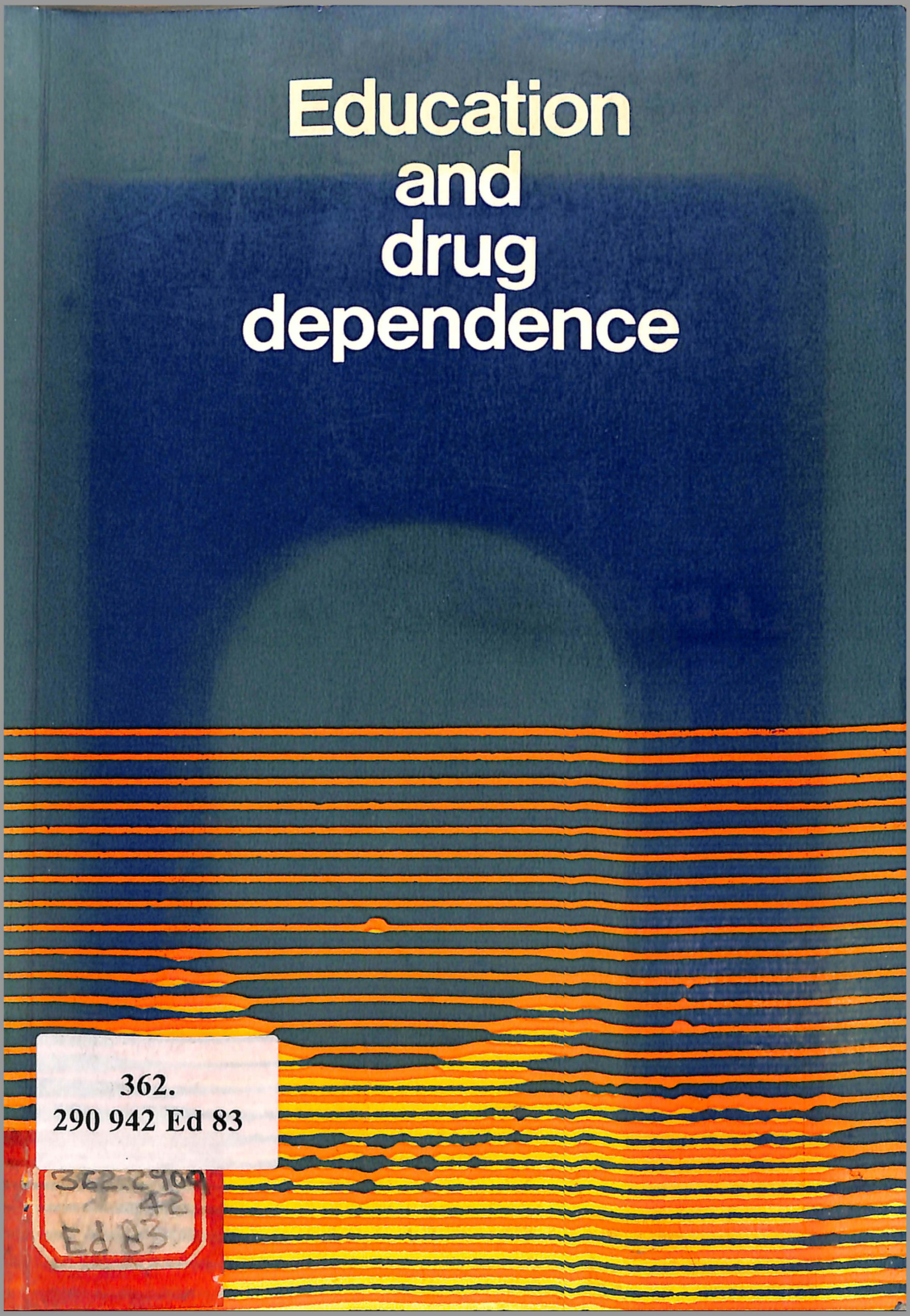
# Education and drug dependence



# Education and drug dependence

A report presented to
The Social Morality Council

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METHUEN EDUCATIONAL LTD
London · Toronto · Sydney · Wellington

First published 1975

Printed in Great Britain for
Methuen Educational Ltd
11 New Fetter Lane, London EC4P 4EE
by T & A Constable Ltd, Edinburgh

ISBN 0 423 89240 1 cased
0 423 89010 7 paper



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Study group on Education and drug dependence

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*Members of the Study Group took part in their individual capacities and not as representatives of organizations.*

# Contents

# Preface

The members of the Study Group are anxious to stress certain points about the nature of its Report. If there were misunderstandings on them, the Report might lose much of any value it may have.

First, this does not claim to be the last word, or anything like it, on a subject on which much research is being done, much is being written and social attitudes are undecided. A number of people confronted with the problem of drug dependence, mostly as teachers or members of government departments, met together to seek agreement on the social and moral realities underlying the problem. Discussions took place regularly over 18 months, under the aegis of the Social Morality Council, which, as its membership shows (see p. 5), exists to promote the kind of consensus between people of differing or conflicting views which makes moral progress in a plural society possible.

The Report is neither a handbook nor a work of research. It is meant as a basis for public discussion and, in particular, as an aid to parents, teachers, pupils, and members of the general public, in forming their personal attitudes to an issue they are liable to have to face: an issue fraught with consequences for society but one on which social habits, legislation, and education sometimes say conflicting things. The members and observers have agreed that the Study Group should continue as an advisory body to help the national Moral Education Project which the SMC has launched with the support of the Department of Education and Science and a wide-ranging sponsorship.

The first paper expresses the reasoned approach of the Group to the use and abuse of drugs in our society. This could, and should, be the public starting point. The following four papers are appraisals of the situation. Since there are no reliable statistics on the incidence of drug abuse, other than for addiction to narcotics, the contribution from Dr Cahal, a leading expert in the field in this country, is especially fortunate. The last three papers apply the attitudes and policies, stated in the first paper, to education, in its social context. Since the Report is mainly concerned with attitudes and policies, and not with information about drugs, no bibliography is included. There is a vast literature on the subject, and many available compendia of information.

The Study Group was formed thanks to some suggestions made by Dr Marita

Harper of the Department of Health and Social Security at the SMC's annual general meeting in January 1971. The SMC is grateful to all who have given their time and expertise, and the members of the Study Group are grateful in turn to the observers from the Home Office, the Department of Health and Social Security, and the Department of Education and Science. These observers, in view of their official positions, are not of course responsible for the value judgements in the Report. But they entered fully into the discussions, and their views have been taken fully into account. They also provided, from authoritative sources, much of the factual information which is the scaffolding of the Report.

Particular thanks are due to the contributors from outside the Group: Dr Cahal, already mentioned, Rev. Simon Tugwell, O.P., for his paper 'Some Aspects of the Drug Scene', and Mr Jim Zacune who provided the material on alcoholism for the paper 'The Drink Scene'.

July 1973

# 1 A rationale of drug use

## Our terms of reference

'Drug dependence' is likely to mean for most people addiction to dangerous drugs like heroin, and perhaps the habitual use of cannabis or LSD. As Dr Cahal explains in the next section, the word 'dependence', in connection with drugs, has been adopted internationally to replace 'addiction'. Yet in itself the word signifies neither an ailment nor a weakness: it is a condition of humanity. People at every level of their being are dependent, both for health and for life itself. Food and water are obvious examples: the French have a phrase: *nous sommes ce que nous mangeons* – we are what we eat. Air is an example of which we are less conscious – until it is polluted. The body is chemically dependent, and drugs are a resource for the assistance or correction of its biochemistry. Many people today owe their continued survival in reasonably good health to permanent dependence on prescribed drugs. Before the word 'dependent' is treated as pejorative, the questions to ask are 'how dependent?' and 'dependent on what?'.

Apart from the dependence of the body on the physical conditions of life, and of some bodies on medically prescribed drugs, a need has been felt in all known cultures for mental stimulus and solace: the kind induced by fermented drink or by products with similar effects, exhilarating, soothing or both. 'Drink' has been seen as an aid to life and creativity, not only to survival. A significant part of the world's great literature has been devoted to it, either in praise of its effects or warning against its abuse. Christian symbolism too, in the bread and wine of Communion, reflects the dual nature of this human dependence.

Under *Education and Drug Dependence* we take our terms of reference to be inquiry into ways in which schools can help young people to distinguish one drug from another, to make a discriminating use of whatever drugs are beneficial and to decide for themselves on the moral limits of dependence. Such decisions are bound to vary, not only with the drug but also with the individual, and this whole area of choice relates to fundamental personal and social values. We do not restrict ourselves to the question of how to prevent young people from drifting into chronic dependence on destructive drugs. Unless a positive and reasoned attitude to drugs of all kinds is widely adopted, there is no hope for the social control of their use by any means.

We have concentrated in the main on the use of drugs not medically prescribed. This is not to ignore that drugs in medicine are sometimes over-prescribed and mis-prescribed. Thalidomide remains a public warning. But prescription is subject to public as well as professional control, whereas potent drugs are obtainable which may be beneficial, which can be lethal, but which are not prescribed. What are the moral limits of dependence on these drugs and how can young people be encouraged to take these limits seriously?

**Drugs: functions and dangers**

Wine and spirits, tobacco, coffee, tea, have over the years been introduced into our culture and domesticated, along with indigenous preparations, as personally and socially beneficial. It should not be surprising that in our day there are new imports: that the young in particular should look for better effects in new drugs than their parents and ancestors found with such acclaim in the old. Nor should it be surprising that there is resentment on their part that the new drugs are forbidden, however justifiably, while alcoholic liquor, with a high toll of victims, and tobacco, which is a killer, are legal. One of the graffiti recently seen in central London read: 'Many pot-critics are hooked on alcohol'.

Broadly speaking, the functions claimed for these drugs, old and new, legal and prohibited, are twofold: they liberate and they give pleasure, i.e., they free the body from discomfort and pain and the mind from tension and stress, and they bring enjoyable sensations or images or experiences. Danger comes at the point where liberation means less freedom, in the sense of less autonomy, and judgement is impaired. In the case of pleasure, enjoyment involves participation to a greater or lesser degree, a two-way transaction, as can be seen in that supreme example of dependence, sex, or in the response to beauty and art. Where participation ceases there is a threshold leading to loss of appreciation and ultimately to passivity and inertia.

These dangers may be more insidious than evident, but there are gross forms of abuse - narcotic addiction, alcoholism, chain smoking - which are evidently disastrous. How can the inexperienced be protected from these? Total prohibition of alcohol or tobacco because of abuse is neither practical politics nor social morality. Cannabis and LSD are prohibited, although the effects of these drugs have not been adequately studied for an authoritative comparison to be made with those of alcohol and tobacco. Prohibition itself prevented adequate research until the recent legal provision for this purpose. Anyone going into the nearest pub can compare the good and bad effects of regular drinking, but the same is

not true of the drug scene, where only the casualties can normally be observed and not those at risk.*

**Social and personal control**

There is the argument that legal prohibitions are always beaten, and that the criminal organisations and practices therewith developed severely aggravate the problem. This is a serious argument and the experience of Prohibition under the Liquor Laws in the USA demonstrated its force. The lesson seems to be that when a drug is already widespread, prohibiton may make matters worse. However, prohibition may be an effective way of limiting abuse before it has become widespread, and this may be socially desirable at a particular time. An alternative form of social control is to make licensed centres available for supervised administration of the drug. Where the use of a particular drug is mainly favoured by young people, legal prohibitions and active social disapproval may aggravate an already complicated generation situation, as we remarked above. The action taken against the drug may seem to the young to be adult aggression against them, which incites or reinforces counter-aggression and polarizes the antagonised generations. 'We live in a society that is constantly consuming drugs, but differentiates between on the one hand alcohol, nicotine, barbiturates and tranquillisers, all of which numb thought processes and are socially acceptable, and on the other hand cannabis and psychedelics that expand thought processes, which are legally penalised. Thus, advocating not drug use but alternative drug use, is regarded as dangerous' (Mick Farren). The use of drugs by young people, other than tobacco and alcohol shared with the whole population, needs to be defused, deprived of its esoteric mystique, reduced to commonsense talking points.

At the level of commonsense there are some obvious rules for a rational personal control of non-medical drug use. To propose any code or reasonable rules may be said to be talking the problem away, instead of facing it. There is no problem if everyone always behaves reasonably, but few do, even educated responsible adults who, say, smoke or drink. For what it is worth, a counsel of perfection for the use of drugs, including alcoholic liquor and tobacco, might be:

i not to take to the use of a drug without a deliberate decision which takes into account what the known effects of the drug are, short-term and long-term, and what benefits are hoped for;

*This enquiry tried to get round the difficulty, and evidence was taken privately, at first or second-hand, from people with experience of taking cannabis ('pot') and LSD.

ii to keep under control the amount and frequency, and be able to go without for a week or two without undue difficulty;
iii to be sure that work and other performances are not impaired, that one is not less responsible, and not less able to cope with one's problems;
iv to review from time to time the decision to use the drug, reconsidering it in the light of resources used (time, attention, money) and the benefits received.

However, if you talk to young people in these terms they will laugh at you. Their drug taking begins impulsively or gregariously, picking up current patterns of behaviour, and rules of this kind would not fit their life-styles; they are thinking about things and going about things in a quite different way, so that this rational reflective approach would not speak their language and could communicate nothing.

## Responsibility of the schools p.14

This may be true, but what is the alternative to personal control, which means some self-regulation by rule or principle? For the adult to ignore what is going on, if there is ignorance and there are dangers, is irresponsible and unfair. In the school situation, merely to denounce drug taking and to expel or severely punish culprits may have several undesirable consequences:

i it drives underground whatever discussion or experimentation may be going on, and thereby puts it in a context of rebellion which may give it an adventitious fascination;
ii it makes victims of youngsters who need help;
iii it may give martyrs to the cause.

To restrict oneself to giving information is disingenuous, and practically impossible. Then what line does the responsible teacher or parent take?

Young people today need to be helped to find their way about in our drug culture, not merely to be warned off a drug sub-culture to which they may be attracted. The sophisticated drug culture of modern society includes both therapeutic and non-medical use of drugs, and the boundary is not a simple distinction between use and abuse. Young people should be put on their guard about drugs as such, which are not neatly to be divided into the beneficial and the deleterious. Aspirin, for example, is both. They need education in the use of drugs. They should be encouraged to get reliable information about any drug they propose to take, and to test their use of it by reference to certain controls, such as those indicated in the four rules listed above. At the same time, it should be brought home that addictive drugs can destroy the possibility of control, and

that this is the risk. These general principles can be established with them by discussion, and impressed on them, so that they become part of their own rationality in the matter, a built-in control as distinct from external warnings and imperatives.

The purpose of drug education in a word is to enable people to make up their own minds on the basis of adequate information. In passing on this information to young people, adults must of course be prepared to draw conclusions from it and to offer advice if asked. This calls for no justification and is in fact a duty, though the advice will obviously be the more effective the less it appears to be backed by threats. In the case of a legally prohibited drug, its use on school premises cannot be tolerated. This does not mean that culprits should simply be handed over to the police. In the first instance, if there is risk that the drug will be used or if there is suspicion that it is in use, the situation should be made abundantly clear: that the law must be complied with, that no school or other public authority can indulge private views on the matter and connive at forbidden practices. If, nevertheless, the law is broken and investigations identify the culprits, they have to be dealt with; and this lies in the hands of the school authorities in the first place. We cannot tell them what to do.

If it is argued (as it has been) that the young learn responsibility by exposure to the full social consequences of their acts, this is a counsel likely to destroy those who most need help. Appropriate punishment may be redemptive in particular cases, but there are other forms of help more suitable and lasting as a general rule. The head of the school may not be practised in the skill of counselling, and it is not wise for an unskilled person to try to deal single-handed with a difficult situation in which the whole future of immature persons may be at risk. There is no weakness, no abdication of authority, in a decision to resort to skilled counselling help in such a situation: quite the contrary. The school counsellor, where there is one, is not necessarily equipped to counsel on drugs. This is an occasion when the school should not hesitate to have recourse to any help that may be available, for example in the local Health Education Department, the Association for the Prevention of Addiction, or elsewhere in the community. Consultation and the bringing together of people is the wise course, which is easier to follow and more likely to be successful when there is no gap between teacher and parent and teacher and social worker; and surely this is something that we could ensure before such problems arise.

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**Our attitude**

We suggest in this rationale that the whole range of drug use, therapeutic and otherwise, should be viewed together as a major modern resource for the support,

alleviation, comfort, and enhancement of human life and experience. Along with these benefits are great risks of injury, misery, and destruction; and therefore knowledge, discrimination, and personal control are called for, and should be constantly stressed in every context in which drugs are discussed, and this from an early age when the use of simple medicines in the home must be dealt with. Whatever is said or done, a small proportion will 'drop out' and 'write themselves off'; but much can be said and done, informed by commonsense, to minimize that proportion. Such a rationale of course does not solve any of the real problems, nor settle such questions of social policy as the legalisation of cannabis. But it does express a general attitude which makes a great deal easier the solution of these problems and the settlement of these questions, an attitude that is tolerant and free from hypocrisy, and at the same time plainly and practically directed to human benefit and the prevention of misery and waste. *If such a policy were consistently maintained by adults, it would be easy to share it with the young.* No attitude or policy that cannot be shared with them is worth maintaining.

# 2 Drug abuse in the United Kingdom

D. A. Cahal, MD MRCP

## Some definitions

The problem of drug dependence has been bedevilled for years by semantics. The agencies of the League of Nations and later of the United Nations struggled hard and long to find a definition of drug addiction which would satisfactorily distinguish this affliction from habituation to drugs.

After much deliberation the World Health Organisation defined addiction as:

> 'a state of periodic or chronic intoxication detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include
>
> i an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means;
>
> ii a tendency to increase the dose;
>
> iii a psychic (psychological) and sometimes physical dependence on the effects of the drug.'

Habituation was considered to fall short of addiction largely on the grounds of lack of physical dependence and because it was considered to be less detrimental to society.

The difference between psychological and physical dependence is that an individual who is psychologically dependent does not become physically ill if the drug is withdrawn – this is the case with amphetamines. A physically dependent individual becomes physically ill with well-defined symptoms and signs of illness if the drug is withdrawn.

Ironically, when the struggle to distinguish between habituation and addiction was going on, among the drugs considered to produce habituation but not addiction were the barbiturates. Bearing in mind that a drug which did not cause physical dependence was generally considered to cause habituation but not dependence, it is a sobering thought that in the past twenty years or so evidence has come to light that barbiturates can and do cause physical dependence. More than that, they cause physical dependence of a much more severe and dangerous form in certain circumstances than that caused by what have come to be known

colloquially as the narcotics (e.g., heroin and morphine). Sudden withdrawal of barbiturates from a patient who is heavily dependent on this group of drugs can lead to convulsions and death. Similarly intravenous abusers of barbiturates do cause considerable detriment to society. Following a report that such individuals were numerous and blocking casualty departments, the Department of Health and Social Security carried out a nationwide census over a three month period in 1970 to determine the magnitude of the problem. The census uncovered fewer than 300 abusers of barbiturates by the intravenous route (incidentally over 80 per cent of these individuals were known to the Home Office as being addicted to narcotic drugs). Although their number is small, they cause a greatly disproportionate amount of trouble to the medical services. They are frequently sufficiently intoxicated to require hospital treatment. At best, they block casualty cubicles for hours until they have recovered sufficiently to be discharged, only to be re-admitted after a very short period, having become re-intoxicated. At worst, they may require admission to a medical ward for expensive and time-consuming treatment and even, because of the irritant nature of the drugs they use, for surgical treatment of ulcers and in extreme cases for amputation because of gangrene. They also tend to be rather unpleasant patients - dirty, unkempt and aggressive and cause distress to other patients with whom they come into contact, not to speak of trying the patience of the hospital staff who have to treat them.

Therefore on the two major counts which were supposed to distinguish habituation from addiction this major group of drugs was placed in the wrong category.

The differentiation between habituation and addiction did not last long, as it was realised that both are manifestations of the same condition, and the terms were replaced by the single term 'drug dependence', although colloquially the terms addict and addiction are still commonly used to avoid constant repetition of the cumbersome terms 'drug dependence' and 'drug dependent individual'. The difference between physical and psychological dependence is still recognised.

Another WHO Expert Committee on Drug Dependence met between 1964 and 1969. They defined drug dependence as:

> 'a state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterised by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug.'

In the opinion of the Committee seven different types of 'drug dependence'

were discernible:

i morphine type
ii barbiturate - alcohol type
iii amphetamine type
iv cocaine type
v cannabis type
vi hallucinogenic type
vii khat type*

The Committee used the term 'tolerance'. This is the phenomenon which occurs when the dose of a drug has to be increased to maintain the effect. The Committee also made one definition which has assumed increasing importance, that of 'drug abuse'. This they defined as the sporadic or habitual use of drugs for purposes or in a manner other than those which are medically acceptable.

This definition is important because the drug problem is one which is constantly changing in its nature and severity. More and more when experts come together they are tending to use the term 'misuse' or 'abuse' of drugs to define the problem. Heroin makes the sensational headlines in the press. It causes what would have been called in earlier times 'addiction', but now is called 'dependence'. In some countries, notably in North America, heroin dependence is a serious problem both quantitatively and qualitatively. In the United Kingdom the problem has grown in the past fifteen years, but is minute compared with that in other countries, and is small in the United Kingdom compared with our main drug problem which is the multiple abuse of drugs.

## Control of misuse by legislation in the United Kingdom

The layman cannot begin to understand the nature of the drug problem in this country without some knowledge of what drugs do and of the history of the attempts which have been made to control their misuse by national legislation and by international agreements.

The body is a highly organised mass of cells of different types. Each type of cell has certain functions, some more specialised than others. When a drug acts on a cell it can only do one of two things, stimulate it to greater activity or depress it to less activity. It cannot change the basic function of the cell – for instance it cannot make the pancreas, which secretes insulin, suddenly start secreting thyroid hormone.

*Not a problem in this country

The drugs which are misused affect the nervous system, and here is a complication. The nervous system is in fine balance, some parts of it opposing the activities of others. Therefore a drug which depresses one part of the nervous system which normally inhibits the activity of another part will have the overall effect of stimulating the latter. Many drugs have a stimulant action on one part of the nervous system but a depressant on another. For instance, morphine depresses most parts of the brain but stimulates the vomiting centre. Since, however, its overall effect is a depressant one, we classify it as a depressant.

Other drugs, notably all the barbiturates in clinical use, are pure depressants of the central nervous system. According to the exact nature of the drug, the dose, and in some cases the route of administration, they can produce any degree of depression of the central nervous system from mind sedation to general anaesthesia or, in cases of poisoning, coma. Some drugs, notably cannabis, are difficult to classify as stimulants or depressants. The overall effect of cannabis is usually depressant but can be very variable, being affected by such factors as the mood of the patient and the setting in which the drug is taken.

The hallucinogens, such as lysergide (LSD), are classified according to their ability to produce hallucinations. Some are probably predominantly direct stimulants of certain areas of the brain, others may act by depression of other parts of the brain. For instance, it is known that lysergide is a potent antagonist of an important substance serotonin, produced by certain cells. Whether its hallucinogenic action is entirely due to this property cannot be stated with certainty.

The international agreement which controls narcotic drugs is the United Nations Single Convention on Narcotic Drugs 1961 which replaced by a single instrument the existing multilateral treaties in the field, reduced the number of international treaty organs exclusively concerned with control of narcotic drugs, and made provision for the control of the raw materials of narcotic drugs. The United Kingdom is a signatory to the Convention and implemented its obligations under the Convention by the passage of the Dangerous Drugs Act 1965.

It is a commonly held misconception that there is a 'Dangerous Drugs Act'. There have been many. At the moment of writing, the two most important are the Dangerous Drugs Act 1965 and the Dangerous Drugs Act 1967. These have been repealed by the Misuse of Drugs Act 1971 but remain operative until this Act comes into operation.*

*The Act came into force on 1 July 1973.

## The 'British System'

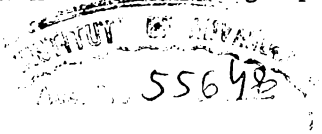
Briefly, the events leading up to the passage of the Misuse of Drugs Act 1971 and the present philosophy of treatment of narcotic addicts in this country began with the report of the Rolleston Committee in 1926. The most important recommendation of this Committee was that narcotic addicts should be regarded as sick individuals and not as depraved criminals. The responsibility for dealing with them therefore lay with the medical profession and not with the authorities dealing with law enforcement. The treatment of narcotic addicts in the United Kingdom is still based on this fundamental concept.

Indirectly, partly as a result of this philosophy, it is still widely and erroneously believed that there exists in the United Kingdom an individual known as a 'registered drug addict'. It is true that the Home Office keeps an index of known narcotic addicts, but the idea that these individuals have some sort of immunity from the laws governing possession and use of narcotics is quite wrong. It is not an offence to be a drug addict, but it is an offence for an individual, be he known to the Home Office or not, to traffic illegally in or be in illegal possession of drugs controlled by the various Dangerous Drugs Acts that have been in operation from time to time.

The United Kingdom has been fortunate in being spared a problem of narcotic addiction on the scale which is encountered in many other countries. In 1960 the total number of addicts to narcotics known to the Home Office was only 454. Young narcotic addicts were relatively rare. A disproportionate number of addicts was found amongst members of the medical and allied professions. This reflected accessibility by this professional group to the drugs concerned. Most addicts used morphine or pethidine and only 68 were using heroin. This information is derived from the report of the Interdepartmental Committee on Drug Addiction published in 1961.

The Committee had been appointed to determine whether the recommendations of the Rolleston Committee ought to be revised in the light of developments during the 1950s. There had been a growing suspicion that the misuse of drugs had increased in that decade. In 1950 the misuse of cannabis was almost unknown. Convictions connected with this drug were rare and mainly of coloured seamen in ports who were found to be in possession of large quantities. In one industrial town well-known to the author cannabis could not readily be obtained on the streets in 1950. By 1955 it was very easily obtainable and in 1958 in the same city the author saw two individuals, one a known heroin addict, smoking cannabis in public. The habit had undoubtedly increased in that city and there was good reason to believe that it had also grown in other parts of the United Kingdom.

There were also suspicions that the habit of misusing amphetamines had increased



among young people over the same period. Moreover it was estimated that the total quantities of barbiturates prescribed by general practitioners in the National Health Service had risen from 90,000 pounds in 1951 to 162,000 pounds in 1959. In general, however, the Committee saw no reason for radical alteration of the recommendations of the original Rolleston Committee.

By 1964, however, the overall picture had changed for the worse and the Committee was reconvened. They found that between 1959 and 1964 the number of narcotic addicts known to the Home Office had risen from 454 to 753. The number of addicts to heroin had risen from 68 to 342. More seriously, there were no addicts to heroin under the age of 20 known to the Home Office in 1959 but 40 in 1964. The number of known heroin addicts aged 20-34 had risen from 35 to 219. The Committee found that the increase in addiction to heroin appeared to be centred very largely in London, but indications of a similar trend, on a much smaller scale, had been observed in one or two of the other large cities.

The major source of supply had been the activity of a very few doctors who had prescribed excessively for addicts. In 1962 one doctor alone had prescribed for addicts no fewer than 600,000 normal doses of heroin. There were other examples nearly as bad. These doctors were acting perfectly legally under the law as it then stood, but this situation was to lead later to considerable changes in the law.

The second report of the Committee made recommendations which were very different from those made in its first report. Amongst other recommendations were:

i there was now a need for further measures to restrict the prescribing of heroin and cocaine;

ii all addicts to dangerous drugs (i.e. drugs covered by the Dangerous Drugs Acts) should be notified to a central authority;

iii to treat addicts a number of special centres should be established, especially in the London area;

iv the prescribing of heroin and cocaine to addicts should be limited to doctors on the staff of these treatment centres;

v it should be a statutory offence for other doctors to prescribe heroin and cocaine to an addict;

vi an advisory committee should be set up to keep under review the whole problem of drug addiction.

This report was published in 1965. In the meantime there had been activity in the field of legislation against drug abuse in the form of the Drugs (Prevention of Misuse) Act 1964. This Act was passed to deal with problems arising out of the misuse of other drugs, notably the amphetamines and hallucinogens which could

not be controlled by the Dangerous Drugs Acts. The legal situation was that no drug could be controlled by the Dangerous Drugs Act unless the United Nations Narcotics Commission recommended its control or appeared to be about to make such a recommendation.

Briefly, the Act made it an offence to be in illegal possession of certain drugs, such as the amphetamines and lysergide - though at the time the Act was passed lysergide and the other hallucinogens were not causing much of a problem in the United Kingdom.

For the sake of brevity it is necessary to omit an account of much of the activity which took place between 1965 and the passage of the Misuse of Drugs Act 1971. Under the Dangerous Drugs Act 1967 a Regulation made mandatory the reporting of addicts or suspected addicts to the Chief Medical Officer to the Home Office. This Regulation came into force early in 1968. Whilst this Regulation has been extremely useful in making available the firmest statistics on addiction to any group of drugs, because these are the only firm statistics on drug abuse available an effect has been to concentrate attention both at home, and even more so internationally, on addiction to narcotics in the United Kingdom. Yet this is not our major drug problem.

In addition, a second Regulation under the same Act effectively limited the issue of licences to administer heroin or cocaine to doctors working in treatment centres, of which there are fourteen in London. There are only three towns in England with a problem large enough to warrant setting up clinics on the London model and even there the number of patients using the clinics is very much smaller than in London which, with its immediate surroundings, contains more than 80 per cent of the country's narcotic addict population.

The available statistics, the existence of the treatment centres and the methods of treatment used there have aroused world-wide interest and led to many accounts, some of them regrettably inaccurate, of the 'British System'. The clinics have been in operation for over four years and the action taken appears at least to have contained the narcotic problem. Based on returns for 1970, there are fewer than 3,000 known narcotic addicts in the United Kingdom, of whom fewer than 1,500 were known to be using narcotics at the end of that year. The use of heroin in the clinics has fallen from 3.2 kg a month when they were first set up and has levelled out at about 1.2 kg a month at present. The use of methadone has, however, risen. Statistics of its use are not, unfortunately, available before August 1969, but its use now has also levelled off at about 1.2 kg a month.

This is not the place to discuss the 'British System', its successes and its failures. To do so would take up a great deal of space and the time has come to concentrate on the problem of multiple drug abuse.

## The incidence of drug misuse

To begin with it must be clearly understood that an addict is abusing drugs, but a drug abuser is not necessarily an addict. The multiple drug abuser will abuse almost any drug he can lay his hands on - in some cases it is difficult for the pharmacologist to understand why he abuses some drugs which have very unpleasant side-effects.

Statistics are hard to come by concerning the extent of the abuse of drugs other than those for which notification is mandatory. To the obvious question 'Why not make notification mandatory?' the answer is that for many reasons this step is impracticable. Drug-taking habits change with remarkable rapidity. What is fashionable one week is out of fashion the next. Since multiple drug abusers use more than one drug simultaneously, often no clear clinical picture emerges to arouse suspicion, for the effect of one drug may mask the observable effects of another taken at the same time.

The most commonly abused drugs other than the narcotics are barbiturates, amphetamines, cannabis and lysergide. Others are abused, and sometimes their abuse follows a very peculiar pattern. For instance one preparation, which it would not be in the public interest to name, crops up time and again in restricted areas. The pattern of abuse has been repeated with such regularity that one is confidently able to reassure local authorities that the problem of its abuse will last about three months and then disappear as mysteriously as it began.

Those who abuse barbiturates intravenously have already been mentioned. The impression gained is that this form of abuse is fortunately dying out - those who practised it have learned the hard way. Intravenous abusers of barbiturates are always young. There are two reasons for this. The habit only began recently and those who do not stop it do not live to become middle-aged. The gross oral abuser of barbiturates is usually, but not always, young. He develops a tolerance and can take at one dose quantities of barbiturates which would kill an individual taking a barbiturate for the first time.

What of the middle-aged or elderly patient who nightly takes a normal therapeutic dose of a barbiturate to obtain sleep? Such a patient is undoubtedly psychologically dependent upon the drug but is he, or more usually she, abusing the drug? Is she doing herself or anybody else any harm? If one has this difficulty in defining abuse it is obviously hard to make notification mandatory.

Amphetamine abusers may be of any age. Like abusers of barbiturates, cannabis and lysergide they are difficult to treat because they generally lack motivation for treatment. They want drugs not treatment and can obtain them with varying degrees of ease from illicit sources if licit sources are not available. Figures for amphetamines and barbiturates prescribed on the National Health Service in

general practice are readily available but they do not reflect the extent of abuse, and the monitoring of private prescriptions is almost as difficult as the problem facing the enforcement authorities in stamping out illicit trafficking.

Many hundreds of papers have been written about cannabis, but progress in investigating and assessing this drug is slow. In the pharmacology laboratory one is seriously hampered by the fact that cannabis cannot easily be administered to experimental animals by any route other than feeding it. Two constituents of cannabis called tetrahydrocannabinols can be administered by injection and they are known to produce similar effects to cannabis in human beings. But we are far from certain that these are the only active constituents of cannabis. Moreover, they are injected into experimental animals whereas human beings usually smoke cannabis. The findings in animals with THC therefore are of interest but not conclusive.

The therapeutic value of cannabis has been in doubt for nearly twenty years, and in 1960 the Interdepartmental Committee on Drug Addiction stated that 'cannabis has practically no therapeutic use'. The Committee also stated that in their view 'cannabis is not a drug of addiction - it is an intoxicant'.

The bulk of the mass of contradictory evidence on cannabis supports the view that cannabis is not a drug of addiction. The degree of danger associated with its use, however, is another matter. Emotions run high on the subject, but the present state of affairs is that there is no scientific evidence that its occasional use is dangerous. This is not, however, to say that evidence that it is dangerous may not be forthcoming in the future. Tobacco had been in use in this country for some four hundred years before its undoubtedly dangerous nature was demonstrated.

Because to all intents and purposes cannabis is no longer used therapeutically in this country, virtually all supplies are of illicit origin. Therefore it is impossible to state exactly how much is being used, but there is no doubt from indirect evidence that its use has increased markedly in the last few years, though it is not known to what extent. Increased seizures, increases in convictions may reflect no more than increased activity on the part of the enforcement authorities. Witnesses to the Advisory Committee on Drug Dependence which published a report on cannabis in 1968 were asked to guess how many people in the country used cannabis. Their guesses ranged from 30,000 to 300,000.

There have been several attempts by sociologists and others to try to determine and evaluate the factors which lead an individual to abuse drugs. In the course of these investigations attempts have been made to assess the incidence of drug misuse. Some of these investigations have been ingeniously designed but, to some extent at least, all have been retrospective surveys with all the difficulties associated with this type of survey. The retrospective survey relies to a large extent on the memory of the individual who is being investigated. Drug abusers

are not very reliable informants. The survey also relies on questionnaires and it is extremely difficult to find a truly random population to question.

A well-known and often quoted survey is that of Binnie (University of Leicester, Vaughan Papers No 14, 1969). Binnie sent a questionnaire to determine the attitudes to drugs and drug takers of students at the university and colleges of higher education in an English midland city. He sent out a questionnaire to a random sample of 5,000 individuals in the institutions concerned. His results were interesting, but what many observers have missed is that although the sample which received the questionnaire may have been random the proportion of the sample (48 per cent) who took the trouble to reply may have been, and probably was, highly biassed. This 48 per cent were, for one reason or another, sufficiently interested in the subject to reply. The remaining 52 per cent possibly had no interest in the subject and consigned the questionnaire to the waste-paper basket.

What is needed, and will take a long time to carry out, is a prospective study of drug takers from the moment they come to notice. It will involve a certain amount of retrospective work to determine if there are any common factors which led the subjects to the misuse of drugs. What we badly need to know is what happens to the abuser of drugs once he has started his career.

Throughout this chapter a deliberate attempt has been made to reduce 'statistics' to a minimum. This has been partly in an effort to take the limelight off the narcotic problem on which we have the hardest statistics, but also to emphasise by omission the unsatisfactory nature of the figures we have on the subject of multiple drug abuse.

Neither the author nor anybody else has any idea of the number of cannabis users in the United Kingdom. To start with it depends on how one defines a cannabis user. If one includes the once-for-all experimenters the number is probably very great. If one only includes the heavy habitual users the number will be much smaller. The former group probably do themselves no harm. One cannot be sure about the latter. True, most users of cannabis who seek medical advice appear to have no more than a panic reaction or anxiety state because they are worried about using cannabis, but there have been cases of severe psychotic episodes among heavy users.

Again Campbell et al (1972) showed that out of ten young patients attending a neurological clinic for various reasons nine had abnormal brain X-rays for their age. Some would be borderline for elderly patients, but one would have been judged definitely abnormal even in an elderly patient. These young people varied in their presenting signs and symptoms, but their histories had one thing in common - they all used cannabis. Campbell's evidence is far from conclusive that regular smoking of cannabis leads to irreversible brain damage. Unfortunately all his subjects had used other drugs as well, including lysergide and amphetamines.

There are other very technical reasons for not jumping to conclusions from Campbell's work. Nevertheless, the fact that multiple drug abusers, including heavy users of cannabis, presented with symptoms and signs suggestive of organic disease at a neurological clinic, rather than with symptoms of mental illness at a psychiatric clinic, must surely make one pause before making the bald statement that 'pot is harmless'.

One reason why it will be difficult to set up prospective studies involving cannabis is that, as yet, there is no known method of detecting cannabis or its metabolites in normally accessible tissue fluids when it has been smoked. Since the clinical manifestations of recent cannabis abuse are so protean it is virtually impossible to detect with certainty a cannabis user for follow-up at an early stage.

Similarly lysergide abuse appears to be increasing. This, although not a drug of addiction, is thoroughly dangerous in inexperienced hands. It is also remarkably potent. It is possible to 'take a trip' on as little as fifty microgrammes ( a microgramme is approximately one twenty-eight millionth part of an ounce). Therefore smuggling is easy. Only in the most ideal laboratory conditions has a metabolite of lysergide been identified in the blood. Clinically its effects can mimic exactly serious mental illness.

We therefore have a drug problem in the United Kingdom, but the one which receives the most publicity is not the major one. To solve it will require the collaboration of members of many disciplines - doctors, nurses, sociologists, teachers, and others. Most of all it will require patience.

# 3 Tobacco smoking

## The human cost

The physical damage caused by cigarette smoking is now a commonplace. Nevertheless, a resumé of the toll of this particular addiction seems appropriate at the start of this section*. Estimates for the number of deaths attributable to smoking cigarettes vary considerably. This is because many of the deaths are due to a number of factors in addition to cigarette smoking. The main causes of death are, in order of frequency, diseases of the heart and blood vessels which may result in heart attacks, strokes, etc; chronic bronchitis and emphysema (an irreversible condition, in which the patient is chronically short of breath), and carcinoma or cancer of the lung. The chief of these illnesses - cardiovascular disease - is exacerbated by conditions of modern life as well as by smoking. Such conditions include the presence of stress and frustration, overweight, and lack of exercise. It should nevertheless be made clear that the rise in cardiovascular deaths, especially among young men, has gone along with the increase in cigarette smoking by the groups under observation. The great killer is the cigarette.

Sir George Godber in his Report for 1969, as Chief Medical Officer for the Department of Health and Social Security, wrote: 'Because of cigarette smoking, some 80,000 premature deaths probably occur in England and Wales each year and for the whole United Kingdom the number must approach 100,000'. The Report notes that a high proportion of these deaths occur in older people who might otherwise have lived only a few years longer. Nevertheless, a number of deaths - and often, these are the most tragic - occur among people who have heavy family responsibilities. Looked at in this way, the problem of cigarette smoking is a particularly horrifying one. Among men only aged between 35 and 44, 1 in 8 of all deaths dealt with in the Report were due to smoking, and among those aged 45 to 64, one quarter. Another factor often not taken into account is the amount of sickness and absence from work caused by smoking. It is difficult to estimate how much working time is lost, but it is probably at least 26 million man days a year. At the time of writing, this represents a loss rather

*At the end of this section is a diagram of the factors which reinforce the average schoolboy who is an experimental smoker into becoming either an established smoker or a non-smoker.

larger than that caused by industrial action.

In terms of gross human wastage, one may regard the smoking of cigarettes as causing death on a scale equivalent to the last world war or the bubonic plague in the middle ages. It is the largest single preventable cause of death in our kind of society, and by far the commonest cause of cancer. Today, out of some 110,000 dying each year from cancer, 28,000 people die from cancer of the lung. Forty years ago cancer of the lung was scarcely heard of.

### The young smoker

What particularly concerns us here is that smoking is an increasingly common phenomenon amongst the young. In this country, and even more so in the United States, the average schoolboy will try a cigarette. The figures indicate that 75 to 80 per cent of all schoolboys try smoking. Of these, all but approximately 15 per cent will become established adult smokers. Smoking amongst young girls is rapidly increasing, though it has not yet reached the rate found amongst boys. Of established smokers of cigarettes, not more than 15 per cent will be able to give up the habit, should they live long enough to have the opportunity to do so.

The process whereby the schoolboy, having puffed at his first one or two cigarettes, becomes a habitual smoker is a very interesting one, and it is here that there is a possibility that intervention, if firmly and wisely applied, might be effective. Education from many sources, and not exclusively health education, seems to be necessary. If health and general education is going to be at all influential, it would seem sensible to start it as early as possible. In the United States, children of 8 or 9 years receive anti-smoking education.

The pattern of smoking and the reasons for smoking among schoolchildren are entirely different from those found amongst adults. Among children, smoking is largely the outcome of psychological and social pressures existing in them or around them. The antidote lies in counterbalancing these pressures successfully - often not at all easy to achieve. Nevertheless, we have time on our side at the start to some extent. It takes as much as ten years for the adolescent pattern of smoking to change gradually to the adult pattern, and intervention at the adolescent stage - when smoking is largely socially conditioned and is not such a vital part of life as it is for adults - is likely to be more effective than later on, even though we have no evidence that this is necessarily so. It is of interest that certain schools in America provide their adolescent pupils with smoking rooms. The adolescents may use these rooms on condition that they also attend anti-smoking clinics. However, this approach may well be rather näive.

The interesting factor about smoking amongst schoolchildren is that the phenomenon appears to have nothing to do with the pharmacological properties

of nicotine. In fact, it takes children some time to become accustomed to the nausea produced by this substance. However, smoking is clearly associated with deeply ingrained and often ineradicable social and educational situations. A study of these may indicate how to help, if not how to prevent. Referring to the diagram, on the left-hand side are the factors that promote smoking. If the members of groups with which the adolescent identifies are smokers, this will powerfully influence his own behaviour. Admired older boys or girls who smoke will be copied as will admired younger members of the school staff. All this is related to the adolescent's need to discover himself through identification with others. A child who smokes is often socially disadvantaged. He is a poor achiever at school, comes from the Registrar General's lower social classes, leaves school early and has a poor academic record. He does not identify with school values. This situation makes a nonsense of presenting to the adolescent smoker the image of the clean-limbed young footballer who does not smoke. It is useless - counter-productive even - to do this if this particular type is not admired. In contrast, use has been made in America, of a technique which involves getting a young smoker who has given up to talk about his experience to other young people of similar age.

Personality factors greatly influence tendencies towards early smoking. These include many aspects of failure, including doubts about personal worth and attractiveness. The smoker does not show greater sexual activity than does the non-smoker, but he may show greater interest in members of the opposite sex. The child's reaction to his own poor school performance and doubts about personal worth raise the possibility of preventing smoking by giving poor performers in school experiences of success and appreciation.

A third major factor in influencing the promotion of smoking is what has come to be called the 'anticipating adulthood syndrome'. Looked at carefully, this is not the outcome of aspiring to attain true maturity but, rather, a rejection of the status quo. To help in this sort of situation effort would need to be at a very fundamental level and probably in terms of changing the basis of the child's school and emotional life. The young smoker who is reaching after adult status will associate with precocious but not necessarily mature groups, will wish to seem tough and to over-emphasise his own maturity, and will wish also for success with girls. He will, typically, be against school and what school stands for and, when he leaves school, his rate of smoking will increase sharply. He will leave school early, somewhat naturally, as he is against school. He may be physically precocious and admire what he considers toughness, though not necessarily athleticism. (Toughness is, in fact, a rather deceptive quality and does not usually go along with emotional strength.) He will often have been subjected to excessive discipline, and it would be difficult to say whether this is

the cause or consequence of his behaviour. That is to say, we do not know whether the typical child smoker behaves in such a way as to attract excessive discipline or whether his revolt against school and its discipline takes the form of smoking. Should he belong to social classes C and D, his chances of becoming a permanent smoker are over 90 per cent.

Influences which will prevent the experimenter from becoming an habitual smoker tend to be associated with the higher socio-economic classes. In fact the child of a professional family today, and, strangely enough, the entrant to the university from whatever family he may come, has only a 10 to 12 per cent likelihood of becoming a smoker. If he does become a smoker, his life-style may become somewhat a-typical of his class, indicating some form of breach with his social background.

Parents are an important influence. It does not matter so much whether they smoke or not, but their attitude towards smoking is important. If they express disapproval of the habit, discourage smoking, and keep cigarettes out of reach of their child, then their child is helped not to smoke.

The example and the attitude of the head of the school and staff are influential, particularly the example of younger staff members, who are admired by school-children and used as prototypes. A non-smoking staff is of considerable help to the children. The 'atmosphere' of the school is also of importance. A low staff turnover, with good relationships between staff and children, and an acceptable level of discipline, all help. These are, of course, features of a 'good' school, where children are helped and respected as individuals and are, therefore, less likely to be needful of such compensations as smoking may provide.

Personality factors also help to account for non-smoking. High self-esteem, and acceptance of school values, mitigate the need. Oddly enough, right at the bottom of the list of factors promoting non-smoking comes health education and the health risks. These aspects, it seems, must not only be known about, but must also be perceived as relevant to the self. We may ask whether smoking and all that it stands for socially is of such importance that it overrides health considerations, or whether an effective method of health education has not yet been found.

### Adult smoking

The development of the adult pattern of smoking, as we have seen, takes about 10 years. Some features of this pattern warrant our attention as relevant to the whole issue of prevention. It should be said at the outset that a great deal of simplistic thinking has gone on about adult smoking along with a great deal of moralising. These näive approaches are now giving way to scientific study.

Adult smokers may be divided approximately equally into two types (see McKennel and Thomas, *Adults' and Adolescents' Smoking Habits and Attitudes,* HMSO, 1967). These two types are the 'consonant' and the 'dissonant' smoker. The consonant smoker is not particularly concerned about his smoking, can give up relatively easily, and his smoking is largely socially conditioned. A fair guess is that he is still smoking to the adolescent pattern and that his smoking does not fulfil very deep psychological needs but is largely related to the social acceptability of the habit among his friends. Because he is not motivated to give up smoking, he does not come to the anti-smoking clinics, and there has, accordingly, been very little opportunity to study him. McKennel's studies, however, suggest that if the 'consonant' smoker could by some means be brought into clinical care he would find withdrawal fairly easy. This means that in theory, at least, if one had access to all such smokers, the death rate from smoking could be approximately halved.

A much more intransigent problem is the dissonant smoker who, typically, suffers from various forms of dependency. This type of smoker wishes to give up smoking, and is motivated to do so, but wants help with his dependency problem. He may attend smoking withdrawal clinics already well motivated to give up smoking, but at these clinics he merely receives further motivation by the anxiety engendered. This sets up a negative cycle. Naturally enough, a large number of such smokers cease coming to clinics, since they are looking for help with their dependence and not for information on the ill-effects of smoking. It is necessary to take a fresh look at anti-smoking clinics - as is now being done.

The process of change whereby the adolescent smoker gradually takes on the adult pattern is probably largely due to an insidious reinforcement of the impulse to smoke. We know very little about the pharmacological properties of nicotine, but it is certainly true that, for some people, the inhalation of nicotine is a source of psychological reward. That is to say it gives pleasure. It may also relieve tension or sleepiness or be stimulating in proportion to the dose inhaled. Hence the adolescent discovers that smoking may actually be helpful to him in some situations and not be exclusively something which bolsters his identification with a particular group.

Another reinforcer comes from the circumstances in which people tend to smoke. For example, a young man may be sharing a cigarette with his girl friend on a bench in the moonlight while in love, or over a cup of coffee in pleasant circumstances. Whether or not smoking originally made him wish to vomit and cough, he now associates the cigarette with the pleasure derived from the situation he is in. Quite reasonably he then unconsciously deduces that, if he is in an unpleasant situation, the pleasure-giving qualities which he has now come to associate with the cigarette will rescue him. This converts him into the kind of smoker who uses smoking to control his moods and feelings - 'affect control',

as it is called by the researchers. Cigarette smoking for the control of mood is one of the most powerful factors in making a dissonant smoker continue to smoke. This gives us a lead towards ways we may help.

Dr Sylvan Tomkins, a clinical psychologist, has identified a number of types of smoker. For most of these, the control of feelings plays a greater or smaller part. One of these types is the 'positive affect' smoker. This is the individual we all know so well, and with whom many of us can identify, who associates smoking with situations of pleasure. A good dinner is not complete unless followed by a cigarette or a cigar! Smokers who smoke purely for pleasure can usually give up easily and stay off easily, as we have noted.

The 'negative affect' smoker presents a different problem. This is the person who depends on smoking to relieve emotional distress. He can give up with some difficulty, but is liable to relapse when he finds himself under tension again. He is one of the most difficult smokers to deal with and needs long-term attention. He goes through a period of intense fear, and even mourning, in his attempts to stop smoking because he feels that he has no longer any way of controlling his psychological pain. One would postulate that some method of building up the strength of his personality might help him, but experiments on this are in the very early stages. Such a smoker is quite likely to suffer from severe depression during the withdrawal phase, and treatment with anti-depressant drugs has been effective with some such smokers.

A third type - the addictive smoker - is the most difficult of all to withdraw. He smokes for both positive and negative motivations. He uses smoking to control almost every situation in which he finds himself. Smoking is part of his life, indeed almost part of his emotions, and even of his body. When he gives up smoking he will have extreme difficulty and suffer greatly. However, he will suffer so much that, once he is out of the wood, he is very unlikely to wish to go through the process of withdrawal again, and will stay off cigarettes. Various methods of helping the addicted smoker have been tried. One which is relatively successful is to give him an excessively horrific warning of the amount of suffering which he can anticipate, and therefore to generate a certain amount of courage. Thereupon, he goes through a genuine process of bereavement. A part of his life has gone and he must live without it. When such cases cannot be helped to beat their addiction, the only way forward may be to suggest less dangerous forms of smoking.

### Reducing the problem

Attempts at helping people to give up smoking based on careful diagnoses of the motivations for smoking have only just begun, and have not yet been fully

evaluated. This approach would, however, seem to make far more scientific sense than the present techniques of moralising and exhortation. If the different types of treatment required by these different types of smokers were to be made fully available there would clearly be a very considerable manpower problem. It is, therefore, of particular value that so much thought is currently being given to the prevention of smoking in the young.

There has been a certain amount of controversy over what has popularly come to be known as 'safer smoking', but which might circumspectly be known as less dangerous smoking. Among things safer to smoke than cigarettes are cigars, pipes and, possibly, synthetic tobacco. Evidence about the health effects of pipes is very well established and it is known that the pipe smoker runs a risk very little different from the non-smoker. A problem is, however, that a cigarette smoker who takes to pipes may continue his habit of inhaling, thus depositing the carcinogenic tar in the lungs and being at equal risk with the cigarette smoker. The lifelong cigar smoker runs a slightly greater risk than the non-smoker; there is little evidence about cigarette smokers who change to cigars. Commonsense would again suggest that if a cigar-smoker inhales he is at a risk which is as great, or possibly even greater, than that of the cigarette smoker.

The tobacco industries and others are making considerable efforts to produce a synthetic tobacco with less harmful health properties than the normal product has. Results so far show that these are a considerable improvement on natural tobacco but that they still carry some danger to health and may even introduce new and hitherto unsuspected hazards. It would be wrong to allow the younger generation to think in terms of a future in which they can obtain a safe cigarette.

Perhaps the whole problem of smoking should be looked at in an anthropological light. No society recorded by historians and anthropologists has ever existed without some mild pharmacological method for heightening pleasure, and increasing the endurance of pain. It happens that in the twentieth century society has chosen for these purposes a particularly lethal substance. Is tobacco smoking a problem of addiction or is it simply the response to a fact of human life which we must attempt to rid of its risks? Whichever view we take, the dangers of cigarette smoking are manifest, and the best way to mitigate them is to reduce the number of young people who turn to cigarettes, for whatever reason. The evidence shows that to embark on this purpose is to set ourselves a complicated task which will not respond to apparently obvious approaches, but requires a sympathetic understanding of the status and identity problems of youth.

# Smoking among school boys

## Influences promoting smoking

*Reference groups who smoke*

- Contemporaries
- Older boys
- Young staff

this is connected with decision making ability

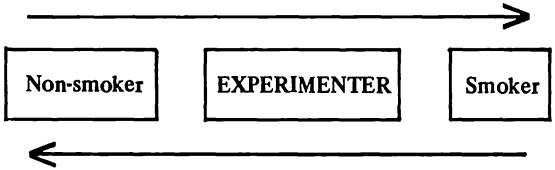
*Personality factors*

- Poor school performance
- Doubt about personal work and sexual attractiveness

*Anticipating adulthood syndrome*

- Associating with precocious group wish to seem tough and a success with girls
- Anti school
- Will leave school early
- Physical precocity and toughness
- Lack of emotional maturity
- Being subjected to excessive discipline
- Poor self acceptance in relation to school values

The average school boy is an experimenter. The points to the left or right of the diagram determine his ultimate adult smoking behaviour.




## Anti-smoking influences

*Parents*

- Expressed disapproval of smoking
- Discourage smokers
- Keep cigarettes out of reach
- Small middle class family

*Example* of head and staff at school, particularly young staff.

*Atmosphere of school*

- Low staff turnover
- Good relationships between staff and boys
- Acceptable level of discipline

*Personality factors*

- High self esteem by boy
- Acceptance of school values

*Perception of Health Effects* as relevant to self

# 4 The drink scene

## Drink dependence

A point made in the opening section of this report, obvious enough but needing emphasis, was that 'dependence' is not necessarily a dirty word. Still more obviously this is true of the word 'drug'. Some drugs are therapeutic, others make for relaxation or stimulus; some in both categories are 'dangerous'; all like much else in life, are liable to abuse. Where in this context does the drug known as alcoholic liquor belong? The question concerns alcoholic liquor, not 'alcohol'. About the latter, by itself, no doubt is possible. It is deadly. But the average table wine contains 10-12% of alcohol by volume, beer and cider less, and even spirits rarely more than 40%. The rest is mostly water. The elements which give these drinks their varieties of flavour and effect, in other words their character as distinct from their strength, are present in very small proportions, and some defy analysis. Alcohol in wine rather resembles the physical element in sexual love; too little makes for insipidity, too much for coarseness. To talk about these highly popular drinks as 'alcohol' is misleading. In their taste and their effects, quite apart from their chemistry, they cannot even be called alcoholic solutions.*

## The cultural background

In the western world the problems of behaviour posed by alcoholic drink are almost as inescapable as the problems of sex. Education about them is correspondingly important. Moreover education in 'drink' needs to take even more account of historical and social realities than education in the use of other drugs. These realities are mostly evident, but it may be useful to summarise them and suggest some conclusions.

'Drink' has been ubiquitous throughout our recorded history. It is a truism that Mediterranean life, to which Europe owes so much and with which Britain has formed new ties through the European Economic Community, has roots in the culture of the olive and the vine. This is still partly true today. The EEC includes

*For example a glass of claret produces a different quality of stimulus from a glass of burgundy, though the alcoholic content of each may be identical.

two countries - France and Italy - which are the largest wine producers in the world; countries where wine drinking* is habitual to all classes of society, manual workers included, and is even more normal a social phenomenon than beer drinking in England; where wine growers too are far more numerous than brewers in Britain, since viticulture is still largely in the hands of small proprietors, though increasingly organised in co-operatives. Other things being equal, the new social mobility involved in membership of the Common Market is liable, among other effects, to influence British drinking habits.

Added to this, the cult of drink in European literature is almost as much in honour as sexual love. The great creative writers seem nearly all to have been drinkers - it is impossible to imagine Shakespeare making his famous apostrophe to sherry† in *Henry IV* (Part I, scene 2) unless he had been one. At the same time this very dependence leads these writers to sound warning notes against abuse, and throughout literature the strain of warning runs parallel with the strain of praise. Homer's story of Elpenor who broke his neck by walking off a roof under the effects of a hangover could almost be a warning against 'taking a trip' (*Odyssey X,* 552-560). Horace, whose work has been called a secular breviary, says that nothing in the lives of teetotallers goes right but adds a list of moral failings due to drunkenness‡. Writing on drink, particularly wine, in our own time, has become voluminous, and much of course is technical. French doctors have argued about what Pasteur really meant when he called wine 'la plus saine and la plus hygiénique des boissons'.

## Puritanism

European tradition, as a whole, makes a prima facie case for fermented liquor, especially wine, as a psychotropic drug whose use is to be recommended subject to warning against abuse leading to drunkenness and alcoholism. But, as usual, there are distinctive factors in the British background calling for separate consideration. First, perhaps, religion. Hilaire Belloc, asked by a foreigner why public lavatories were underground replied that it was ultimately due to the Reformation. Be that as it may, the puritanism, which both in its Protestant and Roman Catholic forms has left its mark on Europe, has left a special mark on the 'Anglo-Saxon' world. The contemporary reaction in this world is correspondingly strong. Attitudes to food and drink have been affected, like attitudes to all the pleasures of the 'flesh', sexual pleasure included. If subterranean

*Consumption in the 1960s was well over 100 litres per head of the population a year.
†No doubt a sweet one
‡Blind self-love, conceit and betrayal of trust.

urination has been connected with it, so has drinking behind frosted glass. By contrast, until virtue clashed with cakes and ale in the sixteenth and seventeenth centuries, British attitudes to drink must have differed little from those in modern France, for example.

**Politics and drunkenness**

The second factor has been social - the growth of a proletariat, more or less co-inciding with the availability of cheap spirits. Maurice Healy in *Stay Me With Flagons* (Michael Joseph, London, 1940) attributed Irish drunkenness to British oppression. But at least the eighteenth and nineteenth century British poor were little better off than the Irish. The down-and-outs of Hogarth's London sought escape from harsh realities in gin. Distillation of spirits, which is the separation of alcohol from fermented liquor by boiling, had been first introduced to Europe in the fourteenth century. By present standards a single whisky contains about the same proportion of alcohol as a half pint of beer or a large glass of wine. It was some three hundred years before spirits became serious competitors to the more popular liquors sold in ale houses and wine taverns. No restrictions were placed on these establishments until the first controls by licensing in 1494 and then again in 1552. This legislation became the foundation of all subsequent control in Britain. In spite of a continuing prevalence of drunkenness it was not thought necessary to introduce more stringent regulation until the seventeenth century when spirits finally became popular.

By the period 1720-50 Britain had experienced its first 'gin epidemic'. Gin was blamed for the greater part of poverty, murder and robbery which were so prevalent in London at this time. After several (unsuccessful) attempts at near prohibition, control of consumption was achieved by increasing taxation (a fruitful source of revenue) and by more effective control of sale. These two measures have always been the bedrock of British alcohol legislation. Although temporary control was achieved, the 1800s saw an even worse era of 'gin palaces' and public houses, concomitant with intolerable industrial and domestic conditions. Beer and gin complemented each other to produce widespread drunkenness. It was said that 'Everybody is drunk. Those who are not singing are sprawling. The sovereign people are in a beastly state.' A spate of legislation throughout the century attempted to bring the population back to sobriety and much of it was encouraged by the emergence of a strong temperance movement*. In 1899 the first Royal Commission on Licensing found little improvement

*In his 1860 Budget Gladstone removed the duties on table wine in order to wean the 'artisan' class from spirits, but this was not maintained.

concerning the drink problem, but the small gains in the last quarter of the century were due in large part to 'the zealous labour of countless workers in the temperance movement'. Nonetheless the Report said that 'a gigantic evil . . . remains to be remedied'.

At the turn of the century convictions for drunkenness were running at about 200,000 per year, and by the outbreak of the First World War the drink problem was still acute. Lloyd George regarded drink as the greatest of the three deadly foes: Germany, Austria and drink. A Liquor Traffic Control Board was established in 1915 and dramatically improved the situation by a drastic reduction in licensing hours (from 19½ to 5½ a day), direct restrictions on the supply of liquor, and increasing the price by heavy taxation.

The reasons for the apparent downturn in drunkenness from the First World War to the 1950s are still a matter for speculation. Taxation and licensing seem to have been influential, as have competing leisure activities such as televsion, and the improvement of conditions in housing. It is no longer necessary to seek comfort and solace in a pub. Pubs themselves began to change, through the efforts of brewers to make them more respectable as well as attractive and to cater for the increased popularity of wine.

### Wine snobbery

A third factor in the British scene is basically geographic: though there are now said to be over 40 English or Welsh vineyards producing wine for sale from freshly pressed grapes (as opposed to 'British wine'), Britain can never produce wine on any commercial scale and has to import it from varying distances. Thus, for reasons of cost, beer or cider have been the staple drinks, and even from Plantagenet days, when two wine fleets a year reached England from Bordeaux, wine was mostly the drink of the middle or upper class. The Gladstone budget, mentioned above, was a flash in the pan. Shortly after his time the class distinction in drinking habits gave rise to a new phenomenon. Alongside the great country house cellars and the old port drinking squirearchy, there emerged an elitist cult of fine table wines - claret, burgundy, hock, etc. - considered as 'works of art'. This was partly a genuine reaction against philistinism and puritan distrust of good living and took its positive inspiration from the French cult of 'gastronomy'. Partly it was a form of snobbery like any other. It found expression both in wine drinking clubs and in a literature often more fulsome than informative.

## The contemporary scene

Since the '60s, the scene, like so much else, has changed once more. Consumption of all alcoholic drinks in Britain has increased both in absolute and per capita terms. In 1969 the adult population drank about 29 gallons of beer, just over half a gallon of spirits and a gallon of wine per head. The average household spends between 4-8% of its total income on drink. Wine drinking in particular is on the increase. It is ceasing to be an elitist habit and is beginning to be taken up by all classes to a greater extent than at any time since the seventeenth century. There is much more variety of it available, good and bad: the British wine trade had - like its clientele - been largely conservative. But now alongside 'classical' clarets and burgundies, wine from 26 countries can be bought here. With recent exceptions, prices since the war have risen much less than those of many commodities: drinkable 'plonk' can at present be had for about the same price as undistinguished but genuine claret 20 years ago. Trade and consumption has also been modified by the growth of world demand. North America and Japan have discovered wine not only as a normal drink but as a status symbol. They look to the quality vineyards of Europe to supply the need: hence the astronomic rise in top claret and burgundy prices in the last few years. Retail prices of these wines in Britain are already over £100 per dozen. We have heard of venerable bottles bought not to drink but to keep in niches like statuettes. This is a boom comparable to that in French Impressionist painting, and it has led to similar financial speculation which the consumer can only deplore. One must add that from the wine growers' point of view, as with other farmers in continental Europe, prices had for long been unrealistically low, and some increases were inevitable. Despite inflation, at the time of writing (April 1973) wine good enough to show the novice what all the fuss is about is still obtainable at around £1 a bottle (75cl), and the phasing out of duties accompanying the introduction of VAT might reduce this further.

## Alcoholism

It is against this social and historical background that we can best distinguish the good and bad in the drink scene and suggest a discriminating approach to the use of alcoholic liquor, as we have tried to do with other drugs. We have already looked at the vice of drunkenness over the centuries and must now turn to the disease known as alcoholism.

Not surprisingly, authorities link the incidence of alcoholism in society with the levels of alcoholic consumption and public drunkenness. In view of the overall increase in drink sales and the rise in arrests for public drunkenness in

England and Wales in the last few years, it is therefore fair to assume that alcoholism is similarly on the increase. The habitual drunkard is the visible tip of an iceberg - the alcoholism of 'skid-row' represents only around 7% of the total problem. The remainder of the estimated 350,000 Britons with a drinking problem incur physical, social and mental damage while continuing to live in their own homes. Dr J. A. Jaffe, the head of President Nixon's special office to combat drug abuse, said in a standard textbook on pharmacology:

> 'the large role that the production and consumption of alcoholic beverages play in the economic and social life in Western society should not permit us to minimize the fact that alcoholism is a more significant problem than all the other forms of drug abuse combined.'

The production of alcoholic liquor in Britain is big business. In 1970 the Brewers Society, the principal trade association concerned with production and distribution of alcoholic beverages, calculated that the industry had an invested capital of £1,700 million - more than three times that invested in the aircraft and aerospace industry. More than 120,000 people are employed in brewing and distilling. The industry produces about 200 million gallons of spirits a year and almost six times that amount of beer. More of this output is consumed by the home market but liquor, especially spirits, is a substantial export winner.

*It appears that about 95-98% of the drinking population comes to no harm. But a minority does.* There is no completely satisfactory definition of alcoholism because it is a complex phenomenon which can be described by reference to its physical or psychological symptoms, the adverse effects it may have on the drinker, his family or society, or in many other ways. The World Health Organisation's definition is the most widely accepted. Alcoholics are:

> 'those excessive drinkers whose dependence on alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and mental health, their interpersonal relations, and their smooth economic and social functioning; or who show the predromal signs of such development. They therefore require treatment.'

Alcoholism is a progressive condition. It takes between three and twenty years of high alcohol intake to become dangerously dependent. In their book *Alcoholism* (Penguin Books, London, 1965) Kessel and Walton have suggested three stages in the development of alcoholism; excessive drinking, the addictive stage and chronic alcoholism. Excessive drinkers are not alcoholics though they may become so. Their drinking pattern starts like that of the heavy social drinker, but they begin to drink more, and surreptitiously. They plan ways of drinking, without others knowing, to gain positive relief from pressures and

tensions. Finally they become compulsive about drink, and their interests narrow. This phase moves on to the period where work tends to become affected as heavy daytime drinking develops. Social and interpersonal relationships suffer; supplies of liquor are concealed and food is neglected. Suicide attempts often result. The addictive stage passes to the chronic stage with the development of additional physical and/or mental disorders.

Although these stages may not be completely distinctive and do not represent the individual variations in alcoholism, a similar type of progression is often found. Of course not all excessive drinkers will increase their drinking in the manner described.

The lack of agreement on the definition of alcoholism, the propensity for alcoholics to hide their illness, and the variety of problems caused by alcohol make it very difficult to estimate the extent of this disease in Britain. Both indirect and direct methods of estimation have been used. Indirect indices attempt to relate such things as overall consumption, death certificates, and the prevalance of cirrhosis of the liver, to a likely incidence of alcoholism in the general population. Direct methods are most often surveys of selected populations, or surveys of reliable informants such as doctors, social service agencies, health visitors and the like.

It is impossible to give a description of a 'typical alcoholic'. One of the most striking features of the condition is the variety of people it seems to affect, but certain characteristics are more common than others. Alcoholism seems to affect men more than women, with ratios of men to women varying in several surveys from 2:1 up to 7:1. The peak age is between 40 and 50 years, although recently fears have been expressed about the growing number of young alcoholics in their twenties; and even about excessive drinking as early as 13-14. It has been suggested that, on average, male alcoholics were first drunk at 20 (31 for women), had their first amnesia - memory loss - at 30, took to 'loss of control' drinking at 34 (42 for women) and early morning drinking at 35, sought medical advice at 39 and reached the worst stage of alcoholism at about 42 years for men (46 for women).

It has also beeen reported that young persons are taking alcohol in conjunction with drugs. The number of persons involved is not known, but the drugs commonly taken with alcohol are barbiturates, mandrax, amphetamines and anti-histamines. This is a dangerous practice which occasionally has a fatal outcome. The dangers of taking alcohol along with other depressant drugs such as barbiturates is due to the mutually summative effects of the drugs concerned.

Alcoholism appears to be more prevalent in urban than rural areas. In Cambridgeshire the ratio was 2:1. Among urban alcoholics men of Irish and Scottish nationality have a greater rate of harmful alcohol dependence than

would be normally expected. There are also relatively more alcoholics who were raised as Roman Catholics than those who were raised in the Church of England or as Jews. These factors are of course not explanatory in themselves but point to more complex underlying phenomena. All social classes are affected by alcoholism, although it is possible that there is a higher prevalence among both the higher and lower social class groups.

This short list of common social characteristics is by no means exhaustive but only represents some of the most consistent findings in alcoholism research. It has also been widely found that alcoholics have many difficulties in personal relationships, anxieties and other emotional problems which they are attempting to solve. Research has failed to delineate a trait, or set of personality traits, which would identify those most likely to develop drinking problems. The development of alcoholism is a complex interaction of an individual with his social environment which is unlikely ever to be unravelled by simple personality labels such as 'weak-willed', 'neurotic' or whatever.

As for the consequences of prolonged heavy drinking, the physical ones are well known. Most common are development of a fatty and scarred liver (cirrhosis) and peptic ulcers. There can be damage to the nervous system (peripheral neuritis) and, in advanced cases, irreversible brain damage. Prolonged drinking often coupled with inadequate diet also gives rise to vitamin deficiency diseases and in some cases weakens the heart muscle (cardiomyopathy).

Alcoholics also suffer more direct effects from their dependence on this drug. It is responsible for tolerance and withdrawal symptoms. Tolerance is the phenomenon where a person needs more of a drug to get the same effect. It is common experience with alcohol to find two drinks are needed 'to feel good' whereas before it was only one. This type of physical reaction can take on much greater dimensions as drinking continues over many years. Withdrawal symptoms - the craving of the body for its accustomed dose of alcohol can take the form of 'morning shakes' or delirium tremens (DTs). Frequent amnesias, where the alcoholic may lose his memory of a part, or all, of an evening's drinking are a not uncommon symptom.

There are also social consequences to be considered. Virtually all studies of alcoholics have shown a significantly high proportion to be single, separated, divorced or widowed. There is evidence of a high degree of family disruption. Drunkenness offences pose difficult problems, although drunkenness is not alcoholism. In 1971 there were 82,961 convictions for drunkenness in England and Wales, 2350 convictions for dangerous driving under the influence of drink, and 37,575 non-indictable offences involving drink. To this list of social consequences can be added the influence of alcohol on crime, suicide and absenteeism, accidents and inefficiency in industry, among other things.

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To cope with the personal and social consequences of alcohol abuse an array of treatment and rehabilitation facilities exist. On the medical level treatment is given in general and psychiatric hospitals as well as twenty-two specialised alcoholism units. In 1968 over 11,000 alcoholics were admitted to hospitals in England, Wales and Scotland. There is both in-patient and out-patient treatment as well as a variety of approaches from psychotherapy, through therapeutic communities, to aversion techniques such as mild electric shock treatment and the administration of the drug Antabuse which causes a violently unpleasant effect by inhibiting the metabolism of alcohol. There are conflicting reports of success, with estimates of maintained abstention ranging from 20% to 60%. The role of voluntary organisations is recognised as essential in treatment, and the scope of these activities is growing to meet an increasing demand.

## Temperance

The phenomena of drunkenness and alcoholism partly explain and no doubt partly justify the movement for total abstinence, commonly known as Temperance. Its religious roots are chiefly in the Non-conformist tradition - though not exclusively. Maurice Healy, the claret lover already quoted, was a convert from an Irish Roman Catholic League devoted to this cause. The historical emergence and the merits of Temperance have already been mentioned. The movement is still with us and deserves objective and sympathetic presentation in any educational inquiry.

Temperance appeals to three arguments:

i personal responsibility to God and to Society. Drunkenness and alcoholism are anti-social, and the risk of escalation to them involved in any form of drinking is held to be unjustified. Leaving God aside, this is an argument equally acceptable by Humanists. Its validity of course depends on whether the risk of social and personal damage outweighs the pleasure and the benefit, if any, of drinking. It is not seriously argued that the moderate drinking, in which the majority of our society indulges, is harmful in itself;

ii it has been said that the example of abstinence is needed to strengthen the resistance of those who for temperamental or other reasons are most at risk;

iii the stimulus and relaxation sought in drink are considered ersatz forms of the uplift and peace to be found in religious experience.*

*Counter-arguments stemming from other Christian traditions relate to the person of Jesus. He was a drinker, it is maintained, and even on one occasion turned water miraculously

## A rationale of drinking

Quite enough has been said in this rèport to leave no doubt about the evil of drunkenness and of alcoholism. It is easy to condemn the one and deplore the other. But is there a case for the moderate drinking which so many of us still go in for without becoming habitual drunkards or alcoholics? Assuming there is, it might run as follows in the concluding paragraphs of this section.

First the term 'moderate'. Obviously it concerns not only the total quantity of drink consumed but also its alcoholic strength. Drinking is not only for 'kicks' but also to supply the body with fluid*: hence the danger of high strength drinks slipping down too easily†. French propaganda against alcoholism has recommended a daily consumption of not more than one litre of table wine, with higher tolerance for heavy manual workers and lower for the sedentary. 'Aperitifs' (i.e. wines, like vermouth or sherry, fortified with spirit to about half as much alcoholic strength again) have been discouraged - not unreasonably. People in health no more need aperitifs than aperients. But socially the acceptance, and even approval, of moderate drinking, as well as its legal toleration, is unlikely to change much in the foreseeable future. If it were not for the dollar-earning of whisky, one could just imagine bottles of spirits carrying a government health warning. But not bottles of wine, beer or cider. Drink, like constant change, is here to stay, and we must educate for it.

An intelligent interest, and even a discriminating taste, in drink can be safeguards against excessive drinking caused by ignorance, bravado or psychological insecurity. Drink should be approached, unromantically, both as a useful means

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into wine - a high strength wine, incidentally, since it came at the end of a celebration and drew compliments from the guests. He also instituted a sacrament for which fermented grape juice is believed necessary. (This belief is not shared by some Christians, and has even caused difficulty in Anglican/Methodist reunion talks.) Whatever the validity of these counter-arguments, the cult of wine has undoubtedly been over-glamorised by some writers with a religious background, prejudiced in favour of Latin culture, notably the 'Chester-Belloc' school. It should be remarked here that alcoholism is about six times commoner in France than Britain.

*J-J Rousseau in *Emile* refers to a wine as 'noir et grossier mais désaltérant et sain' (black and rough but thirst-quenching and healthy).

†One safeguard could be the statement on all bottles containing alcoholic drink of the alcoholic content (measured decimally in percentage by volume), as well as of the total fluid content. This is already done with spirits and Italian wines, but only with French 'vin ordinaire' and not with beer or cider. In European wine legislation a minimum natural alcoholic strength is commonly specified but not a maximum. French wines are often 'chaptalised', i.e. sugar is added to the fermenting grape juice to increase the alcoholic degree (percentage) of the wine. The practice, intended to correct imbalance, is liable to abuse, and has been criticised both on grounds of health and of taste.

of combined stimulus and relaxtion and as a social lubricant, valuable in overcoming timidity and - subject to the condition Shakespeare (Macbeth, Act II, Sc. 3) noted - in sexual relations. The regular 'dose' will vary with the individual, but once ascertained can exert a stabilising influence on the whole person. Wine in particular has been recognised as an aid to artistic creativity. There is moreover a specifically medical case for drink, which, naturally enough, has been most strongly argued, against some opposition, in wine-growing countries like France. It is summarised, with a wealth of useful detail on the whole subject, in a study by Dr Jean-Max Eylaud, *Vin et Santé,* Vertus Hygiéniques et Thérapeutiques du Vin (La Diffusion Nouvelle du Livre, Soissons, 1960). Of course, if such aspects were insisted on too strongly in education, the impression might be given of a paternalistic attempt to present drink as an attractive - and legal - alternative to other drugs.

Education in drink ought to be associated with education in food. Not only because the latter is desirable for its own sake, since so much health and happiness depends on eating, but also because, as a matter of common experience, drink is healthier and less inebriating taken with, or immediately after, meals than before or between them. Education in food and drink, apart from its agricultural interest, covers the quality and appreciation of these products. Since, as part of the new concern for the quality of life, there is an increasing volume of English writing on 'gastronomy', it is worth asking what the point of this subject, often stigmatised as esoteric or at best bourgeois, ought really to be. Apart from the obvious need to make the best use of raw material, its first purpose should be to enable the subject of food and drink to be forgotten in favour of more important topics. People are preoccupied with food and drink when it is bad: when it prevents relaxation and becomes a social irritant. No doubt some marriages do break up for this reason - in spite of the television commercials. Secondly, it can be a worthwhile subject in itself: wine-making and even brewing and distilling, like cooking, can be arts*. Their prosaic functions do conceal a romance. The fact that art has an educative role is accepted. But because the higher forms of art appeal to sight and hearing, there is no reason to despise taste and smell. The 'great' wines justify their reputation, if not their price. Inaccessible to all but a few, except on rare occasions, they nonetheless set a standard. Because people cannot afford Impressionist pictures they need not for that reaosn be indifferent to the quality of wallpaper.

*A good description of the art of cooking is a couplet by the modern French writer on food, Curonsky, who did much to debunk over-elaborate cuisine:

'La cuisine, c'est quand les choses
Ont le gout de ce qu'elles sont.'

(Cooking means things tasting of what they are).

So much is being written at present to meet the interest of a new and wider public in the production and appreciation of drink, as well as food, that even a summary bibliography would be impossible here. Every aspect is covered: viticulture, home-growing and brewing, buying, storing, tasting and drinking*. But no book can replace individual experience and the cultivation of individual taste, which needs to be asserted all the more confidently in the face of advertising pressures and of standardisation threatened by the takeover of small businesses. Beer and spirits have long been big business: wine with its greater subtleties and the higher degree of excellence it can reach, is now following suit. A more positive development has been the endowment of wine scholarships and the grant of diplomas in 'mastership of wine', eagerly sought by young people starting careers in the trade. Also to be mentioned is the recent formation by the Wine and Spirit Association of Great Britain of the Wine Development Board, part of whose aim is to popularise wine by ridding it of false mystique, and whose Secretary, incidentally, is a Methodist. The Board issues educational material and arranges lectures for schools.

*One small booklet perhaps deserves special mention: *Bluff your Way in Wine* in the Bluffer's Guide series (Wolfe Publishing Co, London, 1967). Despite its title it contains an astonishing amount of down-to-earth, common-sense information for 30p.

# 5 Notes on what local authorities are doing about education in the use of drugs

This survey is merely a rough sampling, for complete information is not available. What follows is based mainly on the response of 87 local authorities to questions circulated in 1970, with detailed examples from 6 of them. About half of the 87 respondents stated that there was no drug problem in the area or that nothing was done in the schools for fear of exciting interest where there was none. The great majority of the other half relied on the Health Education Department, who made resources (speakers, posters, leaflets, booklets, tapes, films, slides) available to schools on request, or included drug hazards in their own health programmes, or arranged meetings to provide information and opportunity of discussion for teachers, sometimes together with parents and perhaps social workers. The activity of Health Education Departments in this respect ranged from monitoring material to that of one London borough who reported:

> 'Have an extremely flourishing Health Education Department who use films, film strips, tapes and slides, leaflets and posters etc. They give lectures in secondary schools, hold meetings for parents with speakers from psychiatry, probation service, social work agencies etc. Hold meetings for youth club leaders, head teachers and social workers, have discussion groups with teachers, have discussion groups with youth clubs, boy scout groups, etc. Work in homes for unsupported mothers, hold forum on drugs in secondary schools and give advice to individual teachers.'

Obviously this spate of activity is not wholly and solely concerned with drugs, and many Health Education Departments insist that drugs are dealt with only in the context of an extended programme on such general topics as human relations, developmental behaviour, problems of adolescence, health hazards and health resources, or responsibilities of citizenship. Where the Medical Officer of Health (and Principal School Medical Officer) happens to be particularly interested in and informed about the subject of drugs (as, for example, in Wolverhampton) he will give special attention to this in his own way in connection with the schools. Or it may be that another officer, say, the Local Education Authority Adviser for Health Education has this special interest and has worked out appropriate local methods of information and action.

**Points taken from the replies**

Two authorities mentioned the Teachers Advisory Council on Alcohol and Drug Education, which they associated with their work.

Two said that the local Teachers Centre had organised courses.

Two mentioned conferences for or discussions with senior pupils.

One county authority, feeling that education in schools is too late, 'endeavours to work with young mothers on the needs of bringing up children and really as a last resort some work in youth clubs dealing with drugs in their social context'.

Some authorities have established inter-disciplinary or liaison committees which include teachers.

Where counselling was mentioned as a means of available help the point was made that the offered service was not likely to be made use of unless available in the right setting. One way was to include it in the context of a general advisory centre on a range of topics of interest to adolescents, another by peripatetic counsellors visiting the centres of youth culture out in the community.

Three points were repeatedly stressed, and emerged as a consensus of practical experience:

i drug use should not be dealt with as an isolated topic, which would dramatise it as a worry of adults about young people, but should find an inevitable place in a broad programme to do with health or social responsibilities or problems of growing up and the like;

ii the subject should be dealt with by teachers, rather than by visiting speakers;

iii teachers who do venture to deal with the subject need special preparation and help, which the local authority should be able to provide.

Below are extracts from four replies of local authority health officials to a letter from a member of our working party.

1. From the Adviser for Health Education in a university city:

> 'Perhaps I can briefly outline what I have done as an Adviser, which does appear to have produced an encouraging response. This may differ somewhat from the approaches adopted by Health Education Officers, in that I believe this work is best undertaken by knowledgeable teachers rather than visiting experts. At first teachers lacked confidence in their ability to cope and turned to the itinerant speaker for help, but this pattern is gradually changing.
>
> (a) Lectures on the misuse of drugs have been specifically arranged for an invited group of teachers who are already involved in Education for Personal Relationships. The belief that drug-taking is a symptom of an underlying

problem may mean that these teachers, with whom the young are more willing to discuss their problems, have a particular advantage in this field.
(b) In general, visiting speakers have been limited to one of our teachers, who had worked for a couple of years in an addiction centre, and myself. I found it of great benefit to visit addiction centres, talk with addicts and ex-addicts, work in close co-operation with the local drug squad and staff of the local addiction unit, in order to widen my knowledge of the subject.
(c) A variety of literature has been distributed to the teachers to keep them abreast of current developments.
(d) Some schools have followed a comprehensive programme of Health Education which covers many of today's social hazards, including safety of drugs; alcoholism; smoking; advertising techniques; and mental health. Drug abuse then becomes a natural development of the programme rather than an isolated and emotional crisis talk.
(e) I have produced a 35 minute tape recording to accompany a collection of about 45 slides on the subject of drugs. These I have shown to a small group of staff in individual schools, who feel they can contribute to the topic through their own subjects of Drama, English, Biology, Health Education, Religious Education, etc. We have discussed this material and I have answered their many questions on facts and on methods of presentation. The teachers have then borrowed the recording and slides to use in the way which they feel most appropriate. This has resulted, for instance, in some quite interesting creative writing taken from the standpoint of the concerned parent or friend rather than romanticising the image of the drug-taker. We are still exploring the possibilities of this approach and tape recording some of the young people's responses.
(f) One school set a group of their 4th year pupils the task of searching out information and visual aids on the subject of drugs and then themselves presenting it to their colleagues. This did appear to be most successful, certainly with the group pursuing the project.
(g) We have tried using tape recordings of drug addicts speaking, but until now have not apparently struck the right balance. I hope again in the near future to record the comments of addicts from our local addiction centre and to try again with this. I prefer not to bring an ex-addict into the school.
(h) A variety of audio-visual aids have been used. The films have been of a poor standard and have been replaced by slides which have proved more successful.
(i) Many talks have been given at parents meetings by a combination of the police, psychiatric workers and myself.
It is difficult to measure what is successful in terms of the number of young

people who have been deterred from experimenting with drugs, but judging by the response shown to the various methods listed above, they would appear to offer a considerable degree of encouragement.'

2. From the Health Education Officer in a northern industrial city:

'(i) Continuous broad spectrum education on the dangers of misuse of drugs per se, i.e. abuse of medication, stressing the 'right' substance at the 'right' time in the 'right' quantity for the 'right' person and avoidance of self mis-diagnosing and mis-prescribing. This education is provided not only in sessions specifically devoted to drugs but rather as a theme through most of the general health education subject matter provided to both young people and adults, professional people and parents.
(ii) Alcohol and alcoholism are treated as an integral part of drug abuse and dependence and also as a subject in its own right.
(iii) The 'usual' educational techniques are adopted for group teaching in addition to providing individual students with information, advice and insight about the question of drugs in connection with special projects to be carried out in schools, colleges, etc. (We supply a constant stream of requests for this type of assistance.)
(iv) Wherever possible we avoid dealing with the subject of drug dependence out of the context of a general health education programme, although we do regularly provide short specialised courses for a number of weeks on modern hazards to health or health in adolescence which puts drugs in perspective as a health problem and related to decision making about drug-taking by individuals (and community decision making on other hazards, e.g. venereal disease, promiscuity, cigarette smoking, etc.)
We find the greatest benefit from the use of socratic methods, particularly when dealing with young people. We attempt to show them that society is concerned not only with the problems of today but also with the perpetutaion of problems into the next generation and the effect that such perpetuation could have on their situation as future parents with responsibility for their own children.
Obviously we work in close liaison with teachers, social workers and other agencies concerned with general social issues. We see our role as providing specialist re-inforcement either to or through the teacher in the school and not merely functioning as an outside agency.
I think that the above will give an indication of our general approach which is conducted on a person to person basis rather than through impersonal or publicity techniques - we do however make use of these as general support for our programme.'

3. From the Health Education Officer in an industrial city in the south-west:

'1. Although in the past, I have at the request of head teachers, arranged for a speaker from this Department - usually a doctor - to give talks on drug dependence, I am now convinced that this is wrong. To isolate a particular health hazard by inviting a guest speaker into a school, puts the topic into the wrong context. I am afraid that many of us have been guilty in the past of a similar error in relation to sex education.
2. We are trying to get schools to treat the subject within the broad framework of health education, the bulk of which must be done by the class teachers; we in the Health Education Section supply the Health Education Co-ordinators in the secondary schools with the necessary materials and aids etc., and the Section also serves as a source centre for all teachers.
3. Earlier this year, 4 meetings of the Health Education Co-ordinators were held at the Teachers' Training Centre. At these meetings the teachers were able to hear talks from the head master of a grammar school, a consultant psychiatrist, a dispensing pharmacist, a lecturer in medicine, a probation officer and a police inspector of the vice squad. At the final session teachers were given folders containing a catalogue of recommended books, leaflets, films, filmstrips and tapes on drugs, alcoholism and smoking.
4. A consultant surgeon, who is keenly concerned with the drugs problem, has set up a panel of doctors - about six - who are available to give talks to members of staff at the request of school heads. So far, only two schools have availed themselves of this service.'

From the Senior Medical Officer in a midland town:

'I think it is important that the subject of drug abuse be discussed in the wider context of drugs in modern society. We have included the subject of drugs in our health education programme over the last three years. It became clear in 1967 that with the massive press and television coverage young people were talking about the subject and there were many misunderstandings and misconceptions. We are long past the stage where by talking about the subject we are introducing an idea . . . The question of at which age we should introduce this topic is still pertinent. At present we do not generally discuss the subject below the fourth year. However, one head teacher has now requested that we start this health education in the third year. It will obviously vary in different parts of the country and in different schools in the same town.

As to head teachers' attitudes to making the whole subject of drugs part of the school programme, there is still wide diversity of views on this. Sadly, a number of head teachers still persist in burying their heads in the sand and hoping that the problem does not exist. All the evidence is to the contrary. This is not to say that every school has drug takers. What I think we can say is that almost any young person of fourteen upwards would be able to get hold of these drugs should he or she want to. A number of them unwittingly and without desiring it find themselves in a coffee-bar or at a party where drugs are being offered. Our health education on this subject is aimed at replacing ignorance with knowledge so that at least the young person will have some chance of withstanding the persuasive talk of the pusher should he meet it.

We have a Drug Working Party which has representatives of all the disciplines in the town, including the teaching profession, where we collect information and decide on action locally. There is ready co-operation from the Headteachers Association with this Drug Working Party. Last year we organised a four-session programme, giving the background to the drug scene, basic effects, ideas of what local workers, for example, youth club leaders, probation officers, and drug squad, are doing. This was very well received and at the request of the teachers we are repeating this course again this autumn.

As to who should do the teaching, I think there is no one answer. The teachers should obviously be well informed and able to discuss in a balanced honest way the whole subject. I think there is also a place for others of us, whether it be a health education officer, a doctor, a probation officer or a member of the drug squad, to come into schools to answer more detailed questions and to give another slant to the whole problem. I see this, and many other topics of health education, as a team approach.'

# 6 Drugs education in schools

## What not to do

There seems to be a fairly united body of opinion on what schools should not be doing about drug abuse, but less agreement upon what they can or should do. Dr George Birdwood (*Drugs and Society,* vol. I, no. 4, Jan. 1972, p. 7. Macmillan Journals Ltd in association with the Institute for Study of Drug Dependence) points to the 'potential for positive harm' in education which is supposed to prevent the misuse of drugs by adolescents.

Doctors, social workers, psychologists, and educators agree that shocking people by photographs of wasted addicts, and by descriptions of withdrawal symptoms, which was formerly approved, should be eschewed. If the shocking pictures and descriptions are inaccurate for various drugs in different situations, adolescents from their personal knowledge will often spot the inaccuracy and thereafter may disbelieve any other information given in school about drugs. An adolescent's desire to take risks may lead to experimenting with drugs, after he has been presented with shocking pictures and descriptions of the results of misusing drugs. Scaring techniques for preventing accidents on the roads have not notably changed the behaviour of road users.

Outside lecturers and star-turns are disapproved of, save perhaps for sixth-formers who want, and are ready for, advanced information. A special visitor to a school may not only stimulate a wrong interest in drugs but also find it hard to pitch his talk at the right level of vocabulary and technical content for his unknown audience, some of whom may already know it all, while others may be uninterested and uncomprehending.

A dangerous star-turn is the former addict. If he has really stopped misusing drugs, he will unconsciously be telling his audience that they can try drugs and then give up, as he has done.

On drugs and drug-taking there is so much material, printed, visual and on tape, that if it were all available to pupils in the hope that they would then make their own decision, it could create an obsessive interest (a French girl drug-taker is quoted in the booklet of the Advisory Centre for Education *Where on Drugs: A Parents' Handbook* (ed. Beryl McAlhone, Advisory Centre for Education, p. 40) as saying: 'They've made such a campaign against drugs in

France that it makes you interested. There's something on television about it every day. It pushes you towards it.') This underlines the danger of what might be called 'drugs instruction': booklets of information about the colours, shapes, sizes, nicknames and effects of various drugs. One secondary pupil expressed his thanks for such material by saying, 'Now we can tell if we're being cheated'.

It is a *non sequitur* to assume that if knowledge replaces ignorance there is automatically a greater chance of a young person's resisting the persuasive talk of a friend or a pusher. The appeal to reason (or to what we see as reason) is not enough, because an adolescent's actions may be motivated by fashion, excitement, desire to take risks, or by deeper emotional problems.

Perhaps some detailed information on the effects of different drugs is desirable for parents, many of whom are worried about the risks their children are exposed to, particularly if such information is given as part of a group discussion, organised, for example, by a Parent-Teacher Association, at which parents can share and reduce their anxieties; but it would be harmful if the effect were to make them feel they should be looking for drug abuse in their children's every change of mood. The Advisory Centre for Education in the booklet referred to above, gives a categorical No in answer to the question, 'Should you be watching for signs that your children are misusing drugs?'.

## Responsibility of schools

Schools can no more ignore the misuse of drugs than they can ignore safety education, when one realises from clinical histories that a high proportion of drug users (even leaving aside alcohol and tobacco) start such use while still at school (John Payne has called this phenomenon the 'virtually obligatory flirtation with cannabis'. See 'No help for the young?' in *Drugs and Society,* Vol. I, no. 7, p. 8). Dr Ian Hindmarch's research (see 'Age groups at risk' in *Drugs and Society,* Vol. I, no. 1, Oct. 1971, p. 19) into the pattern of drug use in school children suggests that young adolescents (14-15 years) are particualrly at risk with amphetamines and dangerous experiments with drug and alcohol mixtures or with solvents, glues, cough-syrups, etc. He points out that prices are a large factor in this. Most boys and girls of this age do not know the dangers of misusing amphetamines and are further at risk because of their own beliefs and appraisals of drug taking, which often amount to a positive attitude towards it, and because it is condoned by important figures in adolescent culture.

It is to be expected that all teenagers will be in contact with drugs at some time or other, and so far as it can, the school should take steps to protect them, as it does from other dangers. Even in primary schools, there is room for helping young children to discriminate among the various drugs and medicines they are

likely to see at home, and it is not too soon to begin education in their correct use.

As with sex education, talks on the use and misuse of drugs must not be separated from a general programme of health education. Health education should deal with some forms of illness, which should include venereal disease, mental health, and the misuse of drugs. The programme should be given within the school curriculum, largely by the pupils' own teachers, and linked to such subjects as science, social studies, home economics, geography, history, religious education, as well as to those activities which satisfy emotive needs such as poetry, drama, music, painting, and dance. Drugs education in schools - like all education - should be given within the context of a proper relationship between teacher and adolescent, based, that is, on sympathetic understanding of the latter's situation (especially his emotional situation) vis-à-vis society.

Why is an adolescent liable to take drugs? If we decide it is partly because of his dissatisfaction with a competitive, status-ridden society, it will be not merely useless, but actively harmful, for the school to present itself (or the teacher himself) as a pillar of that society. This would lead only to further alienation of the adolescent and a yet greater possibility of drug-taking. So there should be no adopting of an authoritarian, prescriptive, 'we're telling you what to do' attitude. Teachers' ignorance of details of drug abuse is considerable, whereas a class might well know more than its teacher. (There is a case for instruction books for teachers, as well as for expert guidance by in-service courses.) Further, it is obvious to adolescents that many (most?) adults are hooked on tobacco, alcohol, or bingo, and a holier-than-thou posture would be seen by the rebellious youngster as another example of the general dishonesty and hypocrisy of adults, including teachers.

If we decide that drug misuse may arise from the need to seek relief from acute anxieties, it is no use attempting to give drugs education in a school which, by the climate it creates, helps to preserve or even increase those anxieties. Drugs education starts with steps to build a school society in which the young person can grow up without undue and unfair stress, without boredom, and without feeling rejected. Though one must recognise that some unhappiness is normal and necessary for development, certain forms of school organisation can exacerbate a feeling of rejection to the point where it undermines self-confidence - streaming at too early a stage, demotions, undue emphasis on competitive examinations; and, sometimes, unthinking verbal behaviour by teachers, such as sarcasm, nagging, and constant comparison of one pupil with another.

Everything possible must be done to reduce the credibility gap which may exist between teacher and pupils, and to keep the lines of communication open. Prescriptive lessons could produce drug taking for the sake of defiance. There is

need for teacher-education (as well as instruction) in tackling the misuse of drugs by adolescents; the teacher should not panic as soon as a pupil is suspected of pot-smoking. 'I have no hesitation in letting it be known that instant expulsion will be the fate of anyone introducing drugs into the school', one headmistress is quoted as saying in the Advisory Centre for Education's booklet previously referred to; perhaps she would then have recourse to aspirin for instant relief. Elevating a particular crime to such a height is a sure way to drive some children into committing it. Nor should the teacher have a stereotype of 'the drug taker' (who is often another stereotype 'the addict'). He should not parcel all drugs together as equally dangerous; nor forget that adolescents' moods will vary in the course of nature almost as widely as if they were taking drugs. All this will help keep communications open - in both directions. Whatever a teacher may say or not say, example is likely to do more to encourage or discourage smoking or drinking.

There is the possibility that some younger teachers may be using forbidden drugs on themselves and for that reason may exercise a benefically moderating influence on pupils who do. But will parents approve of such an influence? And can heads or local education authorities employ criminals on their teaching staffs?

## Lines of approach

The big question is: how can pupils be persuaded that drug taking is not a purely personal matter? Because of their generally sympathetic attitude towards misusing drugs, can we point out to them that drugs are considered too dangerous even for adults to be left free to decide for themselves about them? Would they find this argument convincing, or would it merely lead to a demand for the legalisation of pot? On the whole it is more likely that we shall reach them along two other lines.

The first line is the *personal* approach which arouses compassion for the tragic consequences, such as broken lives and failed examinations, of misusing drugs that they are quite likely to have seen for themselves. It is not institutions or traditions or even causes, but people that matter to adolescents. By concentrating on people, teachers may enable pupils to realise the dangers in misusing drugs, and thereby, alter their neutral or sympathetic attitude to drug taking. Teachers can help pupils to consider drug abuse as a failure to respect and treat properly their own bodies and brains. Girls are impressed, for example by the potential danger to the foetus.

From arousing compassion and respect for the person one can move to the second line of approach which is to arouse their *social* conscience, to persuade

pupils to think about drug taking as a social problem, to prompt them to ask (with the teacher) *why* drug taking has spread and *what* can be done about it. Young people are concerned about many aspects of the sort of society which produces the desire to escape through drugs, and if the teacher pursues the inquiry with them (not for them), there is a good chance of convincing the potential (or even actual) drug takers in the group that there is a case for preventing an activity which so many see as a purely private matter. The teacher cannot, however, foster this attitude unless he is honest and is willing, for example, to accept criticism of the misuse of tobacco, alcohol, and over-prescribed psychotropic drugs by adults. The teacher is at liberty to suggest that drugs are more dangerous than alcohol, since both dependence and toxic symptoms appear earlier with them, but it might be risky to suggest that they are more dangerous because, being illegal, they often put the user in touch with criminals, for contact with criminals often appears exciting.

The social conscience of young people, which is precisely what often alienates them from the establishments they see around them and turns them towards drugs, can also be the means by which they are brought to realise that this particular 'solution' to problems is an inefficient one, that it creates further social and personal problems without solving any, and that the drugs problem today has arisen because so many people have so many problems to which they have seen only this false 'solution'.

## Methods

When one has begun to work out this positive approach to drugs education in secondary schools, one can use it as a touchstone to test methods and materials. In trying to enlist the social conscience of adolescents, one must beware of simply appealing to their emotions: emotive media such as films may frighten or fascinate - or bore.*

*One of our members supplied comments by boys and girls from his fourth and sixth forms on a film which we judged to be one of the best on drug abuse. The comments illustrated the difficulty of producing an effective film about drug abuse for adolescents.

The film had been shown to two groups of the fourth form and to a group in the second year of the sixth form. The view generally expressed was that they had not been looking at an authentic film about real people; they had been looking on at a piece of contrived play-acting, which did not come home to them as a felt experience. Even in the fourth form, some had seen more of the real thing for themselves. The only spontaneous episode was a drug party, so that the most positive impression was in favour of drugs.

Three other comments to the point were: (1) the film tried to do too much, in covering the abuse of several prevalent drugs; (2) it would have been more worth while to have dealt

Books about misusing drugs are soon out of date, and even when written by authors whose personal record of help to young people is unexceptionable, seem so often to offend by an unconscious talking-down or by unspoken assumptions about moral rules which the writer has used in assessing whether drugs are being misused. Not only should the validity of a moral rule be explained, but its particular applications should also be justified.

The appropriate method for leading pupils towards an understanding of the difference between using and misusing drugs has already been outlined. If an authoritarian attitude is to be avoided, the traditional posture of the teacher facing rows of pupils must be changed. The small group discussion is the most productive technique. The class should be split into groups of five or six, each with a secretary to record the main ideas or conclusions, and each given a small specific subject to talk about (why are drugs particularly taken by teenagers? why was there no teenage drugs problem twenty years ago? why do adults smoke and drink? what can be the results of an adolescent's regular use of pep-pills?). These groups will readily talk for most of a lesson, without boredom, and then come together again for report-back and general discussion with a well-informed and sympathetic teacher, one whom the pupils know well and in whom they have confidence (perhaps a Head of House, with pupils from his own House, or a Year-Master or Mistress - someone known to the pupils in a helping, guiding capacity). With this approach, there is no danger that talk will be at the wrong level of intelligence or vocabulary, and the ice will be broken for questions of fact to be raised by the pupils themselves, and for individual help to be asked for later if it is wanted. As with sex-education, much of the value comes from later individual follow-up by the pupils.

The implications of this informal, pupil-centred technique are not always fully realised even when it is advocated. A booklet on some educational TV programmes for teachers about drugs, distributed by the Inner London Education Authority, says, for example: 'It might be a good idea to hold these discussions away from the normal classroom where habitually it is the teacher standing out in front who is the authority' (*Drugs: Handbook for Teachers*, I.L.E.A. Educational Television Service, Autumn 1970, p. 6). If it is indeed habitually so, a single discussion is not likely to get off the ground merely because it is held elsewhere.

Group discussion has been developed as a powerful skill in the teacher's hands - though like any other skill, one that has to be acquired. The Humanities Project of the Schools Council, for example, is built on this method, supported

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with social aspects of drug abuse; (3) the film left them with nothing to think about afterwards. These comments not only indicate the difficulty of producing an effective film, but also provide some criteria for teachers in the selection of films, if they want to use this kind of material.

by materials for study on selected topics. In the Penguin Education series 'Connexions', Peter Newark's *Out of Your Mind?* is an excellent topic book for group discussion of drugs. A mixed group, bringing together parents, pupils, and experts on an equal footing of open discussion can break down barriers.

This brings us back to the real help which schools can give to adolescents at risk. By creating an organisation and a climate which will reduce a pupil's feeling of inadequacy, the school will give constructive help in growing up but without imposing either too much control or petty tyranny. Whenever necessary, the school will guide and will create a meaningful curriculum for the pupils who have personal crises and family difficulties. The school should facilitate access to welfare agencies, both official and private, and should provide both a haven for the acutely distressed and outlets for those burning to change the world.

Physically mature and intellectually critical adolescents are denied any significant and active role in our society. The school can and must try to give them a social role in community development and in the study of the local environment, and the like, in which they can see they are actually influencing that environment. But, lest we heap on our teachers a burden of guilt, let us not expect them to accomplish such a Herculean task without change within society itself.

# 7 Personal development in the school environment

## The appeal of drugs

A young person who is happy and fulfilled, and well-adjusted socially, is unlikely to get hooked on drugs. Or on anything else. Young people who become dependent on violence, or smoking, or drugs, or alcohol are, typically, rather inadequate personalities looking for a prop to bolster their self-esteem, a compensation for some gap in themselves, or an escape from circumstances they find intolerable, or from depression.

What of the appeal of drugs as purely pleasurable? This question leads us on to a more fundamental one: what are the pleasurable elements in taking drugs? The answer would seem to be that they are varied, and that they vary with the individuals who take them. The 'up' drugs bring pleasure to the depressed and isolated by lifting them into elation and sociability. The 'down' drugs bring the solace of forgetfulness to the overwhelmed. For those who find their ordinary life inadequate, the world of fantasy that the hallucinogenic drugs can offer is a glorious escape.

There are also those who take drugs for the enhancement of perception and self-awareness that they can produce. Assuming that the research into addictive smoking conducted by Professor S. S. Tomkins and his associates in the United States is relevant to the drug scene also, then those who take drugs purely for the pleasure of adding an enhancement to life are least at risk. Professor Tomkins finds that the smokers vulnerable to becoming addicted are those who depend on cigarettes primarily to dispel unpleasant feelings, stress, and anxiety.

Tomkins and his associates are convinced that it is the attempt to dispel negative feelings, not positive pleasure, which really gets a grip on behaviour. They also see the search for escape from stress as covering a whole range of palliatives. In an, as yet, unpublished paper Ikard and Tomkins state: 'Smoking, however, is only one mechanism among many that can be used to manage such negative affect. Alternative mechanisms include drinking, using drugs, fingernail biting, reading, sleeping, sexual behaviour and eating'. Overall, it seems wise, in a study of drug dependence, to give most of our attention to drug taking in which the diminution of negative feelings is a primary, if not the chief, motivation.

Since any sense of personal ineffectiveness is anxiety-promoting, particularly

in adolescence, it is in this area that we should especially look for strategies to offset the risk of drug dependence. Moral condemnation of drugs as an indulgence, or medical stress on the hazards of drug-taking, cannot be expected to provide sufficient motivation to steer the potential addict away from addiction. The more dependable prophylaxis is to prevent young people getting into that condition of vulnerability when they are drawn towards drugs as an escape, or when a single releasing experience of drug-taking will be so self-enhancing as immediately to take on the significance of an indispensable support.

To differentiate between drug-taking for the life-enhancing experience it can offer for well-set-up young people, and drug taking as an escape from self, or situation, is not to suggest that any drug taking is free from risk. Young people who are apparently well-adjusted, who try drugs as an experiment, may turn to them again when overwhelmed by some difficult situation, or may, in the very act of taking drugs, discover a need for support, or a mode of self-enhancement, which they did not know existed. When LSD was being quite widely used for psychiatrical research, one theory of the difference between good and bad trips was that LSD could actualize an individual's potential neuroses. This theory did not gain acceptance, but it makes a probably valid point: that weaknesses of identity and poor integration of personality may be opened up under the influence of drugs which may then induce a need for drugs to offset them. It is a common claim in the drug scene that the only cure for a bad trip is a good trip. The situation we have to face is that a sense of personal ineffectiveness - of being inadequate, of being unable to cope - cannot but be a significant factor that increases the vulnerability of young people to drug dependence.

Making allowance for drug-taking as exploratory behaviour, as a search for excitement, as revolt, as social imitation, or as a dare, we are left with, almost certainly, a bulk of those at risk who are powerfully drawn to drugs because they are an attractive antidote to the pain of inadequacy and frustration. These are the ones who are most vulnerable to becoming drug dependent. The stressed person seeks relief and, having found relief, will not readily give up the means to it.

We must also consider the positive dimension of the effort to turn a minus into a plus. Human beings seek to enhance the quality of life they experience. We are striving creatures. The beginner at golf who has at last 'broken 100' immediately sets his sights on breaking 90. However beautiful the dahlias were last year, the keen gardener is planning something bigger and better for his next year's crop. Next summer's holiday is expected to be better than the last one; at least as good; worse is an intolerable thought. The person who has just mastered a new skill is a happy person. This on-and-upness of human personality can take on sick forms, as in the social competitiveness of 'keeping up with the Joneses', or the restless,

destructive rush of the consumer society, but, basically, the urge to self-enhancement is a positive force carrying human achievement forward. The frustration of the urge may make drug-taking a tempting compensation. For the inadequate, there is the incentive to lift themselves up to the normal; for the normal there is the urge to advance in achievement and fulfilment. Both conditions of being can be helped or hindered by the impact of education. Hence the relationship between education and the drug scene.

### The most vulnerable

It seems logical to start with the group of secondary school children who are likely to be most vulnerable to a sense of personal inadequacy, those towards the lower end of the meritocracy ladder whose road to self-confidence is inevitably more difficult than it is for those for whom success at school acts as a constant reinforcement to their sense of personal value. Again to draw an analogy from research into smoking, both in America (Lieberman Research Incorporated, 1969) and in England and Wales (J. M. Bynner, HMSO, 1969) it was found that, to quote the American Report, 'Cigarette smoking among teenagers is inversely related to academic achievement and aspiration'. No doubt the reasons for this are complex, but it accords with the view that a sense of inadequacy makes young people vulnerable to seeking the kind of support and group status that smoking or drugs provide.

How far can education be regarded as therapeutic to a sense of inadequacy? In theory, it should be therapeutic; in practice it is often the reverse. Those who can play the learning game along conventional lines are relatively all right, but those who cannot are at hazard. Even if the less able academically survive the infant and primary years of schooling unscathed what happens to them at the secondary stage is likely to deplete their confidence rather than to build it up. Secondary education is still too subject-centred and too examination-motivated for it to be a self-enhancing experience for the low-attainers.

There are, of course, many notable exceptions to this: schools where human values are uppermost, and where the confidence and personal development of all pupils are carefully assured. All the same, we are left with the disturbing and difficult fact that, however kind schools may be to their duller ones, the values of the school, all too often, have the effect of making the non-academics feel themselves to be inferior citizens. Although schools may struggle to prevent this happening, it is hard to make ground against the built-in value system. The prime aim of many, if not most, secondary schools is the attainment of examination results. It is here that the chief kudos is, commonly, to be gained. Consequently, those who are stumbling along in the rear of the race are likely

to be handicapped not only in attainment but also in self-esteem.

To link status primarily to academic attainment, as our secondary schools are inclined to do, has a fatally limiting and constraining effect. The able children are in a position to flower under the benison of a good, or reasonably good, level of success; the remainder are left to find self-enhancement *in some area outside the dominant value system of the school.* Some fall back on their muscles and seek to make their mark by violence. To participate in the drug-scene - part revolt, part escape - is another tempting alternative to the unattainable status offered by the educational system. The leather-jackets and Hell's Angels play it both ways.

The academic emphasis in secondary education generates stress not only by the values it selects as the determinants of its functioning, but also by the competiveness arising from those values. Children may have to strive hard to win acceptance in a school of high status and, once in, may find themselves in a constant climate of competitive personal selection. This is, by its nature, an extremely stressing situation with which adolescents may have great difficulty in coping.

If we are to create an educational system that gives dignity and status to all young people, then the *dominant* values of secondary education must cease to be those of academic attainment. Personal development, and the quality of participation and contribution within the life of the school community, and the wider community, should become the chief criteria of evaluation. This approach would give everyone a chance to find a role, and an identity, that is self-enhancing rather than self-depleting. All kinds of innovations are beginning to appear in an effort to achieve this, but it is proving an obstinate problem and we have still a long way to go before the less able scholars (in traditional terms) can be assured of a relevant and rewarding school experience. The raising of the school leaving age makes this adjustment in the style and values of secondary education all the more urgent.

Standards in academic achievement are not, let it be noted, under threat. What is necessary is that schools should become less obsessed by academic standards, and more concerned about standards of personal development for *all* children. Exam-passing can be a game the bright ones play to their hearts content, but the respected values of the school community should be elsewhere, and should be seen to be elsewhere. Until this change in values becomes characteristic of secondary education, we cannot avoid producing, year by year, hosts of young people forced to make up for a sense of personal inadequacy by one undesirable form or another of demonstrative compensation. This conclusion arises from the nature and needs of adolescents themselves. We have to work with their nature and needs if we are not to reap a whirlwind of anti-social protest.

**Other liabilities**

But, of course, all drug-dependents are not low attainers. Many are bright young people with a good school record. Typically, however, this group of drug takers shows signs of stress, and its members are often under-attainers in terms of their potentialities. The pressure on student counselling services at universities shows very clearly that high academic achievement does not necessarily imply an equivalent *personal* development. Many authorities believe that personality stress usually precedes drug-dependence. The schools are not responsible for primary personality distortions that develop before the child reaches school at all. We must ask, however, whether we are, as yet, doing anything like enough to spot and help stressed inadequate children as they move up through our schools. For one thing, stressed children are often the product of homes where parents are over-ambitious, and may be imposing their expectations upon their children rather than allowing the children to develop as themselves. Or the home may be a source of relational stress. Or parents may be indifferent to the school life of their children, which creates its own kind of stress. Schools can often help, in such instances, by re-educating the attitudes of parents. Close communication between home and school is a notably better way of discovering stress in children than leaving its diagnosis to home or school alone.

Poor social capacity is an undermining form of inadequacy that may be found at all ability levels. It may persist, unresolved, throughout the school years and produce great problems when the young person goes on to further education or to work. The loners, the isolates, and the shy ones, are under a serious handicap, and are vulnerable to dependence on alcohol or drugs to give them the courage to relate to others. The over-aggressive are also in jeopardy - from rejection by others. Adolescence is the time when the individual emerges as an independent member of society. Social education should, therefore, be a primary concern of secondary education. This requires that our secondary schools shall be places where social education is a constant outcome of the community life, and where the socially inadequate can be assured of patient, understanding help.

A point worth noting here is that, whereas the natural support groups of adolescents are, say, from three to ten members, the organisational groupings of the school - set, class, house group, tutor group, year-group - are usually much larger. When the school does not offer support groups, the adolescents are likely to build their own outside the school. One way of looking at an intimate pot circle is as such a support group.

It helps greatly with problems of inadequacy and stress if the secondary school is 'open' to all kinds of personal problems. To regard personal therapy as a job for experts outside the school is to renounce a major responsibility of the school.

All communities *are* therapeutic - or the reverse - by their very nature. They cannot avoid influencing personal development, positively or negatively. Every discussion on a subject that is felt by the young people to be significant is potentially therapeutic, as is every friendly face-to-face chat, every positive relationship, and every word of encouragement. The secondary school should provide a network of care spread wide enough to catch any of its members who are falling away from identification with it, through isolation, discouragement, home difficulties, personal difficulties, or any other source of stress. To feel alone with one's problems is a great incentive to turn to the alternative existence which drugs offer, whether in the lonely escape of the stoned or the warm community of a pot session.

**Political protest**

A special sector of the drug scene is closely tied up with political action. Here drugs can no longer be regarded as just an escape but become an element in activism, almost a badge of protest. This group argues something like this: 'The Establishment is rotten and must go. One of the Establishment's gimmicks is to crack down on drugs because its members want a way of squashing the protest of youth. Meanwhile the Establishment types swallow away at their alcohol and puff on cigarettes and cigars without let or hindrance. Any self-respecting young person should join the drug scene in order to show them, and their tame fuzz, that they are not going to be allowed to get away with it.'

There is, of course, an element of justification in this. The young have a sense of being harassed by the police. They feel that the evidence that occasional pot smoking is physically or psychologically harmful is slight, as compared with, say, the physical risks of smoking ten cigarettes a day. They find it hard to correlate the severe penalties against pot with the fact that every High Street is flanked with tobacconists. The argument that two blacks do not make a white does not offset the feeling that they are being discriminated against unfairly. The question for educators is how to present the situation as it is and yet to counteract the incentive to take drugs as a symbol of protest.

Some schools are attempting to do this by bringing the social and political realities into the schools. Humanities courses are designed to bring young people into a sensitive, responsible relationship with human society. 'Orientation' is beginning to be seen as a proper purpose of secondary education. 'Environmental Studies' can give children a realistic concept of urban and rural environments. The Schools Council's Moral Education Curriculum Project is designed to develop sensitivity and social awareness. The right trends are there, and are growing, but they are, as yet, too weak to have much effect on the secondary school population

as a whole. The disturbing fact is that many young people are so faithfully echoing the values of the meritocracy struggle that they themselves reject such broadening education as *is* offered to them.

The ecological approach is of especial value in helping young people to get both drugs and their social responsibilities into perspective. Threats to the future of the planet are readily understood, and the citizen's role in combating them is clear, and related to the immediate environment. The human body itself is part of the eco-system, and respect for life, and the cycles which sustain it, leads into consideration of what respect for one's own body and brain entail. Information about the range of drugs and their effects can, thus, be considered in the wider context of life itself. To 'blow the mind' with drugs then becomes an act against that exquisitely elaborate and delicate instrument of life, the human brain. The adolescent's sense of awakening social responsibility can be set against the fact that drug dependence leads to passivity and that all drug-taking carries within it the threat of losing personal autonomy.

Hence, the way to break the unfortunate bond between drug-taking and political activism would seem to be for the schools courageously to enter the field of social criticism and environmental defence. The world *is* in a parlous state. Our materialistic society is in desperate need of humanizing and modifying. Now the vote has been given to eighteen-year-olds, it seems educationally obvious that the political and social realities should be opened up and discussed in our classrooms.

## Relevance of the curriculum

But the role of the curriculum in combating the lure of drugs goes deeper than the expansion of its social content. The secondary school and university students' complaint that their courses are not sufficiently 'relevant' adds a personal dimension also to the feeling that curricula are inert. 'Relevant' in this context appears to mean 'relevant to a purpose felt to be significant'. What is relevant for the student is preparation for life, as a person, a worker, a participant, a lover. Young people want to be successful in those fields of life which interest them and which they feel to be important. Schooling, not infrequently, seems to young people to be something imposed and external rather than the road to life. This creates a restlessness and dissatisfaction wihch can easily spill over into revolt. All forms of revolt and the drug scene are inevitably linked. It is not accident that the years of emergent adulthood - 15-21 - are also the years of high vulnerability to drug use.

The most profound challenge of drugs to education is the claim that 'a good trip' can give a sense of meaning to life - a perception, a vision, a sense of unity, a

comprehension of depth - more significant as an experience than anything offered by the humdrum of ordinary living. It is a chemically based experience and, therefore, induced rather than self-generated. But this does not detract from its vividness and richness while it is there, for those who have this kind of positive reaction.

[This offers a far-reaching challenge to curriculum development. To provide integration, breadth, and social content - the main purposes of much curriculum development today, and excellent in themselves - would seem to be nothing like enough. The young seek significance and fulfilment within the context of a vision of what life can and should be. They find themselves involved in purposes - and being educated to be involved in purposes - which in their heart of hearts they cannot share: purposes that are mainly economic and utilitarian and which often run counter to their ideals.]

To double the national standard of life in twenty-five years may serve as a political slogan; it is not really the sort of challenge to touch the aspirations of the young. Where does the quality of life come in? When is the grabbing for sectional interest going to stop? Who is for the sort of co-operation between the nations that alone can offer hope of a kinder, juster, more relaxed, more beautiful world? Why are there so many victims in human society? These are questions the young are asking - and often receiving a dusty answer to, or none at all. The schools cannot rest content until they have transformed secondary school education into a form which seems to the young to show real caring about the significance and purpose of life. Unless we can succeed in that, the young will increasingly refuse to identify with our aims and look elsewhere to appease their frustration - a frustration that may be aggravated by the fear of chronic unemployment.

Of course, a proportion of our schools are alert to all this and are vigorously at work reshaping the way of life they offer so that it draws young people into happy, formative co-operation as they share experiences that take them on towards self-confidence, maturity, and competent adulthood. In our autonomous British education system the future exists within the present. The problem is how to expand the best fast enough to offset the motivation crisis in our secondary schools, and the frustration and alienation that it breeds.

The young are right to resent the unacceptable. Conformity to a society that is going nowhere is spiritual death. If we want the energies of youth to be with us, then we have to bring youth into partnership in creating new and more significant ends, and in working out how we may strive together to achieve those ends. The dynamism of such endeavour could add the dimension to life which is at present missing. The young man who said 'I have given up drugs; they make me passive' had found something better than the drug experience to live for. For some,

meditation has become the way to more profound experience and involvement. The lesson of it all is plain to see: the experience of education, and of society itself, is too shallow and too utilitarian to touch young people at the core. The very existence of a drug problem warns us of how hungry we have left the young for something of enduring value in their lives.

# Appendix

## Some religious aspects of the drug scene

Rev. Simon Tugwell, O.P.

The drug scene is a very variegated phenomenon; it is perhaps misleading to talk of a drug scene at all: all kinds of people are involved, for all kinds of reasons, in the illegal use of certain drugs, and by no means all of them are socially or morally conspicuous in any other way than this. But at least some areas of the drug scene appear to call for comment from a religious point of view, if only because the people concerned tend to see themselves in a religious light.

A very obvious sign of this is the frequent denunciation and rejection of the *materialism* and the *rationalism* ascribed to our society.

Considered from this point of view alone, the psychedelic people clearly belong to a tradition going back over a century to the Romantics, with their idealisation of the Middle Ages and the non-rational. They have affinities with the theosophists, spiritualists, Pentecostals, and the widespread drift towards things occult and things oriental. Although many of these movements see themselves as harbingers and initiators of a new age, in fact they show many symptoms of being rather a relapse into primitivism (McLuhan's comments on tribalisation are pertinent). Astrology, spiritism, magic seem to be forms of religion characteristic of primitive peoples: and a preference for passion and prophecy rather than human reason would seem to threaten the very principle that distinguishes the less primitive from the more primitive.

It would be intolerably triumphalist (and rather old-fashioned) to believe that all progress away from the primitive is invariably a good thing; but equally it would be näive simply to decry all progress as one long falling away from some primal perfection. This reflection, I think, highlights at least one important ambiguity inherent in *all* modern spiritualities, whether drug-using or not: are they really helping us to recapture values and abilities that we had forgotten?

Or are they simply undoing the achievement of millennia?

A useful tool here is provided by the word *transcendence.* From any limited viewpoint, something *other* appears to be transcendent. And as such it appeals to the human spirit of adventure. And this, where it is accompanied by the complementary virtue of domesticity, is a very healthy thing. A man needs both the familiar and the exotic. But it can have an unhealthy form, in which it becomes an almost pathological inability to endure routine, familiarity, sustained effort.

It is the contention of classic Christianity that these twin needs, for the familiar and the exotic, are both satisfied to the full only in God; and in Him alone are they fully reconciled. He it is who is at once the most *homely* of all, *closer to us than we are to ourselves,* and yet also the *wholly other,* the one *known best by unknowing,* the mystery beyond all telling. In such paradoxes as these, our forefathers found infinite satisfaction, it seems.

The trouble begins when the two aspects of deity fall apart. In the zeal of her reaction against Quietism, the Roman Catholic Church more or less banished mystical experience from the lives of most of her faithful, leaving them with a religion consisting chiefly of dogmas and morals. A similar thing happened for different reasons within Protestantism. Inevitably there followed in due course the *mystical* reaction against all this dogma and morality and this produced the outcrop already mentioned, of theosophy, spiritualism, and so on.

From within a materialistic and rationalistic world-view, this reaction appears to be a real way of *transcendence*, of getting into *the other.* But in fact, all that happens is a simple inversion: what was on top is now underneath, and vice versa.

All the authentic religious traditions of mankind teach that there is a *further* transcendence that is necessary. In the famous Zen Oxherding pictures the final stage, after spiritual realisation, is the return to the market place, to ordinary life. In Augustine we find a similar thing: the mystical ascent to the heights is not sufficient by itself; the soul is *reverberated* back to the very beginning, and has to start again, precisely with the Incarnation. Pure *spirituality* itself has to be transcended; the really spiritual man is one who not only contemplates and goes into ecstasy, but also eats and drinks to the glory of God.

Similarly, all the world religions insist in their own way on the importance of doctrinal orthodoxy. Mystical, paranormal experience has to be checked by its conformity to human reason, informed by religious faith. St John of the Cross teaches that no spiritual experience is to be accepted as valid until it has been related to the spiritual director, who stands for church doctrine and human reason. Dogma, ordinary human intelligence, and mystical experience all go hand in hand. Without the dogmatic safeguard, mysticism ends up only in insanity (or at best vanity).

In so far as the use of drugs for *religious* purposes, or as an exercise in mind-expansion or exploration of *other* states of consciousness, is stopping short of this second stage of transcendence, it will not get very far in liberating individuals, in that what it gives with one hand in the activation of forgotten powers and sensations, it takes away with the other in a general devaluing of more everyday capabilities. Similarly, it will not make for a renewed and integrated society. In so far as it is chiefly a reaction against materialism and so on, a way out of a society that is felt to be simply cramping and oppressive, it does not essentially alter the situation. The reverse side of a halfpenny is no nearer than the other to being a shilling.

The challenge posed by this aspect of the drug scene is that we - and this obviously challenges the churches most especially - should seek to reintegrate the non-materialist, non-rational elements in human experience and potential, but without sacrificing human reason, and in such a way as will do full justice to man's bodiliness.

And this means for the churches freeing religion from its role as merely endorsing social conventions: religion must be more than something to hide behind. It must be now (as in the beginning) a readiness to follow the call of the unseen God to come out into the wilderness. But also a readiness to take the praeternatural in our stride, and not be unduly impressed by it. It is not amazing gifts of tongues and prophecy, fantastic generosity in almsgiving, total self-sacrifice even to the point of martyrdom, that ultimately matters: but simply that we should learn how to love (I Corinthians 13), with a love that comes from the very source of all life (poured out in our hearts by the Holy Spirit, as we say), a love that is unselfish at the very root, and so is unselfconscious and unselfseeking in its operations.

And this means learning to be simple and spontaneous, *as little children.* Perhaps the most serious objection to drug religion, as to spiritiualism, Pentecostalism, and many other -isms and movements, is that they are not quite *young* enough, but have got stuck at a gawky adolescence. Perhaps, at their core, they are, in fact, not a rebellion against our society, but simply a symptom of it; perhaps they simply show up in more acute form the basic defects of our whole generation. Whereas most of us settle down comfortably within the security of our limitations, they actually experience them as, precisely, limitations. If we would help them, we must first help ourselves; we must find, in their cri de coeur, an expression of our own radical frustration. And then together we must seek to become free, whole, and peaceful.

This suggests that certain aspects of the drug scene do have a genuine significance for religion, and that there may well be a religious solution for some parts of the drug problem; in spite of the ambiguities and dangers that I have mentioned, I

think there are people in many of the new religious movements of our day who are genuinely looking for wholeness and reality, and finding help on their way, and I am sure that we have much to learn from all these things. All the same, it must be said that we should not be unduly satisfied that drug users simply go over to other kinds of spirituality, which still stop short of what I have called the second stage of transcendence. Drug dependence can be replaced by a kind of addictive spirituality, which, in the long run, may be just as pernicious.

# 8 Social controls

Why social controls over such a personal habit as the use of drugs? Does this not belong to a private domain over which public authority has no jurisdiction? In his essay *On Liberty*, John Stuart Mill declared: 'Over himself, over his own body and mind the individual is sovereign'. He might have been speaking of the use of drugs for personal enjoyment. But even he limited his principle in application to 'human beings in the maturity of their faculties', and explicitly excluded persons under age who are in the care of others and 'must be protected against their own actions as well as against external injury'. Nevertheless, there is a private domain in which society ought not to intervene unless this can be justified as required by the public interest.

Obviously there is a public interest here as well as public responsibility for protection of the young and the specially vulnerable. For those who damage themselves by the misuse of drugs are a charge on scarce medical resources, and undermine the self-dependence that is expected of normal adult citizens: they become irresponsible or apathetic and are a burden on others. If there is misuse which has or is capable of having harmful effects sufficient to constitute a social problem (and these are words used in the Misuse of Drugs Act 1971), the non-medical use of these drugs cannot be left as merely a private choice. Forms of social control may be needed to reinforce, or even to replace, self-control where it is insufficient.

Education in the use of drugs, and education as preventive of drug dependence, are positive forms of control which help the young to achieve a discriminating reasonable use of drugs and to develop other resources with which to respond to difficulties and misfortunes. A form of control that is not deliberate works through prevailing behaviour patterns and the attitudes and opinions which are general in the society and tend to encourage, support, and normalise conforming behaviour, attitudes, and opinions. These will be reflected in and reinforced by social pressures, including advertisements. Thirdly, social control is exerted with deliberation through laws which regulate or prohibit the use of drugs.

These three forms of social control should reinforce one another, but they are liable to be in conflict. Education in the rational use of drugs may be contradicted by the behaviour norms and attitudes in society, by what parents and teachers

are seen to do. The law may seem to discriminate without rational grounds in treatment of the use of different non-medical drugs, so that the privation or interference affects unfairly one class of users. Any coherent social policy demands an attempt to harmonize these different forms of control, so that they do indeed reinforce one another.

In particular, the law is a normalising and reinforcing agency with marginal effect, and runs grave social risks if used in a democracy to seek to impose changes of behaviour on a large scale. So far as the law limits or regulates the use of drugs, as in the case of tobacco and alcohol, or by the new regulations on the issue of prescriptions containing controlled drugs, this is a form of legal control which is thought to reduce consumption without witholding the drugs from those who want them or, in the case of prescriptions, need them. The control of a drug by prohibition is different in principle, for it makes the mere possession or use of the drug a criminal act; and insofar as a substantial minority want to use the drug, or are criminally using it, the majority of their fellow citizens are trespassing upon their private lives - the very situation which alarmed Mill as a possibility. This majority, it may be suspected, are not very clear about what is being done in their name; nor of what would be involved in any alternative. First, a reminder of what the law is.

In respect of drugs subject to the Single Convention on Narcotic Drugs, 1961, including cannabis, the United Kingdom, as a Party to the Convention, is bound to impose certain minimum controls. The whole of the Convention is based on the concept that the use of the controlled drugs should be limited to medical and scientific purposes, and so far as possession by members of the general public is concerned the following specific requirements apply:

i Article 30. 'The Parties shall . . . require medical prescriptions for the supply or dispensation of drugs to individuals.'
ii Article 33. 'The Parties shall not permit the possession of drugs except under legal authority.'

As regards all the controlled drugs except the naturally occuring ones (opium, coca leaves, and cannabis), these two requirements are met by granting legal authority to persons to be in possession of drugs which have been lawfully supplied to them on prescription. However, no such provision has ever been made in respect of the naturally occurring drugs, since they have never been used therapeutically in the unprocessed state in this country, and they cannot, therefore, be prescribed by doctors or lawfully possessed by members of the general public.

Consequently, short of amendment or denuniciation of the Convention there is doubtful possibility of legalising non-medical use of cannabis or any other

controlled drug. Nevertheless, there is a discretion as to penalties. Article 36 requires that any action contrary to the provisions of the Convention 'shall be punishable offences when committed intentionally, and that serious offences shall be liable to adequate punishment particularly by imprisonment or other penalties of deprivation of liberty'. It would thus be perfectly possible for a Party to decide that unauthorised possession of controlled drugs for personal use was not a serious offence and should be subject to a minimal penalty.

As regards the hallucinogens, such as LSD, stimulants, such as the amphetamines, and other drugs acting on the central nervous system, there are no binding international obligations until such time as the Convention on Psychotropic Drugs, 1971, comes into force after ratification by the necessary 40 countries. This will then require the most stringent controls to be applied to the hallucinogens and stimulants, but again penalties in respect of unauthorised possession for personal use would be at the discretion of each Party.

The Misuse of Drugs Act, 1971 (which came into force on 1 July 1973) repeals the Drugs (Prevention of Misuse) Act, 1964, the Dangerous Drugs Act, 1965, and the Dangerous Drugs Act, 1967. In Schedule 2, the Act lists a large number of *controlled* drugs in three categories. A includes cocaine, methadone, opium, mescaline, and LSD. B includes cannabis, cannabis resin, and amphetamine. C lists benzphetamine, chlorphentermine, methaqualone, and seven others. Importation and exportation of controlled drugs is prohibited, and it is unlawful to produce, supply, or offer controlled drugs or to have them in possession, unless produced or prescribed for medical or scientific purposes under specific regulations (as recently in the case of cannabis). The Act is enforceable by powers given to the police to search and obtain evidence. The Act increases the penalties provided under the Customs & Excise Act, 1952, and allows a maximum of 12 months imprisonment and £400 fine on summary conviction of production or supplying or possession with intent to supply any drug in lists A or B; on indictment for these offences, the maximum penalty is 14 years imprisonment or a fine or both. Possession of any drug in list B carries a liability to 6 months imprisonment and £400 fine on summary conviction, 5 years on indictment. The penalty allowed on summary conviction of producing, supplying, possessing, or possessing with intent to supply any drug in list C is six months imprisonment or £200 fine or both; on indictment, 5 years or a fine or both for production or supplying or possession with intent to supply; for possession, 2 years or a fine or both. *Misuse* in the title of the Act is defined as misuse by taking a *controlled* drug by self-administration.

If a Party to the Single Convention on Narcotic Drugs, 1961, did decide that unauthorised possession of a controlled drug for personal use was not a serious offence and should be subject to a minimal penalty, like the fine for unauthorised

parking, the decision would of course destroy the logic of the law and make it indefensible: use of the drug would not be a serious offence, but the means by which it was made possible would be. In practice, anyhow, it is hardly possible to discriminate between consumer and *pusher.* Smuggling of course could be penalised independently. To enact stringent controls and be chary in enforcing them condones lawlessness and is, again, indefensible. There is in effect no law unless there is an effective law. What is an effective law, and how effective can it be in this case?

If the law is clear and the penalties for infringement are deterrent and it is strictly enforced, provided the public are behind it, the law can control behaviour. In this case, the law can and does reduce the availability and consumption of the controlled drugs. Even the liquor laws under Prohibition in the USA did strikingly reduce consumption. Of course a great deal gets through, and the demand for the prohibited drugs establishes an organised criminal underground traffic. Thus there is a sizeable unlawful moderate, probably harmless, consumption of prohibited drugs, with some heavy, probably multiple, consumption that is harmful. A minority who mean to have them get their drugs, but they get them in undesirable ways, and are alienated by the law. For many young people the differential attitude to tobacco and cannabis is itself a source of alienation from the law. The known serious damage done by smoking still leaves every shopping centre well endowed with outlets, and engages the government only to the extent of issuing health warnings, while the questionably harmful effects of cannabis are met by a total ban on distribution and heavy penalties for possession and use.

This alienated minority is mainly a minority of young people, an important minority. They are deprived of lawful access to drugs they deem beneficial. Theirs are the careers liable to be affected by convictions. Experimentation with legally forbidden drugs makes it difficult for young people to discuss it with parents or teachers because they are guilty of a criminal offence; and parents or teachers or club leaders who receive confidences may feel that they are required to inform the police. Once the police are informed, the matter is in their hands and not in the hands of parents or teachers or club leaders. The police are responsible for enforcement of the law, and are bound to interfere and search for evidence and in so doing can hardly avoid a certain amount of harassment. But the young feel strongly that they are singled out for particular harassment. Colourful clothes and long hair, they feel, incite the police to action, whereas 'straight' clothes and trimmed hair assure freedom from police attention. This has gone a long way to destroy trust in the police among the young. It leads on easily to treating law as a tool of the Establishment - something to be despised, not respected.

respected.

Is this too high a social cost for this form of control with its limited effectiveness? Repeal of the law against, say, cannabis, apart from international complications, would be not easily reversible and would have consequences for which the community would have to be prepared. The use of the drug would become more widespread, and the increase in quantity available would mean increase in some heavy cumulatively-harmful consumption as well as more relatively harmless consumption. Unless cannabis of whatever kind were to be left freely available, decisions would have to be taken on the nature, extent, and manner of government control or supervision. Whether there is total prohibition as at present, limited control and regulation, or total freedom, there are pros and cons, problems and uncertainties, which should be seen and weighed in the full context of social cost and benefit. The social responsibility for the policy, and for the conditions on which it rests, is shared by all in a democratic state.

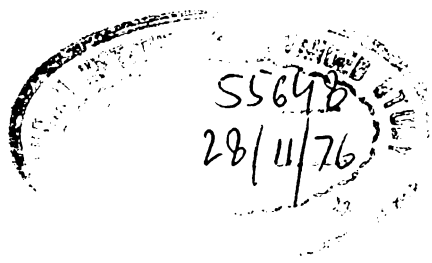
There is another aspect of law effectiveness in a democracy which ought to be taken into account: appeasement of a worried, anxious, or angry public. This may become necessary if the problem seems to be getting out of hand; and there is a passage to the point in the Task Force Report of the President's Commission on Law Enforcement and the Administration of Justice which was published in the USA in 1967:

> 'The other matter is that the apparent satisfaction produced by passing a criminal law directed at drug users must have some social function, perhaps it does at least alleviate public anxiety or allow one to single out for punishment at least someone who represents the bad thing happening. If that is the case, then any revisions in handling drug users which focussed only on users and on the fact of risk, but which failed to realise the intensity of public worry, and perhaps satisfaction with punitive approaches, might well generate further troubles - this time not for drug users but for the public deprived of at least this form of expression.'

In other words, the law is also a form of social control over emotional reactions of the public.

If education in the discriminate use of drugs, and education for the full development of the person, were entirely successful, so that non-medical drugs were in moderate use that was more beneficial than harmful, obviously there would be no social problem and no need to ban nor stringently control the use of drugs; those who damaged themselves by excessive use would be few, and could be helped. Prevailing example would maintain moderate use as normal. Education in its general content, and by special programmes, should contribute to this possibility, however contradictory the other forms of social control

may be. But until the three forms of social control do reinforce one another, there is not only a social problem, but also social immorality.



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Education and drug dependence

Is dependence 'a dirty word' or 'a condition of humanity'? At what point does it become dangerous? Is our society too intolerant of the need for drugs, including drink and tobacco, or too permissive? The Social Morality Council's report points the way to an attitude 'free from hypocrisy and at the same time plainly and practically directed to human benefit and the prevention of misery and waste'.

Valuable work is continually done on the treatment of addicts. This report starts a stage farther back, by asking what attitudes in schools and homes make drug dependence a danger at all and how the danger can be minimised.

It is 'neither a handbook nor a work of research'. Neither was it produced by do-gooders without expertise or practical knowledge. Several contributors are working teachers (some of them also parents). Another is a doctor who is perhaps the leading expert on narcotic addiction. Evidence was taken from young people with past experience of 'pot' or LSD. 'The purpose of drug education is to enable people to make up their own minds on the basis of adequate information.'

Many who took part in the study had never met before. The SMC, which sponsored it, 'exists to promote the kind of consensus between people of differing or conflicting views which makes moral progress in a plural society possible'. Its recently published report, *The Future of Broadcasting,* had the same object. Both reports are seen as resource material for the SMC's national Moral Education Project, launched a year ago with both Government and Opposition support.

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