some education authorities such as ILEA have established Media Resources Centres and this body has duly produced a health education guide line. Their first effort in the drugs field was far too uncritical of some of the materials they recommended, although in the light of the lack of knowledge that existed at the time it was a fair attempt. The value of this sort of local effort is that the material can be up-dated in the light of local experience of its use and this is what has been happening to this particular package. The need for local awareness follows on from the Bradford experience, and although it is not an easy task, it is certainly a worthwhile one. The Schools Council has now got in on the act with a project on health education and we can look forward to their report.

But education in school must take full account of the nature of communication within the school and teachers should therefore avoid like the plague some of the so-called teacher-proof materials that are appearing. In spite of reports to the contrary, drug use does vary in both content and extent from area to area and from school to school and even class to class, therefore, the teacher must know what is going on and then place this information within a broader health framework.

The aims of drug education in schools is not to prevent drug use, as this is impossible, but it is to enable individuals to make decisions based on realsitic interpretations of evidence. The aims therefore are the same as in many other areas of education and do not require special justification. Drug use is part of our society and always has been therefore if one of the aims of education is to prepare individuals to take their place in society, education about drugs naturally forms part of this. It is necessary to sort out clear aims which are educational not preventive. To ignore it because it is unpleasant constitutes a neglect. Certainly, there are particular problems associated with drugs education, but the fact that it might be difficult is not an argument for not teaching it.

The most important of the problems on drugs education is created by the attempt to treat education about drugs as an exercise in preventive medicine. You cannot deal with the problem of dependency by talking about drugs. The two are separate.

Education about drugs concerns drug use as part of patterns of behaviour within society; it properly belongs in social science lessons where it can be viewed in perspective against a background of sociological theory on deviance, delinquincy, etc.

Drugs education can also properly be taught as part of general health

education in which the perspective of a whole range of health matters can be brought to bear. It is in this respect that the DES pamphlet 'Drugs and the Schools' (1972) makes its contribution, and although this panphlet has been much criticized for its omissions it is nevertheless prime reading for teachers, particularly the final section which makes it clear that punitive action is unlikely to be helpful. But for most teachers the ISDD publications are the most useful source of information. Other aspects of drug use, such as the legal question rightly form part of such an approach, but not as a sledgehammer to force a teacher's opinion on pupils. Education is not indoctrination.

Drug education has formed part of GCE syllabuses in sociology for some time, and taught as part of sociology it is effectively placed in a proper context. But if placed in a course on social problems as part of the non-social-scientific 'social studies' lessons taught in some schools then the fears of those who feel that it might do more harm than good are realized.

Treating drugs as part of social problems while seemingly reasonable may in fact create awareness of social pathology rather than an understanding of society. Pupils may be given the impression that society is falling apart under the pressure of divorce, drugs, and delinquincy. The emphasis in such courses is on deviance as if this were something apart from society as a whole, and it leads to the development of just those attitudes it is designed to prevent. Because many people confuse giving information with helping individuals to learn to cope with the stresses of living they misguidedly slant the information they impart. Thus the content of education prevents the development of realistic attitudes about society. One example of this is the view of society's institutions as democratic and fair. When teaching concentrates on the way institutions are supposed to function rather than how they do in fact function, individuals are left with unrealistic ideas which leave them embittered when faced with the reality of a system which operates 'differential enforcement' and clamps down on those whose dress, opinion, etc. are not those of middle class respectability (Becker, 1963; Lambert, 1969).

By fostering an idealistic conception of the democratic society rather than preparing individuals to cope with it as it is, schools may encourage the problems which lead to deviance and confirm the opinion that adults never tell the truth except when it suits them. It is vital that clear objectives if suited to what is valid educationally are honestly presented.

Conclusion

'Does drugs education do more harm than good?' In so far as it is possible to answer on the basis of present evidence the answer would appear to be that present educational practice can do more harm than

good if it enables individuals to confirm their existing prejudices and attitudes and does not prepare individuals to cope with stress. This failure is in part due to confusing teaching about drugs and the prevention of drug use.

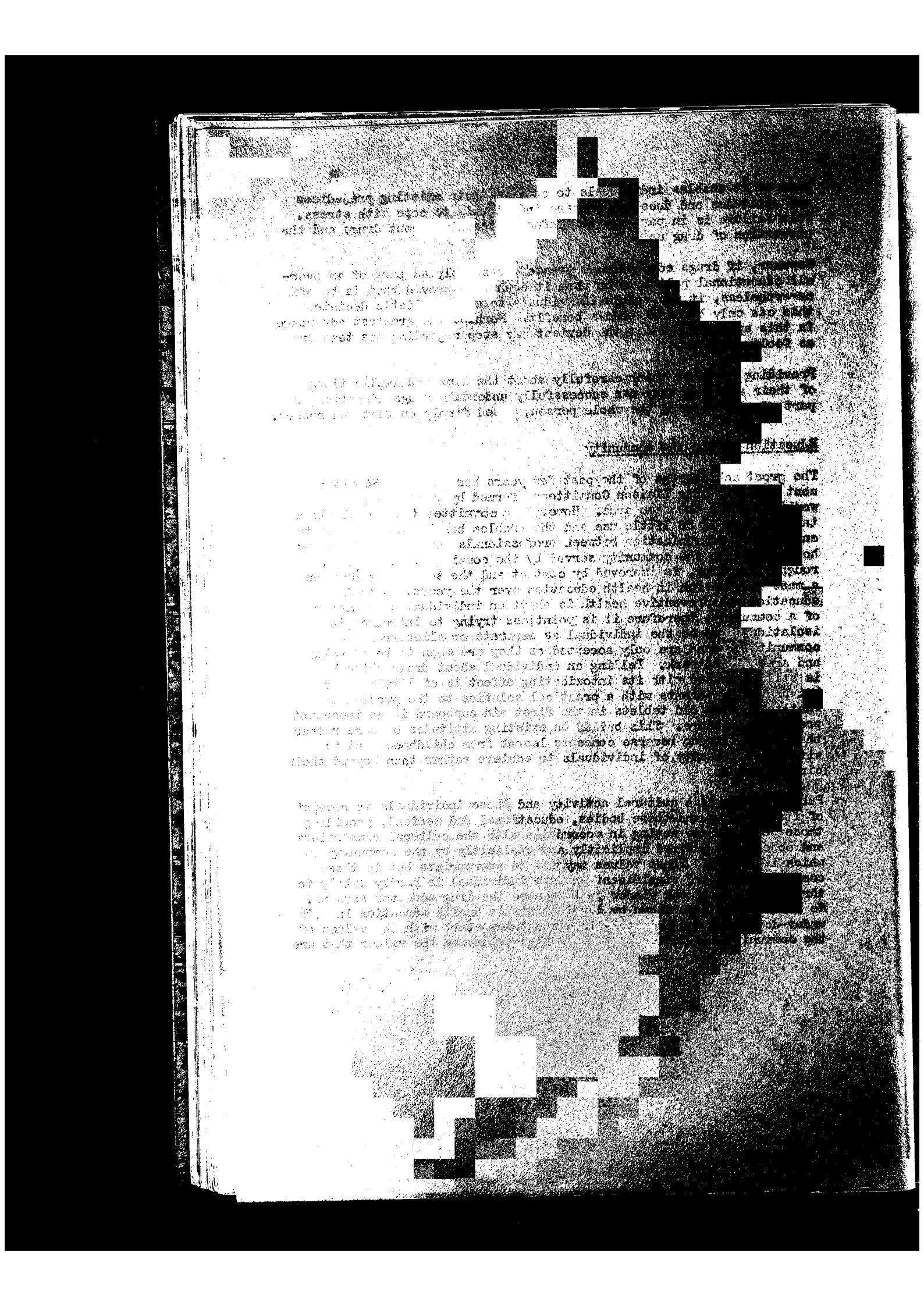
However, if drugs education is treated reasonably as part of an overall educational policy, even then it cannot be proved that is beneficial, nevertheless, it may enable individuals to make realistic decisions and this can only be considered a benefit. Perhaps the greatest advantage in this approach is that the deviant may stop regarding his teachers as fools or liars.

Providing teachers think carefully about the aims and implications of their actions, they can successfully undertake drugs education as part of education of the whole person, based firmly on fact and reason.

Education within the community

The great achievement of the past few years has been the development of local Drug Liaison Committees, formed by professionals working within the same area. However, a committee that is simply a talking shop is of little use and the problem has been one of how to ensure that communication between professionals could take place and how to educate the community served by the committee. The first, roughly speaking, is improved by contact and the second can draw on a mass of research in health education over the years. Health education and preventive health is about an individual as a member of a community, therefore it is pointless trying to introduce in isolation ideas to the individual as separate or alien from the community. Ideas are only accepted as they are seen to be of value and are seen to work. Telling an individual about drugs while he is still obsessed with its intoxicating effect is of little value but providing parents with a practical solution to the problem of what to do with old tablets in the first aid cupboard is an important preventive measure. This builds on existing attitudes of care rather than attempting to reverse concepts learnt from childhood, and is within the capacity of individuals to achieve rather than beyond their circumstances.

Public health is a cultural activity and those individuals in receipt of its services and those bodies, educational and medical, providing those services are acting in accordance with the cultural constraints and objectives defined implicitly and explicitly by the community in which it occurs. These values may not be appropriate but to those concerned they are significant and the individual is hardly likely to throw them out of the window just because the drug educator says so. We must as has been shown by developments in health education in both under-developed and industrialised countries start with the values of the community and members of it and then emphasise the values that are



appropriate to the need for realistic drug education. Communications must similarily relate to the individuals needs. (This is discussed later.)

The Drug Collection Week, which has become popular in some areas, is a good example of this sort of community based education. In this sort of exercise local health and education authorities get together with G.P.'s, chemists, the local press, voluntary bodies and schools to bring everyone's attention to the need for security in the storage of drugs and the disposal of unused drugs. The effects of such a programme include not only the preventive importance of reducing supply but also the educational value of re-awakening concern for the safety of the young and the informative value to the medical profession of the consequences of their prescribing habits.. Not the least benefit of this is that everyone can pat themselves on the back and feel that they have done something useful. That feeling is the most powerful tool at the health educators' disposal.

Education within the community then must be based on a clear purpose tackled from the means that are available to fulfill that purpose. Planning for the health of the environment in which you live is difficult but is possible.

Education of the professional

This is not an easy task as different professionals have very different orientations and conceptualisations upon which to draw. Professionals often do not find it easy to talk to one another. It is important within professional courses to provide not just information but the chance to meet informally and discuss away from the threatening theatre of the fully public meeting the issues which concern them.

Unfortunately there are really no experts in this field and one professional must, while presenting the thing as he sees it, be prepared to learn from another even if that other belongs to a low status profession.

The education of doctors for example in dealing with stress problems such as drug us is very limited. They have very little idea of how to provide alternatives to a prescription. Since this problem involves social factors and the whole question of personal interaction medical education does not provide the background necessary for doctors to assume (as they have tended to do in the past) the expert role in this issue. Similarily, nurse training fails although there has been recent improvements. The police were diffident at first but now in some areas receive more training than the average nurse. The education of teachers in spite of the psychological and sociological study involved in initial training results in practically little idea of how to come to terms with the problems the pupils face. Few courses give any

[redacted]

realistic weight to such techniques as role playing and group work either for the benefit of the teacher or his future pupils.

A new move was the establishment of the Drug Education Consortium (now defunct) which ran several in-depth courses at the Polytechnic of Central London. That course provided a much sounder basis to professional education than odd one-day attempts. A further hopeful sign for professional education is that the Drug Dependency Discussion Group, until now a fairly restricted body, has now received a formal constitution and membership is open to all professionally or voluntarily concerned with drug dependence. The D.D.D.G. could play an important role in professional education, particularly given attempts at integration with other bodies.

A non-preventive concept in drug education

One obvious thing about drug use is that it is universal indeed, the society that does not use drugs both medically and non-medically can be considered deviant. The international nature of drug use makes it obvious that any attempt to eradicate the non-medical use of drugs is doomed to failure and it would be a gross affrontery to the values of hundreds of millions of people. No one objects to the use of drugs, what people object to is the use of drugs other than the ones they happen to use themselves. Thus it is entirely a matter of where you live and in which age you live which determines the form of drug use which will cause offence. This fact is central and must be kept in mind. The simple fact is that individuals respond selectively to information, an idea current twenty years ago, has now filtered through to the drug education world, so education should enable us to make the best use of the drugs we are taking with a view to coming off at a later date when relevent.

The majority of the education in the field of drug abuse is community inspired and has its origins from a grass-roots level rather than being imposed from on high. This is by far the best way of setting about this project, because in this way each local community can find out what is best for it and the source of information it requires. Not only is it a question of educating people and the parent generation about drugs but of also educating the medical profession in correct usage and prescribing habits. It is necessary for everyone to come to terms with the fact that we are living in a drug sodden society. Therefore education on how to reduce drug casualities, rather than preventing all use, should be a priority.

The comments above now sound very commonplace but resistance to a non-preventive approach has been strong. But looking back just a few short years it is amazing to think how difficult it has been to get people to accept what now looks like plain common sense. Planning drug education involves certain principles common to all good educational practice, and consideration of appropriate communications. Often in

realistic weight to each t[illegible] either for the benefit of th[illegible]

A new move [illegible] Education Committee (now defunct) [illegible] at the Polytechnic of Central London. [illegible] regular basis to professional [illegible] of Camden Hospital sign for professional [illegible] by Drug Dependency Discussion Group, until [illegible] formed a [illegible] constitution [illegible] individual interested in or currently concerned with [illegible] and a [illegible] important role in profess[illegible] tegration [illegible]

A controversial [illegible] drug education

One of [illegible] drug use as though it [illegible] society [illegible] be considered [illegible] it obscures [illegible] in accord [illegible] of adult [illegible] drugs, [illegible] the use of drugs [illegible] then [illegible] you [illegible] use [illegible] in mind. [illegible] information [illegible] to the [illegible] best [illegible] left [illegible]

The [illegible] education in the field of drug abuse [illegible] implies [illegible] from a drugs-proof level [illegible] imposed [illegible] by far the best way [illegible] this [illegible] local community [illegible] what [illegible] profession [illegible] order [illegible] the parent [illegible] about [illegible] the medical profession [illegible] usage [illegible] is necessary for everyone [illegible] to [illegible] drug action [illegible] Therefore [illegible] reduce drug casualties, [illegible] prevent [illegible] priority.

The [illegible] very commonplace but resistance to non-[illegible] been strong. But looking back just a few short years [illegible] how difficult it has been to get people [illegible] common sense. [illegible] drug education [illegible] common to all good educational practice, [illegible] communications. Often in

community health, communications are not appropriate, but unless you ensure that your communication has meaning it will be pointless. Certain planning principles can help to ensure effective education.

1. Clarify the objectives of all those likely to influence the outcome of education and try to integrate the varied objectives of those involved.

2. Clarify the content used, so that it does actually meet the objectives.

3. Apply methods of teaching which meet not simply the abilities and knowledge of the participants, but their expectations of the outcome and the demands of the content.

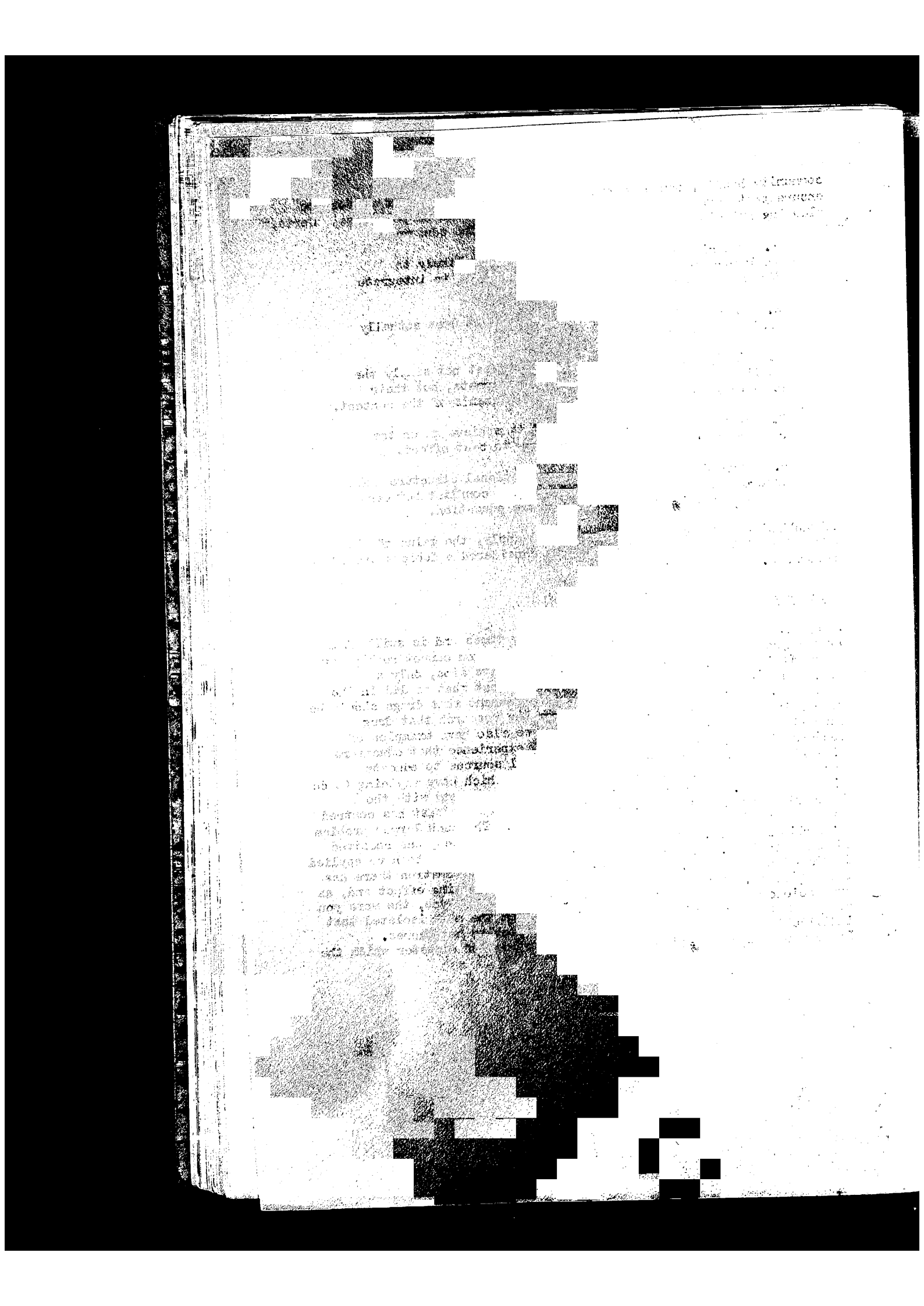
4. Consider what it is possible to achieve given the resources and apply those resources to best effect.

5. Provide an appropriate organisational structure and ensure that there is no insurmountable conflict between the organisation and the aims of the education.

If sufficient of these principles do not apply, the value of the education will be marginal and must be considered a dubious use of resources.

Conclusion

Drug education has come through some tricky times and is still at a crossroads and not knowing what its purpose is you cannot really say where it is going. There is no concensus on its aims, only a concensus which is apparently international that what we did in the past was worse than useless and general agreement that drugs should be placed in a broad context. We know from the research that drug education can be counter-productive, but we also have examples of successful programmes. We know from past experience that educators will find themselves under pressure from all sources to educate about drugs for a variety of reasons, few of which have anything to do with education. There is rightly a concern in society with the indiscriminate use of drugs, but this concern in the past has centred on a comparative handful of young drug users. The much larger problem of barbiturate use, not to mention alcohol and tobacco, has received little attention. The reverse law of information seems to have applied in that the more dangerous the problem the less information there has been about it. Information seems to have an amplifying effect and, as any sociologist or communications theorist will tell you, the more you define an individuals's behaviour as a problem the more isolated that individual becomes and hence the more of a problem he becomes. Information tends to act to fulfill the prophecy of disaster which the



public holds must inevitably follow from the concumption of the odd cannabis cigarette.

To educate about drugs you must have some knowledge of drugs, but knowledge about society and individuals is more important than a descriptive awareness of the effect of a particular substance. Such descriptions are usually inadequate anyway. It is this knowledge, based on the situation that actually exists in the area in which you work, that enables successful drug education to take place. You have to build on the potentials available as exercises in drug collection show us.

All societies use drugs. The more sensible recognise this fact and provide the cultural support necessary so that individuals can, if they choose, handle this situation without being forced to fail as members of the society. Given that drug use is part of society, we must educate about drugs, it is neglect of our responsibilities to ignore it. But it is from the general use of drugs in society that our education should build. Teaching should not start with consideration of the illicit sue of heroin by a handful of individuals, thereby separating this use from society as a whole.

Education about drugs therefore should be designed to enable individuals to understand and make realistic decisions about the use of substances which form an important part of social existence. This must include barbiturates supplied by G.P.'s and alcohol supplied by publicans.

Drug use can be placed in the health education curriculum or in a syllabus for sociology. The same rules apply for teaching it as apply to any good educational programmes. If you regard the subject as special, don't teach it, leave it to someone who is less anxious. If you are working in a community health framework use the example of drug collection to remind yourself that without creating anxiety you can carry out valid education. As a professional remember the contributions that other professionals can make and work with them, preferably, within the auspices of a Liaison Committee.

Drug education is not about preventing drug use, it is not even about preventing illegal drug use. This is not possible.

It is at its least and at its best about enabling individuals to decide from knowledge for themselves. If we achieve that we will have achieved a great deal.

3. COMMUNICATION PROBLEMS IN COMMUNITY HEALTH

The importance of problems of communication is well known in medicine, for example, in the field of psychopathology the role of disordered communication in the development of neurosis and psychoses is recognised. However, disordered communication forms only part of a continuum which, if we think of correctly interpreted messages as those falling within a range of acceptable tolerance and those falling well outside the range as being disordered, still leaves a large number of messages at the borderline which are potential sources of communication breakdown. Within the field of community health these borderline cases are the more common and more important since often the participants will not recognise that they are failing to communicate appropriately.

In this article I propose to outline the factors necessary for communication to take place and then potential failures of communication. Some research on the wording of health messages is considered finally.

Prerequisites for communication

There are certain prerequisites for communication to take place and these can be grouped under three headings:-

1. The knowledge of the universe which individuals possess (cognitive factors).

The knowledge of the universe aspect concerns all the information the individual possesses, that is his whole 'cognitive map', the general and the particular.

The general knowledge - this would include knowledge of the cultural situation within which behaviour takes place, that is, the total situation from which behavioural options can be drawn. In any self-determined act the individual must be able to define the situation before him, and the family and the community are the primary sources of definition learning, through which he learns how to respond to situations and to which situations to respond. An individual can use the response of communication appropriately because it has meaning for him through the fact that is culturally significant.

The particular knowledge - generalized knowledge is put to use in a specific situation at a given time, making use of additional knowledge derived from the situation such as the status relationship between participants, knowledge of the addressee, etc. However, since individual experience and culture varies communication breakdown

can occur because the participants are drawing on a different knowledge of the universe; in effect they see the situation differently, but for the most part there are a sufficient number of shared meanings and patterns of symbolism for communications to take place.

2. Affective state (the motivational and interpersonal aspects of any communicative act).

We must assume that there is a motivation for communication, and this lies in the importance of communication for goal fulfilment and the existence of culturally-derived psychological states of satisfaction and dissatisfaction, which serve to motivate the individual to act to change an undesired state into a desired one. Communication is a possible means of achieving this. It is probably obvious from this that the motivation for communication includes more than just information-giving and information-seeking elements. It includes also attempts to achieve cognitive consistency, enhancement of self-image, emotional reinforcement, confirmation of relationships, etc.

The arguement is that communication can be seen as one aspect of behaviour both arising out of and motivated by the individual's existence as a social man - a behavioural option to be chosen. Thus the individual may have more to gain by communicating misinformation than information if, for example, he can thus avoid making a fool of himself in the eyes of the recipient of his communication. So deliberate mis-communication is a factor to be taken into account.

Bernstein (1972) in his work on codes, underlines the importance of the social relationships and meanings which are available to individuals in a communication situation as the determiner of the actual communication that is chosen. Therefore, depending on their experience within a culture, individuals learn not only patterns of representation and symbolism (knowledge of the universe, etc.) but patterns for the selection of communication options and also the motivations for communication. The whole value system of the individual is involved and questions of what should or should not be communicated to whom in which circumstances become vitally important.

3. Covert rehearsal (processes in the selection of options).

Prior to any communicative act in the interpretation of any communication there must be a process of survey, consideration, and selection of the particular behavioural options chosen. (For the purpose of this discussion a reflex action such as a cry or a smile cannot be considered to be a communication although, of course, it may have meaning for the recipient. It would be a communication only if initiated for that purpose.) This process can be considered to include:-

a) The existence of a stimulus to communication or interpretation.
b) A process of cognitive consideration of possible courses of

action including the assessment of the presenting situation so that the action is appropriate; the amount of goal fulfilment likely to result from each possible action; and which course will best suit immediate and overall personal interests. This process will also include factors such as the expectation of the likelihood of reciprocal action on the part of the recipient of any communication, and the use of all relevant knowledge of the universe. The procedure would result in selection from a system of behavioural options of which communication would be a possible choice.

c) Given that the individual selects communication as the appropriate course of action, he has a further system of choices leading eventually, but systematically, to the actual text (words, etc.) to be used.

The individual is, therefore, choosing a course of action based on self-interest. (The complexity of these choices does not rule out the possibility or the probability that the system allows decisions to be by-passed thereby providing a more direct link between the original stimulus and final response. This arguement, however, is outside the scope of the present discussion.) This interpretative process works on a two-way basis, the recipient is also making choices about meaning, etc. The recipient may also take into account factors such as manner, facial expressions, and so on that were not intended as part of the message. He may even decide that the message is not addressed to him anyway. The importance of the recipient's view of the communication has been outlined by Lane (1974) in discussing education, and drugs.

> What matters then, is not the communication but what recipients do with the communications they receive. In particular does the individual view himself as someone to whom the message is addressed. Such research as there is suggests that ...(information)...is likely to be used selectively by individuals. Thus the drug user may accept pro-drug education while the non-user may accept antidrug messages. The person who does not care may ignore the message altogether, regarding it as something not addressed to him in spite of its preventive or information aspects. We must, therefore, look at the groups to which communications are directed.

Within any of the prerequisite factors - knowledge of the universe, affective state, covert rehearsal - are numerous potential sources for communication breakdown. For the individual working within community health this potential is increased since he is working across cultural barriers and has to interpret and transmit information based on specialized conceptualizations which are outside the general culture available to the recipients. He is also concerned in an area which involves complex motivations but clearly circumscribed options for interpersonal behaviour that may limit the physician's role, while

many of his clients do not use the same patterns of communication as he does himself, and there is a lack of an essential ingredient in planning messages, that is, feedback.

Interim summary

In considering communication it must be kept in mind that the individual taking action in a situation is attempting to bring about a desired state which may not be compatible with the professional's interpretation of what is good for him. The individual selects what he considers to be appropriate courses of action based on his knowledge of the situation. If he chooses communication as an option he must assess not only his own action but the likely response of the recipient. He must select, based on this information, an appropriate textual content which reflects the meaning to be conveyed and the relationship between himself and the addressee. Often in community health practice the messages are not culturally significant, they do not bring about a desired state, and are not appropriately coded. Therefore, they do not have an effective force of meaning since they satisfy none of the three prerequisites for communication.

Sources of communication breakdown

There are many possible sources of communication breakdown but four are of particular interest in the field of community health since they can be prevented.

Deliberate and non-deliberate provision of mis-information

As the end product of communication involves our whole value system, where the individual has some value at stake he may pass on inadequate or inaccurate information such as claiming to clean his teeth when he does not, or failing to pass information to a superior which may place him in an unfavourable light. Information from an external source may become mis-information because its limitations are not clear or if unpleasant it may be negated by saying that 'they' do not know what they are doing anyway. Information from a superior is often assumed to be correct when it is not. All this information once it becomes a matter of record takes on an independent existence which gives it a degree of immunity from dispute. As the size of the communication network becomes greater, the volume of it all makes it immune, particularly if stored in a computer. Although the formalization of information in computer records aids clarity it can result in subtleties of meaning being lost. However, more careful planning of information can do much to overcome this. Questions such as how will the information be validated, how will its limitations be classified, and what codification should be given to the basis on which the original interpretations were made and subsequent interpretations

developed, should be treated as urgently as consideration of what information is to be stored and to whom is access to be allowed.

The nature of information coding

Information has no inherent meaning, its meaning is derived from a given frame of reference (see below) and the interpretations placed upon it within a given coding system. Therefore, the likely response is problematic yet apparently based on a rule governed by a selection of options. Therefore, although the possible range of difficulties is wide they are not insurmountable and they can, in practice, be overcome. For example, a consultant dealing with a disturbed 14-year girl felt that he had established a good relationship following an initial interview, the girl's interpretation was completely different. The reason appeared to lie in a misuse of language. The consultant had asked to see her school project work and she had agreed. He had used the usual question format, 'Would you like to bring your project? This, of course, could be answered by yes or no, but by convention it is taken to mean not simply that the respondent would like to do so but in fact will. However, it is also the convention for teachers to give orders using the question format, e.g., 'Would you like to shut the door?' from a teacher's lips means in fact, 'Shut the door.' As this girl viewed the consultant as a sort of superior teacher she interpreted his question as an order and, therefore, came to the conclusion that he was just as bossy as everybody else. They were drawing different meanings from the language used. Once the cause of the communication breakdown was located it was a simple matter to put things right and the attempt to do so did much to cement the relationship. However, the breakdown could have been avoided if less attention had been paid to the words, and more to other signs of communication such as the girl's manner.

Research over a period of years has shown that variables other than words affect meaning and response. These are particularly important in preparing messages for a wide audience. Such factors as the status of the communicator (Coleman, Katz, and Menzel (1957) for example, have shown that how a doctor views his colleagues affects the weight he gives to their ideas), the fear-arousing level of the communication (Janis and Feshback (1953) have demonstrated the importance of this variable on the acceptance of health education messages), and the existence of opinion leaders in a group can mean the difference between success and failure (Menzel and Katz (1956) have found this to be important in determining whether new drugs are adopted). McQuail (1969) gives a review of the research in this field.

Social position

The relationship that exists between the participants in a communication affects the language used from decisions as to whether

or not communications should take place down to the choice of words to be used. Therefore, the effect of the position of an individual within the social structure and its associated status on communication patterns must be considered. Elling, Whitmore, and Green (1960) in a study of mothers who failed to follow treatment instructions for their children suffering from rheumatic heart disease, found that they felt that they were being 'looked down on' by the clinic doctors. This unconscious communication of a lack of respect led the mothers to ignore the treatment necessary for the care of their children. Consideration of diagnosis and treatment are insufficient, for a greater awareness of the interpretations that patients use in assessing their situation can do much to circumvent such difficulties. A discussion in Sebeok, Hayes, and Bateson (1972) outlines the whole range of interpretations involved in patient/doctor relationships and clearly indicates that words alone are not enough in these situations.

Frame of reference

The frame of reference against which an individual forms or interprets a message must affect the ability of others to respond appropriately. An important cause of communication difficulty in community health is that the professional man is transmitting a message about a highly conceptualized subject from within a specialist frame of reference to a recipient without those concepts. The professional man is, therefore, not only sending a message but is also trying to create the necessary imagery on which an appropriate interpretation can be based. Some believe that a way round this problem is to tell those concerned as little as possible, but this is not the case since silence is itself a message variable which equally is open to misinterpretation.

It is clear that the practitioner must take responsibility for the interpretation of his words, for if he does not no one else will. Once health education and preventive measures generally are less concerned with particular campaigns and more with giving individuals the potential to make realistic decisions for themselves this particular difficulty can be overcome.

There is much from the specialist culture of health matters that could usefully become part of the general culture.

An experimental study of communication

In an ongoing study of communication I have been looking at messages in use in health education to see if any predictions could be made about the likely response to a given message. In one experiment a quasi-random sample (every third person from a secondary school

register) of sixty-five schoolchildren was chosen and shown several short, and a few long, health education messages. They were asked to explain the meaning of them. Two tests, covering the reading difficulty of the messages and their acceptability (measured by the extent to which they were understood) were used and very large differences between the messages were found. Some gained nearly 100 per cent acceptance while others were misunderstood by every pupil.

The three messages having the greatest success are given below. The first was understood by all but two of the pupils, the second by 68 per cent, and the third by 33 per cent.

1) A baby must be protected by locked drug cupboards. This statement contained no terms which presented difficulty, it was short and pupils were able to relate it since they all had younger siblings for whom they could accept responsibility. The ideas that babies are too young to know was grasped. This level of understanding was achieved in spite of the fact that the key idea in this sentence is only implied, i.e. a baby must be protected by locked cupboards from dangerous drugs. This type of implication is in common use in the language, however, and hence its meaning is clear.

2) Parents should not take pills in front of their children. This contains no difficult terms, is short but is less familiar and requires the child to take the role of the adult. Additionally many of the subjects' parents did take pills in front of them and they could see no harm in it.

3) Medically-prescribed drugs must be treated with respect. There proved to be some difficult terms in this statement, that is, 'medically' and 'respect' but not 'prescribed'. The terms themselves are not difficult but they are used in an unfamiliar way in this message and the key idea is somewhat obliquely stressed.

The longer sentences, those involving two or more qualifications or clauses, never gained more than 35 per cent acceptance and those involving more than five clauses were rejected completely by some groups of pupils. The factors which seemed to govern the response (a non-linguistic analysis is being used for the purpose of this article) were:-

a) Familiarity - the more the individual could relate to it the better.

b) Length - the shorter the better. The introduction of qualifications caused the acceptance rate to drop sharply.

c) Knowledge of the key terms - the more well known the better. The exception to this was when the general meaning of the term was

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Table 1. Level of acceptability of the key terms grouped from highest to lowest.

Group	Key Terms
1	Problem, prevention, illegal, responsibility, relationship, achievement
2.	Personality, authority, dependent
3.	Society, development, isolation
4.	Deviance, expectations, conformity, experimentation, democratic, maturity, inadequacy, rehabilitation, delinquency, environment, adolescent, addiction, culture

This is, of course, no surprise but many messages in use were open to misinterpretation. This study is, of course, measuring understanding and not the extent to which someone will act on the message. The reading study revealed that many messages demand a level of reading ability greater than that possessed by those at whom the message is aimed. A clear hierarchy of terms emerged related to the extent to which the pupils could relate them to their life, their 'concreteness' (Table 1).

Conclusions

Communication involves a number of clearly defined factors and pathologies of communication can often be traced to the inappropriate selection of options from within the system of factors. In preparing health messages, particularly within a community framework, attention must be given to these factors so that high levels of acceptability can be achieved. Not only must attention be given to the message but the likely response to the message also. Communicative aspects of community health must be approached as rigorously as its medical aspects. There is little point in finding an answer if it cannot then be communicated to those who have to act upon it. Community medicine faces particular problems in this respect and if the promise of the reorganization of the National Health Service in 1974 for better health care is to be fulfilled, communication must be considered as a subject worthy of study.

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Conclusions

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It has been argued that education is not directly about prevention but rather about knowledge. But the fact that many pupils do try often dangerous drugs means that prevention must be considered.

Clearly since it appears that drug users often have other problems it is necessary to look at individual aspects of drug use and the influence of the school.

The following paper does this, and then the question of predicting drug use and the role of the teacher and the different forms of intervention needed is covered.

But it is already clear that we need to be concerned not simply with the drug user as a drug user but as a person, who may or may not use drugs in a dangerous fashion. Those who do so, do so as part of wider patterns of personal difficulties, and it is to these difficulties that our attention should be directed.

5. INDIVIDUAL AND SYSTEM ASPECTS IN DRUG DEPENDENCE

There are two important aspects of drugs education which are, unfortunately, often confounded: that is, helping individuals with their problems and education about drugs. This section looks at the first of these and argues that the school can be an important influence both negatively and positively. Both group and individual approaches to the problem are suggested.

As implied in the title, this section deals with two main areas, and this is intended to lend clarity to what are involved arguements. That is those aspects of dependency which manifest themselves in terms relevant to individuals in the school system, but not dependency in its entirety. I am not concerned here with the occasional user. The importance of the term 'dependency' in this article is to the extent that an individual's persistent use of a substance or substances is such that the organization of his overall behaviour is disordered by this usage.

The individual

The drug addict is someone who is dependent on drugs. True; but unfortunately, it is still the case that lay, and sometimes medical, poeoplelump all the actions of such drugs and all the activities of drug takers into one amorphous mass so that it then becomes possible to talk vaguely about drug addiction as if this were an expression of a simple equation - i.e. drug + patient = addiction. In fact this is not the case (Willis, 1969). The view that drug + patient = addiction is still common and it leads to the view that if you separate drug and individual the problems cease. This makes educational as well as medical nonsense, for we are dealing with personal problems for which some individualsfind partial answers indrugs, in the absence of any available perceived alternatives. Willis refers to various studies which show that different people use drugs for a variety of reasons. It must be recognised that not all of these reasons will create a problem. Although, as Mattke and Steinigen (1972) point out, we should not forget the drug itself and its actions.

Why exactly some problems lead to dependency is not clear and the whole area falls into that unfortunate category of multi-causal. The label multi-causal is unfortunate, because it makes it difficult to unravel the varied contributory factors. However, something that becomes apparent from the statement by Willis is that mass media slogans which lay the blame completely on drugs as if in some magical way they transformed secure well-adjusted individuals into babbling idiots, are misleading at the least, and, at worst, are positively dangerous. It is sad that the reported statements of some educators

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at conferences are full of such scare-mongering. It must be recognised that a certain amount of drug use takes place. The occasional user should not be the subject of the hysterical over-concern to which he is at present subjected.

If there is any agreement in the field of dependency it is that the drug-dependent individual in some way has an inadequate personality or has learnt this particular way of handling personal difficulties. Laurie (1969) came to this conclusion in his review of the evidence and Dale Becket in a pamphlet for parents published for the Association for the Prevention of Addiction (1972), stresses the fact that a secure individual is unlikely to become dependent on drugs. Similarly, from the research evidence it is becoming clear that some sort of personality problem is at the basis of such drug use. A useful summary of the evidence is available from the Teachers Council on Drugs Education. The existence of problems such as family background and poor education is clearly indicated in this summary although those of good education, etc. are also drawn into dependency (Hicks, 1972). However, the difficulty in isolating the actual personality variable which might lead to dependency was made clear in an article by Teasdale, Seagraves and Zacune (1971) in which they pointed out although as a group the drug dependent scored highly on Eysenck's Psychotism Scale only a minority of drug users actually answer the questions in the psychotism direction. Other data show, again as a group, that drug users score highly on scales of neuroticism (Halstead and Neal, 1968; Rosenburg, 1969). However, it may be that development of the Psychotism scale might provide a useful predictive tool related to the likely response of individuals to treatment. This is considered later.

This difficulty is perhaps to be expected since several of the factors which may lead an individual to try drugs are symptoms of normal adolescent experimentation (Lane, 1970; Richter, 1970) and this is, in part, a popular view (Craven and Birdwood, 1971). But, the idea that individuals may be led to dependency rather than minor experimentation as part of normal adolescence is as incomplete an answer as is sole reliance on personality factors as the key. Although many people agree about this, they often do not realise why this is so or they fail to accept the implications of this. If any of the above factors are to result in drug dependence the individual must first have access to drugs and learn attitudes favourable to their use and discover in using them that they work and are to be valued.

Even if individuals do have appropriate access this does not mean that they will become dependent. Some individuals experiment with drugs, others do not, and some become dependent while others simply use drugs as part of a culture and cannot be viewed as disordered individuals simply because of this use. It is only if individuals learn to place a sufficiently high value on drug use, and/or culture,

so that drug use becomes a powerful motivating factor in their behaviour that there is a danger that it will become the major motivational factor available to them. If it were a question simple of normal experimentation leading to disorder because of the evil and automatic effect of drug use on the personality of the user, the figures for dependency would be astronomical. Unfortunately, various myths accompany drug use of which this is one. This particular myth leads to the view that this is purely a medical problem, as Toby Ryle points out (1972). The addict was a product of family and societal problems which went back for years and it is not helpful to let society off the hook by saying that it is a medical problem.

The cultural aspects, i.e. access, attitude and motive, of dependency makes available to the educator the general area of the sociology of deviance as a theoretical base which may throw light on the learning of drug-dependent behaviour. Sutherlands and Cressey (1955) maintain that individuals learn deviant attitudes in intimate personal relationships, thus we may look to such relationships for the primary learning of dependent behaviour rather than from impersonal sources such as television. Merton's theory of anomie (1949) and, more particularly, the reformulation of it by Cloward (1959) to include the idea of differential access, emphasizes that individuals adapt to the situation they are in, choosing courses of action from those available. For those who fail within the social system, access to the different options is often limited. Withdrawal from society is one form of adaption mentioned by Merton which is relevant to dependency, and this is an option which has a tradition of over a thousand years. But it must be remembered that patterns of drugs use change very rapidly and the information which is most useful is that related to the area in which the teacher works. There is not a typical drug-taking group the stereotype of which can be applied universally. O'Sullivan (1972) for example, has outlined the different groups that can exist in an area of one square mile of London.

Interim conclusion

In terms of the individual, it is simply not adequate to think of the drug-dependent individual as someone whose problems are drugs. Rather, he is someone who is peculiarly susceptible but not necessarily predisposed to dependency because he finds it difficult to cope with stress in alternative ways, and who, because of involvement with a group or individual (or doctor) who has favourable attitudes to drug use then learns to use drugs successfully at least initially, to obliterate or overcome his problems or to find answers to whatever it is he is looking for, and thereby learns to place a higher value on drugs than the alternatives.

The school as a social system may, in part, force or usher the individual to select the option of dependency by denying the individual caseof access to alternative roles.

Systems

We have seen that the development of dependency requires appropriate access, attitudes and some value derived from drug use not as readily supplied from some other source. The process for the development of the potential for such patterns of dependency, may start long before drugs are ever used. Although this article concentrates on influences within the school, this does not mean that there are no other contributory influences such as the family, youth groups or mythology. In this section the extent to which schools can bring about a situation in which all of the above can occur is considered. This does not mean that all schools stand condemned as the causal agents in drug dependency but rather that there are factors in the school system which, given appropriate circumstances, contribute to the creation of the conditions for dependency.

All organizations are constructed to achieve particular goals, schools are no exception. The achievement of these goals is dependent on a number of factors including informal as well as formal influences. Therefore the influence of informal latent cultures within a school are as much a part of achievement within the school as are formal policy decisions. These influences are particularly important when there is conflict, as there always is to a greater or lesser extent, between personal needs and the position the individual holds within an organization, be he teacher or pupil. The position an individual holds (his roles) imposes certain demands and obligations but the means for him to fulfil these organizational demands may not be easily available. Thus, the teacher may find conflict in his concern for an individual with problems as against his position as a member of the staff. The pupil may find himself unable, in ways approved by the school, to meet the demands for success. 'Role dilemmas have their sources both in organizational structure and in individual personality Similarly, both structure and personality influence the varied forms of adoption that are achieved' (Levinson, 1969).

Individuals bring their own expectations and values with them to school and find within the school informal and formal influences. There is thereby an ever present potential for conflict for staff and pupil where such varied interpretations exist, alongside role dilemmas. The existence of such conflict lessens the potential for the realization of the formal goals of the organization and increases the potential for the realization of alternative informal goals.

The individual in the school interprets the behaviour of others and consequently his action is subject to change. Most teachers have

probably been made aware of the interpretive behaviour of their students' behaviour at one time or another. A situation exists in which individuals are not simply doing as they are told but are taking courses of action from within a system of options, based in the relative advantages of the behaviour to themselves. Just think of what pep-pills may appear to offer to the individual anxious for immediate gratification when his confidence is shaken by failure (or perhaps even the young sportsman desperate for success). The existence of this interpretive learning process has been demonstrated in various studies of which Becker's study (1963) of drug use is the most relevant to the present discussion.

Bearing in mind what was said of the conditions necessary for the development of dependency in the first section of this article, consider how favourable the conditions might be for the development of latent cultures when individuals fail to achieve success in ways and at a level they consider appropriate within the school. In fact, anybody who considers himself a failure, whatever the reality of the situation must be considered at risk given the appropriate circumstances. In bringing together individuals with similar problems and values and of roughly similar age, the liklihood of a group based on deviant and possibly drug-based culture being formed is increased.

In spite of the popularity of the image of the pusher it is a fact that most people are introduced to drug use by friends. In a study of Heroin users Willis (1969) found that this was true in nearly every case. Even without a coherent group, a quasi-group relying on the mythology of drugs and some personal contact might be formed, and which is capable of resisting pressures to conform to formal demands because of the levels of ambivalence and apathy which exist in our schools. Individuals thus find within such groups the success denied elsewhere (Mays, 1972; Lane, 1973,DDDG).

We have, then, a situation in which not only does the school structure create conflict through pressures of achievement, etc. which individuals are unable to meet, but it provides the means for producing contradictory alternatives to its goals. However, the availability of drugs within schools is far less than is popularly supposed, probably no more than 10 per cent have some knowledge of drug use and a larger section of this group have only a passing aquaintance (Wiener, 1969). This together with the economics of the matter (raids on mothers' librium or barbiturates in the first-aid cabinet, however, seems to be a growing problem) is a limiting factor. But, the basis for later drug use is laid in many cases at school even though drugs themselves may not be used.

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Possibilities in the need for educational action

If it is true that the school can be a factor leading to dependency it is also true following the same line of arguement that the school can play an important part in preventing the development of problems leading to dependency.

Later is outlined the role the teacher can play by providing alternative successes and it is argued that the professional teacher should be capable of recognising the symptoms of failure to cope with stress situations which the adolescent faces. The later section provides a list of such indications. The techniques suggested, such as using a person's interest in something to get him integrated into a non-deviant group, are derived from social group work theory as applied to youth and community work (MacCullough and Ely, 1969; Matthews, 1966; Morse, 1968). This has certain advantages over individual counselling, although it is usually used in association with it, in that it does not rely as heavily on the form of intimate social relationships which are difficult to establish under the pressures of the school system and it also allows larger numbers to be helped indirectly. The whole structure of individual counselling within schools is so confused at the moment that little of a constructive nature can be said but aspects of this will be taken up later.

The most useful approach for the present is united action jointly with the health and social service agencies particularly the local Medical Officer of Health as a first step, preferably through the work of the Drug Liaison Committees where they exist. However, recognition of the responsibility of teacher for those pupils who fall foul of the system for one reason or another is the start that is needed. Rather than identifying so-called drug users, teachers should identify those who need help for whatever reason. Don't go round looking for addicts, look for individuals who need help. The implementation of the Children and Young Persons Act 1969 may lead to greater flexibility in treatment for the pupil who comes up against the law but again matters vary so much from one area to another. Find out what is going on in your area before you offer pupils to the mercies of the local courts, that is the only advice that can be given. For once 'labelled' they may be driven to further extremes (Lane, 1973).

However, it is not simply a question of individuals with problems needing counselling. For while most people would recognise the right of the individual having difficulties with his GCE studies to sympathetic counselling, many would deny the same right to the individual caught taking drugs regarding this as a matter for repressive discipline. Drugs do involve a number of other factors which are educationally relevant and must be faced. The ambivalent

[redacted]

position of the school in relation to the requirements of the wider community as against its commitments to the individual is an example of this.

If teachers constantly grass on pupils can they wonder if no one will confide in them. This is, of course, not the result of bloody-mindedness on the part of the educators but simply a further example of role-dilemma. Teachers do have a responsibility to the wider community, and their employing authority. They also have a responsibility legal and moral to all their pupils not only those with problems. A local education authority is hardly going to look favourably on a teacher who fails to report the existence of a drugs ring because he wants to retain the participants' confidence!

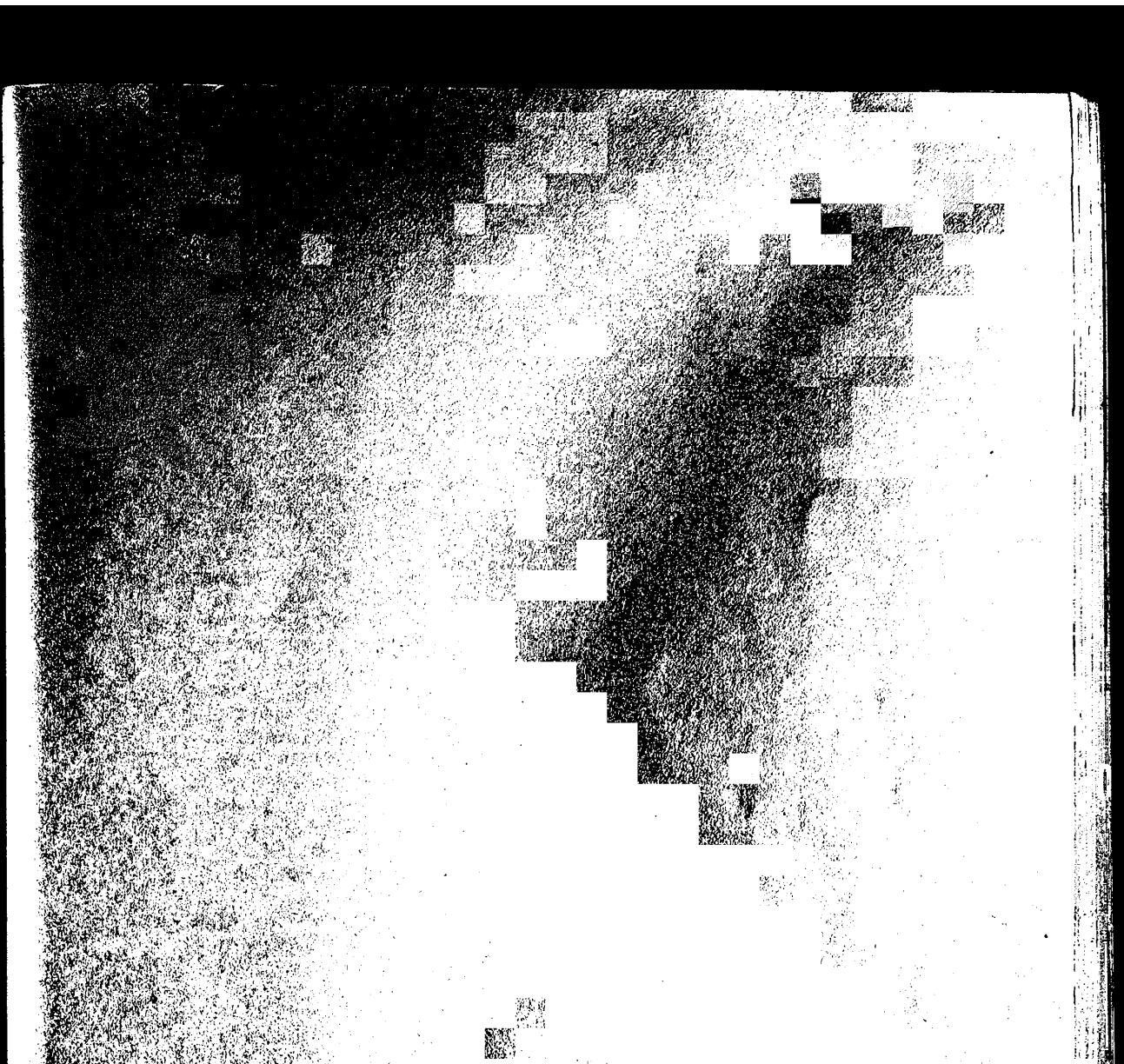
If the teacher is to provide education, that is to provide the individual with a basis from which he can build for himself, he has to accept the implications of that decision, i.e. that the individual must be free to choose. If the individual is to become independent of the teacher his choice must be his own, and not automatically that of the teacher. But this level of choice is not available in many situations. The school which allows individual deviance will provide a situation favourable to such an approach. In the school with restrictive aims and the power to select its intake according to its own demands such an approach may be neither desirable nor useful. Such a school because of the greater concensus between parents, staff and pupils may more easily indoctrinate negative attitudes to drug use - something the permissive school could never do. This does not imply a value judgement on the relative merits of each but simply an acceptance of the fact that different educational situations give rise to the need for different approaches.

The problem of dependency does not arise overnight and there are strict limitations to the action any individual teacher can take. But as part of a co-ordinated policy in conjunction with other local authority services, the school, providing the factors mentioned in this article are taken into account, can greatly reduce the problems of dependency. For those not dealt with here, e.g. the totally inadequate, the hardened sociopath (Yablonsky, 1962) the school can offer little help but through partnership with the other services lies the best hope for these groups as well.

There is no solution to the problem, not because there is nothing that can be done, but because there is no one correct course of action. Each school must as a matter of policy find its own solution based on knowledge of the local situation. Since dependency is the product of a variety of factors, of which school structure is one, then that structure must be taken into account when planning action. It is a responsibility that schools cannot afford to shirk for even if they take no action they are still a part of the development of patterns of

dependency and the individual needs the help of the school to overcome it. What could be more of an educational issue than that the school is part of this problem and what more need could there be for educational action than that the school contributes to the development of delinquent behaviour? (Power, et al. 1967; Mays, 1972) The school is part of this problem and the continuing lack of action and denial by many education authorities of the problem is a sad reflection on the professional awareness of educators. Authorities, schools, colleges, and universities have yet to take positive action in this area, both in terms of education and counselling, although there are indications that concern and interest is giving way to positive action.

Fortunately, ignorance is giving way to action but the success of the odd school or education authority is not enough, for until schools accept responsibility for the deviant he will be driven to further extremes until recovery becomes beyond reach. If we are to deal with failure, brilliant high spots will not do. An achievement-based society valueing success through education will create frustration for the rejected. If we do not believe in them they will retaliate or withdraw (Lane, 1970). And, deal with failure we must if prevention is to have even a dog's chance of success.



6. PREDICTORS OF DRUG USE

It quickly becomes apparent to those working in the field of drug use that dependency is not one overall phenomenon, yet in spite of the fact that it is a major research area little clarity has been forthcoming. In particular, consideration of the nature of failure and the motivation of dependent individuals has been lacking. Although statements such as 'youngsters take drugs out of curiousity' have been common, a thorough consideration of motivation in dependency and motivation in treatment has not taken place and no one could argue that analysis of motivation has been propagated in the way that personality analysis has.

The consideration of such hypotheses might include the differences in the learning of drug-dependent behaviour between different users. Even apparently similar usage might include such varied reasons as the difference between those who use drugs to deal with a non-severe stress situation, those who simply use drugs as part of a recreational activity and those whose dependence is induced as part of the normal cultural response of a doctor to his patient. The similarity over a wide range of characteristics of so-called 'problem users' to other deviant groups is well established, and De Alarcon's (1974) data indicate that drug users are different from controls on the same criteria of delinquency truancy, etc. as other groups, such as the maladjusted pupils.

Detailed personality testing, therefore, is likely to produce differences between drug users and 'normal' controls but not necessarily between drug users and other delinquent groups. Kennard (1971) has reported that there are limitations to the usefulness of the Minnesota Multiphasic Personality Inventory (MMPI) approach to personality testing and, for similar reasons, to Cattel's 16 Personality Factor. Four scales were consistently in the abnormal range when testing his sample of drug dependents: depression, psychopathic deviation, psychoasthenia and schizophrenia. In addition, the scales measuring concern with bodily functions, paranoid feelings and ideas, hypomanic feelings and behaviour were high in about half the sample. As reported elsewhere (Rosenberg, 1969; Teasdale, 1971) drugs users also score highly on neuroticism and psychotocism. This agrees with work done in America but it appears that drug users are more willing than most to see themselves as disturbed, therefore such scales are misleading.

This opens up possible hypotheses of this factor as a motivation for dependency and the use of measures of the user's attitudes and motivations over time, and his perceptions of himself, his interactions with others and others' perceptions of him. That is, the concern must be with a functional analysis of the values the person finds on the drug-dependent behaviour. Some factors to look for in terms of individual

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response have been outlined previously (Lane, 1970). In the present article the concern is with the meanings of the behaviour.

The following are the types of questions that need to be asked:

1. Which participants (i.e. anyone involved) in a given situation influence the outcome of action taken?

2. Which patterns of response occur in a situation and which are excluded by virtue of that response?

3. What motives underly the existence of the observed behaviour and does any conflict exist between the motives and the professed 'ends' of the behaviour?

4. What aspects of the situation appear to go unrecognised by the participants?

5. To what extent does the existence of the observed patterns of behaviour and the situation within which they occur help or hinder the concerned aims?

6. What meanings do the participants attach to the patterns of behaviour?

Study of delinquent and non-delinquent pupils

In a study of about 500 delinquents and non-delinquent pupils certain individuals became involved in heavy drug use subsequent to the collection of initial data and prior to the collection of follow-up data. Therefore it was possible to look at aspects of personality and motivation (other aspects are not reported here) and compare features of drug users with other delinquent and non-delinquent groups (Table 1).

Table 1. Toughmindedness (P), extraversion (E) and neuroticism (N) scores of drug users prior to use, matched age, sex and school sample of conduct-disordered pupils and comparison random sample.

	P		E		N	
	mean	SD	mean	SD	mean	SD
Drug users	8.5	3.66	18.5	4.0	14.3	2.3
Conduct disorders	8.2	2.83	16.0	2.53	12.18	4.5
Random	3.9	2.59	18.07	4.3	11.1	3.3

N = 30

Drug users	[illegible]
Conduct disorders	8.2
Autism	3.9

N = 30

Differences include high P scores on Eysenck's (1975) new personality questionnaire. High P consists of tough-mindedness, assertiveness, aggression, coldness to human relationships and is related strongly to personality disorders and criminality. Low attainment compared with ability, truancy, higher incidence of self-reported illness and accident, less fear of physical injury, membership of deviant groups, a feeling of being disliked by teachers, difficulty in forming relationships, viewing the world as difficult or a battle of wits and fairly high levels of self-sufficiency, impulsiveness and manipulative attitudes to people.

These differences between heavy users and non-users existed prior to drug use. However, these characteristics were shared by other delinquents who were non-drug* users and the only differences between the delinquent non-user and user were luck, in terms of access to drugs; personal isolation and self-sufficiency, other delinquents being more group-dependent; and less fear of physical injury. However, there were no differences between delinquents who were occasional users and other delinquents except subsequently in terms of their attitudes to drugs other than alcohol and, of course, in terms of access. The drug-using group as a whole only showed differences from non-users because of the very high scores in antisocial directions of heavy users. Thus, it was only the individuals who later became heavy users who showed significant differences. Their drug use was frequent and often irresponsible and all had defined purposes in using drugs - one as a sexual substitute, another to feel less wound-up inside, a third because it was dangerous and made her feel really bad - all reasons related to personal needs rather than the use of drugs for recreation. They tended to use alcohol in the same way although it was less preferred.

However, not all of the heavy use led to increased problems, at least not at the time of the study. For one of the group heavy contact led to involvement with a less-delinquent group of individuals and consequently less-manifest delinquency, and another tense and aggressive individuals become less tense and able to take a more active part in life. Thus, it was motivations in use, 'the meaning aspect', which provided important information at this early stage.

None of this is information which can be used to predict drug use since the dividing line between the potential problem user and non-problem user was virtually non-existent except by the collection of data in a very time-consuming manner. Given the numbers spotted even using this data, it would be an unjustified use of resources. Epidemiological registers, therefore, while charting historical trends, would be inappropriate for extrapolations, particularly in view of rapid change in patterns of use. This is particularly so since measures such as this cannot predict the social situations (system aspects) which individuals will meet, a factor very important in drug use (Lane, 1973). Rather it

[illegible]

points to the need to pay attention to factors of personal stress in all youngsters and not simply drug users.

However, the P scale has proved significantly useful in indicating response to therapy and the likely persistence of problems of behaviour and may therefore have a diagnostic value (Lane, 1975). However, an obsession with predicting drug use by youngsters is likely to be an expensive and fruitless exercise. This largely confirms other studies, drug users tending to reflect traditional characteristics of other deviant groups. To look at them as 'drug users' therefore is valueless. Some drug users will not present personality adjustment problems, others will, but not simply as drug users. The tendency to impulsive, destructive, manipulative behaviour and often patterns of truancy has been indicated here and elsewhere, (De Alarcon, 1974). Therefore, it as such, rather than simply as drug users, that preventive intervention is necessary.

The data from this study indicate that some of the personality variables noted in drug users were present prior to drug use, but not that those variables automatically led to its use. If one looks at the motivational data made available from the questions it is established that several factors of access and influence from others, as well as the individual's social situation, were present, supporting the move to drug use. Once in the pattern, which at first may require only accidental access or a particular crisis, the meaning placed on the behaviour, not simply to the drugs used, varies and the individual's behaviour begins to restrict access to alternatives. It must also be noted that the numbers of individuals studied was very small: 12 out of 500 were heavy users and therefore the results need to be treated with caution.

However, based on separate studies (Lane, 1975) involving about 70 subjects, it appears that these factors, particularly the P scale and the level of neuroticism (N), seem to relate to outcome with other problems groups, such as the behaviour- and learning-disordered, and consequently response of drug users to psychotherapy may be similarly related. The relationship between the personality factors and outcome is certainly worth further investigations. It has been established that recommendations for treatment of those who come before the courts are affected by personality, for example, probation officers are far more likely to advise probation for introverted, neurotic types than for extroverted and very unneurotic individuals. Re-conviction rates are similarly high for the latter group (McWilliams, 1975). It appears that response to discipline in schools is lower in the low N groups and the response of pupils to counselling is similarly related, with the tough-minded and low-neuroticism pupils progressing significantly less than the tender-minded (low P) and neurotic (high N). Thus, it becomes possible to talk in terms of alternative therapies (Lane, 1976). (See Table 11)

[redacted]

Table 11. P, E and N scores of early and late responders to therapy for learning and behaviour disorders.

Therapy	P mean	P SD	E mean	E SD	N mean	N SD
Early	2.0	1.26	14.5	1.94	13.2	3.78
Late	5.2	3.98	13.67	6.14	7.8	3.83

N = 20

Conclusion

Predicting drug use is likely to be a fruitless exercise. Certain features such as the psychotism and neuroticism factors in personality do seem to relate to outcome.

The nature of the motivations and the meanings individuals see in their drug-use behaviour are important in understanding that use. In examining characteristics of drug users, therefore, a somewhat broader picture of the individual is needed than that provided by either questionnaires or subjective personality evaluations alone, and that picture based on personality and motivational characteristics in the individual and his situation, while not predicting use, may help to ensure effective response to therapy. Speculatively, it may be that the supportive rehabilitation hostel of the ROMA type or personal counselling may suit the more introverted, tender-minded, anxious individuals, while the stricter regime of the concept-based houses (drug rehabilitation units) Alpha and Phoenix, etc. may be required for the tough-minded, impulsive and less-anxious individuals (which would additionally include potentially using and non-using delinquents). This type of selective response is beginning to work with behaviour disordered adolescents and it is on the present evidence worth considering for other drug users whether in the courts or in the general practitioner's surgery.

7. Conclusion : APPROACHES TO PREVENTION

In stressing the importance of characteristics such as 'high P' it is important to recognise that 'high P' does not cause dependency. Rather, these characteristics are reflected in a range of problems and individuals (based on other variables) find varied patterns to resolve them.

Not all dependents are 'high P'. Not all behaviour problems in school are preventable by the same approach.

A more flexible concept is needed, based not on categorisation of the pupil as a drug user, delinquent etc., but by a dimensional analysis of his position.

Such an approach to analysis looks at the variety of problems and potentials of the individuals, not the label attached to him.

The prediction study above indicated a similarity of characteristics between pupils with different categories of deficit who did or did not respond to therapy. Dimensions of individual and system behaviour were previously outlined which predisposed failure to respond.

An experimental approach to intervention for behaviour problems is needed. That is, each analysis is created as an experimental hypothesis to be tested by evidence. The therapy resulted from this hypothesis testing and itself was considered to be a further hypothesis to be tested. It was thereby a continuing process of evaluation.

Briefly, the difference between these concepts is as follows.

A categorical non-experimental model

In this approach, the process of diagnosis consists of assigning a pupil to a given category. Thus a pupil under-functioning in academic work may be tested for intelligence. If he scores less than say 70 points, he is deemed educationally subnormal and assigned to a school for such pupils.

Similarly, a pupil with severe behaviour problems in school may be ascertained maladjusted or in need of child guidance and referred to a school or centre. The relevance of the programme offered at the centre or school does not enter into the diagnosis.

A dimensional experimental model

In this model, behaviour is assumed to exist along a normal dimension. For example, the same traits of personality exist in everyone in varying degrees.

Analysis consists of testing the influence of such as these traits on current behaviour and finding a way of taking account of the influence. It includes the situation of the pupil and any proposed alteration via therapy in the analysis. Analysis includes any predisposing, precipitating or maintaining factors in the behaviour.

[illegible]

In intellectual deficit it is not the score that is of interest, but the natural 'style' of the performance. The child who disrupts the class is not assigned to a maladjusted category, but rather the factors in that class influencing the pupil's behaviour are examined for potential for change in the situation.

In the same way, the drug user is not seen as someone who uses drugs, but rather an individual with a particular pattern of cognitive response style and set of family and social circumstances contributing to maintaining an ineffective life style.

These need to be analysed, their contribution assessed and a programme established. (Lane 1974)

The danger is that instead of analysis of the case, a cookbook approach is adopted. That is, the person has a problem, so try this, then that. Intervention via counselling is the currently favoured recipe in the cookbook.

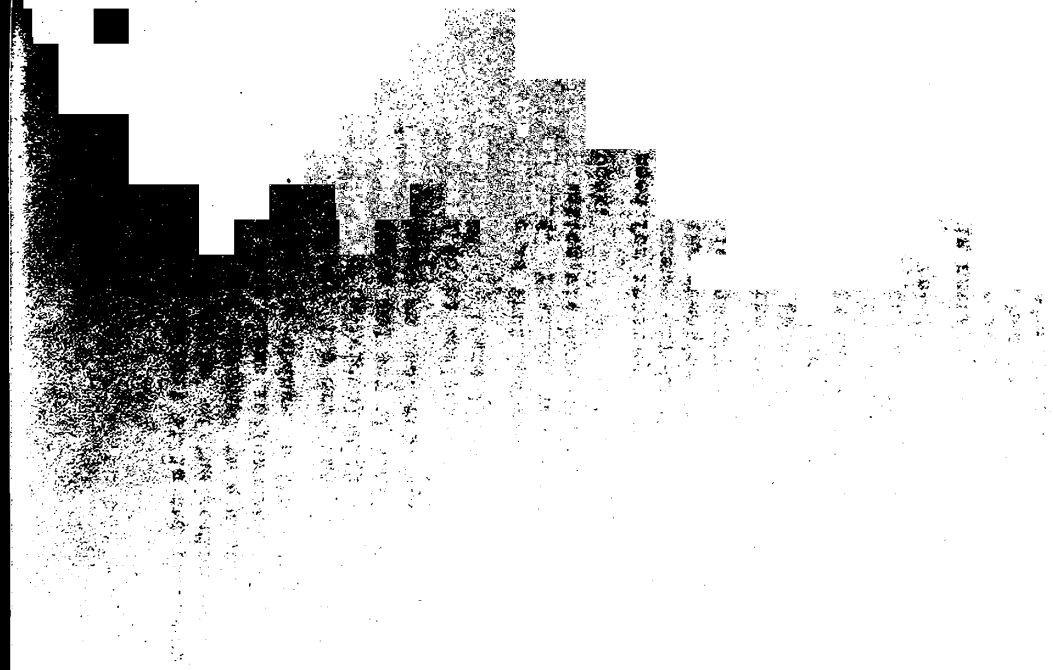
The need for intervention with some individuals has been outlined. The most common cry is for this intervention to be through counselling. However, the question of what counselling involves, and how valid it might be, is not given careful consideration.

In one sense, the bandwaggon cry to teach them about drugs has now made way for a bandwaggon to hand the entire matter over to the 'school counsellor'. Counselling is many different things to different people, but basically it can be said to take place 'when one person accepts responsibility for helping another to decide upon a course of action to understand and change patterns of behaviour which distress him, disturb his relationships, or affect his social behaviour'.

While it is normally considered to be a one-to-one affair, it can include a whole range of techniques and situations. For example, Audrey Newsome has described the setting-up by Keele University students of a 'nightline' service called Contact, in response to the upsurge in drug use. However, this service failed to meet the needs of drug users, because such users failed to identify with those running the service; but it did provide a valuable support for other groups, the lonely and isolated for example.

But those working in the student health service at the University found that 40% of students who used drugs had suffered parental loss and that 50% used drugs to combat depression. Few sought help with drugs as the presenting factor.

These sorts of problems are likely to grow more intense unless institutions plan to meet the needs of the people who use them. This problem of actually getting to the people you want to contact has also been stressed by Lane in the school situation. Keele ran student seminars as one way into this problem, and likewise Lane set up informal 'encounter' type groups, which any pupils could join. Yet often it was the teacher who needed the support, to deal with the pupils who concerned them and teacher support counselling is practically non-existent. (This is being provided experimentally by the author and is mentioned later). For it was often better to work through teachers who already have a relationship. Effective counselling is therefore concerned with co-ordination of support rather than simply one-to-one sessions. This raises the question of training teachers and others in techniques of support.



The experience in the Reading Education Area would seem to indicate that limited training can improve relationships and the research of Lawrence, Carkhuff and Berenson would seem to support that. Attempts along these lines have been tried by the Drug Education Consortium and may be repeated in association with the DDDG. A study by Lane reports similar success.

Thus it is possible to train counsellors, but how effective is such intervention likely to be ? The research of Eysenck etc. has demonstrated that psychotherapeutic intervention is often valueless. And Carkhuff has shown that specific theories and techniques are not as important as basic human relationship skills. Therefore, the form intervention takes has to be carefully weighed.

Lawrence has pointed to the use of counselling with pupils having reading difficulties, but Lane has shown that such intervention is less effective with some types of individuals than others.

The impulsive, manipulative, tough-minded pupil is unlikely to respond. Given the previous indications that drug users are often just such, the question of alternative intervention has to be considered.

Counselling may be of value to some, but it is not the panacea that many expect it to be.

Dealing with behaviour problems in school takes a great deal of time , since for all behaviour, truancy and disruption, whether among drug users or non-drug users, one has to delve beneath the surface to find what is wrong, for the behaviour represents adaptions by individuals to their situation. But if prevention is to mean anything, it must involve dealing with a range of difficulties of adjustment in the school situation, before drug use becomes a problem.

We are dealing with individual's with different personalities, with different views of their situation and with different potentials to cope. The problem therefore has many facets, and needs flexible solutions. We must also remember that it is the teacher who defines 'the problem', not necessarily the child. With some, therefore, there will be only a small measure of success depending on what one's criteria are and with others, there will never (except maybe temporarily) be any success, however hard one tries, given the constraints under which we work and the stresses it entails. The individual problem is dynamic; it changes sometimes from day to day and on many occasions the pupil does not do the expected.

There is a great deal of overlap of the traditional categories used to differentiate problem groups and terms such as domestic and occasional truant, disruptive and impulsive, behaviour disordered and so forth apply in differing degrees, depending on the individual. These terms and others used here describe patterns, <u>they are not diagnostic categories</u> Essentially, it is not category, but an understanding of what the behaviour means to those concerned which will clarify thinking, and which should govern our response.

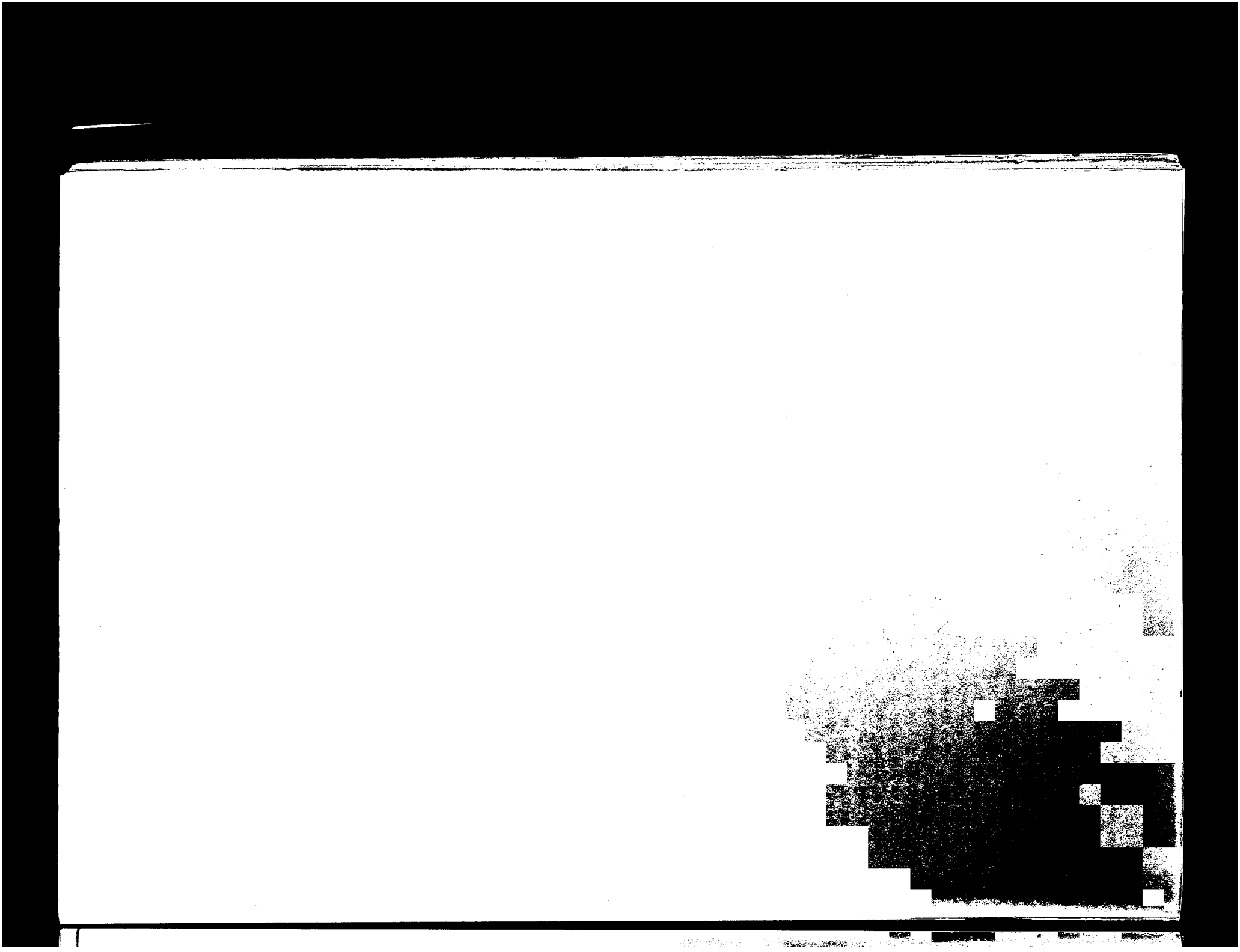
Lane, Green and Johnson have pointed out that, to help towards solving the problems, more co-operation is needed between teachers, and feel that many teachers do not quite realise the enormity of the problems children face.

They are only concerned with their own children, and some, like it or not, give a sigh of relief when difficult pupils truant, and do not follow it up. Pastoral staff, for example, are in a position to take a look overall and often have the knowledge necessary to help the individual. But this can only be achieved if 'pastoral' and 'academic' staff work together. The frequent cases of mishandling complained of is a problem - how can it be communicated to staff that sometimes sensitive handling is needed, that not all pupils need a kick up the pants, although some undoubtedly do. Staff able to 'wind down' disturbed pupils pointed out that they sometimes may face antagonism and accusations of being 'soft' from other staff. These are real problems which cannot be avoided.

Solutions cannot be easily found, and provision of support to pupils who include drug use as part of a pattern which is wider, will present some considerable difficulties.

However, the position is becoming more optimistic, and approaches which look at both the system and the individual, that is approaches which change schools (Lane 1975) do offer the potential which members of the DDDG have long sought.

There is a long way to go, but in this, as in others areas, the experiences of the DDDG shows that in sharing ideas and expertise, that is in partnership, lies the hope for the future.



Dealing with the disturbed child in school: a new development

The increasing concern over children whose behaviour in school is described as 'impossible', has given rise to varied suggestions for intervention. One of these is gaining increasing popularity, that is the Educational Guidance Centre, designed to work with children over a short period and return them to school, reformed.

How this is to be achieved is less than clear although most talk vaguely about forming a relationship with the child. This article describes the work of one centre which makes no such claim, but which nevertheless has a clear idea of its philosophy and methodology. (Not claiming to use a relationship is not equated with not caring)

The Hungerford Educational Guidance Centre, run on behaviourist lines within the framework of Contract Therapy, provides for children with severe behaviour and learning difficulties (but not for learning difficulties alone) within ILEA (DO3)

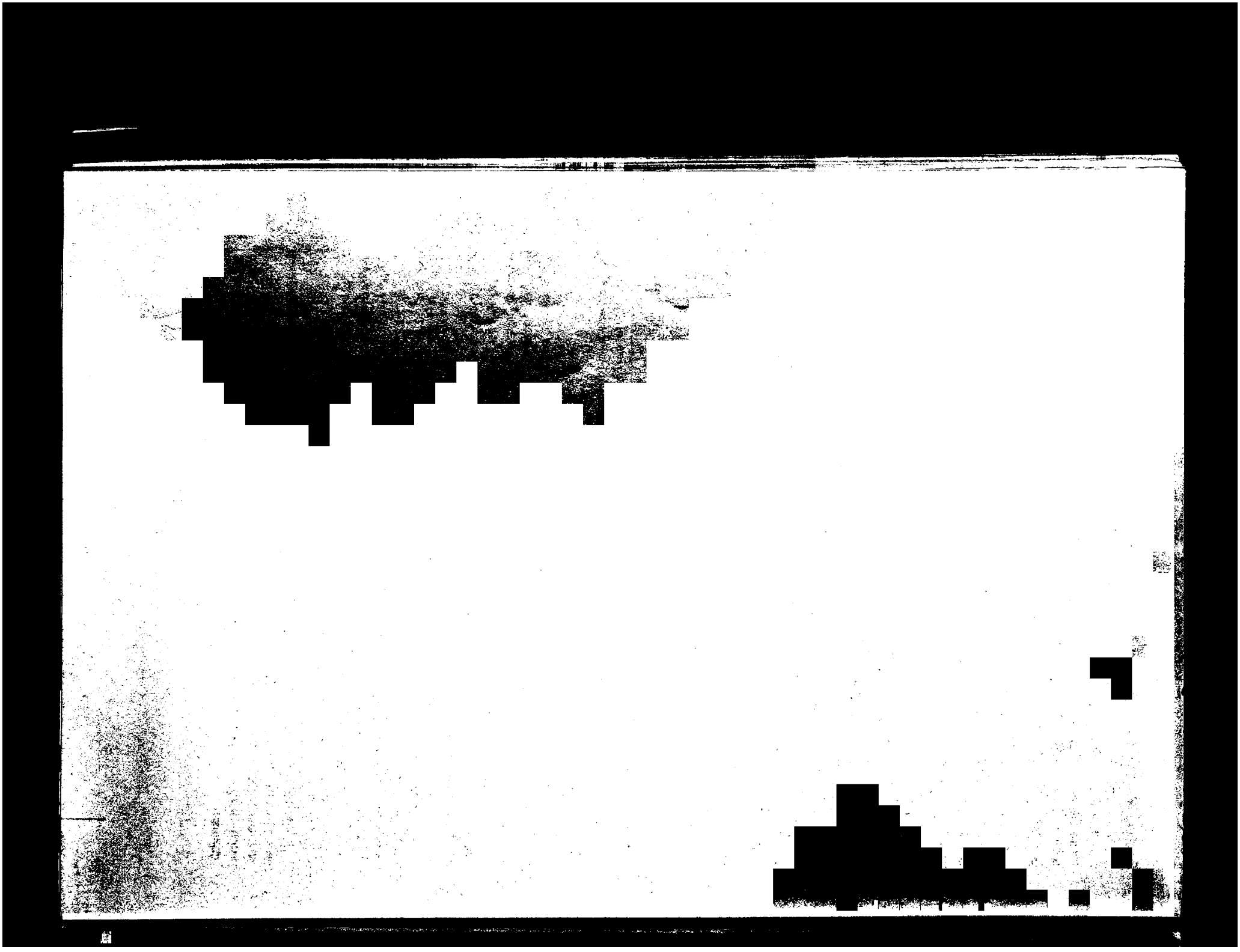
It is able to provide short term therapy because it works very closely with schools. It is thereby able to intervene at crisis points not six months later. Essentially it provides a means whereby the school and centre together provide the therapy for the child.

A typical case might include a child who has had difficulties over a period of years in reading and other communication skills and whose impulsive, 'acting out' behaviour has led him into conflict with teachers. He has now developed hostile attitudes to teachers and is not responding to remedial help, correction or support. He will also have other difficulties and an assessment of personality etc., would be undertaken. But the essential part of the diagnosis would be full discussion of the child with his teachers using concrete examples of the difficulties, with some attempt being made to give these an order of priority. Discussion with the child would then take place on how he saw the situation and the things he wanted to change. Observation of the child in class would follow or precede that discussion to look at the behaviour and the factors which trigger it or reinforce it.

With all that information a functional analysis (Lane 1974) of the behaviour would be undertaken to establish, what needs changing, what it is possible to change, what the potentials are in the situation for change, and what meanings the behaviour has for all those involved. A therapy contract would then be drawn up for the school and child specifying what is to be changed. How it is to be changed, and the rights and obligations of those involved, careful discussion with parents would also take place.

Things that can be done within the school in terms of rewards, controls etc. are then outlined and specific concrete techniques specified to be followed by the school in conjunction with the centre. What is to be done at the centre is also specified, there are no attempts to create an air of mystification. It may be that the child can be helped totally within the school with the support of the centre or by attendance at school and centre for part or most of the week. That decision will vary from case to case.

Modification of behaviour using various techniques such as contingency management and stimulus control are carefully evaluated for their consequences on behaviour and attitude within the centre and the school so that adjustments are made as necessary. Thus each child would have a programme unique to himself although the basic procedures are common.



The centre is thereby providing (or attempting to provide) both therapy and concrete advice relevant to the specific case. It also provides facilities to the school to extend the range of educational diagnosis and therapy that they are able to offer, and through weekly open case conference sessions and seminars in addition to regular contact with schools, make available more widely techniques found to be effective. The centre also continuously evaluates itself to ensure that it offers flexible and effective response to the needs of those it serves. The emphasis is on educational response, the centre is not in any sense an alternative to educational psychology, advisory teachers or child guidance, indeed the centre can only respond because such facilities are available and it is able itself to make use of such facilities to ensure that appropriate action is taken.

The Hungerford Centre is only one of a number of such centres, all of which work along different lines. This, given the experimental nature of short term intervention (a few months or less) is as it should be. The particular contribution of this centre to that experiment lies in the concentration on behaviour therapy principles, and modification simultaneously in centre and school, together with an emphasis on working with the teacher not simply the child. Working in this way involves several problems since you are offering flexible and rapid intervention. The aim of concrete advice also raises the problem of obtaining reliable information.

One of the main problems is access to appropriate information. Getting information on the actual behaviour that is causing difficulty is difficult since the tendency to think in terms of labels together with a resistence to specify, means that finding what triggers or supports the problem behaviour, becomes like finding your way through a maze. This applies to both information from professionals and parents.

Two examples:

A ten year old boy referred for severe learning and behaviour problems, was found to be of limited I.Q., (63) have a specific learning disability of auditory channel handicap, and was a constant source of fun to his peers since in exchange for a sweet he would do anything. Getting him to lick up puddles like a dog was the current preoccupation. He was very impulsive, and uncontainable. His parents would volunteer no more information on what they did to contain him than that. "We do the best we can". This it turned out was to lock him in his room.

His school was able to introduce teaching for his handicap and rewards for appropriate behaviour based on advise his parents were not prepared to recognise that he had a problem. But some progress was made at school. Professional information likewise often lacks specificy, the labels abound, neurotic, over anxious, etc., but as Cattell has demonstrated different professionals mean different things by them. Children are often presented with a label for their difficulty such as Dyslexia, which tells you nothing of the child's problems. Unfortunately, having used the label the professional tends to define the problem in terms of the assumed correlates of Dyslexia such as word reversals rather than in terms of the actual behaviour of the child. In fact, 'Dyslexic' children often have problems of auditory and not visual analysis.

Attention needs to be focused on actual behaviour and simple devices such as a diary of events listing behaviour and the preceeding and subsequent events can provide it. But

these are threatening unless it is clear and true that they are to enable the diarist to gain an understanding of the behaviour and not to point a finger of blame.

Once behaviour is specified the approach of the centre is to determine, using techniques such as functional analysis, (Lane 1974) what it is possible to do given the potentials in the situation.

The contract is then drawn up. A typical contract is included below.

SAMPLE CONTRACT

BETWEEN PAT MAY AND DAVID LANE

A

CONTRACT FOR THREE MONTHS

The following is agreed

1 Times to come

Thursday morning

9:15 - 9:30	Tea
9:30 - 10:00	Thinking lessons
10:00- 10:30	Choice
10:30- 11:00	Break
11:00- 11:30	Difficulties in school work
11:30- 12:00	Choice
12:00- 1:30	Lunch

Tuesday afternoon

1:30 - 2:30	Scripts on problems with people
2:30 - 3:00	Tea
3:00 -	Home

2 Reports to school - To be sent by David Lane with the agreement of Pat May.

3 Report book to be filled in by teachers on improvements.

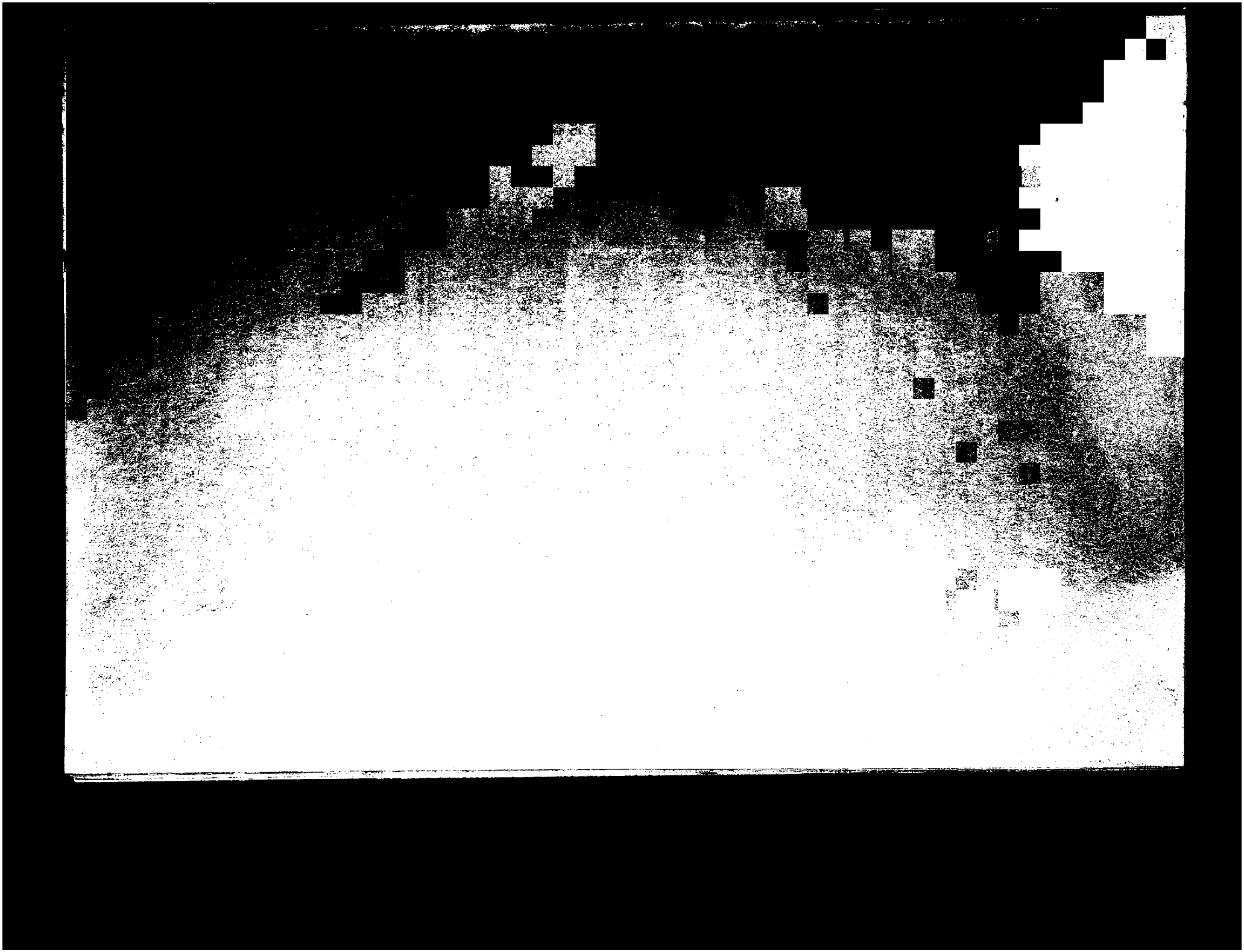
4 Letters to parents - when necessary and by agreement.

5 Behaviour *1 - agree to certain basic rules of behaviour

6 Time scale - One morning and one afternoon for three weeks. At end of three weeks a decision to continue will be made. After three months, return to school with the option of continued contact with the Centre.

7 Work *2 - Maths - most things to be covered. English - spelling, writing, punctuation, stories, etc.

8 Tokens to be earned for behaviour and work to be exchanged by barter.



Committment

David Lane and Pat May agree to work together to improve those things listed above. David Lane on his part undertakes to try his best to help Pat to become as good at these things as she wishes to be and states his belief that she is an important person who when taught will be able to do the things listed. Pat May on her part agrees to to try her best.

David A Lane

Pat May

Date

*1 The behaviour is separately specified based on two measures, the Bristol Social Adjustment Guide filled in by the teacher and the pupil, and the Eysenck Personality Questionnaire, sometimes the BSAG Family Edition is used. This provides an objective and agreed determination of what is to be changed. Separate contracts can also be agreed for other items of behaviour.

*2 Actual work cards can be specified to work on particular difficulties in the contract but this is not usually necessary.

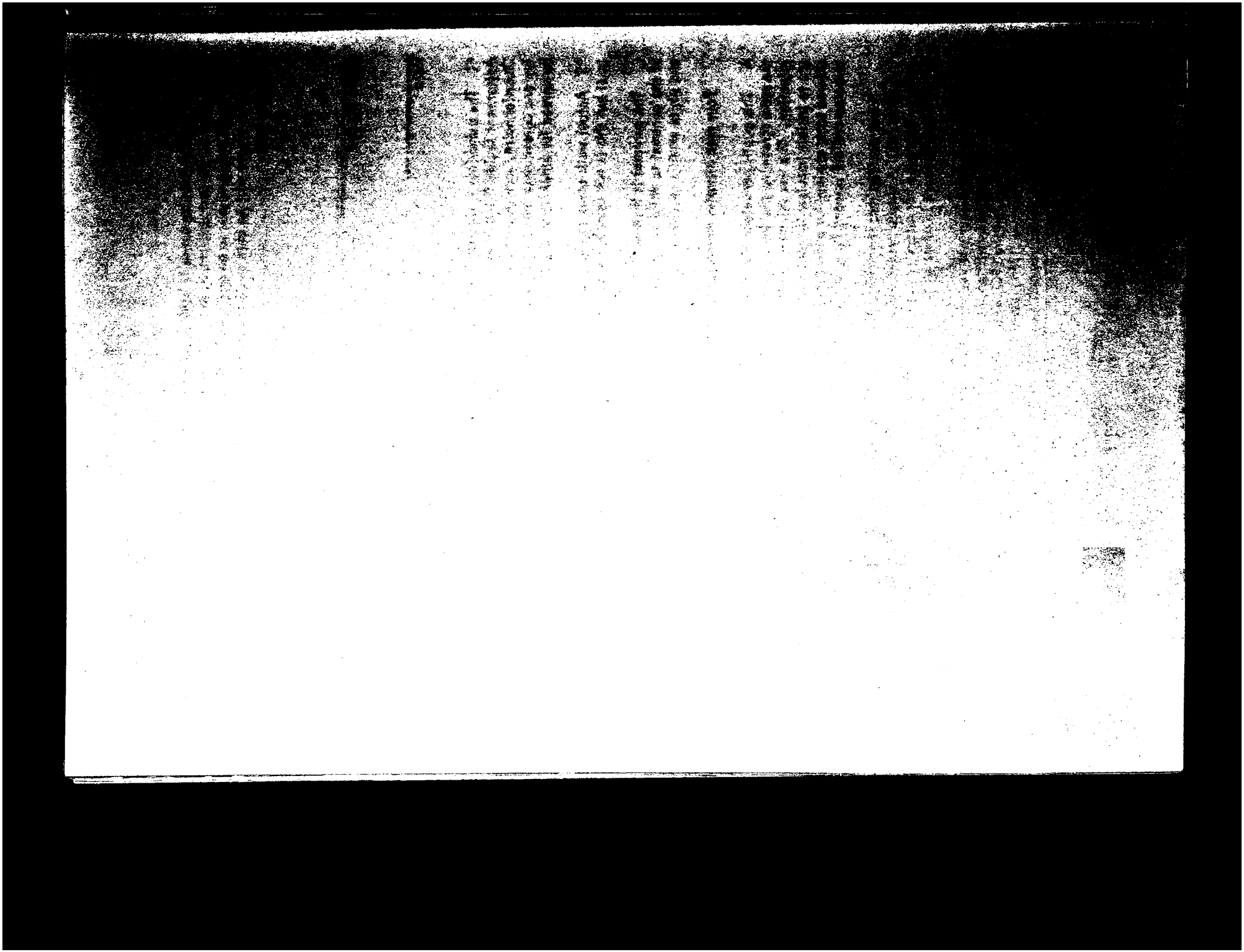
The contract is then carried out with continuous evaluation built in. The advantage of the contract to child and parent is that we cannot manipulate them. It states in black and white what is required.

Four case histories would perhaps help to illustrate the approaches.

A This pupils behaviour described as weird, included hiding in curtains, running round the room screaming and knocking things over, some fire setting, and not unexpectedly peer rejection. She was thirteen. Evidence was available of severe 'inconsequence', a failure to inhibit impulses for long enough for their consequences to be foreseen. The child showed some anxiety for adult attention, that is she did make a point of checking teacher response and did respond for a few seconds to tellings off.

It was decided that the actions of significant adults not their words would probably influence her. A simple contract of reward for attending behaviour of increasing periods not only improved her attention but the reinforcement of adult attention for good behaviour brought improvement in other areas.

B This pupils behaviour was very aggressive and had not learnt to read in spite of many years help. She had been written off. Very strong hostility to adults, (on the BSAG) and toughmindedness (on the EPQ) added to her very low tolerance of frustration, and a visual association/memory (ITPA) disability provided strong indications of why she was so difficult. Only utilitarian rewards meant anything therefore the school gave her permission to miss certain lessons, which she did anyway, in return for good behaviour in lessons



she liked. After much manipulating by her and the enforcement of punishments from the contract she eventually stuck to the contract. In the lessons she missed, she with her school counsellor undertook relaxation therapy (simple to use and of great benefit to even psychotic children) and when that was controlled teaching designed to deal with her disability, then an attempt to teach her to read. About five months saw her back in class as a reasonable student and not one reported incident of beating up pupils, going for teachers, or other misdemeanours. Her reading still has a long way to go but is at last improving.

C Several pupils in one class were causing difficulties, and various attempts to bring change via punishments had failed. Observation and discussion revealed that the punishments really were not having the intended effect. Keeping pupils after school in fact provided them with an excuse to be very late home and also acted as payment of bad behaviour to wipe the slate clean.

Teachers also were loth to stay and supervise detention and therefore punishment was used inconsistently.

During the school lunch hours various attractive activities went on and therefore it was decided to use 'time out' from these to control behaviour. It was easy for teachers to supervise lunch time detentions. Once the pupils realised that time out could mean every single lunch hour and it was proved to them, marked change in classroom behaviour occurred.

D A class teacher was disturbed about two specific behavioural problems. Upon observation in the classroom situation it was immediately obvious that the teacher had overwhelming problems controlling the class. Two primary aspects of behaviour were important to this teacher (1) the class remain quiet and (2) the class follow the rules of the class and lesson; (e.g "What do you do after you've finished with ...?") The children were uncertain about both of these points and continually aggravated and irritated the teacher over them.

Firstly, a list of "rules of the class" was posted where all children could read them. The teacher undertook a "talking" contract with the class; (i.e. if they were quiet for 15 minutes, they could have 5 minutes of free talk.) The teacher was encouraged to vary rewards and emphasize positive behaviour. It was also recommended the teacher suspend individual work with the children for two weeks in order to better observe their behaviour.

After several weeks the behaviour of the class and the attitude of the teacher had changed significantly. The contract was effective with the children. The teacher felt less frustrated with the class, indeed the behaviour of the original "problem" children had improved. Most importantly the teacher began to feel her problems were containable, manageable and that she was doing something about them. Such contracts are potentially extendable to a whole range of problems of pupil/teacher, parent/child, clinic/client relationships.

These studies illustrate using actual cases, although not all from this centre but from these authors, the possibilities in the type of approach adopted in this guidance centre.

It is clearly not the only approach possible, but clarity of aim and method is important whatever the approach. Behaviour therapy has certain advantages in this respect as it is based on clear principles, ongoing research, and is sufficiently easy to understand to enable it to be explained to all participants.

Dealing with behaviour problems in school must involve the school as participants in therapy as must dealing with the child in child guidance involve the family. The potential to do so exists.

Reference: D A Lane (1974) A functional approach to persistent reading failure. Rem Educ 9.3

Hungerford Educational Guidance Centre
Hungerford Road
London N7

Further details of the work are available from the centre and visitors are welcome Wednesday morning. Seminars on dealing with different problems take place on Wednesday 2 - 3 pm.

Basic principles

Two basic principles of B.T are specified and used in the work. These are flexibly applied Contingency management, recognising the behaviour or approximations of it that are to be reinforced, and stimulus control, ensuring that the stimulus which is to control the behaviour in fact does control it, are both used but are specified in concrete terms.

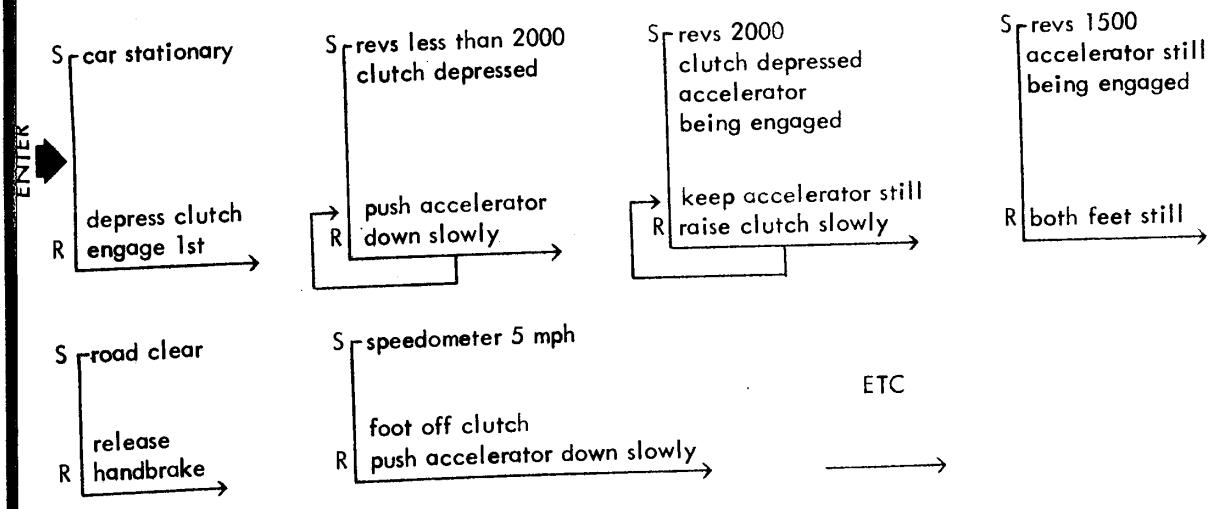
Thus it was discovered that pupils were getting in trouble with teachers for not closing classroom doors. Teachers were instructed to reward any approximation of such behaviour, such as the arm accidently touching the door and it moving slightly. 'Thanks John - here's a token' "What's that for?" asked John. "That's for closing the door, at least nearly closing it", replied the teacher. Etc, etc. That represents a contingency management approach. Stimulus control would mean the teacher saying something like, once the pupil had entered the room., "John would you mind going back outside and closing the door?" "Thanks here is a token." Faulty stimulus control is at the back of much parental mismanagement.

Sometimes stimulus control requires a very detailed investigation of the behaviour to ensure correct matching of stimulus and response. This is particularly true when teaching complex skills.

For example, two pupils were taught to drive as a reward for very greatly improved behaviour. But teaching them itself was likely to be a difficult job. Therefor in order to make it as simple as possible a detailed S-R analysis was undertaken of the skills involved.

A training programme to match stimulus and response was then devised.

Model for changing gear



Very rapid learning was made possible by such specification

Original papers - DAVID A. LANE

Dates and Titles

Survey of Priorities for the DDDG

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1) Education, the state of the Art. DDDG Conference at the King's Fund Centre 1974.
2) Sociological aspects of Drug Use. DDDG Conference at the King's Fund Centre. 1973.
3) Drug Education - Questions and Answers - Educational Research - Journal of the National Foundation for Education Research 1974.
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1) Sociological aspects of Drug Use. DDDG Conference paper at King's Fund Centre 1973.
2) Individuals and Systems - aspects of educational issies in drug dependence - Educational Research - Journal of the National Foundation for Educational Research 1973.

Predictors of Drug Use

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2) Predictors of Drug Use - Community Health Journal of Royal Institute of Public Health and Hygiene 1976.

Dealing with the Disturbed Child in School

Paper of same title for King's Fund Centre. King's Fund Centre 75/280 1975.

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